NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 27 November 2015 at 10:00 a.m.
Committee Room 1, Barnet Town Hall, The Burroughs, Hendon, London NW4 2ER

1. NC LONDON JHOSC - AGENDA PACK (PAGES 1 - 102)

2. NC LONDON JHOSC - SUPPLEMENTARY AGENDA (PAGES 103 - 120)

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 Agenda Item 1

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 27 NOVEMBER 2015 AT 10.00 AM
COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

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MEMBERS

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)

Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Danny Beales (LB Camden)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Jean Kaseki (LB Islington)

Issued on: Wednesday, 18th November 2015

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 27 NOVEMBER 2015

THERE ARE NO PART II REPORTS

AGENDA

Wards

1. APOLOGIES

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

3. ANNOUNCEMENTS

4. NOTIFICATIONS OF ANY ITEMS OF URGENT BUSINESS

5. MINUTES

(Pages 5 - 14)

To consider the minutes of the meeting held on 25th September 2015.

6. DEPUTATIONS

7. PRIMARY CARE UPDATE ON THE "CASE FOR CHANGE"

(Pages 15 - 48)

To consider a presentation on the Primary Care “Case for Change”.

8. JHOSC: FUTURE STRATEGIC ROLE

(Pages 49 - 58)

To consider a paper on the future strategic role of the North Central London JHOSC.

9. NHS 111/OUT OF HOURS GP SERVICES - COMMISSIONING

To consider NHS 111/Out of Hours commissioning.

INFORMATION TO FOLLOW

10. STROKE PATHWAYS

(Pages 59 -

100)

To consider a presentation from Professor Rudd on stroke pathways.

11. WORK PROGRAMME

(Pages 101 - 102)

To consider the future work programme for the Committee.

12. DATES OF FUTURE MEETINGS

Future meetings of the North Central London Joint Health Overview and Scrutiny Committee will be on:

- Friday, 29th January 2016 at 10am at Enfield Civic Centre
- Friday, 11th March 2016 at 10am at Camden Town Hall

13. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

AGENDA ENDS

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North Central London Sector Joint Health Overview and Scrutiny Committee

25 September 2015

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held at Haringey Civic Centre on 25 September 2014

Present

Councillors	**Borough**
Alison Kelly (Chair)	LB Camden
Pippa Connor (Vice Chair)	LB Haringey
Martin Klute (Vice Chair)	LB Islington
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Abdul Abdullahi	LB Enfield
Anne-Marie Pearce	LB Enfield
Charles Wright	LB Haringey
Jean-Roger Kaseki	LB Islington

1. WELCOME AND APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Danny Beales (LB Camden).

2. DECLARATIONS OF INTEREST

The following personal interests were declared:

- Councillor Kaseki declared that he was a governor of Camden and Islington NHS Foundation Trust;
- Councillor Connor declared that her sister was a GP; and
- Councillor Cornelius declared that she was an Assistant Chaplain at Barnet Hospital.

3. URGENT BUSINESS

None.

4. MINUTES OF PREVIOUS MEETING

The Chair reported she had asked for a meeting to be arranged between her and David Fish, the Managing Director of UCL Partners and asked that this be arranged. She stated that she had been very impressed with their work.

RESOLVED:

1. That the minutes of the meeting of 26 June be approved; and

2. That a meeting be arranged between the Chair and the Managing Director of UCL Partners.

5. NORTH CENTRAL LONDON CCG STRATEGIC PLANNING GROUP: ANALYSIS AND RECOMMENDATIONS FOR DEVELOPING A FIVE-YEAR STRATEGIC PLAN

The Chair expressed her disappointment at the lack of a written report on this item.

Dr Debbie Frost, Chair of Barnet CCG and the North Central London CCG Strategic Planning Group, and Paul Jenkins, the Chief Officer of Enfield CCG, reported on progress with the development of a five year strategic plan for the north central London area.

She emphasised that the plan was not concerned with changing things that were best done locally. The NHS in north central London was facing a deficit of £800 million over the next five years. The deficit was still likely to be £400 million after all the various current plans and programmes to address the issue had been implemented. Transformational change was therefore needed. However, it was important that proposals for change were clinically driven. Consultants had been asked to lead on this work and wide engagement had taken place.

There were a number of challenges facing NHS services in the area;

- 60% of the NHS commissioning budget for the area was currently spent on acute hospitals.
- There was a wide diversity of health outcomes.
- The prevalence of mental ill health in the area was the highest in the UK and despite this, a comparatively low level of resources were allocated to treating it and its causes.
- A lot of services were not providing care of a high quality and too many people were going to Accident and Emergency (A&E).

In response to these, the CCGs had looked at a number of key areas in detail;

- Urgent care; Work to develop standardised pathways was being undertaken.
- Right treatment, right place; Primary care needed to be transformed. GPs in all CCGs needed to work together in networks and collaborate.
- Mental health, including child and adolescent mental health services (CAMHS); 12% of resources were spent on this, which was not enough. Parity was needed with provision for physical health. Reductions also needed to be achieved in the number of patients treated as in-patients.
- Estates transformation; 15% of estates were not currently fully utilised.

The next steps would be engagement with local authorities and providers. A specific director and a Clinical Advisory Group would also be appointed to lead the process.

It was hoped that the process would lead to a seamless system of health care, where patients could be confident of receiving high quality services. In addition,

a disproportionate amount of funding would no longer be used up by acute hospitals, leaving enough left over for preventative work.

The Chair stated that it was important that local communities were involved in this process. In particular, local authorities could play a crucial role in taking this forward. Dr Frost acknowledged this and stated that Health and Wellbeing Boards could be used for this purpose as they had the potential to provide a new aspect to preventative work.

In response to questions from Committee Members, Dr Frost and Mr Jenkins stated the following:

- A briefing would be prepared for Committee Members on the Carnall Farrar report. The report was succinct in format and there was no desire to be secretive about it.

- Projects to be undertaken as part of the process aimed to save more than £400 million.

- Approximately 60% of NHS resources locally were used up by acute hospitals, which was too much. Clear pathways needed to be developed which were shared with patients. These needed to be consistent with NICE guidelines and evidence based.

- 7 day access to GPs was to be introduced but the precise details of how this would be implemented had yet to be finalised. It was nevertheless unlikely that patients would be able to see their own GP as part of this although access would probably be through current GP surgeries.

Committee Members expressed concern that they had not been fully appraised of the outcome of the Carnall-Farrar Review. Mr Jenkins stated that there was no intention to be secretive and agreed to provide access to the report. The process was intended to signal the start of a conversation with stakeholders.

The Committee noted that the savings that were required as part of this process were of the magnitude of approximately 20%. Mr Jenkins reported that each CCG would have a process for taking forward decisions made as part of the implementation of the plan. Common issues would be addressed jointly whilst other issues could be dealt with locally.

Dr Frost reported that there was no target for how much the percentage share of funding allocated to mental health was likely to increase to, but it was a priority to invest to ensure better outcomes. There was a need to ensure that people got timely access to services. In terms of the future development of CCGs in the area, whilst greater collaboration was likely to take place, each borough was different and had an individual relationship with its local authority. There was no wish to damage what was already working well.

RESOLVED:

1. That the issue of NHS estates strategy be put on the future work plan for the Committee; and

2. That the report arising from the Carnall Farrar review of the demand pressures in the local North Central London (NCL) health system and the associated financial implications over the next five years be shared with the Committee.

6. JOINT ACTION BY NHS ACUTE TRUSTS, CCGS, LOCAL AUTHORITIES AND OTHER ORGANISATIONS TO REDUCE A&E ATTENDANCE

The Chair commented that the issues referred to in the presentation were very medicalised in nature. Local authorities could play a key role in reducing A&E attendance. She had hoped that there would have been reference to work with care homes. The felt that the focus needed to be more on helping patients to avoid getting into the system rather than dealing with them quicker.

Paul Jenkins, the Chief Officer from Enfield CCG, reported on joint strategic planning by the CCGs in the area to reduce A&E attendance. There were likely to be significant challenges this year. Plans to address winter pressure last year had not been as successful as had been hoped. However, demand had been higher than expected across the whole of London.

Health services were working towards a 7 day service. A&E attendances up to July showed a changeable picture. Two acute hospitals – the North Middlesex and the Whittington – had faced particular challenge last winter. All relevant NHS organisations were currently working on plans for the forthcoming year. There would be £9 million additional money available in addition to funding that had already been identified. There would be particular focus on improving primary care access in Barnet and Enfield. An urgent and emergency care network would also be developed. In addition, a "Stay Well this Winter" campaign would be launched. A winter resilience workshop would be held to refine plans before they were finalised in October.

The Chair commented that it was important that plans were put in place in good time, which was the reason why the Committee had asked for a report at this time.

In response to questions, the Committee noted the following:

- Improving access to primary care was important as poor access was one reason why people went to A&E. There was a perception amongst some people that they would be seen quicker. Additional GP appointments were to be offered every day in order to improve access and reduce the likelihood of people going instead to A&E.

- Access to hospital social workers at weekends was to be improved in order to speed up the discharge of patients who were fit to go home. There was a particular programme focussing on discharge planning.

- Enfield had seen the biggest improvements in access to primary care in the area. Specific work had been undertaken with NHS England to address this issue. In addition, further work was taking place to transform primary care. Work was also being undertaken by individual CCGs to provide support for care homes. Each individual care home was linked to a specific GP. All CCGs had slightly different approaches to dealing with the issue.

- It was unclear why the North Middlesex and the Whittington hospitals had been struggling to deal with the demand for A&E services. A lot of work had been undertaken by the hospitals and they had also received external support. In particular, efforts were being undertaken to determine the reasons for the problems. However, there were similar patterns across London with some hospitals being successful whilst others were struggling. It was not just about A&E but was a whole systems issue.

- 15,000 additional GP appointments were to be offered across Barnet and Enfield. This was a six month pilot project and its results would be assessed to determine its impact on A&E attendance. In addition, extended appointments would be offered in all five boroughs to patients who required them.

- It was not always the number attending A&E that was the cause of problems. Sometimes there were staffing issues that could impact on waiting times. Additional funding had been received too late last year for recruitment of additional staff to take place in time. Action had been taken this year to ensure all relevant trusts knew what funding was available in good time.

RESOLVED:

That a further report by the CCGs outlining the outcome of joint plans to reduce A&E attendance during the winter period be submitted to the March meeting of the Committee and that this include specific reference to how local authorities had been involved in the plans.

7. PROCUREMENT OF NHS 111/OUT OF HOURS GP SERVICES

The Committee agreed to receive a deputation from Keep Our NHS Public on this issue and was addressed by Janet Shapiro and John Lipetz. The issues that they raised included the following:

- It was proposed that the contract would be long term in nature. However, there were still areas of uncertainty that could impact on the specification, including quality standards. In addition, it was intended that GP services would now be available 7 days per week. It might therefore be better if the CCGs were to delay the procurement until there was greater clarity

- CCGs had been found to be better at monitoring contracts on a smaller scale. The current system of each borough procuring their own contract for out-of-hours services had proven to be robust. Procurement of a contract that covered all five boroughs would ensure that a private provider was appointed

whilst the existing arrangements gave local GPs the opportunity to bid successfully.

- There was a lack of provision for effective monitoring of the contract. The CCGs did not have the internal capacity to undertake this satisfactorily. In addition, exit terms were not defined within the contract specification.

- The response rate to the engagement process had been very low. A request for a full public consultation on the issue had been turned down.

In the light of the above, they felt that the Committee should recommend that the proposed procurement should not proceed.

Dr Sam Shah (Clinical Lead), Paul Jenkins (Enfield CCG Chief Officer), Dr Denise Bavin (Camden CCG), Dr Josephine Sauvage (Islington CCG), Dr Debbie Frost (Barnet CCG), Dr Hardeep Bhupal (Enfield CCG) and Pauline Taylor (Haringey CCG) reported on progress with the procurement process.

Dr Sauvage stated that she welcomed the value that was placed on local NHS services. A range of engagement had taken place with relevant local authorities, which had included discussion at Health and Wellbeing Boards. There had also been some engagement at local health overview and scrutiny committees as well as with the JHOSC.

There had been a lot of change within the NHS and this had made the procurement process more complex. A review had taken place within Camden and Islington of why patients were presenting at urgent care services and the problems that they faced. The results of this 'Urgent Care Review' had been incorporated into the procurement process and the specification that had been developed. It was acknowledged that clear and coherent monitoring was required and the contract specification remained a work in progress. A number of comments had been received on it since it had been published. Many comments had been reflected in changes made to the specification and these changes could be tracked in the revised document. Where comments had not resulted in changes, these had also been logged, with clear reasons as to why.

The existing NHS 111 service was contracted to provide services across the five boroughs. Out of hours services had been procured separately, representing different borough groupings. There were two different providers – Care UK in Camden and Islington and Barndoc in Barnet, Enfield and Haringey.

In reply to the suggestion that smaller local contracts would better enable local provider participation, Dr Sauvage said there was a need to be prudent in respect of future funding streams and ensure that services were sustainable and provided value for money. There was a history of the five boroughs working together and collaboration between them was increasing. Joint working would help to address inequities across the area and would provide a means of bringing existing local NHS organisations together as part of a bigger 'whole-system approach. She felt that the CCGs had the capacity to monitor the contract effectively. The

specification was clear about working with local providers. The new contract would help to address cross border issues more effectively.

In answer to questions, Dr Sauvage stated that she understood the need to 'future-proof' the contract. There was a changing landscape and any contract was likely to need to have the flexibility respond accordingly. It was not possible to be prescriptive regarding the preferred delivery structure or groupings during the procurement process as this might be considered to be restrictive. Evidence of local understanding and engagement with the community by service providers was nevertheless to be valued, as would evidence of integration within the local provision of services.

Dr Shah stated that the CCGs wanted the flexibility within the contract to adapt to changing circumstances. He felt that it was unlikely that one provider would take on the whole of the contract. The aim was to ensure that services were integrated and providers were already having discussions on how this could best be achieved. There was no intention to restrict the range of organisations that could apply.

Dr Bavin stated that the CCGs wanted to get away from focussing on structures and wished instead to concentrate more on outcomes. Dr Sauvage reported that there were already existing structures to monitor performance. For example, the 111 contract was monitored via the North and East London Commissioning Support Unit, with the involvement of the CCGs. There was an established collaborative process for this that included scrutiny of quality, safety and patient experience, as well as performance against key metrics.

In respect of contract monitoring, Dr Sauvage reported that they were awaiting the outcome of a national piece of work on quality standards. Once this had been received, it would be possible to be more prescriptive within the contract specification. Dr Shah commented that local as well as national key performance indicators would be used. These could be modified and the CCGs were happy to work with patient groups to determine what these might be.

In answer to questions regarding new national quality standards, Dr Shah stated that NHS England was aiming to promote more consistent service models. However, there were already a number of tried and tested national standards in use. Providers would be required to work with commissioners to develop further the quality standards. Dr Sauvage acknowledged that there was a risk of a provider failing and provision to mitigate the effects of this would need to be made within the contract. There were mechanisms within the NHS to assist in such circumstances.

There was also a requirement for a GP to be involved in monitoring the service and the need for clinical leadership was acknowledged.

Mr Lipetz reported that the proposals to link the 111 and Out-of-hours services were supported. However, he felt that the question of why there had not been public consultation had remained unanswered. There had also not been an opportunity to see the monitoring arrangements. In addition, the procurement

was taking place at a time when federations of GPs and national quality standards were under development. He did not think a case had been made for the contract to be procured across the five boroughs. There were also concerns about the management structure and whether the contract could be controlled in a satisfactory manner.

The Committee noted that there were processes to ensure that there were no conflicts of interest in the procurement process involving GPs. Committee Members were of the view that there was a strong case for bringing 111 and Out-of-hours services together. However, there were some differences between the needs of different boroughs which needed to be addressed. It was noted that the Pre-Qualification Questionnaire part of the process was due to take place in October and the timing of this would enable the national quality standards to be taken into account.

RESOLVED:

That a further report be submitted by the CCGs to the next meeting of the Committee on progress highlighting the following key areas of interest within the specification:

- How commissioners will undertake monitoring and, in particular, obtain relevant performance information;
- Key performance indicators; and
- Differences between individual boroughs.

8. WORK PLAN AND DATES FOR FUTURE MEETINGS

It was noted that facilities for web casting of meetings were only available in Haringey and Camden and that these were dependent on the appropriate accommodation and resources being available.

RESOLVED:

1. That the agenda items for the next meeting, which is to be held on 27 November at Barnet, be as follows:
   - Stroke Pathways;
   - Primary Care Update on the “Case for Change”;
   - NHS 111/OOH GP Services – Commissioning; and
   - JHOSC; Future strategic Role

2. The further meetings be scheduled for:
   - 29 January 2016 (Enfield); and
   - 11 March 2016 (Camden).

3. That the issues of maternity, the new models for Child and Adolescent Mental Health Services and mental health services, including how additional funding will be spent, be added to the work plan.

Alison Kelly
Chair

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NHS
Barnet Clinical Commissioning Group

NHS
Camden
Clinical Commissioning Group

NHS
Enfield
Clinical Commissioning Group

NHS
Haringey
Clinical Commissioning Group

NHS
Islington
Clinical Commissioning Group

NCL Joint Health Overview and Scrutiny Committee

Primary Care Update

November 2015

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London Transforming Primary Care Programme

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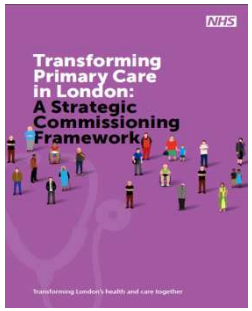
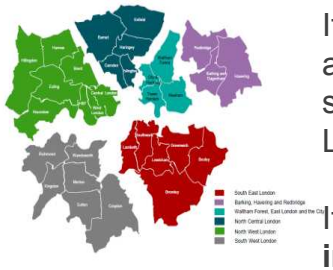
TPC – what have we done so far?



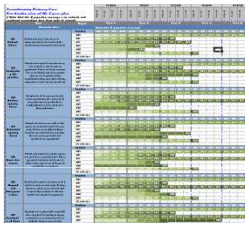
The **Strategic Commissioning Framework** was published in March 2015 and outlines a **vision of consistently high quality Primary care.**

We have had **engagement with over 1,500 stakeholders**, and all areas of London have agreed to this vision



It has been **supported across London**, and is being implemented with the support of local resources and a pan London Transformation team

It is expected that this vision will be **implemented over the next ~5 years**



We have developed pan London five year plans, and early indicators say we can expect 90% delivery of:

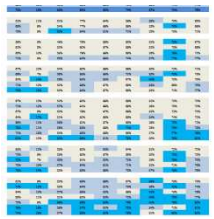
- Accessible care by **April 2018**
- Coordinated care by **April 2018**
- Proactive care by **April 2019**

Held four events, and have another two planned for 15/16:

- **3rd Jul** - Commissioner's workshop
- **15th Jul** - Transforming Primary Care "Into Action"
- **1st Oct –** Access Event
- **4th Nov** - Provider Development Launch
- **Jan** - Coordinated care
- **Mar -** Proactive care

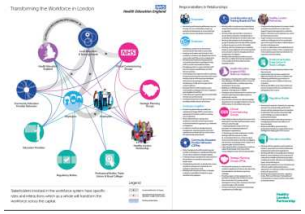
PMCF has accelerated delivery in some areas:

- ✓ The 700,000 patients in BHR have the opportunity to see a GP in the evenings between 6.30pm and 10pm via primary care hubs
- ✓ In SEL 305,000 patients have 8am-8pm,7 days a week access to general practice via new hubs
- ✓ In NWL over 1.4m patients are benefiting from extended access through provider networks



Co-designed a set of draft measures, with local primary care teams and SPG clinical leads to support us to monitor and evaluate the success of the programme *(to be finalised in November)*

Established **the Innovation Group**, including creation of a network of change champions from multi-disciplines across London



Published **a Transforming the Workforce in London infographic**, in partnership with Heath Education England, to illustrate the roles and responsibilities of the key stakeholders in the system

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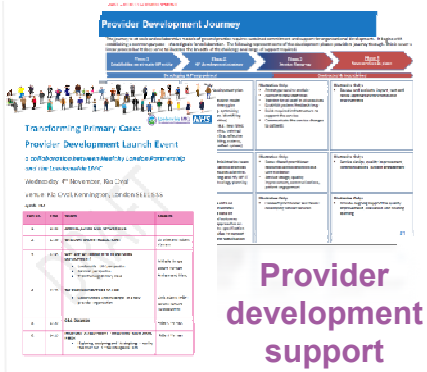
TPC – what are we doing now?

NHS England Programme Reviews

- Developmental sessions with SPGs, HLP and NHSE to ensure that **the delivery plans are robust** and that there is sufficient clarity to achieve the estimated delivery dates. These will support our readiness to baseline the plans.



Provider development support

- **Launched the Provider Development support function** on 4th November, including the provider development tool. This support function will include 1:2:1 meetings with each at scale provider.

Co-commissioning support

- Supporting the local commissioners and NHS England London to move to, and effectively utilise, the new co-commissioning arrangements

Estates

- CCGs are developing **strategic estates plans** by December 2015
- A list of **reserve schemes** have been identified to support greater utilisation of PCIF and there is discussion regarding the **most effective use of the PCIF funds in 15/16**

Technology

- Supporting SPGs in business case development for at scale delivery of Patient Online deliverables
- Engaging with practice manager forums and local CCG GPIT providers to support Patient Online delivery.
- Distribution of Patient Online utilisation trends, capability delivery, and patient activation levels
- Exploring opportunities to utilise PCIF to accelerate improvements in technology

Workforce

- Continued **focus on key challenges** by the Workforce programme and the Primary Care Programme

Innovation Group

- Developing an online discussion forum for the Innovation group to share ideas and best practice, as well as discuss challenges.

- Working with Local Authorities, LMC, LETBs and others through a Strategic Oversight Group to ensure good integration and shared approaches

Sharing best practice

- Sharing examples of best practice delivery across London and providing examples of "what good looks like" for accessible, coordinated and proactive care.

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NCL Vision & Strategy

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NCL Vision & Strategy

Our vision for NCL is an integrated care network of organisations focused on outcomes and shaped by patients.

Case for Change

- Health of NCL's population continues to improve, but inequalities still persist;
- Our health services have many strengths, but quality remains unacceptably variable;
- The 'do nothing' scenario is unsustainable and will deliver a financial gap of £408m in 2020/21 (post QIPP and CIP).

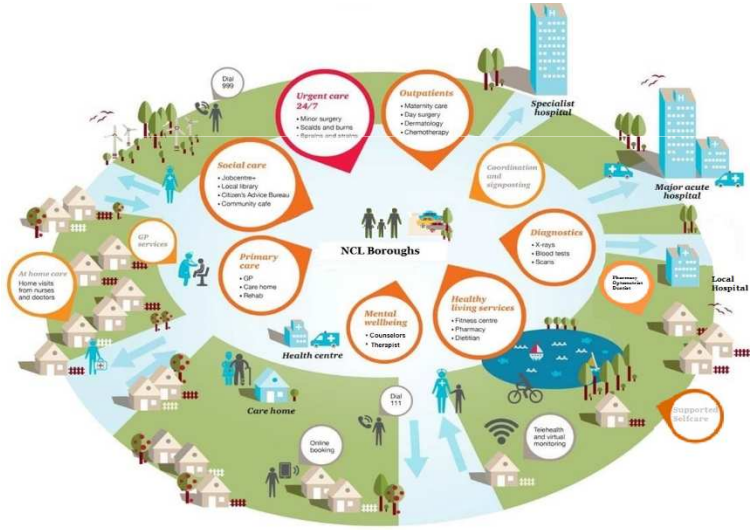

Illustration of the NCL integrated care network of organisations focused on outcomes and shaped by patients

This includes:

- Patients at the centre of a high quality clinically led, integrated care system that is effectively delivered to ensure a financially sustainable health economy.
- Clinically-led commissioning defined and measured by outcomes not input/output process
- Strong leadership, responsibility and accountability at all levels within our member practices and governing bodies, across the local health economy and across all patients.

We have developed a collaborative strategy to deliver our vision.

To address the challenging clinical demand landscape and remaining financial gap, NCL commissioners, providers and Local Authorities must work together and at a bigger scale. Four key programmes have been identified for working together:

1.Acute services redesign: starting with urgent and emergency care

2.Mental health: starting with on transforming inpatient care

3.Pathways: starting with primary care (£6m committed in 15/16)

4.System wide enablers: starting with estates

NCL commissioners have demonstrated strong commitment to work together, already forming a Collaboration Board to work jointly on programmes of work (covering £250M in spend).

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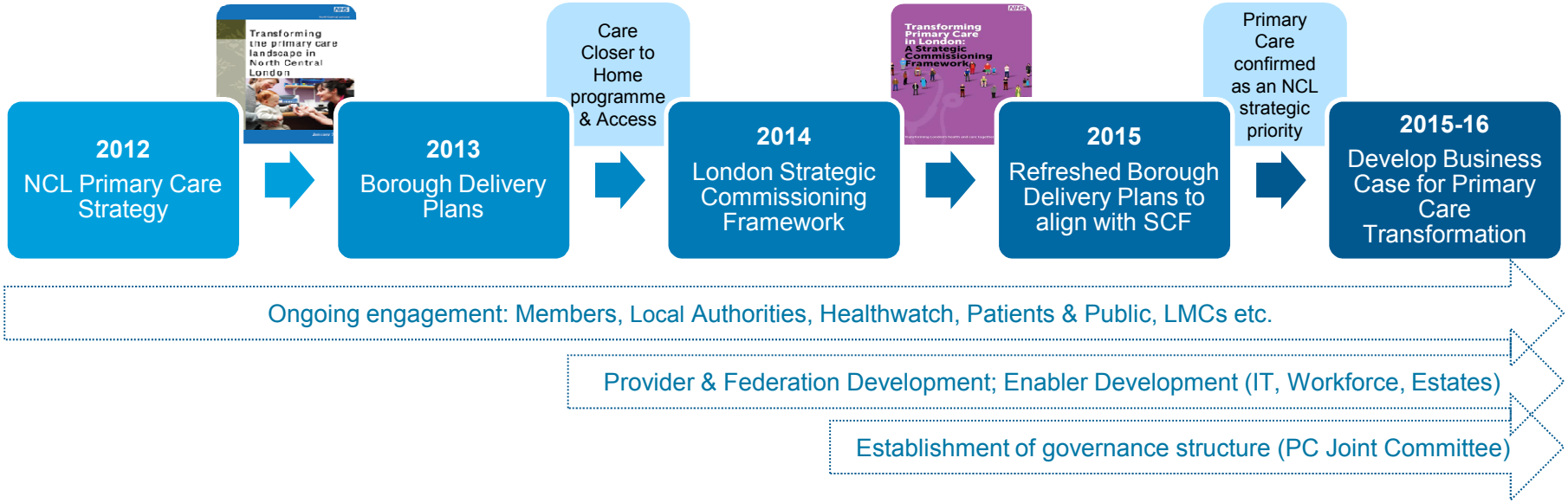
NCL Primary Care Strategy Development

NCL CCGs have a strong history of collaboration on Primary Care



2012: NCL Primary Care Strategy adopted to improving quality and reduce variation. 3 year investment funded by pooled NCL monies.

2013: Borough Delivery Plans adopted by CCGs as they take over from PCTs.

2014: NCL CCGs sign up to SCF and agree to develop Joint Committee with NHS England to start aligning the commissioning system.

2015: Draft SCF implementation plans are benchmarked against London. Deep dive challenge sessions carried out with each CCG.

2015 - 16: Business case development for NCL Primary Care Transformation using GP baseline survey data; financial modelling and primary care evidence base. This will tie in with the national planning process.

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NCL Value Based Commissioning

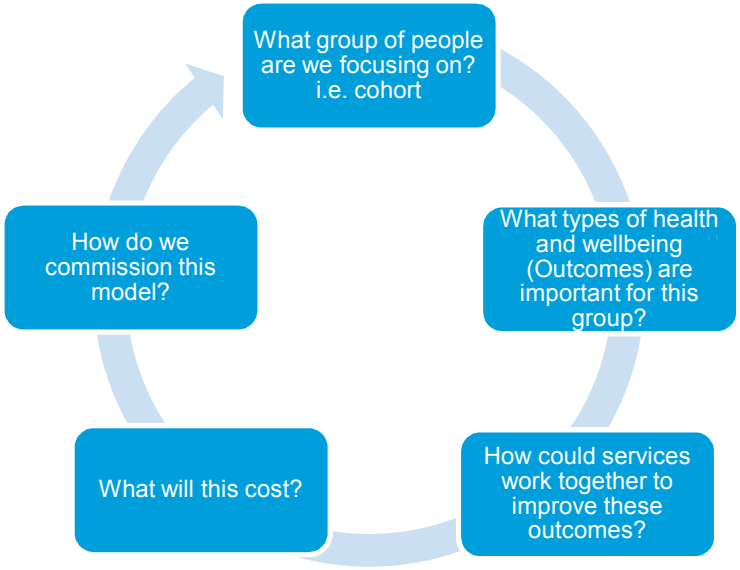
NCL CCGs have been modelling Value Based Commissioning (VBC).

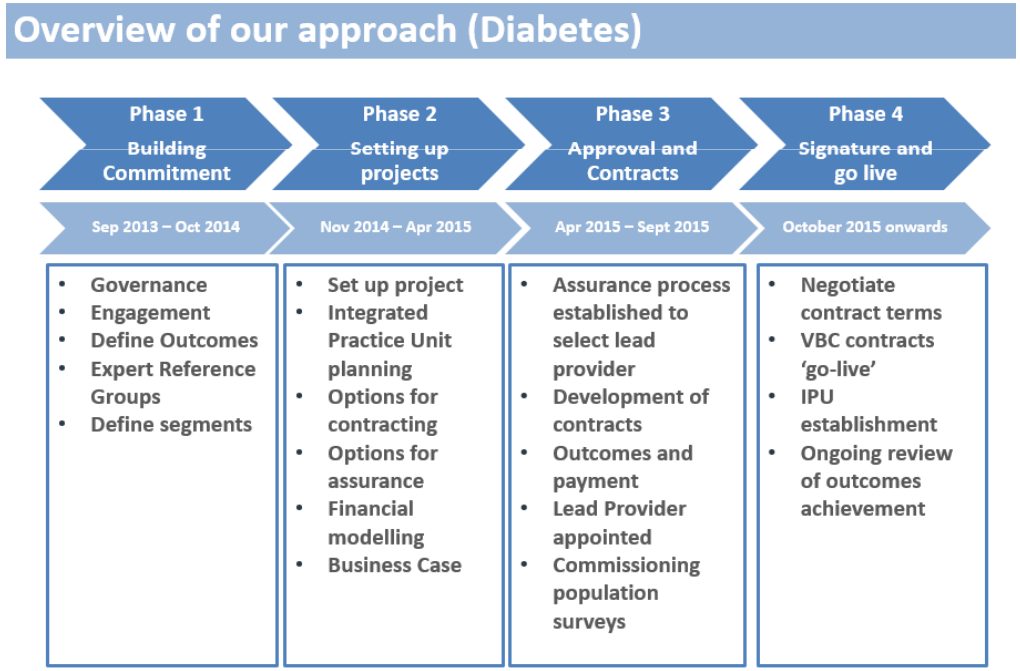
1

Agreeing between patients, providers and commissioners the health outcomes that are priorities for a particular patient group.

2

Aligning provider incentives to base a proportion of payment on collective achievement of priority outcomes and thus driving increased integration between providers.





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Delivering the Strategic Commissioning Framework in NCL

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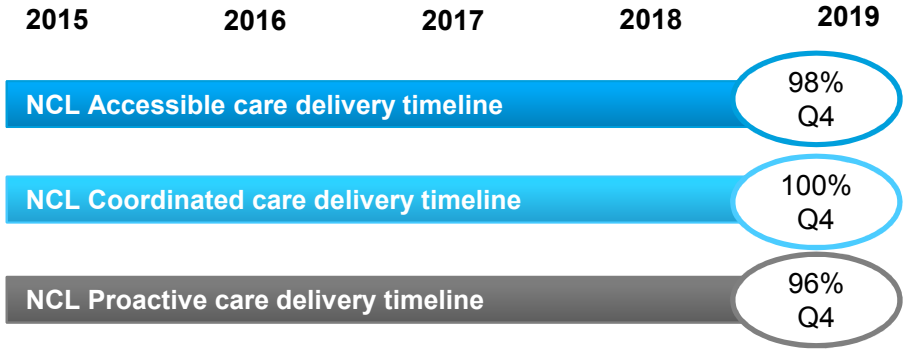
NCL Plan for delivering the London Strategic Commissioning Framework

NCL CCGs have been working to develop borough level implementation plans for delivering the London Strategic Commissioning Framework within the next five years.



Highlights of 15/16 delivery

- NCL GP Baseline Survey (Oct/Nov)
- CCG Estates Strategies (Dec)
- Barnet – CCG developing an access hub to increase pre-bookable appointments (8-8 and weekends).
- Camden – CCG & Federation developing business case for 8-8 access, 7 days a week
- Enfield – Two Primary Care Urgent Access Hub pilots (Oct – Jan)
- Haringey – Extended Hours Saturday clinics pilot.
- Islington - IHUB gone live offering 8-8 appointments 7 days a week (Oct)

Highlights of 16/17 delivery

- Online medical records and online booking of appointments available across all of NCL.
- Barnet – development of local health & wellbeing champions.
- Camden – all patients able to access appointments 8-8, 7 days per week.
- Enfield – all patients able to book a same day appointment after phone triage.
- Haringey – 80% of practices will have a coordinated care register.
- Islington – all practices will have enhanced call and recall system in place for vulnerable registered patients.

Highlights of 17/18 delivery

- All NCL practices able to offer flexible appointment lengths.
- Barnet – 95% of patients will be able to access extended hours services at a convenient time.
- Camden – All patients will be able to access all parts of the SCF specification.
- Enfield – Health champions, care coordinators in place.
- Haringey – 100% of practices will be actively engaged in the design of local service delivery.
- Islington – Local asset map developed with key partners.

Highlights of 18/19 delivery

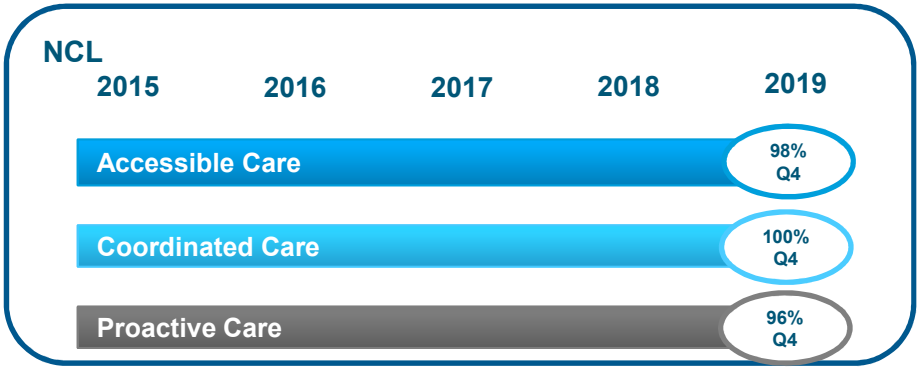
- Two out of three NCL CCGS will be offering full SCF specification to all patients.
- Barnet – 90% of patients will be able to book a same day appointment following phone triage.
- Camden – All patients will be able to access all parts of the SCF specification.
- Enfield – 80% achievement of local asset map developed with key partners.
- Haringey – 100% of patients able to book a more convenient appointment (incl. 4 weeks in advance).
- Islington - All patients will be able to access all parts of the SCF specification.

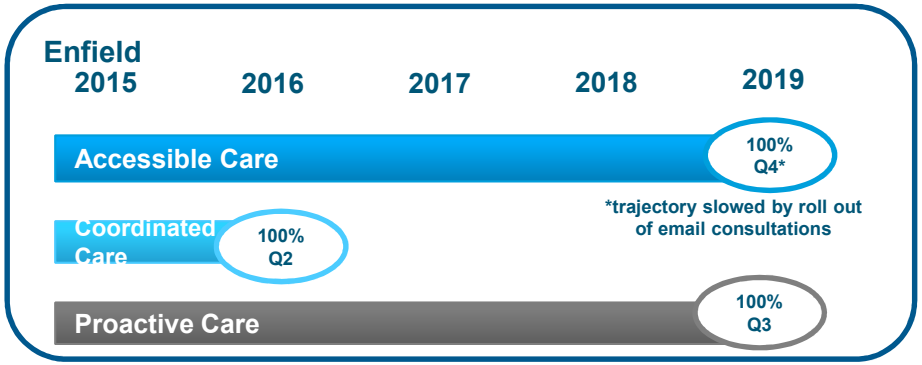
Highlights of 19/20 delivery

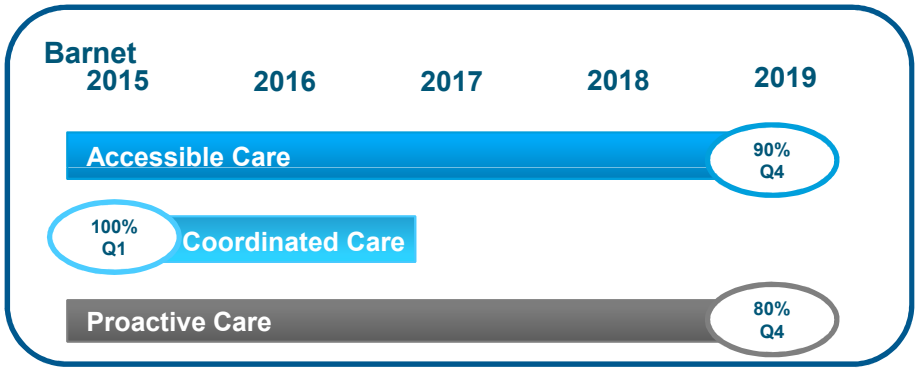
- Barnet – All patients will be able to access 90% of the SCF specification.
- Camden – All patients will be able to access all parts of the SCF specification.
- Enfield – All patients will be able to access all parts of the SCF specification.
- Haringey – All patients will be able to access all parts of the SCF specification.
- Islington – All patients will be able to access all parts of the SCF specification.

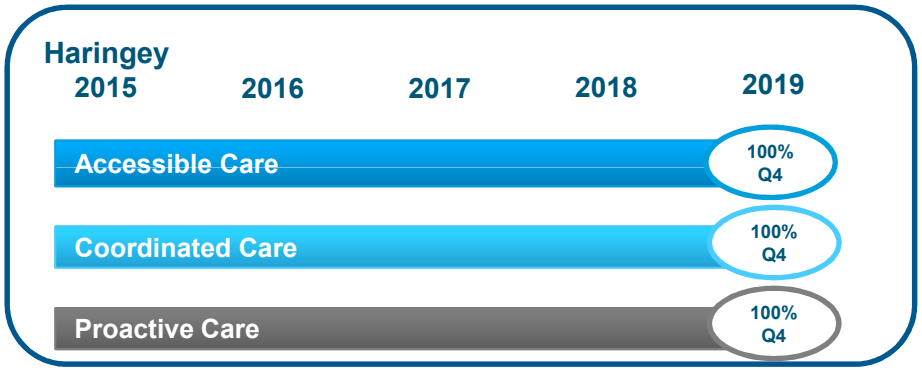
NCL Plan for delivering the London Strategic Commissioning Framework

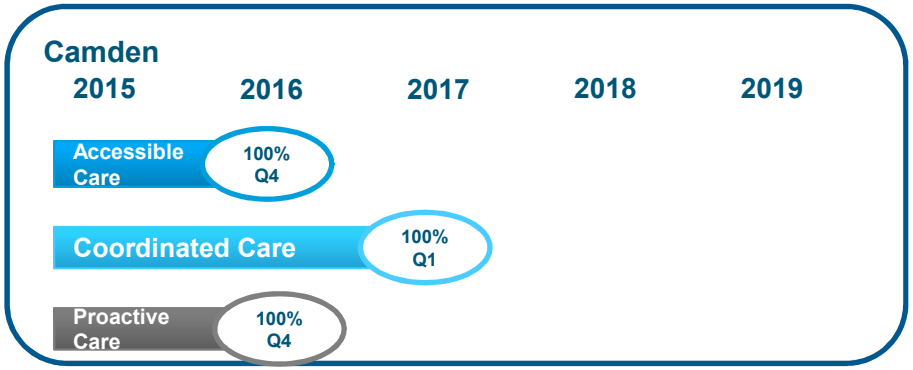
Individual CCG level implementation plans have been developed.

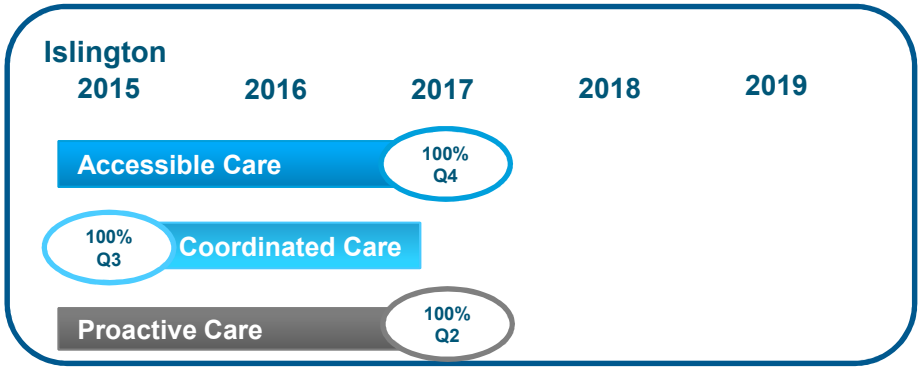












NCL Enablers for delivering the Strategic Commissioning Framework

There are a number of enabler work-streams which are crucial in supporting the implementation of the Strategic Commissioning Framework in NCL.

Enablers	Progress to date
Provider Development	• Working with our GP Federations will enable us to commission for population coverage and support the delivery of our primary care strategy. • Our immediate development priorities are to work with our at scale providers to ensure robust governance and management structures are in place.
Workforce	• NCL needs the right workforce numbers in the right place with the right skills to build integrated teams that can support new models of care. • We are working to understand the needs of new organisational models and establish an NCL workforce development plan including entry level, core training, postgraduate training.
Premises	• Our vision is for a high quality and financially sustainable estate that supports local service transformation within health and social care. • NCL CCGs will have estates strategies by end of 2015 to support better utilisation and planning. • Our long term aim is to develop a borough level single assets database encompassing health, social care, voluntary organisations and potentially private providers.
IT	• NCL requires IT systems that are fit for purpose which can meet the demands of the future by enabling support self management of care by patients. • All CCGs have been working for some time towards effective interoperability and information sharing. CCGs that are further ahead are sharing learning with other areas.

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Our Challenges for SCF Delivery in NCL

There are a number of challenges around delivering the Strategic Commissioning Framework.

1. Developing a financial case

Developing a robust financial model for delivering accessible care, coordinated care and proactive care and identifying where savings can be realised across the wider system i.e. as more care is moved into primary care.

2. Provider readiness

Readiness of provider organisations to take up population or other at scale contracts and the workload capacity of clinicians to take on leadership roles

3. Enablers

Premises: providing quality short term solutions alongside sustainable transformation.
Workforce: recruiting and retaining an appropriately skilled workforce
IT: Developing a sustainable interoperable infrastructure of the future
Co-commissioning: balancing joint working and greater alignment with individual CCG decision making.
Value based commissioning: requires a longer term investment before significant results are visible.

4. Engagement

Patient 'activation' and building knowledge, skills and confidence to self-manage care
Level of engagement from partner organisations e.g. local authority, public health, voluntary sector
Appetite of GPs and primary care teams for transformation
Practices engaging with new ways of working and new technologies

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NCL Co-Commissioning, Premises & Infrastructure

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Co-Commissioning

Co-Commissioning is intended to give local clinical commissioners greater involvement in how primary care medical services are commissioned.

- NHS England and NCL CCG's entered into joint commissioning arrangements for primary medical services from 1 October 2015.
- The first Committee Meeting took place on 5 November at Hendon Town Hall.
- To support the arrangement NHSE has agreed a Memorandum of Understanding with the CCG's supported by a Standard Operating Model for London. This is subject to on-going iterations and updates.

Joint Commissioning Arrangements

- The role of the Joint Committee is to carry out the functions relating to the commissioning of primary medical services. This includes:
  - Oversight of GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, sharing contract monitoring information);
  - Development of newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
  - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
  - Informing decision making on whether to establish new GP practices in an area;
  - Informing decision making on approving of practice mergers, retirements, resignations etc;
  - Ratifying of decisions made by the NHS England Central Contracting Team with regards to 'discretionary' payment (e.g., returner/retainer schemes).

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Premises and Infrastructure

January 2015

- The Primary Care Transformation (formerly Infrastructure) Fund was launched.
- £1bn, four-year funding programme to support GP practices to make improvements to services for local patients including more modern, expanded premises and use of new technology.
- NHS England invited bids for funding in 2015/16.

March 2015

- The first tranche of investment across the country was announced covering over 1,000 GP practices being supported for investment in principle in 2015/16.
- Ongoing due diligence to ensure technical, financial and governance criteria are satisfied.
- The London Region has also developed a local Improvement Grants Scheme aimed at supporting developments that fall outside the national criteria but which support local Strategic Estates Plans.
- NHS England has asked all CCG's to develop a Strategic Estates Plan which includes primary care services.

2016/17

- From 2016/17, it is proposed that a more strategic approach is taken and that CCGs put proposals together for how PCTF should be invested in the future, in line with their local estates plans.
- CCGs have been invited to make recommendations to NHS England to support funding of developments by the end of February 2016, in line with the following criteria:
- increased capacity for clinical services out of hospital and/or training capacity;
- commitment to a wider range of services as set out in your commissioning intentions to reduce unplanned admissions to hospital;
- engagement with providers and commissioners across health, social care and other public services to secure agreed plans.

Premises and Infrastructure

	PCIF London Approval status			
	In progress	Withdrawn or rejected	Deferred (no longer in 2015/16)	Formally approved
Schemes with a value under £100k	60 (£2,077,832)	12 (£414,660)	1 (£82,190)	11 (£199,693)
Schemes with a value of between £100k - £1m	85 (£17,198,212)	13 (£3,031,192)	11 (£3,218,721)	10 (£1,320,779)
Schemes with a value over £1m	4 (£4,288,619)	0 (£0)	0 (£0)	0 (£0)
Total	149 (£23,564,663)	25 (£3,445,852)	12 (£3,300,911)	21 (£1,520,472)

North Central London Schemes		
	Phase 1	Phase 2
Barnet	20	8
Camden	11	5
Enfield	18	5
Haringey	20	7
Islington	8	2

PCIF Delivering for Patients in NCL

Bowes Medical Practice, Enfield

Scheme cost £38,058 (PCIF Grant £30,067)

Conversion of meeting room to C/E room; conversion of administrator room to C/E room and change of use of Practice Managers room to community services room.

Project will facilitate better access for all patients with additional appointments being made available within core hours.

Holborn Medical Centre, Camden

Scheme cost £98,563 (PCIF Grant £77,866)

Conversion of basement to provide additional 2 x clinical rooms.

Project will improve access by enabling more ground floor appointments for frail elderly patients. Additionally the new clinical space will support the proposed additional nursing staff and the delivery of health promotion, preventative medicine and chronic disease optimisation.

Local Premises Update (1 of 2)

CCG	Issue	Progress	Next Steps
Barnet	Regeneration and development of housing in Colindale Area	NHS England working with London Borough of Barnet, Barnet CCG and other stakeholders has developed a Strategic Options Appraisal for the area that identifies a preferred solution to bring in additional (phased) capacity to meet the needs of the new population.	• Consultation on the Plans to take place in Dec & Jan • Development of Business Cases
Camden	Regeneration and development of housing in Kings Cross Relocation of Gower Place, Gower Street and Museum Practices	NHS England working with London Borough of Camden, Camden CCG and other stakeholders developed an Options Appraisal for the area that identifies a preferred solution to bring in additional capacity to meet the needs of the new population in Kings Cross. This service will be provided by an existing practice who shall relocate into the development. New Premises found for Gower Place and relocation being overseen by PM. Gower Street and Museum continue to look for new premises.	• Temporary relocation of Kings Cross Road Practice to SPH pending move to new Kings Cross development.
Enfield	Proposals put forward by developer/ provider for surgery in Pymmes Park. These were supported by local MPs	NHS England working with the CCG, Healthwatch and the London Borough of Enfield undertook a needs assessment in the area to determine the need for additional capacity or services. This concluded that the new development was not needed given the proximity to existing void space at Evergeen CHP and Forest Green CHP.	• Enfield CCG to develop Strategic Estates Plan to consider the future needs of patients in the area following developments and taking account of retirements.

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Local Premises Update (2 of 2)

CCG	Issue	Progress	Next Steps
Haringey	Healthwatch Report and stakeholder concern about capacity as a result of regeneration and developments, particularly in the Tottenham area	NHSE & Haringey CCG commissioned NLEP to develop an integrated Primary Health Care Strategic Premises Plan in response to the regeneration and development schemes. This work was overseen by a Stakeholder Group The Plan has been completed and has been endorsed by NHSE and the CCG. One of the key recommendations was to commission temporary services (a Pilot) in Tottenham Hale pending the development of a long term solution.	• Temporary Pilot provider has been appointed and will mobilise in January • Temporary premises to be secured for 2-3 years • Consultation on wider strategy.
Islington	New Housing developed in the Bunhill area. S106 premises were offered by the developer.	NHS England working with the CCG and the London Borough of Islington undertook a needs assessment of the area and concluded the premises on offer were too small. This was feed back to the Mayor's Office and we secured funding instead ~£1m. New Premises were identified at a nearby Leisure Centre development. NHSE and the CCG undertook appointment process to identify a local GP practice to relocate into these premises with a view to increase capacity.	• Development of Business Cases • Local Consultation

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PMS Contract Reviews

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What are we trying to achieve?

In February 2014 Area Teams received National guidance setting out a **requirement to review all PMS contracts by March 2016**. The purpose of the review is to secure best value from future investment of the 'premium' element of PMS funding.

As a result of these reviews, any additional investment in general practice services that go beyond core national requirements (whether this is deployed through PMS or through other routes) should:

- ✓ reflect joint NHS England /CCG strategic plans for primary care;
- ✓ secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
- ✓ help reduce health inequalities;
- ✓ give equality of opportunity to all GP practices, PMS, General Medical Services (GMS) and Alternative Providers Medical Services (AMPS) (provided they are able to satisfy the locally determined requirements);
- ✓ support fairer distribution of funding at a locality level.

In September 2014, further guidance was issued clarifying that CCGs must be involved in commissioning decisions related to PMS funding

All savings gained from this exercise must be reinvested into General Practice

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Key principles of the PMS review

The key principles underpinning the review process are:

- Decisions on future use of PMS funding are agreed jointly with CCGs
- To ensure that patients have access to the same range of services regardless of what type of contract the practice they are registered with holds.
- There should be equality of opportunity to all GMS, PMS & APMS practices to provide the same range of services
- Proposals for reinvestment should take account overall net impact of any funding changes

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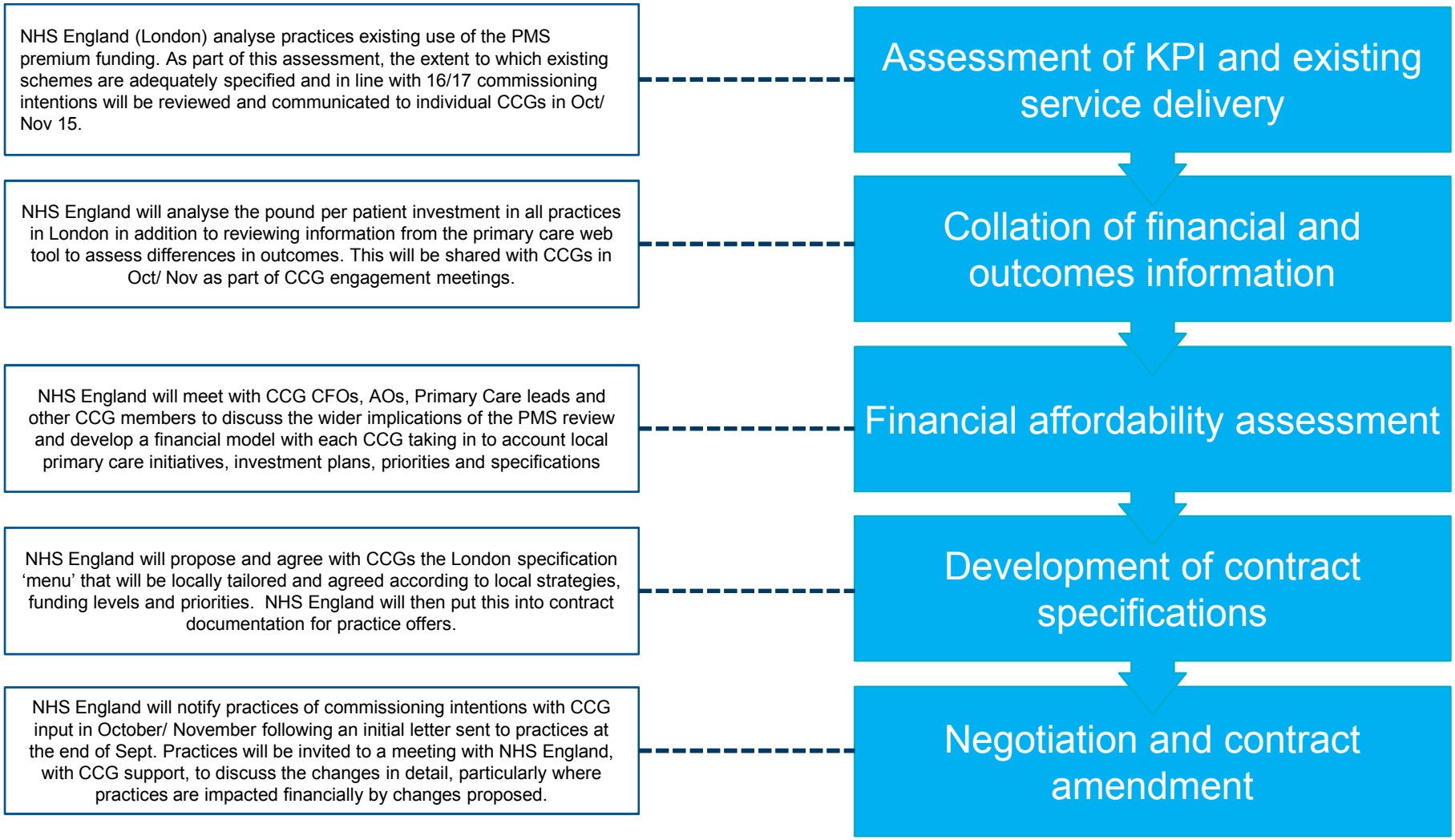
Programme phasing



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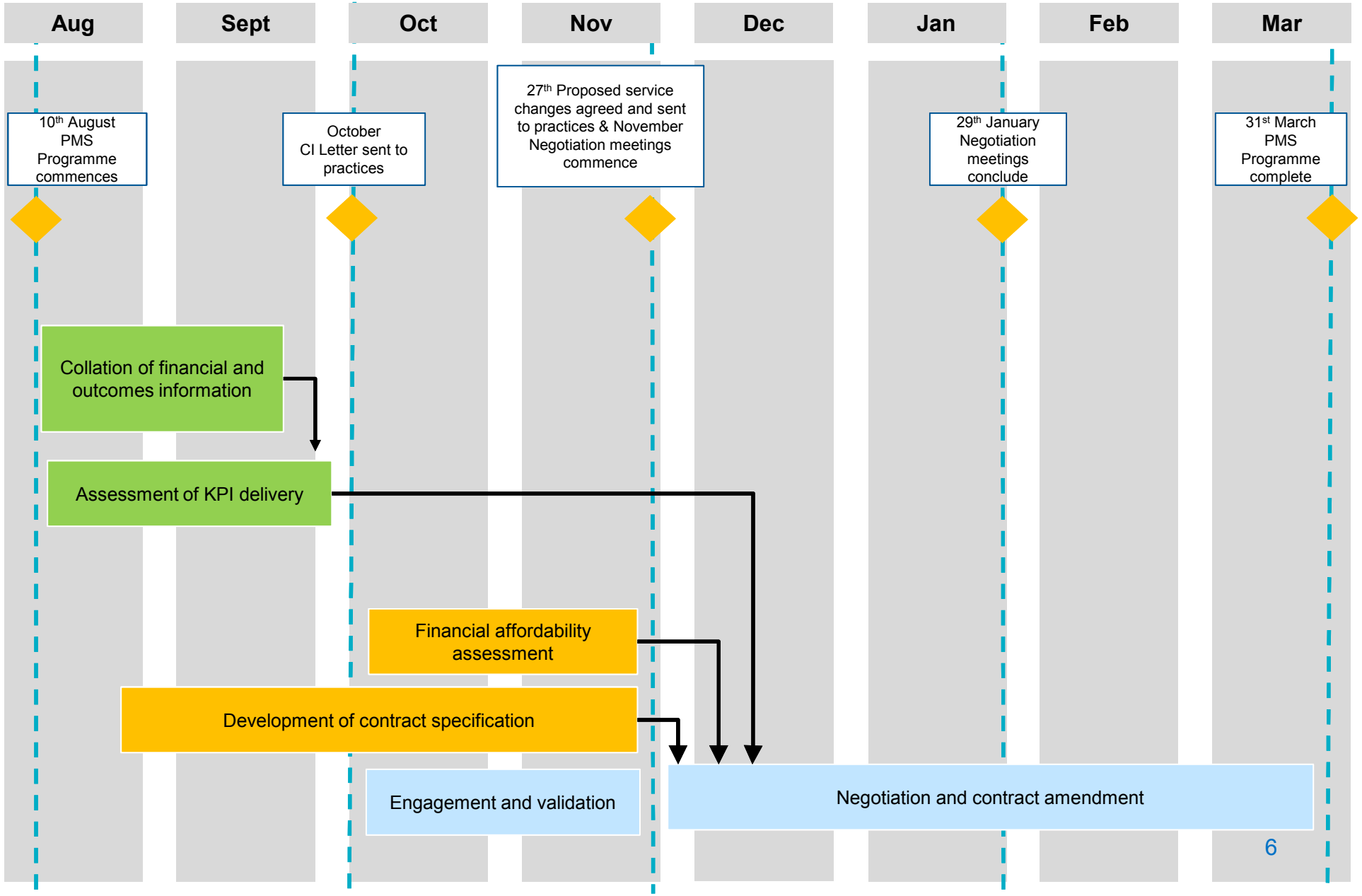
PMS Programme timeline 2015/16



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Appendix A – Strategic Commissioning Framework Specification

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Transforming Primary Care
Strategic Commissioning Framework

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Accessible care specification

Elements of the specification	
A1 Patient choice	Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.
A2 Contacting the practice	Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.
A3 Routine opening hours	Patients will be able to access pre-bookable routine appointments with a primary health care professional (see 'workforce implications' for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.
A4 Extended opening hours	Patients will be able to access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
A5 Same day access	Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).
A6 Urgent and emergency care	Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.
A7 Continuity of care	All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate

Coordinated care specification

Elements of the specification	
C1 Case finding and review	Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.
C2 Named professional	Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.
C3 Care planning	Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.
C4 Patients supported to manage their health and wellbeing	Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing.
C5 Multidisciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

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The proactive specifications

Elements of the specification	
P1 Co-design	Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
P2 Developing assets and resources for improving health and wellbeing	Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy, feel connected to others and to support in their local community
P3 Personal conversations focused on an individual's health goals	Where appropriate, patients will be asked about their wellbeing, capacity for improving their own health and their health improvement goals
P4 Health and wellbeing liaison and information	Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings
P5 Patients not currently accessing primary care services	Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health, including both: i) People on the registered list (but not attending the practice) ii) The unregistered population

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Acronyms

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Page 46

Acronyms

APMS	Alternative Personal Medical Services
BHR	Barking, Havering & Redbridge
CCG	Clinical Commissioning Group
CHP	Community Health Partnership
CIP	Cost Improvement Programme
GMS	General Medical Service
GPIT	General Practice Internet Technology
HEE	Health Education England
HLP	Healthy London Partnership
iHUB	GP Access Hub, Islington
LETB	London Education & Training Board
LMC	Local Medical Council
NCL	North Central London
NHSE	NHS England
NWL	North West London
PCIF	Primary Care Infrastructure Fund
PCT	Primary Care Trust
PMCF	Prime Minister's Challenge Fund
PMS	Primary Medical Service
QIPP	Quality Innovation Productivity Prevention
QOF	Quality and Outcomes Framework
SCF	Strategic Commissioning Framework
SEL	South East London
SPG	Strategic Partnership Group
SPH	St Pancras Hospital
TPC	Transforming Primary Care
VBC	Value Based Commissioning

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LONDON BOROUGH OF CAMDEN	**WARDS:** ALL
REPORT TITLE: Reviewing the role of the North-Central London (NCL) Joint Health Overview and Scrutiny Committee (JHOSC) and its relationship with the 5 NCL borough Health and Overview Scrutiny Committees (HOSCs)	
REPORT OF: The Director of Public Health	
FOR SUBMISSION TO: Health and Adult Social Care Scrutiny Committee	**DATE: 11th November 2015**

SUMMARY OF REPORT
This report proposes that the North Central London (NCL) Joint Health and Overview Scrutiny Committee (JHOSC) and the five London Borough Health and Overview Scrutiny Committees (HOSCs) across NCL (Barnet, Camden, Enfield, Haringey and Islington) work together more collaboratively. The report proposes an approach to determining which items should be scrutinised at the borough and NCL levels and indicates future items of potential interest to the JHOSC.

LOCAL GOVERNMENT ACT 1972 - ACCESS TO INFORMATION:
No documents that require listing were used in the preparation of this report

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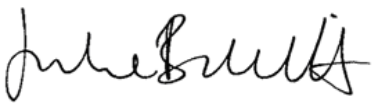
RECOMMENDATIONS:

The Health and Adult Social Care Scrutiny Committee are asked to:

a) note and comment on the proposed role and focus of the NCL JHOSC and its relationship with the five borough scrutiny committees
b) agree the proposed approach for determining future JHOSC agendas

SIGNED: Julie Billett, Director of Public Health



DATE: 29/10/15

1.0 Purpose of the report

To outline a specific role and focus for the North Central London (NCL) Joint Health and Overview Scrutiny Committee (JHOSC) and its relationship with the five London Borough Health and Overview Scrutiny Committees (HOSCs) across NCL (Barnet, Camden, Enfield, Haringey and Islington).

2.0 Intended impact of the report

The intention of the proposal set out here is to make more efficient use of the collective scrutiny resource across NCL and increase strategic coordination between the five NCL borough HOSCs and the JHOSC.

3.0 Contribution by community partners to the report

N/A

4.0 Contribution by professional partners to the report

N/A

5.0 Background

In January 2010, Chairs of health scrutiny committees in the five North-Central London (NCL) Boroughs of Barnet, Camden, Enfield, Islington and Haringey established a Joint Health Overview and Scrutiny Committee (JHOSC) to engage with the NHS on the NCL Service and Organisation Review. The Review was established by the NHS to consider options for reconfiguring acute care across the NCL sub-region. The proposals arising from this would have had wide ranging implications for health services across the sub region and undoubtedly constituted a "substantial variation", thus requiring formal consultation and the establishment of a JHOSC.[1]

Following the 2010 general election, the Review was suspended in light of a change of government policy. Meanwhile, NHS NCL was established formally as a sub-regional commissioning body across NCL. Many key strategic commissioning decisions began to be taken at the NCL level rather than by individual Primary Care Trusts (PCTs). In addition, NHS NCL became the transitional body for the move to GP led commissioning which has ultimately led to the establishment of clinical commissioning groups (CCGs).

On 28 November 2012, the JHOSC held a seminar giving Scrutiny Committee Members an overview of the new arrangements for the NHS that would be implemented fully from 1st April 2013 following the passage of the Health and

[1] Paragraph 30(5) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where someone consults more than one local authority in relation to a "substantial development or variation" of the health service in the area of those authorities, then those local authorities must appoint a joint overview and scrutiny committee
http://www.legislation.gov.uk/uksi/2013/218/regulation/30/made

Social Care Act 2012. This included the abolition of PCTs (and PCT clusters) with their formal role being taken over by, amongst others, Clinical Commissioning Groups (CCGs). JHOSC Members discussed whether there would still be a useful role for the JHOSC to undertake after 1st April and were of the view that the commissioning of NHS services on a cross-borough basis was likely to continue and possibly increase and that there was also still the potential for large scale reconfigurations to be proposed by the NHS. It was felt important that overview and scrutiny was proactive in its approach so that it was able to influence issues at an early stage rather than merely react to proposals once they had been developed.

The consensus therefore was that the JHOSC should continue to meet but on a less regular basis (initially four times per municipal year) and that that decision would be reviewed in one years' time. It was agreed that the JHOSC would have a standing role in engaging with relevant NHS bodies on strategic, sector-wide issues across North Central London (NCL). In addition, it would also consider any proposals involving significant reconfiguration of services across the sector. Finally, it would also have a role, where appropriate, in responding to any proposals for changes to specialised services that would impact on relatively small numbers of patients at individual borough level and where commissioning was undertaken on a cross-borough basis.

6.0 Other London JHOSCs

Other London boroughs have established JHOSCs for the purpose of scrutinising and responding to substantial changes to health service in those areas. Other currently extant London JHOSCs are:

- **The Inner North East London JHOSC** – comprises representatives from the London Boroughs of Hackney, Newham, Tower Hamlets and City of London Corporation. The Committee's remit is to consider London wide and local NHS service developments and changes that impact all the authorities mentioned above. The Committee meets as required and is established in accordance with section 245 of the NHS Act 2006 and Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.
- **The Outer North East London JHOSC** – comprises representatives from the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.
- **The North West London JHOSC** – comprises representatives from the London Boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hounslow, Kensington and Chelsea, Richmond and Westminster. It meets with representatives of NHS North West London to discuss and consider matters concerning the NHS. Any substantial changes in the NHS across North West London are subject to consultation with this Committee.
- **The South West London JHOSC** – comprises representatives from the London Boroughs of Croydon, Merton, Richmond upon Thames, Sutton, Wandsworth and the Royal Borough of Kingston upon Thames. Its purpose is to undertake

scrutiny activity in response to a particular reconfiguration proposal or strategic issue affecting some, or all of the constituent Boroughs.

Additionally, an Inner and Outer South East London JHOSC (Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark) has formed for time-limited periods in the past to consider substantial variations of health services in those areas. Both JHOSCs have since disbanded.

7.0 Current operation

Over the past 18 months the JHOSC has undertaken a valuable scrutiny role across North Central London. Specifically, it has: played an ongoing role in scrutinising the acquisition of Barnet and Chase Farm Hospitals by the Royal Free - an acquisition which will impact on patients across NCL; scrutinised and helped to publicise plans for the reconfiguration of specialist cancer and cardiovascular services across NCL and beyond, listening to and supporting the clinical case for change and offering valuable and constructive critical challenge to the plans; scrutinised proposals to commission an integrated NHS 111 and GP out of hours service across NCL, again offering critical challenge to the proposal; and scrutinised the Five Year Plan of the NCL CCG Strategic Planning Group and efforts being taken by NHS acute trusts, CCGs, Local authorities and others to collectively reduce A&E admissions across the NCL footprint.

There have also been examples where better coordination between the HOSCs and JHOSC would have made better use of the collective scrutiny resources available across NCL. For instance: most of the five borough scrutiny committees have separately scrutinised plans for the Barnet and Chase Farm acquisition by the Royal Free London and the 111/GP out of hours integrated procurement in 2015/16. It is for local borough scrutiny committees to determine their own agendas and in particular to focus on the local implication of any such change. However it may be possible to ensure these more local implications are adequately scrutinised at the JHOSC. Arguably, the JHOSC has also scrutinised issues more amenable to scrutiny at the borough level, such as: hospital food for in-patients at local hospitals, the Care Quality Commission inspection of North Middlesex University Hospital and winter A&E pressures at Barnet Hospital.

A more strategic and coordinated approach across NCL would have the dual benefits of making better use of officer and councillor time and better use of collective scrutiny resources across NCL. Separate scrutiny of the same issues by different boroughs and the JHOSC also reduces the collective resources available for scrutiny of other topics across NCL.

8.0 Proposal for new approach

It is proposed that the when selecting items for the JHOSC work programme, the committee focuses on those items *that relate to the coordination, collaboration and improvement of the 'health system' across North-Central London.* The following list provides examples of work happening at the North Central London level where scrutiny by the JHOSC could add significant value:

- **London Devolution Proposals:** A broad model for reform of health and care in London has been agreed in principle by London boroughs, CCGs, the Mayor, Public Health England and NHS England. There is agreement that London's model of reform must address the whole of the health and care system, but that because of the complexity of health and care issues in the capital, that a uniform city-wide approach would not be successful. In order to address the whole system, the London devolution model proposes reform be undertaken on three geographical levels: local, sub-regional and regional. The principle of subsidiarity would underpin decisions and ensure they are made at the most appropriate level but there is recognition that issues such as hospital service transformation will require collaboration across borough boundaries on sub-regional footprints (albeit with strong linkages to locally led out-of-hospital transformation plans). The NCL JHOSC therefore has an important role to play in scrutinising the development of devolution and transformation plans, and the effectiveness of collaboration and planning at the sub-regional level associated with the London devolution proposals.
- **Integrated commissioning of NHS 111 and Out of Hours GP services:** The five CCGs across NCL are proposing to commission an integrated NHS 111 and GP out of hours (OOH) service to start in April 2016. The proposal is based on the recommendations of the 2013/14 Camden and Islington Urgent and Emergency Care Review. The NCL JHOSC should continue to scrutinise these proposals as they develop to ensure commissioners' plans for public and patient engagement are appropriate and to ensure ongoing scrutiny of the integrated service after April 2016, to ensure it is delivering the outcomes and objectives intended by commissioners.
- **Primary care co-commissioning:** As of 1st April 2015, CCGs across NCL have taken non greater responsibility for the commissioning of primary care through the establishment of joint co-commissioning arrangements with NHS England. Primary care co-commissioning responds to the need to develop out of hospital care highlighted by the Five Year Forward View. The benefits, if realised, include improved access to quality primary and out of hospital care available in the community, greater equity of access, more joined up services and improved health outcomes and patient experience. The JHOSC will have an important role in scrutinising arrangements as they develop across NCL, in how conflicts of interest are being managed and the impact on access to and quality of primary care.
- **NCL collaborative working/commissioning:** The five NCL CCGs asked Carnall Farrar, strategic healthcare advisors, to work with their Strategic Planning Group (SPG) to develop a framework and delivery plan to improve health outcomes, reduce inequities and achieve financial sustainability. The JHOSC will have an important role in scrutinising plans for collaboration as they develop across NCL.
- **Substantial variations:** Substantial variations and re-configurations of services at the NCL level will continue to be a key issue for the JHOSC. In the past 12 months, the JHOSC has played a key scrutiny role in proposals for reconfiguration of specialist cancer and cardiovascular services across NCL and beyond and in scrutinising the acquisition of Barnet and Chase Farm Hospitals by the Royal Free London.
- **Whole system collaboration**: Currently there is no one body whose job it is to scrutinise how the whole 'system' (i.e. GPs, local authorities, CCGs, NHS

Providers and others) across North Central London work together to improve health outcomes, improve integration of services and patient experience and reduce demand on services. friends and family test scores, improve care pathways and reduce bureaucracy and costs

- **Better Care Fund**: Linked to the London devolution proposals, the JHOSC could potentially add value by scrutinising the impact of the Better Care Fund across the five NCL boroughs and the successes and challenges associated with these plans. Important to this would be an investigation of the most effective measures found so far to reduce delayed transfers of care and avoidable emergency admissions.
- **Clinical Pathways**: Commissioners and providers across NCL are engaged in a range of work focused on development of best practice clinical care pathways that extend across provider/organisational and geographical boundaries. The JHOSC has a potential role in scrutinising the impact and implications of this work and associated challenges.
- **Strategic Planning/Resilience Groups**: Increasingly, CCGs are working together to plan and collaborate on a sub-regional level particularly in relation to systems resilience. The North Central London Strategic Planning Group has already assumed primary care co-commissioning responsibilities and it is anticipated multi-borough groupings will increase in importance as part of London devolution proposals. The JHOSC therefore has an important role to play in looking at how well Strategic Planning Groups and systems are working and sharing best practice.

9. Key issues, challenges and risks and their management - focusing on prevention, partnership working and reducing inequalities

Separate scrutiny of the same issues reduces the collective resources available for scrutiny across NCL. This paper proposes a way to manage these risks.

10. Intended impact on reducing inequalities and improving health, wellbeing and value for money

The proposed approach will make scrutiny of the NHS and social care across NCL more joined-up thereby providing better value for money and making better use of the collective resources of borough scrutiny committees to focus on issues which contribute to improving health and wellbeing and reducing health inequalities.

11 What success looks like, measuring success and targets

Outcomes:

- better coordinated health and care scrutiny across NCL including collaborative work planning
- less duplication by NCL scrutiny committees
- A focus on issues of strategic importance by the JHOSC (i.e. which relate to integration or collaboration across NCL)

Measuring success:

- Informal evaluation by scrutiny officers on an annual basis of duplication across HOSC and JHOSC work programmes
- At least one collaborative work planning meeting involving the JHOSC Chairs each municipal year

12.0 Next steps, next month, six months and a year

This report will be submitted to each of the five NCL borough HOSCs and the JHOSC for discussion and agreement at the appropriate juncture. It is proposed that joint work planning sessions involving the scrutiny Chairs are put in place by officers supporting the 5 scrutiny committees and that the JHOSC and working arrangements will be reviewed annually.

13.0 **Comments of the Borough Solicitor**

The Borough Solicitor has been consulted on this report and has no comments to add to this report.

14.0 **Comments of the Director of Finance**

The Director of Finance has been consulted on this report and has no comments to add at this time

REPORT ENDS

Appendix A – NCL JHOSC Terms of Reference

1. To engage with relevant NHS bodies on strategic sector wide issues in respect of the commissioning and provision of NHS health services across the area of Barnet, Camden, Enfield, Haringey and Islington; and

2. To scrutinise and respond to stakeholder engagement, the consultation process and final decision in respect of any sector wide proposals for reconfiguration of health services in the light of what is in the best interests of the delivery of a spectrum of health services across the area of, taking account of:

    - The adequacy of the consultation being carried out by the health bodies including the extent to which patients and the public have been consulted and their views have been taken into account
    - The impact on the residents of those areas of the reconfiguration proposals, as set out in the consultation document
    - To assess whether the proposals will deliver sustainable service improvement
    - To assess whether the proposed changes address existing health care inequalities and not lead to other inequalities
    - The impact on patients and carers of the different options, and if appropriate, which option should be taken forward
    - How the patient and carer experience and outcomes and their health and well-being can be maximised whichever option is selected
    - Whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of the North Central London Service and Organisation Review to the Secretary of State for Health.

3. To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each borough.

4. The joint committee will work independently of both the Executive and health scrutiny committees of its parent authorities, although evidence collected by individual health scrutiny committees may be submitted as evidence to the joint committee and considered at its discretion.

5. To maintain impartiality, during the period of its operation Members of the Joint Committee will refrain from association with any campaigns either in favour or against any reconfiguration proposals that may be considered by the Committee. This will not preclude the Executives or other individual members of each authority from participating in such activities.

6. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people

Procedural Arrangements

Representation
Each borough will be entitled to two representatives on the Committee. In the event of a Member being unable to attend, a deputy may be appointed by the borough concerned.

Chair
A Chair and a Vice Chair for the JHOSC shall be appointed at its first meeting of each Municipal Year. The Chair and the Vice Chair shall come from different boroughs.

Quorum
The quorum for the JHOSC will be one Member from each of? four of the participating authorities. In the event of a meeting being inquorate, it can still proceed on an informal basis if the purpose of the meeting is merely to gather evidence. However, any decision making is precluded.

Voting Rights
Due to the need for recommendations and reports to reflect the views of all boroughs involved in the process, the JHOSC shall aim to operate by consensus if at all possible. A vote shall only be taken if every effort has been taken to reach agreement beforehand. Voting will be on the basis of one vote per authority. In the event of a tie, there shall be no provision for a casting vote on behalf of the Chair and the vote shall be deemed to have been lost.

Dissent and Minority Reporting
It is recognised that issues that emerge during the work of the JHOSC may be contentious and there therefore might be instances where there are differences of opinion between participating boroughs. The influence of the JHOSC will nevertheless be dependent on it being able to find a consensus. Some joint committees have had provision for minority reports but these powers can, if used, severely undermine the committee's influence. Whilst such provision can be made for the JHOSC, it is agreed that use of it is only made as a last resort and following efforts to find a compromise.

Writing Reports and Recommendations
The responsibility for drafting recommendations and reports for the JHOSC is shared amongst participating authorities.

Policy and Research Support and Legal Advice to the Joint Committee
This will be provided jointly by all of the participating authorities. Each authority is responsible for supporting its own representatives whilst advice and guidance to the JHOSC will be provided, as required, through liaison between relevant authorities. Consideration could be given by the JHOSC, in due course, to the provision of external independent advice and guidance, should it be felt necessary. This could be of benefit if it enables the joint committee to more effectively challenge the NHS and may be of particular assistance in addressing issues of a more technical nature, where lack if specific knowledge could put the joint committee at a disadvantage.

Administration
Clerking responsibilities are shared between participating Councils, with the borough hosting a particular meeting also providing the clerk.

Frequency and location of meetings
Meetings will rotate between participating authorities for reasons of equity and access. The JHOSC will meet four times per Municipal Year. However, an additional meeting may be called by the Chair in consultation with the Vice Chair or if requested by at least four participating boroughs.

Servicing costs
In the current financial climate, it is unlikely that it will be possible to meet any costs arising from the work of the JHOSC except on an exceptional basis. Any such financial commitments will need to be agreed beforehand and the cost split between the participating authorities

Introduction

- Report for North Central JHOSC Nov 2015 Sentinel Stroke National Audit Programme Results April - June 2015. Present pan London data to put NC into context
- HASU: University College Hospital
- ASU: University College Hospital
  Royal Free Hospital
  North Middx Hospital
  Barnet
- Non Acute teams: St Pancras, (Chase Farm, Albany Unit: insufficient cases to receive SSNAP report)
- ESD Teams: Enfield, Barnet, Islington, Camden – none submitted sufficient cases to receive SSNAP report

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Executive summary

Overall performance good (all HASU and ASU in top 27% in country)

High performance from UCH except for access to stroke unit where they have struggled to manage with their beds – esp. last winter difficulty repatriating patients. Also need to improve on swallow screening, access to SALT and Dietietics

ASU's performing well overall

ESD – admitting 35% (slightly above national average). Need more data from ESD for SSNAP

Lack of ESD service in Haringey is a major failing

Poor 6 month follow up across all areas esp patients from N Middx

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See transfer tree for the acute units (separate excel file)

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Overall SSNAP Scores

- **HASU**
- UCH B
- **ASU**
- Barnet A
- RFH A
- N Middx B
- UCH B
- **Non Acute team**
- St Pancras C

SSNAP levels. National results:
A - 14 teams (7%)
B - 41 teams (20%)
C - 48 teams (23%)
D - 82 teams (40%)
E - 21 teams (10%)

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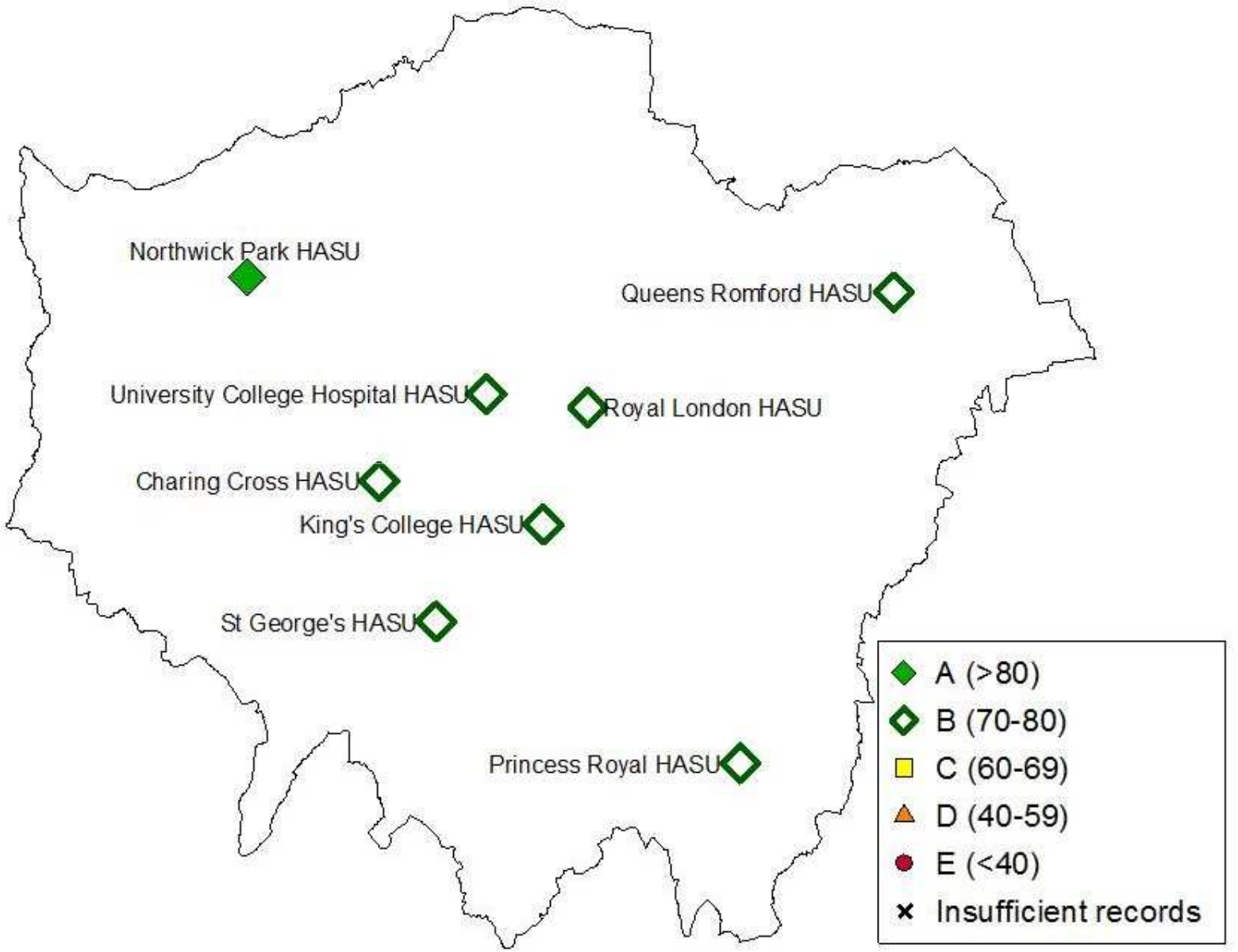
SSNAP Level

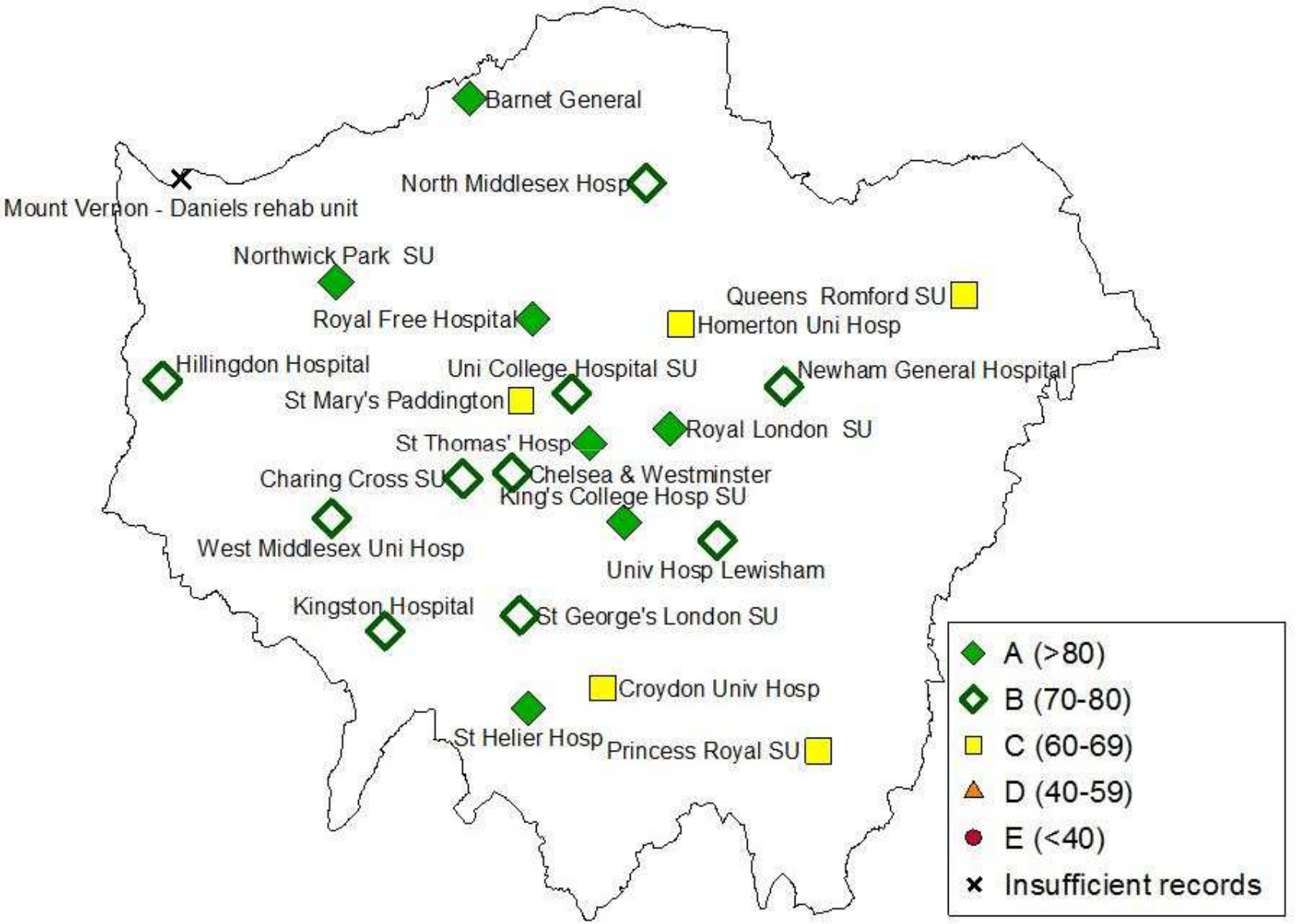
Routinely Admitting Teams



Source: SSNAP Apr-June 2015
Region: London SCN

SSNAP Level

Non-Routinely Admitting Acute Teams



Source: SSNAP Apr-June 2015
Region: London SCN

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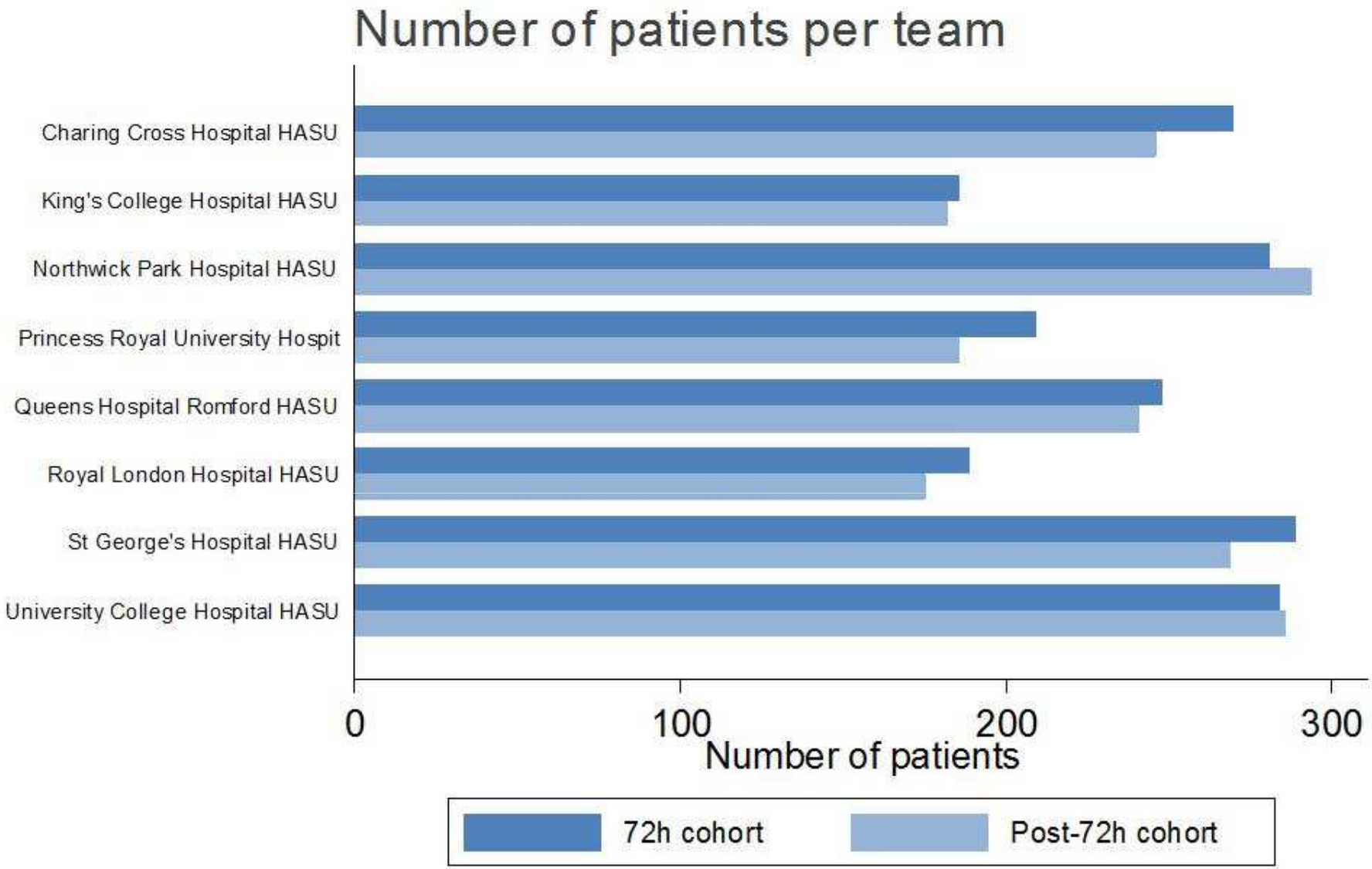

Source: SSNAP Apr-June 2015
Number of patients in both patient-centred cohorts - D2.2 and D5.2

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Team-centred performance table

Routinely Admitting Teams	Number of patients		Overall Performance				Team Centred Data										
Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
St George's Hospital HASU	285	291	B	B	B	B↓	A	D	B	C	A	A	A	B	B	D	B
University College Hospital HASU	283	295	B↑↑	B↑	C↓	A↑	A	C↑	A↑	B↑	A↑	A↑	B↑	B	C	A	A↑
Princess Royal University Hospital HASU	209	210	B	A	B	A	A	C	B	B	A	A	B↓	C	A	B	A
Charing Cross Hospital HASU	266	270	B	A↑	A	B↓	A	C	B	A	A	B	C↓	C↓	C↓	C	B↓
Royal London Hospital HASU	184	192	B	A	B↓	A↑	B	D↓	B↑	B	A↑↑	A↑	B	B	B	A	A↑
King's College Hospital HASU	183	182	B	B	B	A	A	C	B	B	A	A↑	A	B↓	A	B	A
Northwick Park Hospital HASU	281	289	A	A	A	A	A	B	A	B	B↓	A	A	B	B	C	A
Queens Hospital Romford HASU	238	240	B	A↑	B	B↓	A	C	C↓	B	A	A	A	C↓	B	D↓	B↓
Non-Routinely Admitting Acute Teams	**Number of patients**		**Overall Performance**				**Team Centred Data**										
Team Name	**Admit**	**Disch**	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
Kingston Hospital	TFP	44	B↓	A↑	D↓	A	NA	A	NA	NA	B↓	B↓	B↓	NA	A	A	A
Barnet General Hospital	TFP	41	A↑	A	A↑	A	NA	B	NA	NA	A	A	A	NA	B	A↑↑	A
Hillingdon Hospital	TFP	48	B	A↑↑↑	D	A	NA	A	NA	NA	A	B	A	NA	A	C	A
West Middlesex University Hospital	TFP	31	B	A	D	A	NA	A	NA	NA	C↓↓	B	B	NA	B	A	A
Croydon University Hospital	TFP	55	C	A	D↓	A↑	NA	A↑	NA	NA	B↑	C	B↑	NA	A	A	A↑
King's College Hospital SU	TFP	33	A↑	A↑	C	A	NA	A	NA	NA	A	A↑	B↑	NA	A↑	A↑	A
Whipps Cross University Hospital	TFP	X	TFP	E↓↓	X	TFP	NA	X	NA	NA	X	X	X	NA	X	X	TFP
St George's Hospital SU	TFP	63	B↓	A	C↓	A	NA	A	NA	NA	B	B	C	NA	B↓	B	B↓
Newham General Hospital	TFP	35	B	A	C↑	A	NA	B↓	NA	NA	A	A	B	NA	A	B	A
Charing Cross Hospital SU	TFP	81	B↓	A	C↓↓	A	NA	A	NA	NA	A	C↓	B↑	NA	B	B	A
North Middlesex Hospital	TFP	53	B↑↑	A↑↑	D↑	A↑	NA	A	NA	NA	A	A	A↑	NA	B↓	D	A
Chelsea and Westminster Hospital	TFP	34	B	A↑↑	E	A	NA	A	NA	NA	A↑	A	C↓↓	NA	A	A	A
University Hospital Lewisham	TFP	96	B	A↑	A	B↓	NA	A	NA	NA	C	C	C	NA	B↓	A↑	B
Mount Vernon - Daniels Rehabilitation Unit	TFP	X	X	X	X	X	NA	X	NA	NA	X	X	X	NA	X	X	X
Queens Hospital Romford SU	TFP	164	C↓	A	A	C↓	NA	B	NA	NA	C↓↓	C↓	D↓	NA	B	D	C↓
St Helier Hospital	TFP	38	A↑↑	B↓	B↑	A↑	NA	A↑	NA	NA	A	A↑	B	NA	A	A	A
Royal London Hospital SU	TFP	73	A	A↑	B↓	A	NA	A	NA	NA	A↑	A↑	B	NA	A↑	A	A
Northwick Park Hospital SU	TFP	153	A	A	B	A	NA	A	NA	NA	A	A	C↓	NA	A	C	A
St Mary's Hospital Paddington	TFP	43	C↓↓	B↓	D↓↓	A	NA	A	NA	NA	A	B↓	B↑	NA	B	A↑	A
St Thomas Hospital	TFP	47	A↑	A	B	A	NA	B	NA	NA	A↑↑	A↑	A	NA	A	A	A
Royal Free Hospital	TFP	53	A↑	A	B↑	A↑	NA	A↑	NA	NA	A↑	B	B↓	NA	B	A	A
Homerton University Hospital	TFP	32	C	A↑↑↑	D	A	NA	A	NA	NA	A	A	A	NA	C	D	A
University College Hospital SU	TFP	41	B↓	A	B↑	B↓	NA	A	NA	NA	A	B↓	B↓	NA	C↓	NA	A
Princess Royal University Hospital SU	TFP	65	C↓	C↓↓	C	A↑	NA	A	NA	NA	C	B	C	NA	A	B↑	B
Non-Acute Inpatient Teams	**Number of patients**		**Overall Performance**				**Team Centred Data**										
Team Name	**Admit**	**Disch**	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
King George Hospital Inpatient Rehab Team	TFP	24	C	A	A	C	NA	A	NA	NA	B	B	C	NA	B	C	B
St Pancras Hospital	TFP	36	C	A	D↑	B	NA	E	NA	NA	A	A	C	NA	D↓↓	A	B

Source: SSNAP April – June 2015

Team-centred performance table for London SCN

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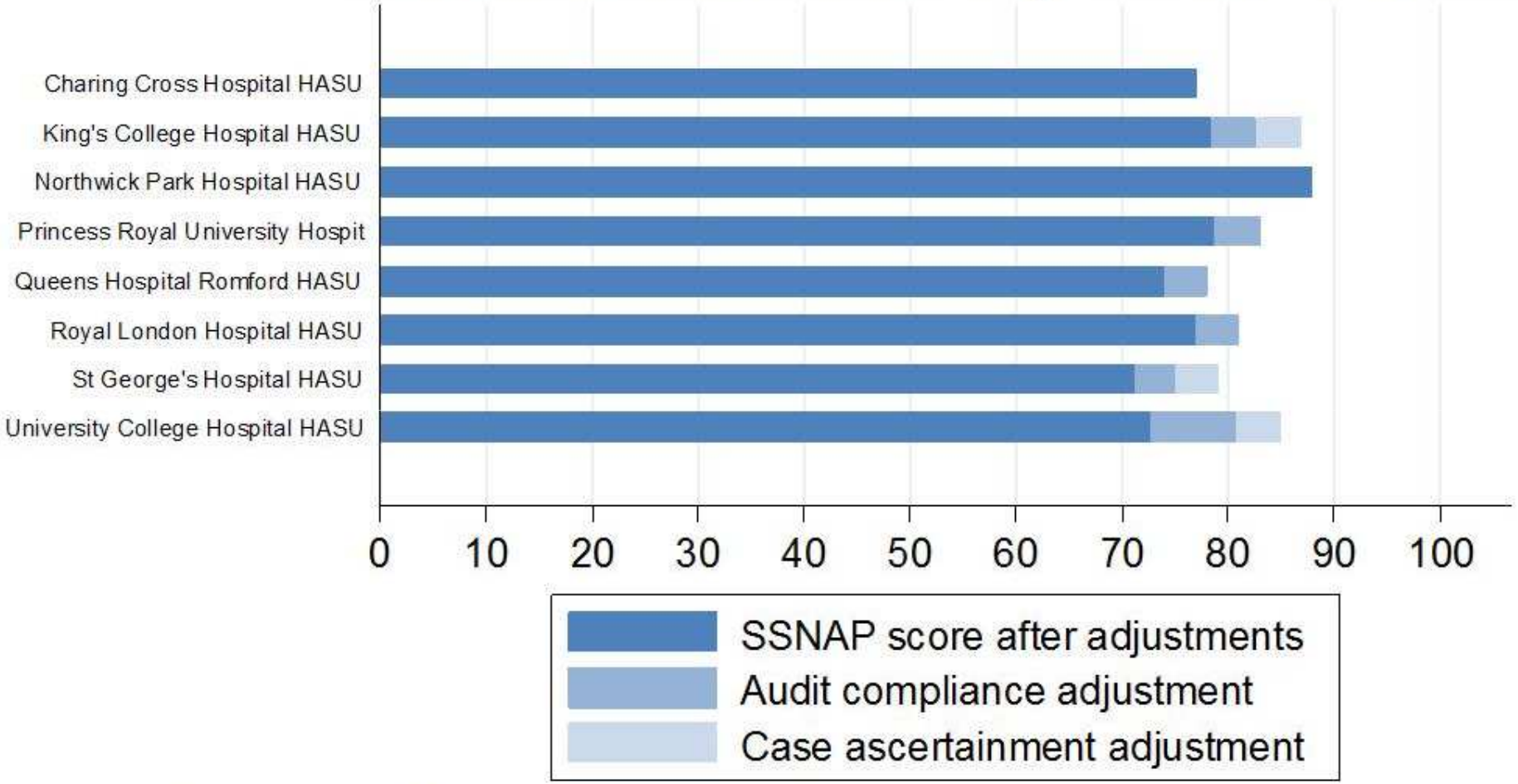
SSNAP score:
Combined Total KI score adjusted for AC and CA



Source: SSNAP Apr-June 2015
Team level results demonstrating the proportion of the Combined Total Key Indicator score which is removed due to AC and CA adjustments to derive the overall SSNAP score

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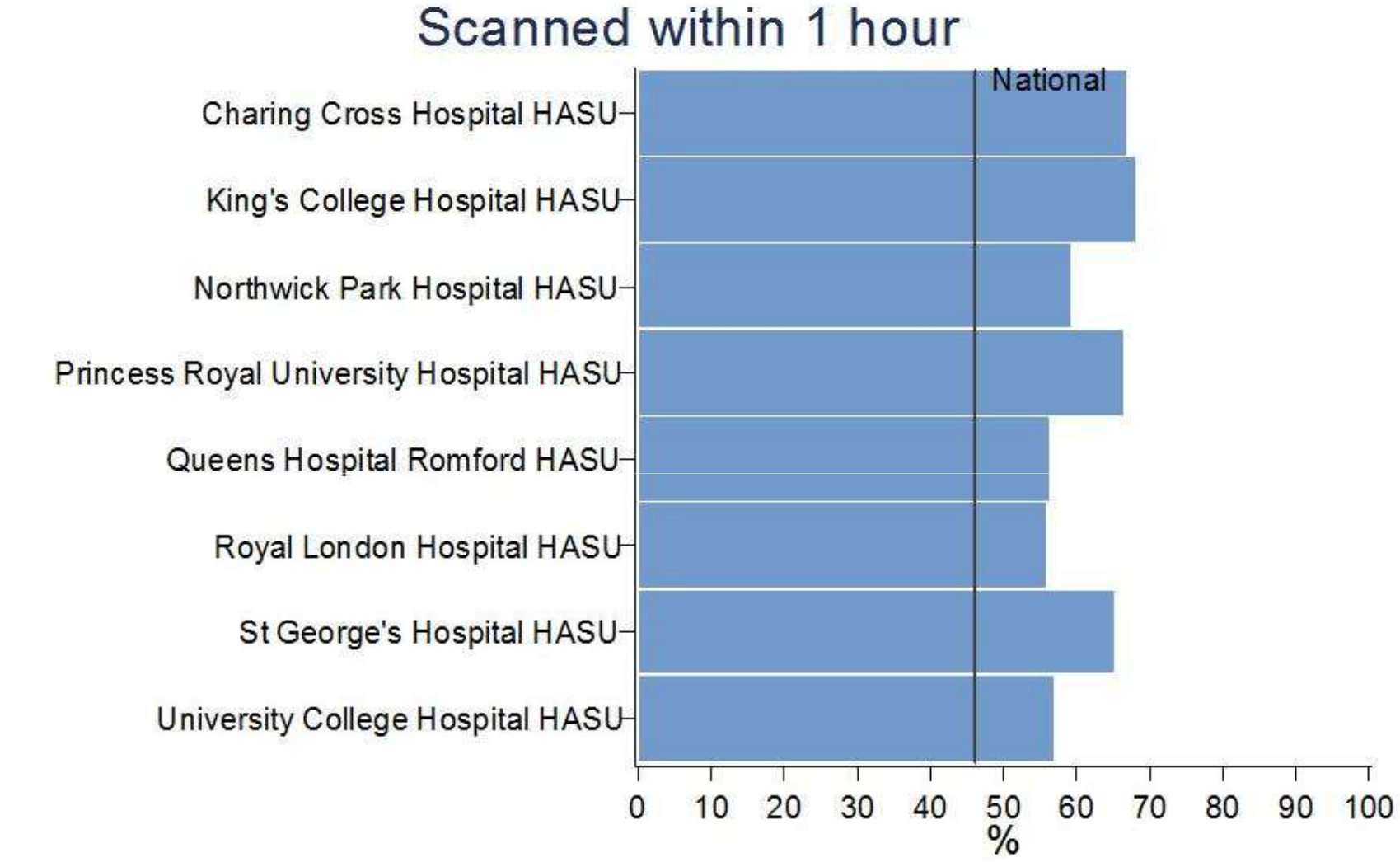

Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 1.1A

London SCN

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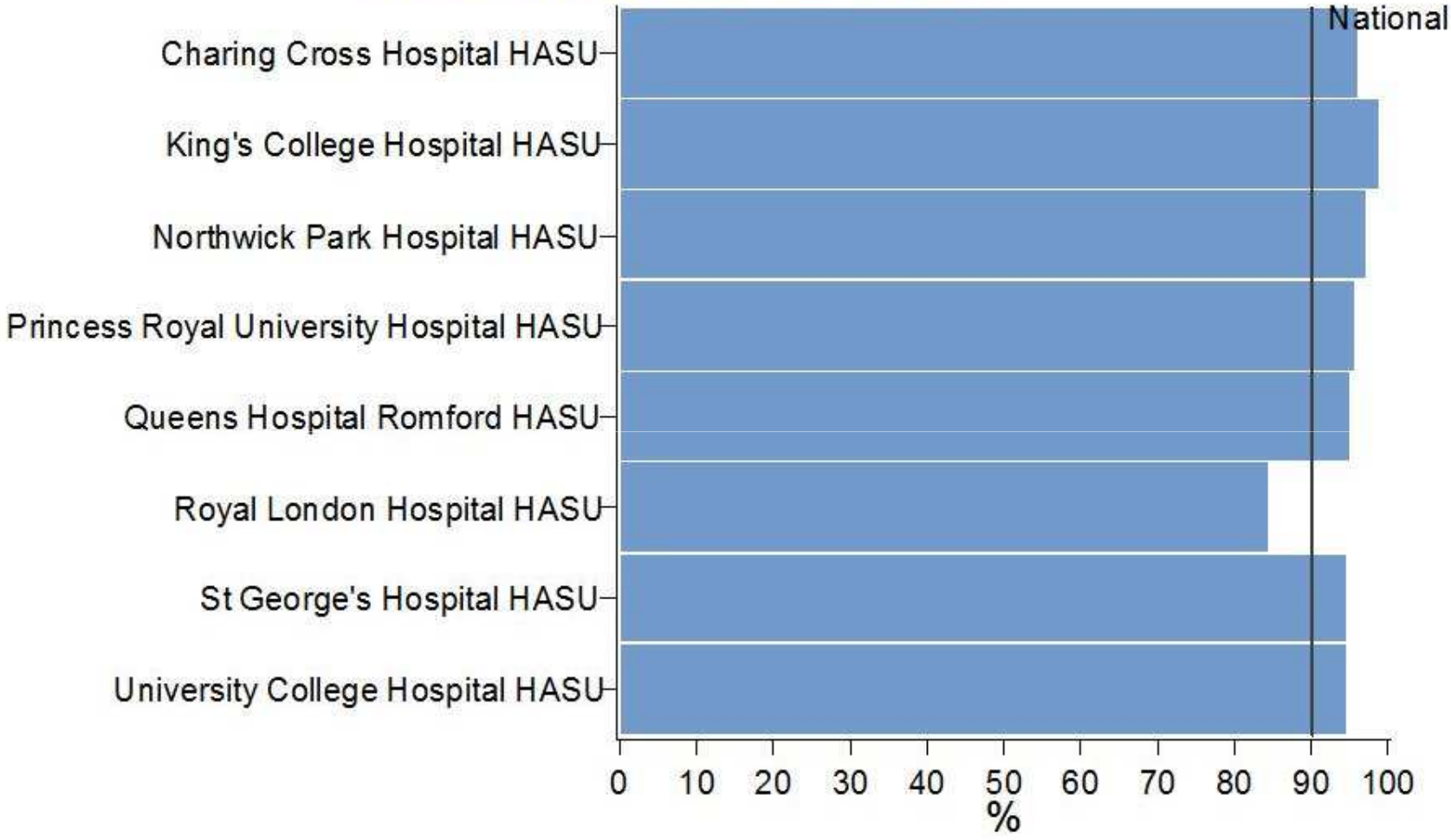
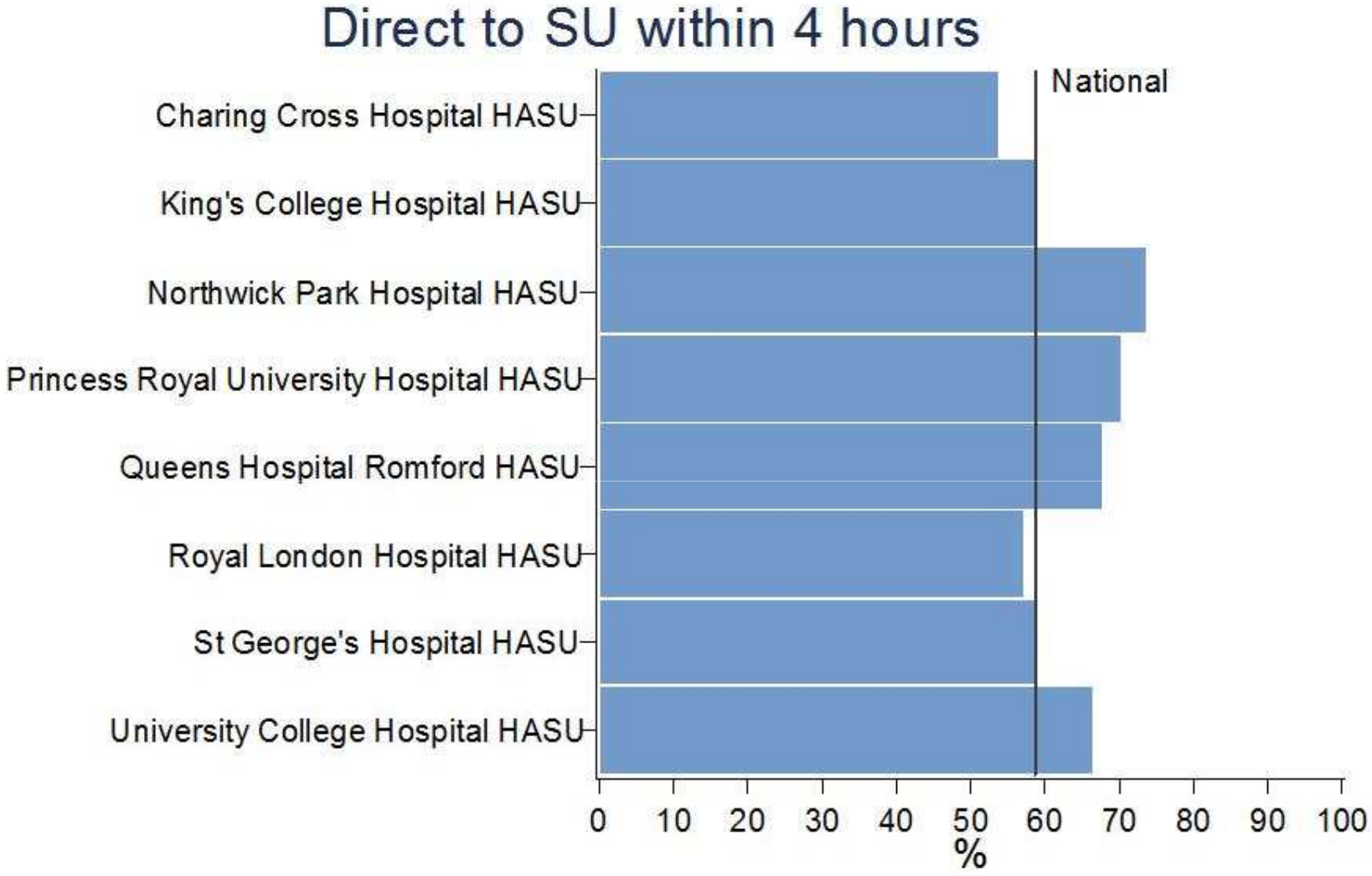
Scanned within 12 hours



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 1.2A

London SCN



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 2.1A

London SCN

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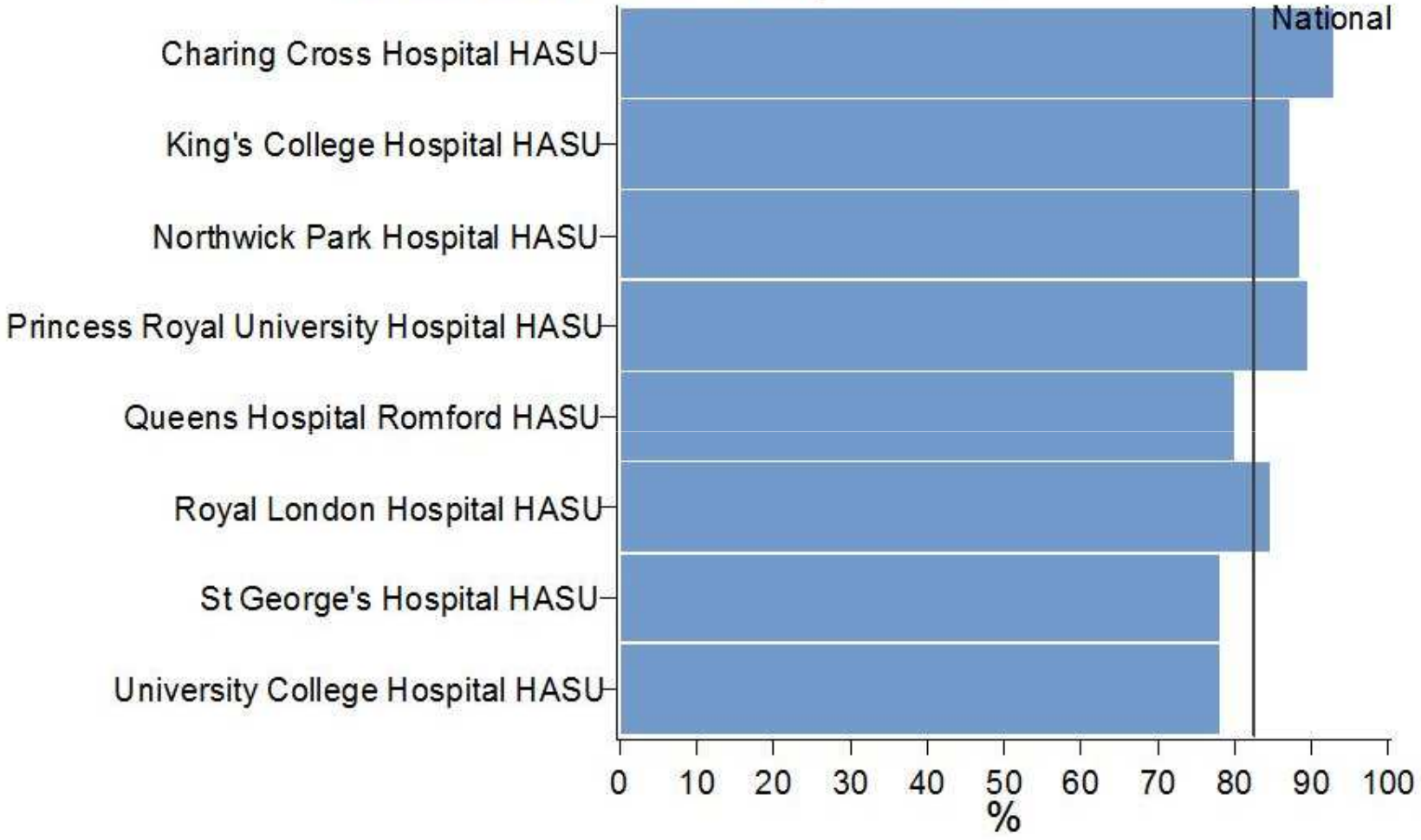
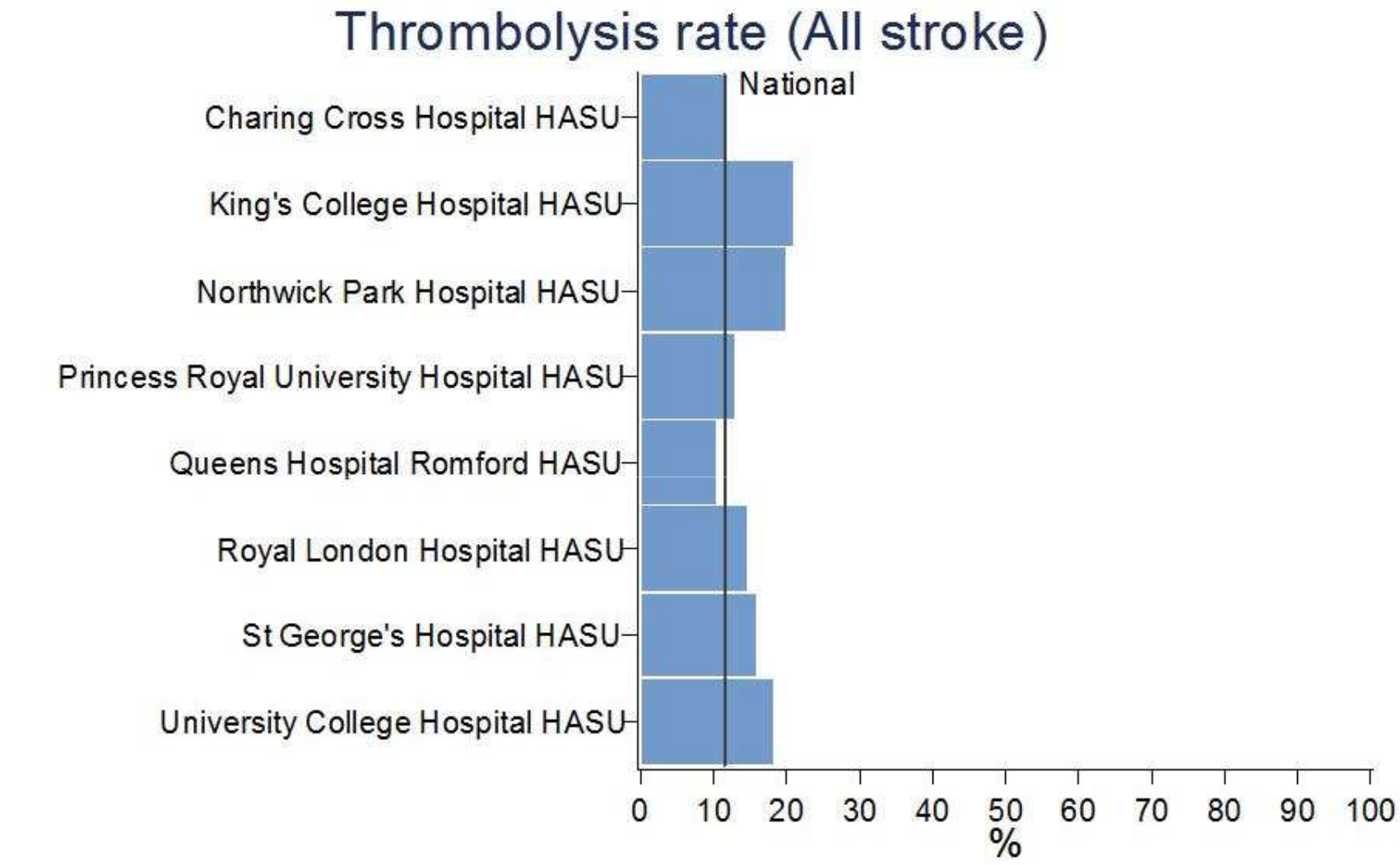
At least 90% of stay on SU



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 2.3A

London SCN



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 3.1A

London SCN

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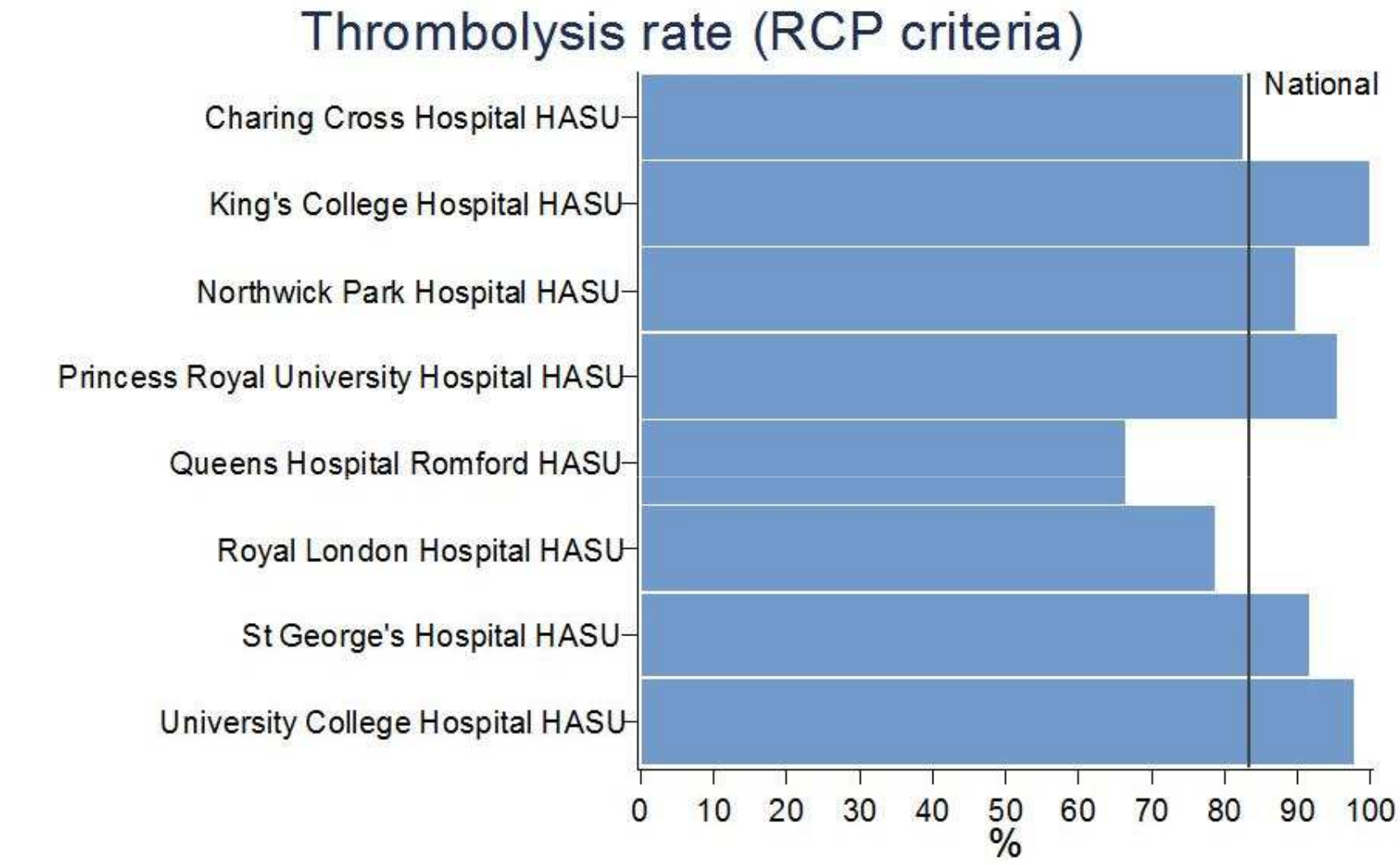

Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 3.2A

London SCN

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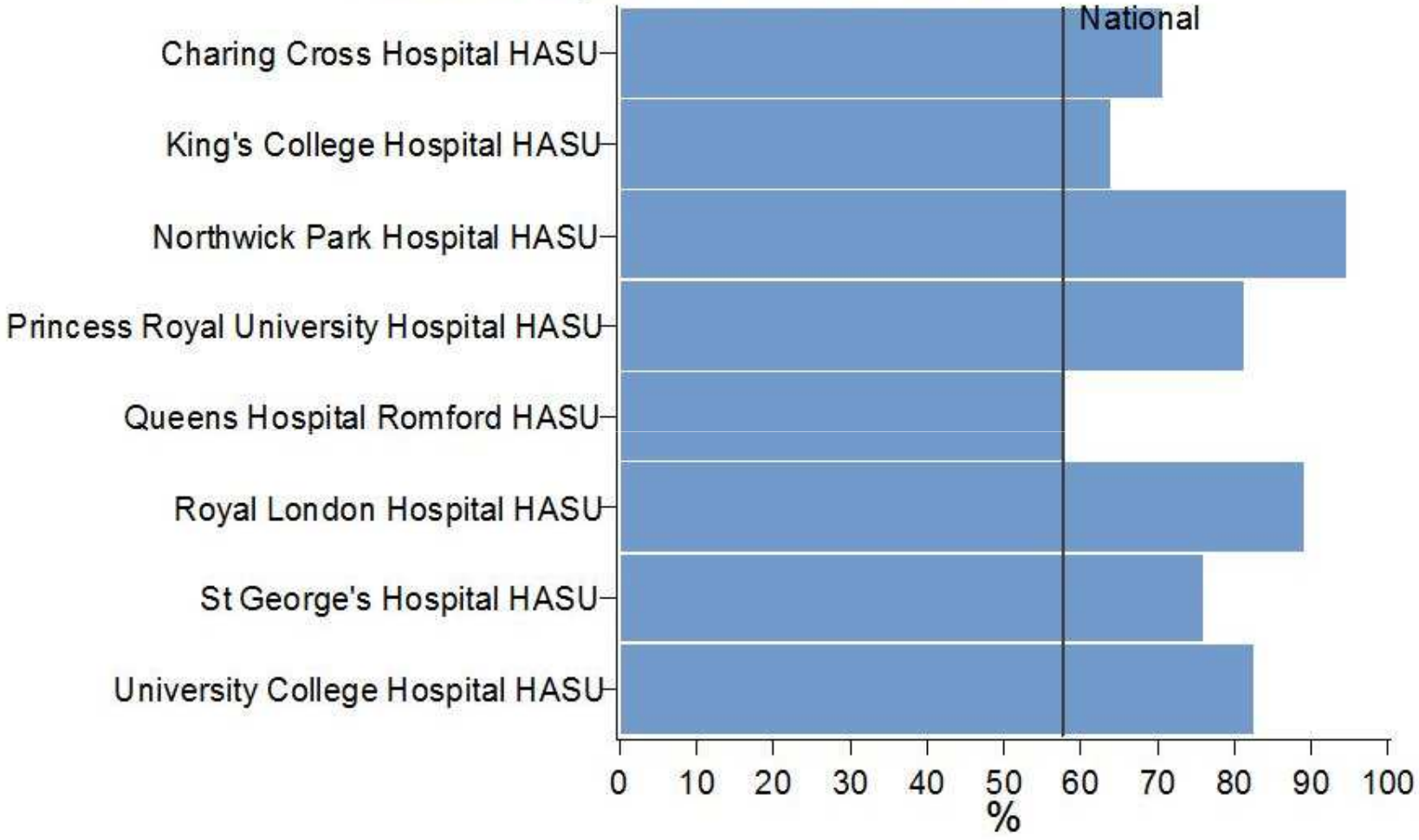
Thrombolysis within 1 hour



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 3.3A

London SCN

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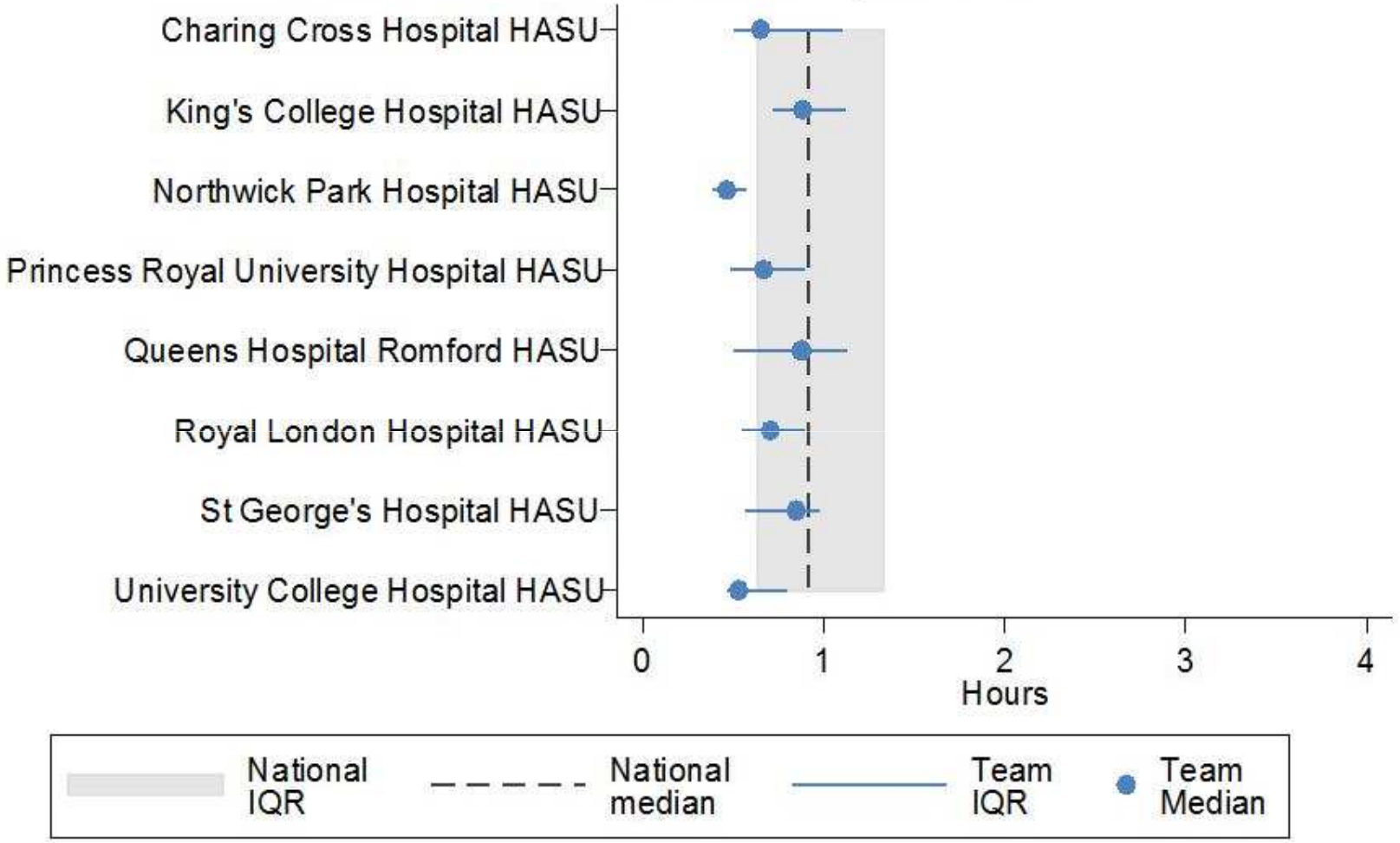
Clock start to thrombolysis time



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 3.5A

London SCN

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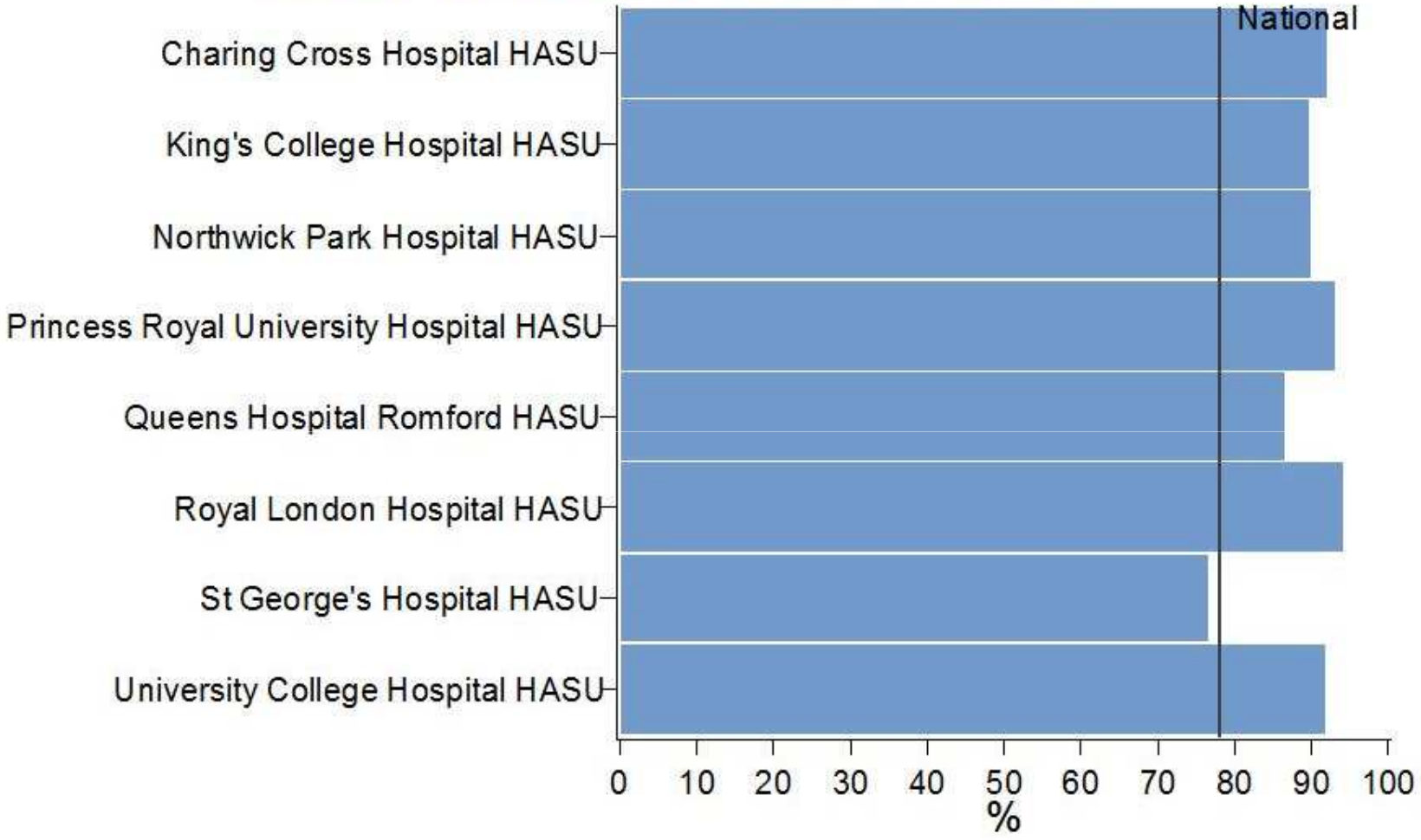
Stroke consultant within 24 hours



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 4.1A

London SCN

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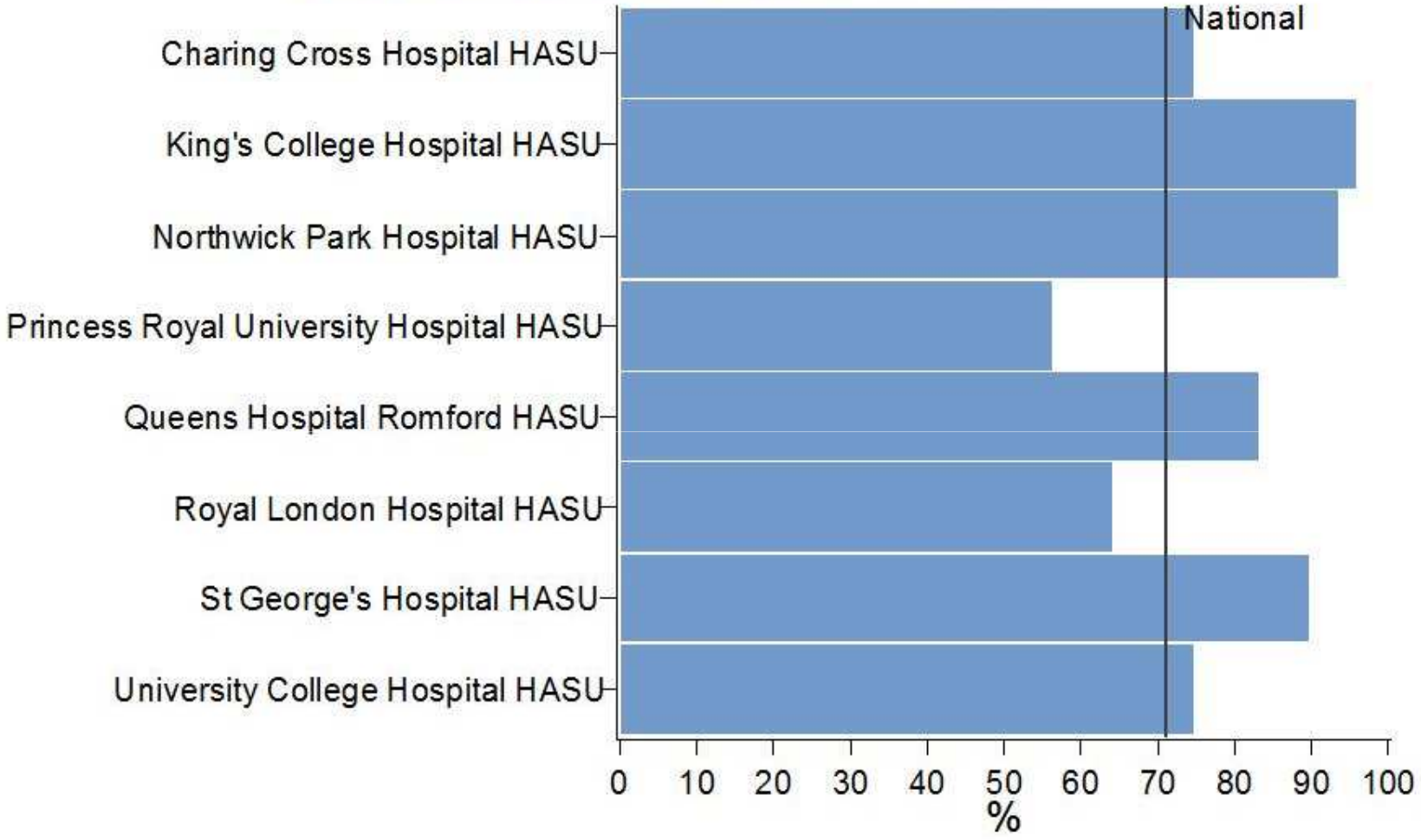
Swallow screen within 4 hours



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 4.5A

London SCN

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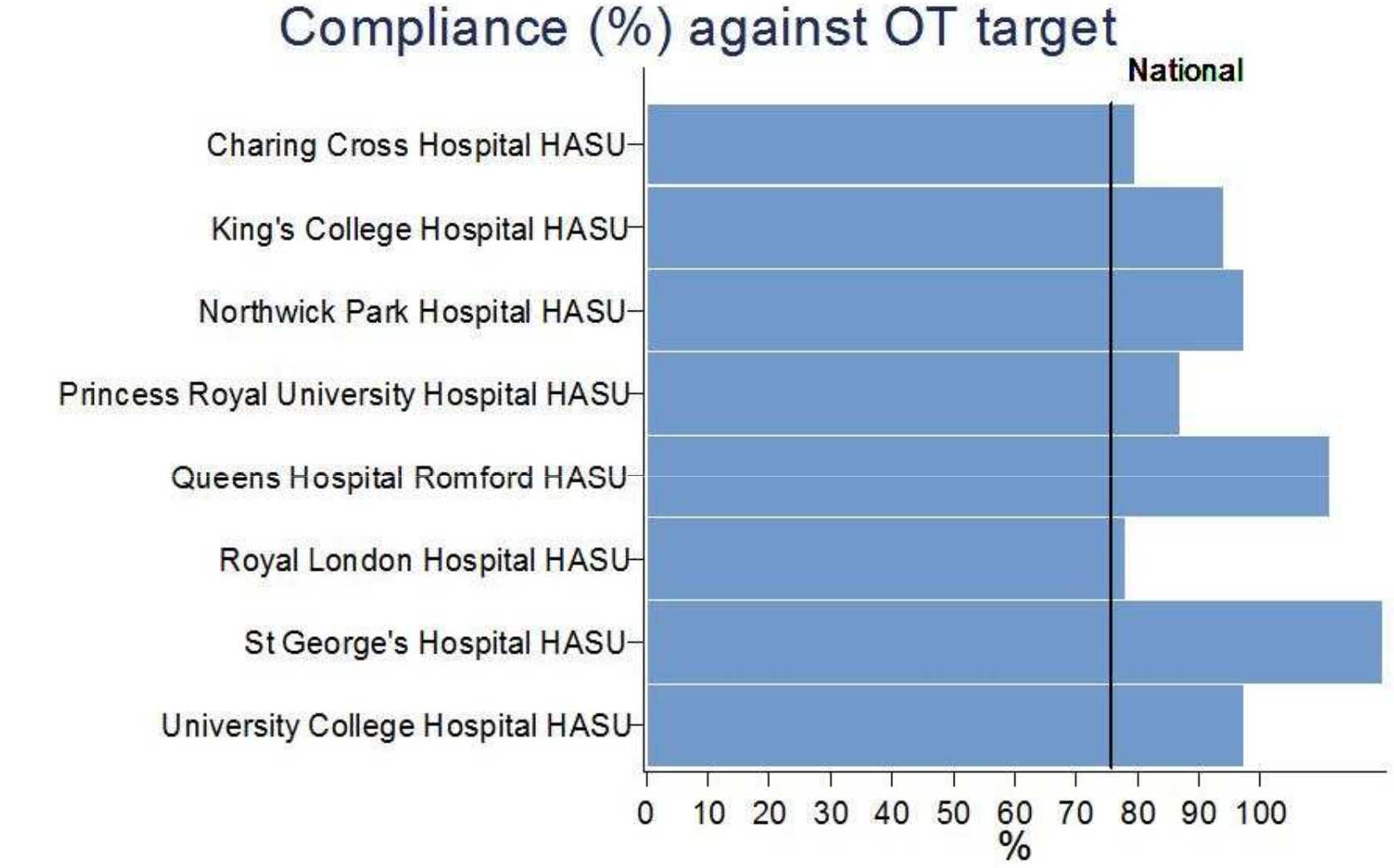
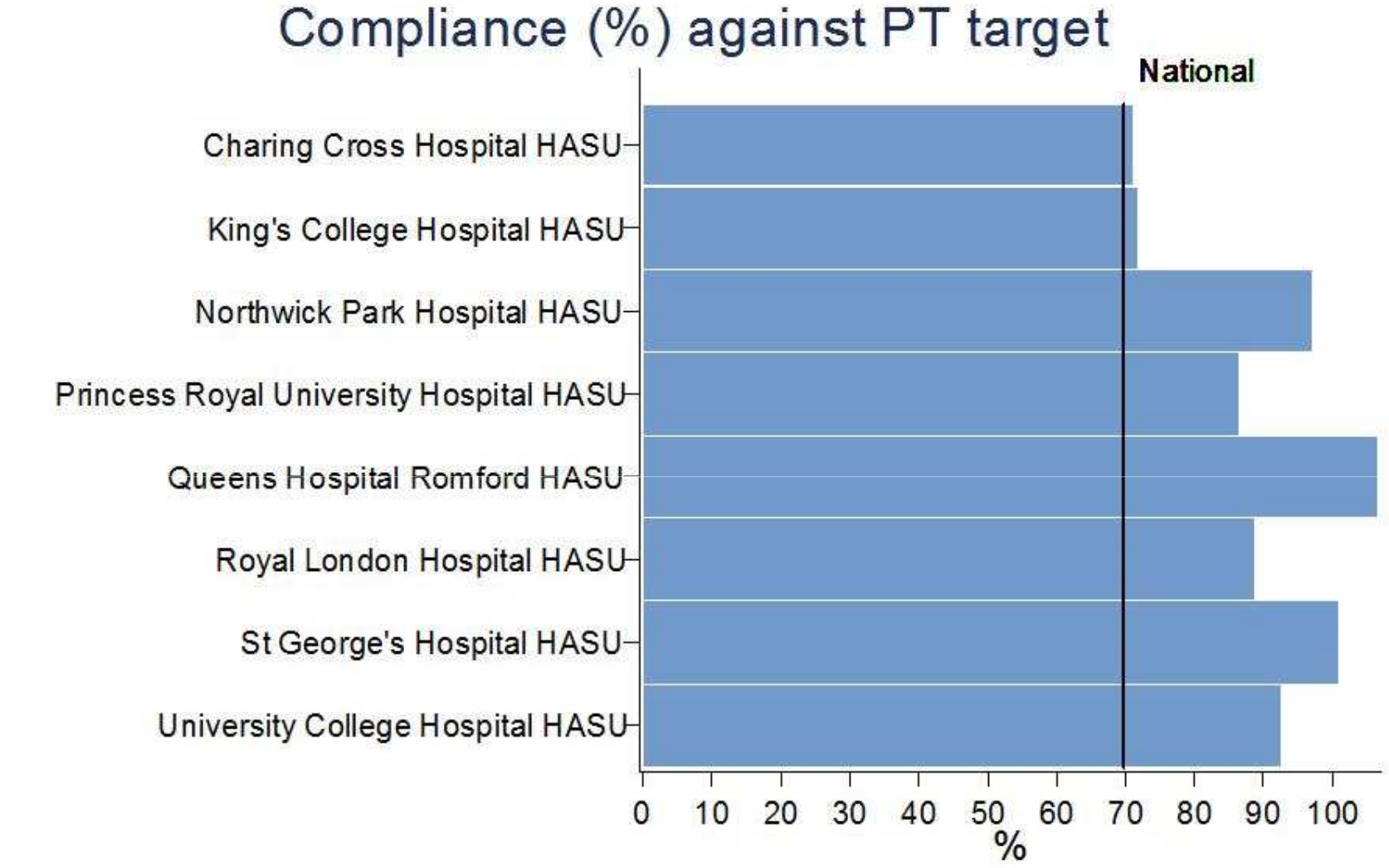


Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 5.4A

London SCN



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 6.4A

London SCN

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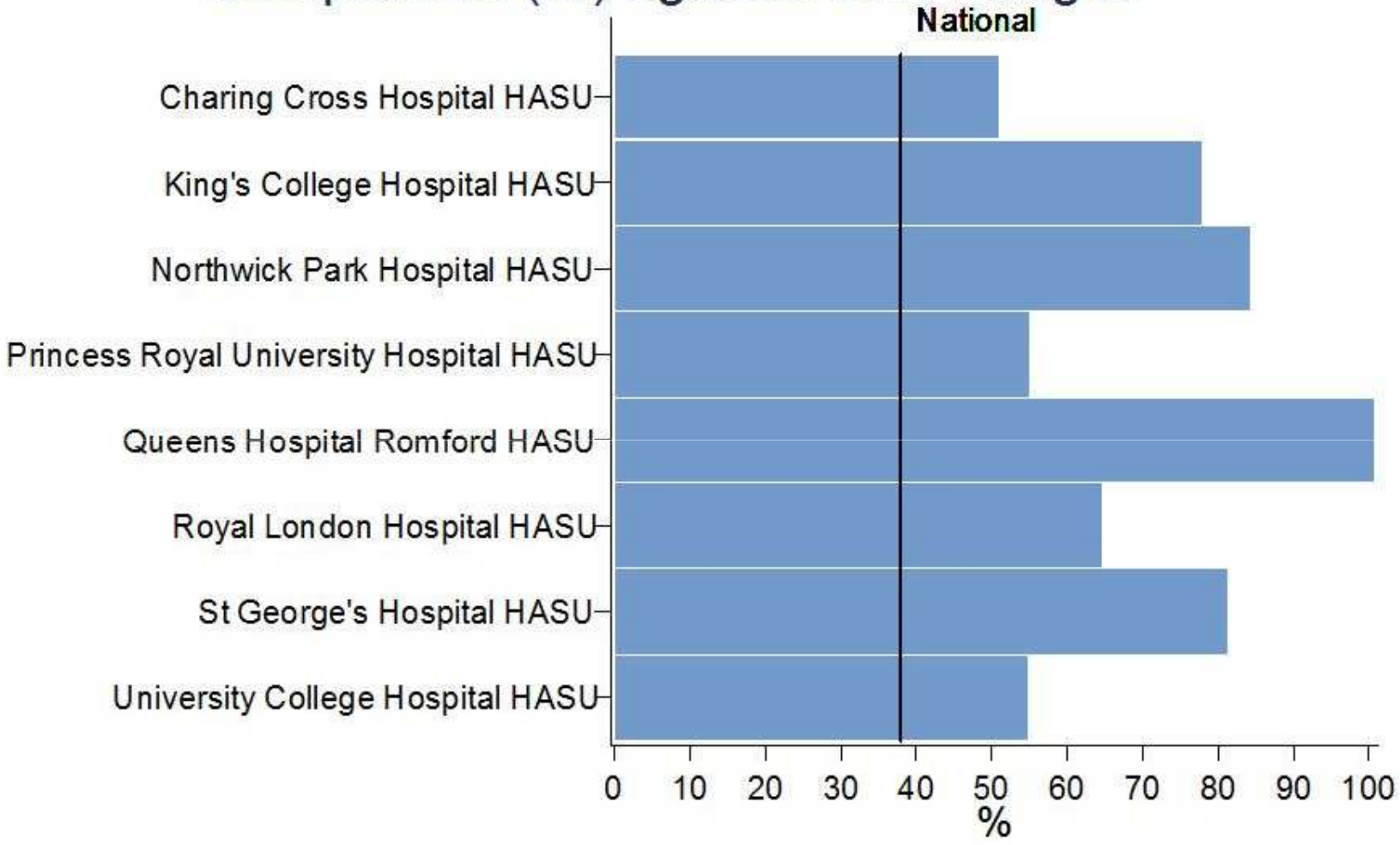
Compliance (%) against SALT target



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 7.4A

London SCN

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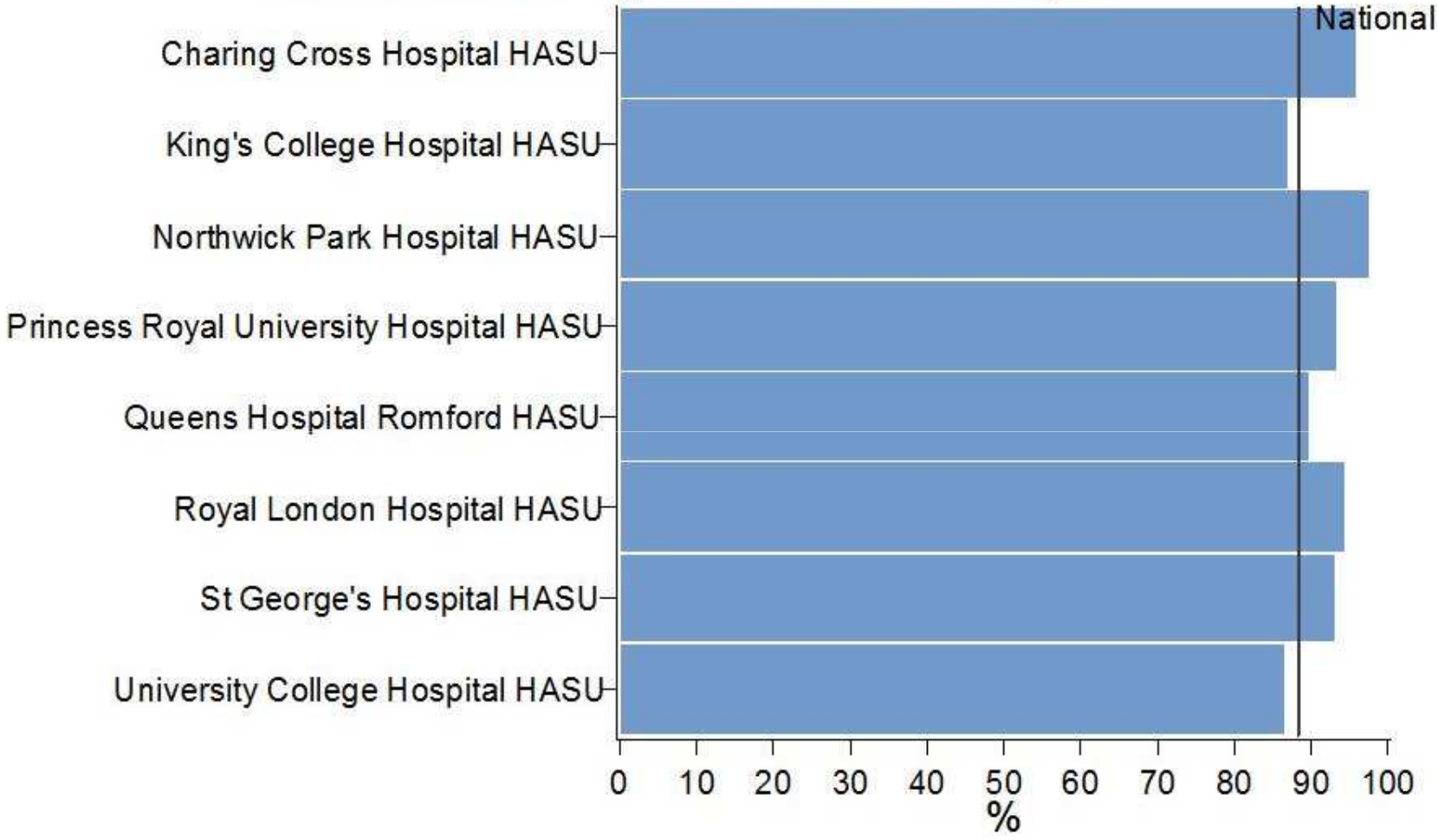
Rehabilitation goals within 5 days



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 8.7A

London SCN

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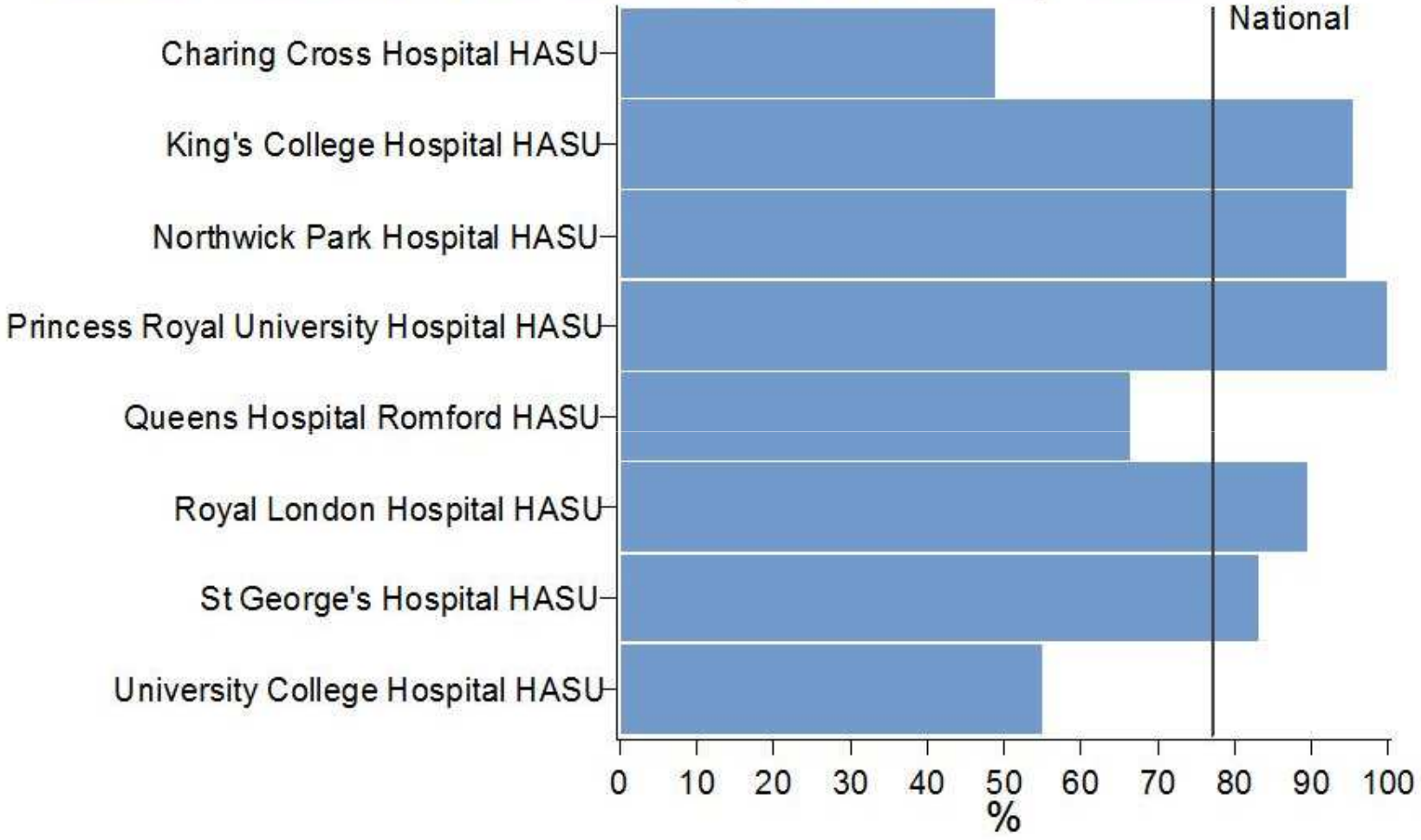
Nutrition screen and seen by Dietitian by discharge



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 9.1A

London SCN

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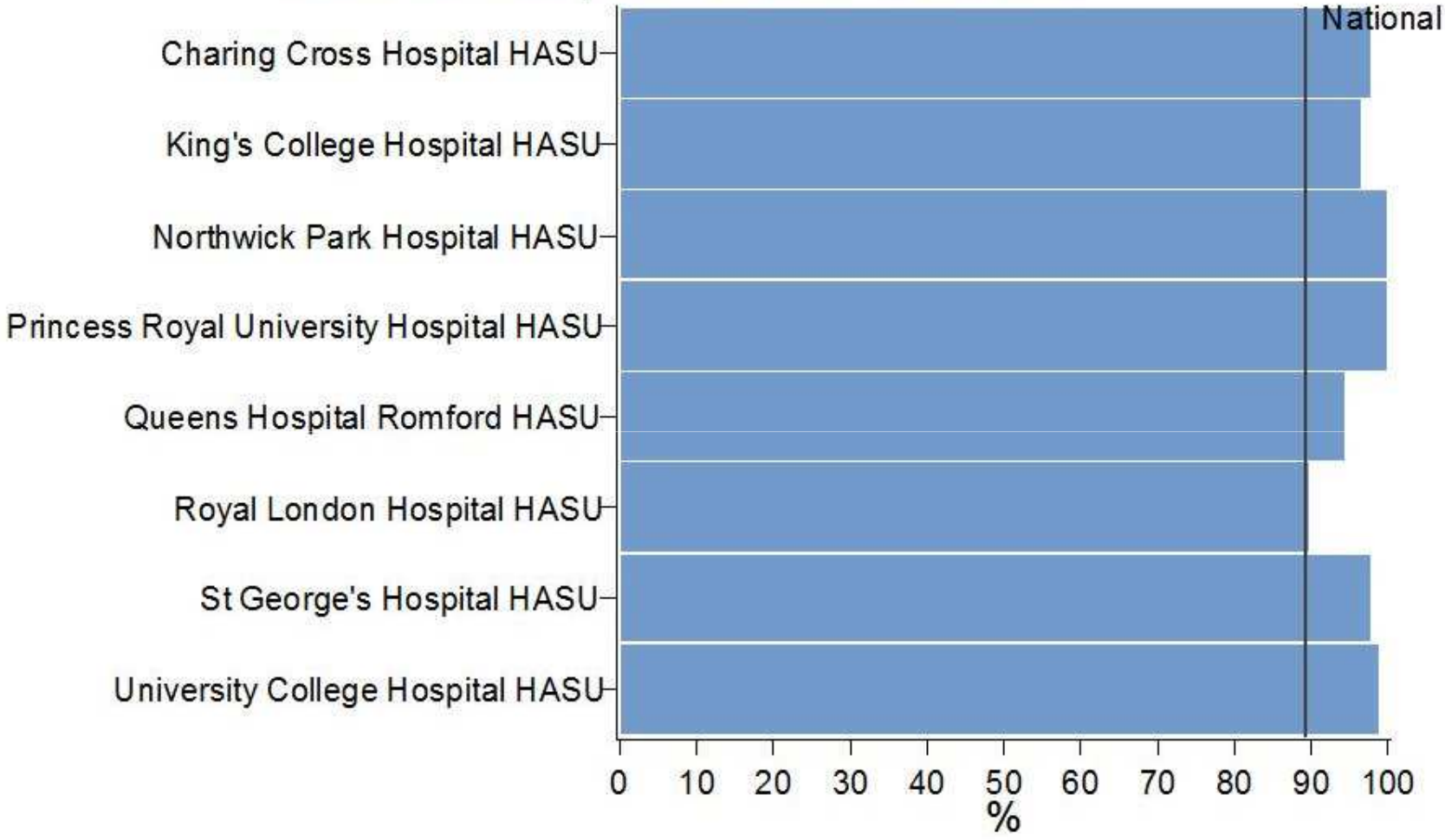
Continence plan within 3 weeks

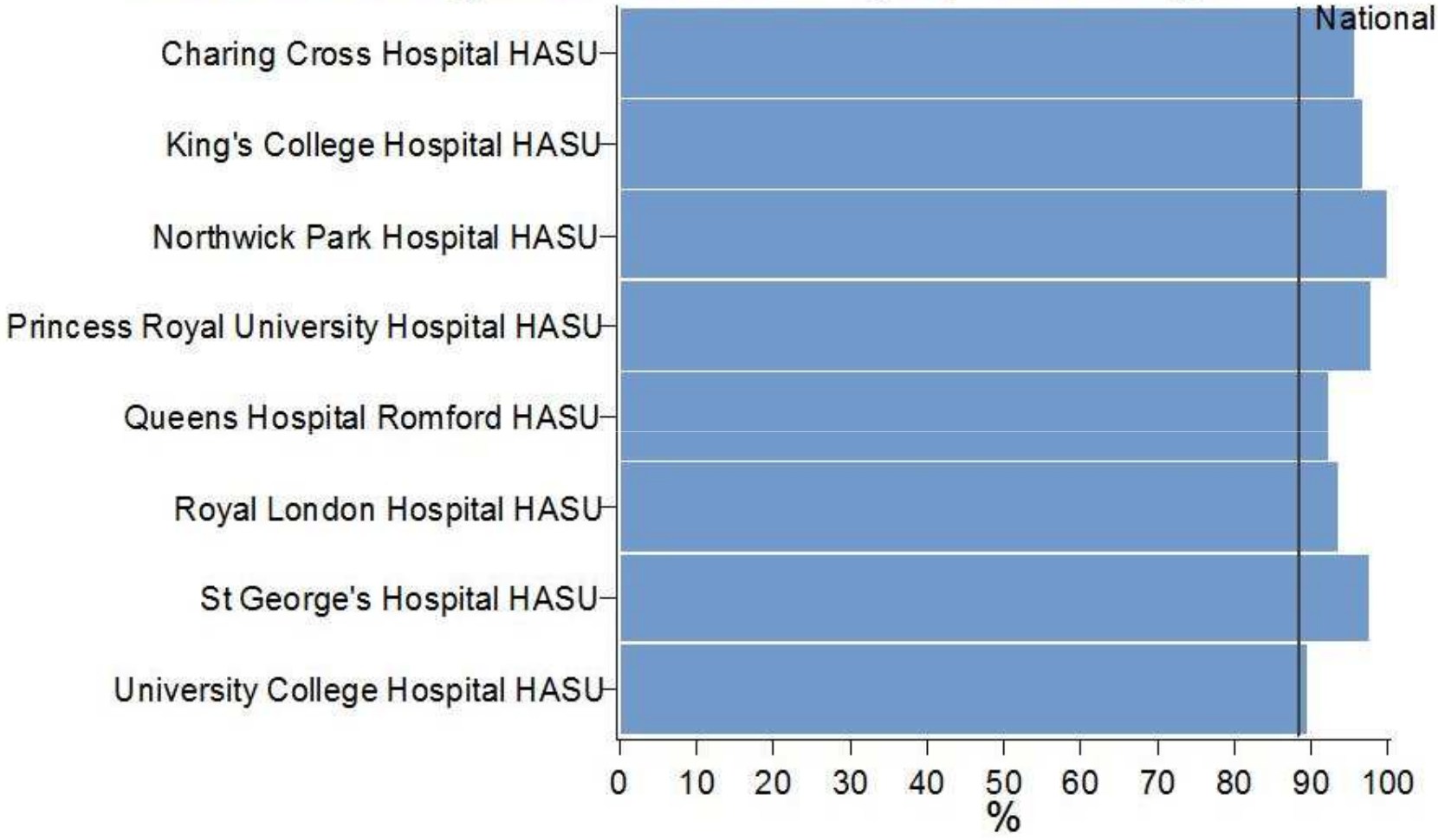


Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 9.2A

London SCN

Page 84

Mood and cognition screening by discharge



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 9.3A

London SCN

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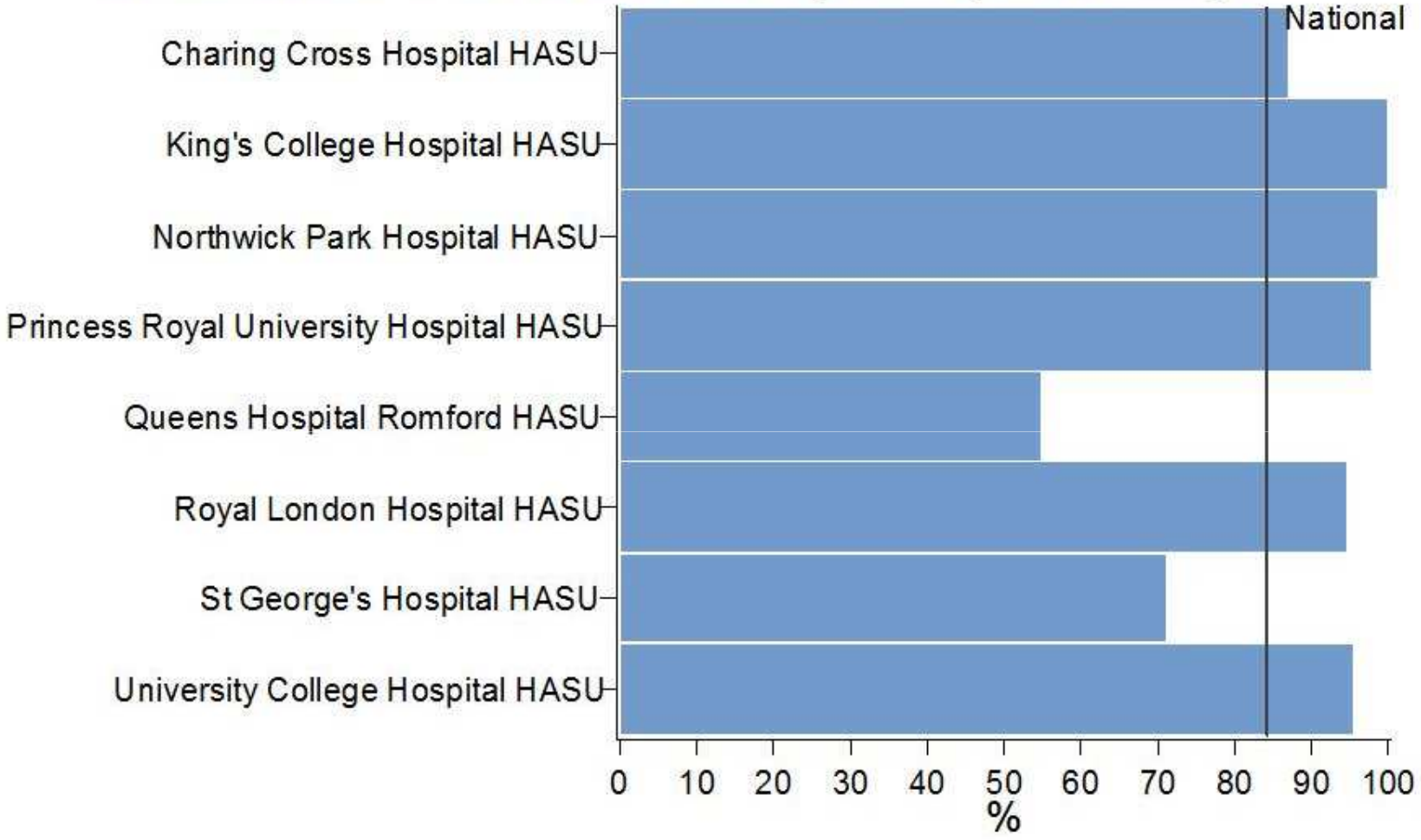
Joint health and social care plan by discharge



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 10.1A

London SCN

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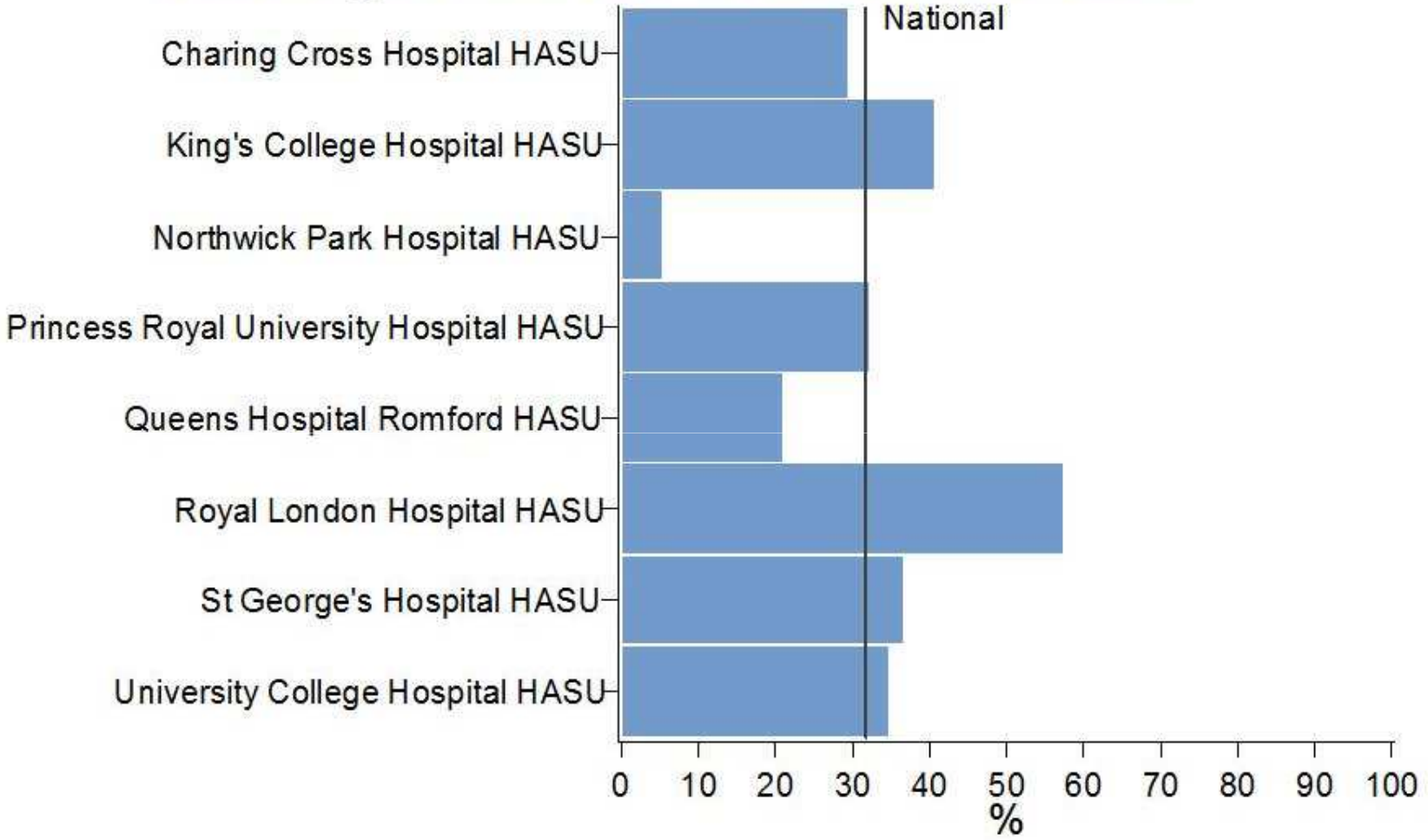
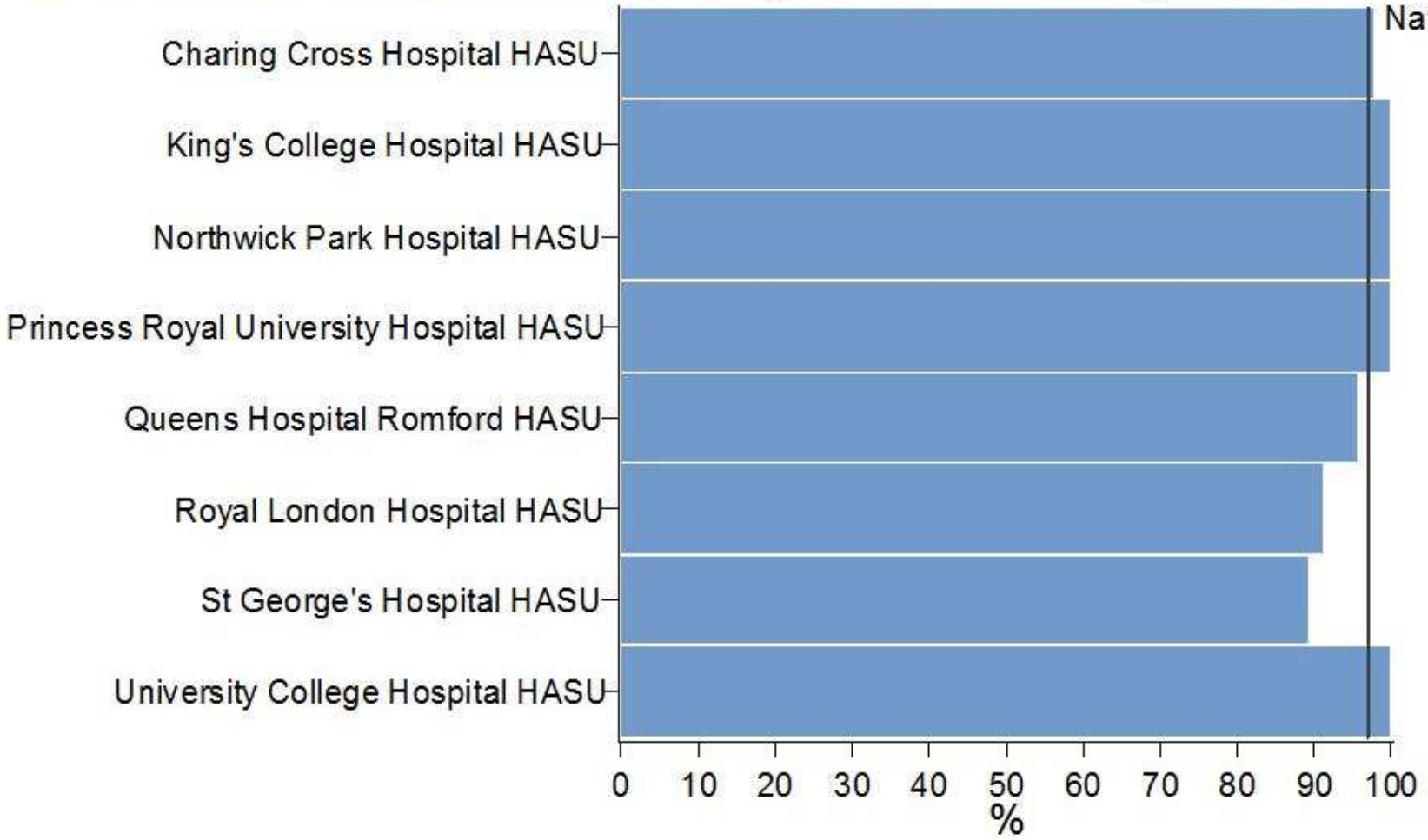
Discharged with stroke skilled ESD team



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 10.2A

London SCN

If in Atrial Fibrillation discharged on anticoagulants



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 10.3A

London SCN

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Non-routinely admitting teams

Non-acute inpatient teams

The following slides contain information about other types of teams within your region.
However, if no other teams have participated in SSNAP in your region, then this information will not be available.

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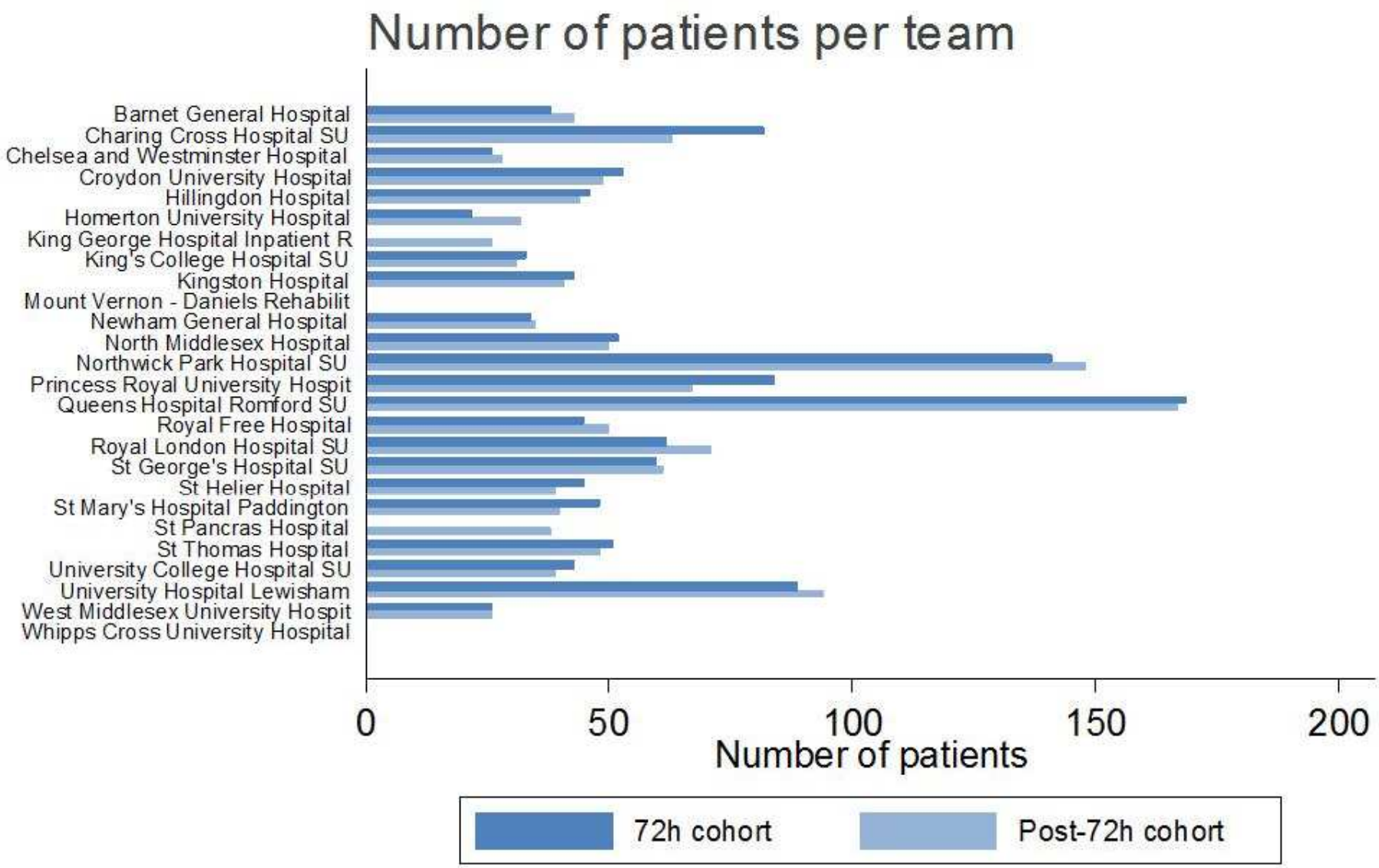

Source: SSNAP Apr-June 2015
Number of patients in both patient-centred cohorts - D2.2 and D5.2

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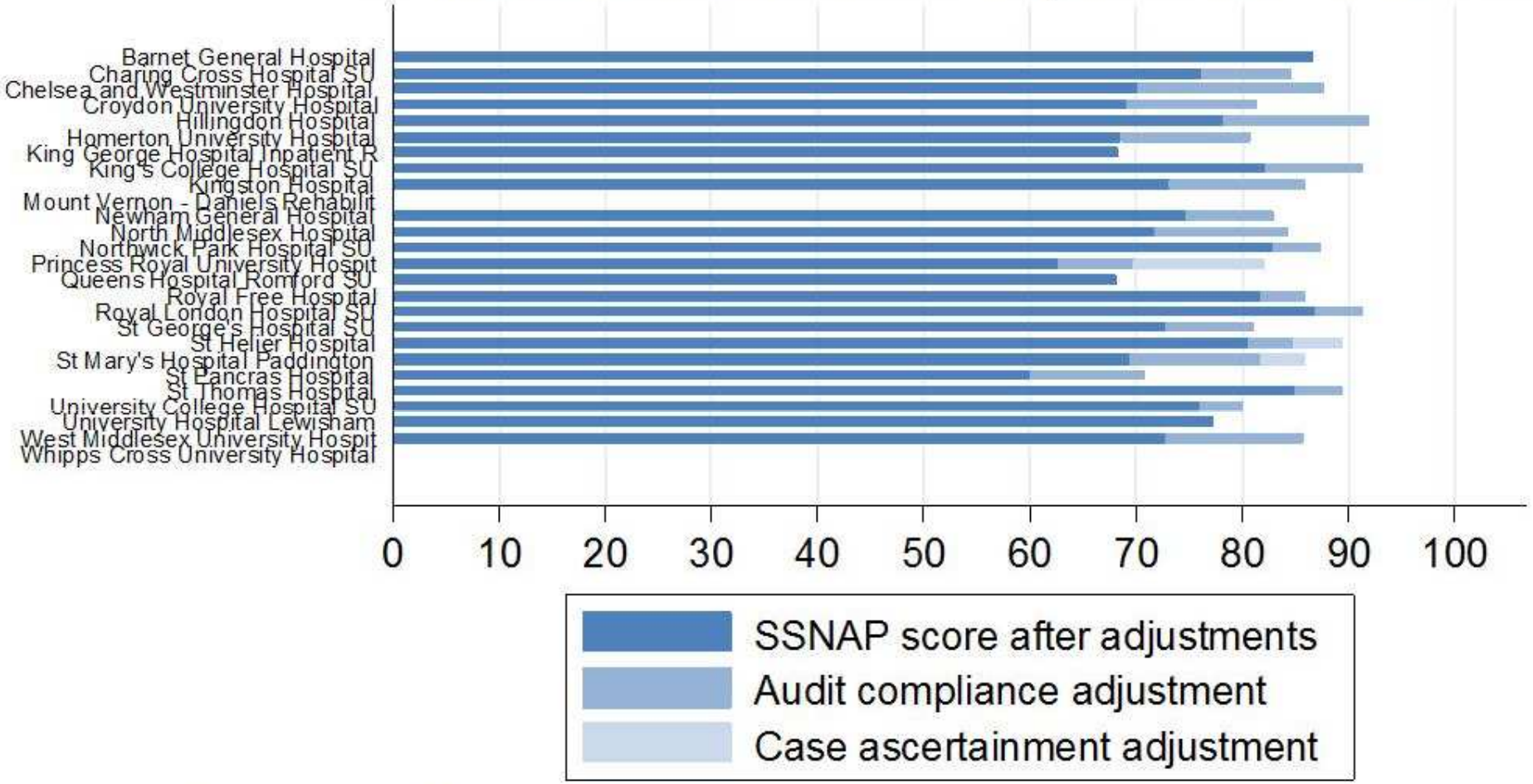
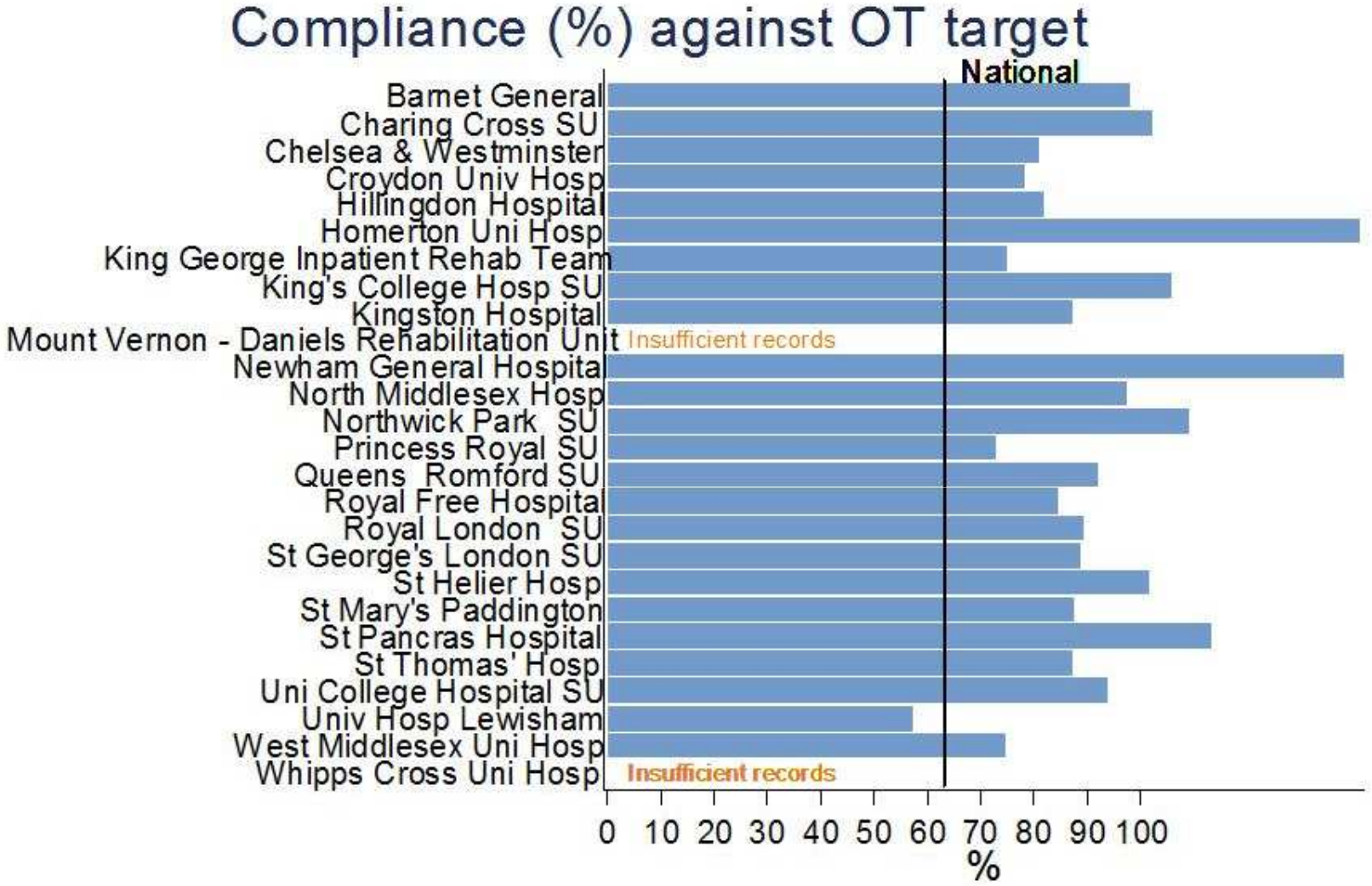
SSNAP score:
Combined Total KI score adjusted for AC and CA



Source: SSNAP Apr-June 2015
Team level results demonstrating the proportion of the Combined Total Key Indicator score which is removed due to AC and CA adjustments to derive the overall SSNAP score



Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 5.4A

London SCN

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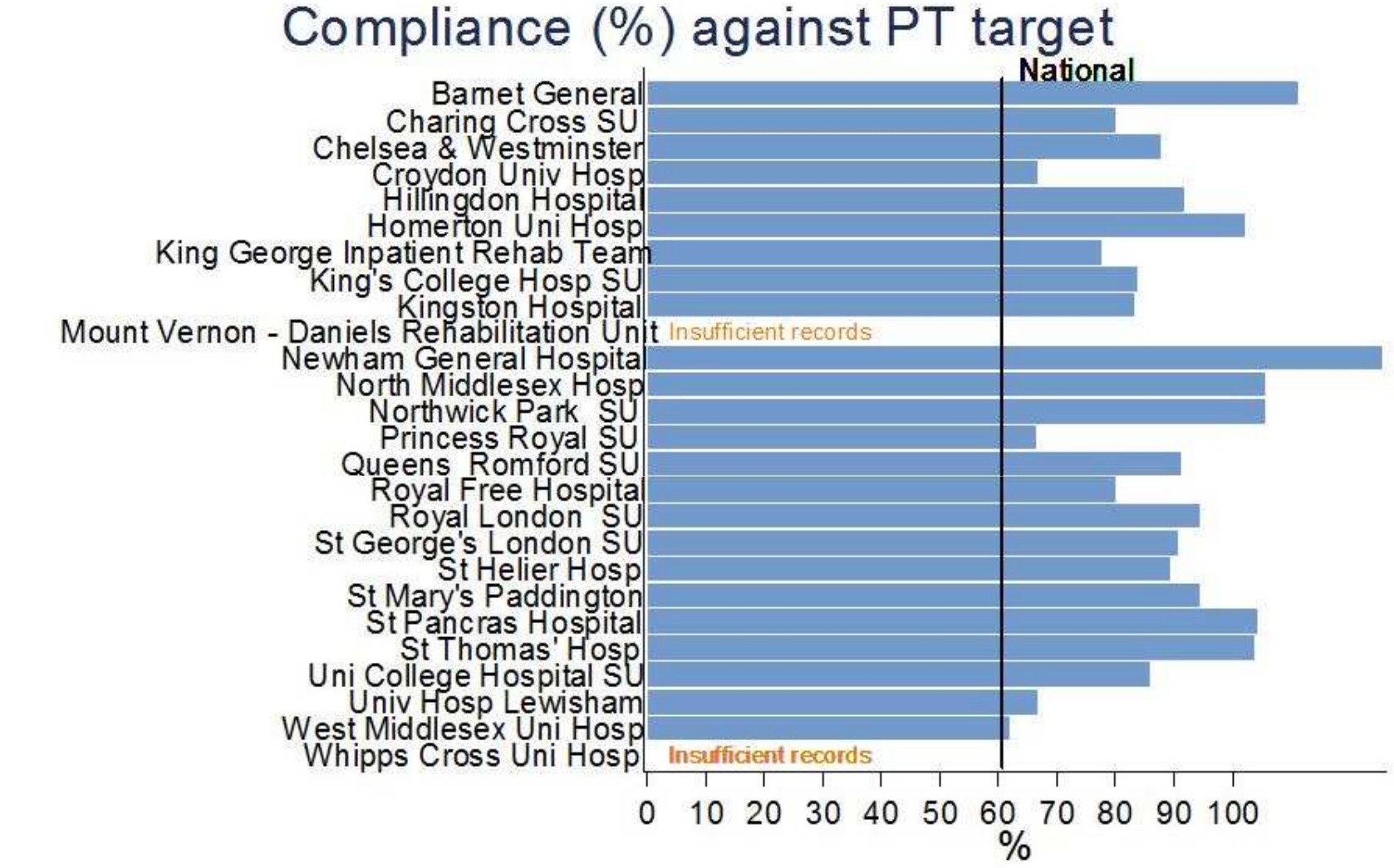

Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 6.4A

London SCN

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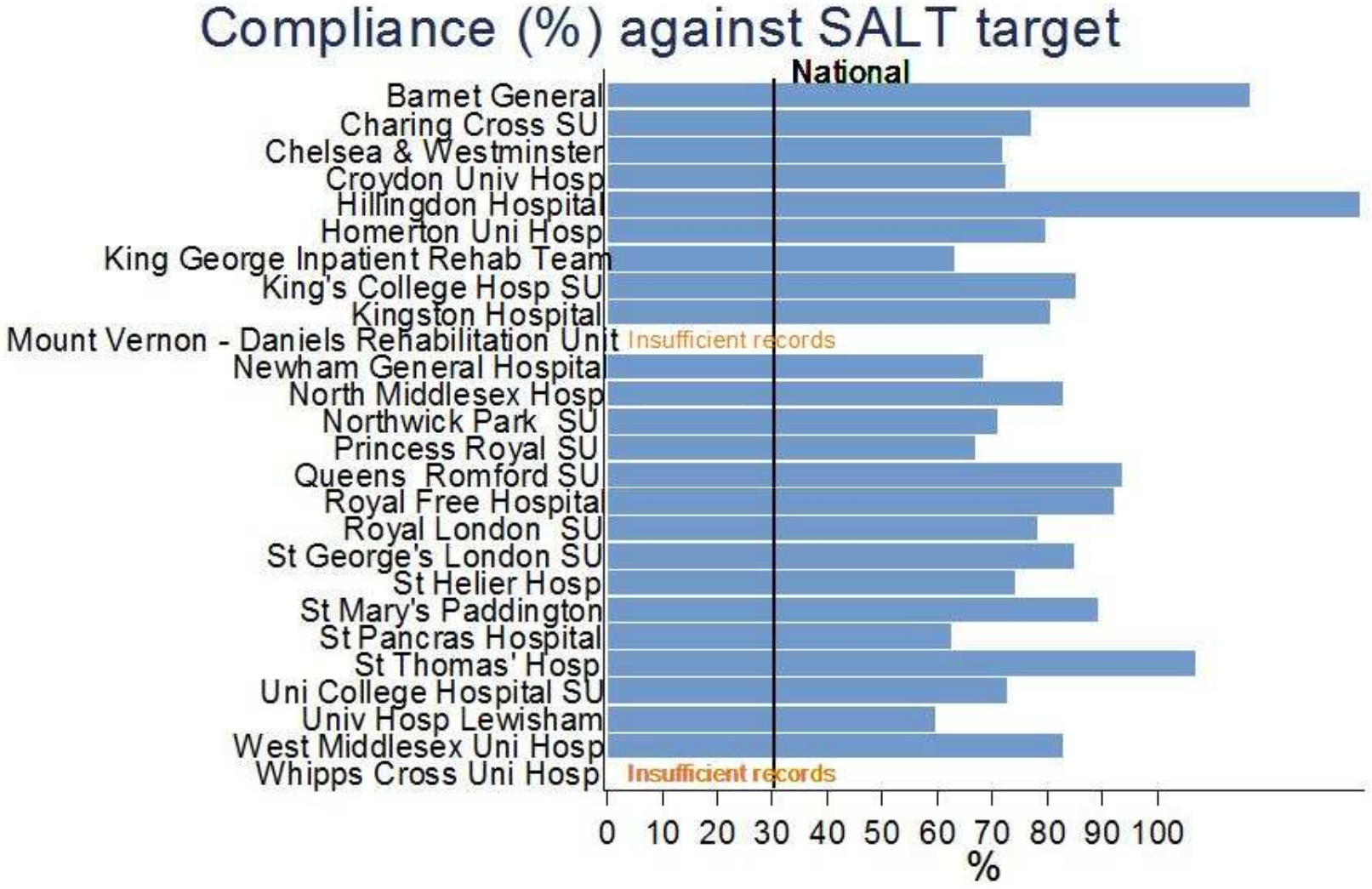

Source: SSNAP Apr-June 2015
Patient-centred results at team level for Key Indicator 7.4A

London SCN

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6 month follow up

N Middx	6% rate
Barnet	30%
RFH	35%
UCH	19%

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Summary

- Overall performance good
- Need to increase data collection from ESD teams
- Need to increase collection of 6 month follow up data
- UCH HASU had significant problems last winter in having sufficient beds to admit all patients to the stroke unit
  - Difficulty repatriating patients esp. to N Middx

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Routinely admitting team London SCN University College London Hospitals NHS Foundation Trust	*Non-routinely admitting acute team* London SCN North Middlesex University Hospital NHS Trust
Royal Free Hospital (1) Directly admitted (287)	Dorset County Hospital (1) Royal London Hospital SU (1) Directly admitted (3) Royal London Hospital HASU (3) University College Hospital SU (5) University College Hospital HASU (42)
288 patients arrived at this team, of which 1 were transferred in from another team	*55 patients arrived at this team, of which 52 were transferred in from another team*
University College Hospital HASU	**North Middlesex Hospital**
295 patients left this team, of which 194 were transferred to another team	*53 patients left this team, of which 25 were transferred to another team*
Discharged home (60) University College Hospital SU (43) North Middlesex Hospital (42) Royal Free Hospital (37) St Pancras Hospital (24) Transferred to non-participating ESD/CRT team (22) St Mary's Hospital Paddington (13) Barnet General Hospital (10) Enfield ESD Team (7) Discharged to a care home (5) Barnet ESD Team (4) Northwick Park Hospital SU (3) Discharged somewhere else (3) Homerton University Hospital (2) Chelsea and Westminster Hospital (2) Camden ESD Team (2) Birmingham Heartlands Hospital (1) Hemel Hempstead Integrated Community Services (1) Royal London Hospital SU (1) Doncaster Community Stroke Rehab Team (1) Whipps Cross University Hospital (1)	Chase Farm Hospital Inpatient Rehab Team (15) Discharged home (9) Discharged to a care home (7) Enfield Community Stroke Rehab Team (6) Homerton University Hospital (2) Danesbury Neurological Centre (1) County Hospital (1)

Non-routinely admitting acute team London SCN Royal Free London NHS Foundation Trust	*Non-routinely admitting acute team* London SCN Royal Free London NHS Foundation Trust
Scunthorpe General Hospital (1) Royal London Hospital HASU (1) University College Hospital SU (1) Northwick Park Hospital SU (4) University College Hospital HASU (10) Northwick Park Hospital HASU (11) Directly admitted (12)	Charing Cross Hospital HASU (1) Northwick Park Hospital HASU (1) Northwick Park Hospital SU (1) University College Hospital SU (2) Directly admitted (3) University College Hospital HASU (37)
40 patients arrived at this team, of which 28 were transferred in from another team	*45 patients arrived at this team, of which 42 were transferred in from another team*
Barnet General Hospital	**Royal Free Hospital**
41 patients left this team, of which 31 were transferred to another team	*53 patients left this team, of which 22 were transferred to another team*
Barnet ESD Team (16) Discharged to a care home (5) Edgware Community Hospital (4) Chase Farm Hospital Inpatient Rehab Team (4) Royal Free Neuro Rehabilitation Centre (3) Discharged home (2) Potters Bar Community Hospital (1) Holywell Rehabilitation Unit - St Albans City Hospital (1) Enfield Community Stroke Rehab Team (1) Herts Valley ESD Team (1)	Discharged home (10) Barnet ESD Team (7) Discharged to a care home (7) Edgware Community Hospital (5) St Pancras Hospital (5) Discharged somewhere else (4) Transferred to non-participating ESD/CRT team (4) Homerton University Hospital (3) Transferred to non-participating inpatient team (3) Camden ESD Team (1) University College Hospital HASU (1)

Non-routinely admitting acute team

London SCN

University College London Hospitals NHS Foundation Trust

Watford General Hospital (1)

University College Hospital HASU (43)

44 patients arrived at this team, of which 44 were transferred in from another team

University College Hospital SU

41 patients left this team, of which 29 were transferred to another team

St Pancras Hospital (11)

North Middlesex Hospital (5)

Discharged to a care home (3)

St Mary's Hospital Paddington (3)

Discharged somewhere else (3)

Royal Free Hospital (2)

Discharged home (2)

Neuro Rehab Unit - National Hospital for Neurology and Neurosurgery (1)

Barnet General Hospital (1)

Camden ESD Team (1)

Transferred to non-participating ESD/CRT team (1)

Queens Hospital Romford SU (1)

East Surrey Hospital (1)

Hillingdon Hospital (1)

Bradford Royal Infirmary (1)

Homerton University Hospital (1)

Non-acute inpatient team

London SCN

Central and North West London NHS Foundation Trust

Royal Free Hospital (5)

University College Hospital SU (11)

University College Hospital HASU (24)

40 patients arrived at this team, of which 40 were transferred in from another team

St Pancras Hospital

36 patients left this team, of which 21 were transferred to another team

Transferred to non-participating ESD/CRT team (11)

Islington Stroke Association 6 Month Assessment Provider (6)

Enfield ESD Team (5)

Camden ESD Team (5)

Camden Community Neurology & Stroke Service (4)

Transferred to non-participating inpatient team (2)

Central London Community Healthcare Stroke ESD Team (1)

Discharged to a care home (1)

Discharged home (1)

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

27 November 2015

Future Dates/Work Plan

1. Future Dates

1.1 Future meetings of the Committee are scheduled as follows:

- 29 January 2016 (Enfield) and
- 11 March 2016 (Camden).

2. Work Plan

29 January 2016 (Enfield)

- LAS Update;
- Maternity Update including mental health support
- CAMHS – New Model

Potential Future Items

Members are requested to consider potential items for future meetings of the Committee. Issues already identified as potential future items for meetings are currently as follows:

- Dementia;
- NMUH – Foundation Status;
- Whittington Hospital – further development;
- Public Health indicators;
- Child obesity;
- Patient safety;
- 7 day NHS.

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 27 NOVEMBER 2015 AT 10.00 AM
COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
E-Mail:	**vinothan.sangarapillai@camden.gov.uk**
Telephone:	**(Text phone prefix 18001)**
Fax No:	**020 7974 5921**

SUPPLEMENTARY AGENDA

Issued on: 24th November 2015

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 27 NOVEMBER 2015

SUPPLEMENTARY AGENDA

Wards

9. NHS 111/OUT OF HOURS GP SERVICES - COMMISSIONING

(Pages 3 - 18)

To consider NHS 111/Out of Hours commissioning.

AGENDA ENDS

Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Commissioning of an integrated NHS 111 and GP out-of-hours service across north central London: Update

November 2015

1. Purpose

This report provides an update to the north central London Joint Health Overview and Scrutiny Committee on the commissioning of the integrated NHS 111 and GP out-of-hours (NHS 111/OOH) service across Barnet, Camden, Enfield, Haringey and Islington (the five NCL CCGs).

GPs representing the NCL CCGs attended the JHOSC on 25 September 2015, and discussed extensively the core principles behind this service model, the engagement that had been carried out, and the timeline for the procurement. The NCL CCGs were asked to return with detail on some of the areas covered verbally in discussions on that occasion, specifically:-

- How commissioners will undertake monitoring of the contract and, in particular, obtain relevant performance information
- Detail on the key performance indicators; and
- Procurement and KPI differences between individual boroughs.

2. Background

NCL CCGs have presented this matter to the JHOSC on four prior occasions. This paper will not cover everything that has been discussed before, but below is a summary of the programme.

2.1. NHS 111

NHS 111 is a free telephone number to help people who have urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways[1] to assess patients and direct them to the most appropriate service.

The NHS 111 service in NCL is currently provided by a single provider – London Central & West Unscheduled Care Collaborative.

2.2. GP out-of-hours services

Out-of-hours services are available so that people can access primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians offer advice and face-to-face appointments if needed. Patients get access to the out-of-hours service by first calling NHS 111.

The out-of-hours services in NCL are currently provided by two different organisations – Barndoc Healthcare Ltd for Barnet, Enfield and Haringey, and Care UK for Camden and Islington.

2.3. Proposed integrated NHS 111 and GP out-of-hours service

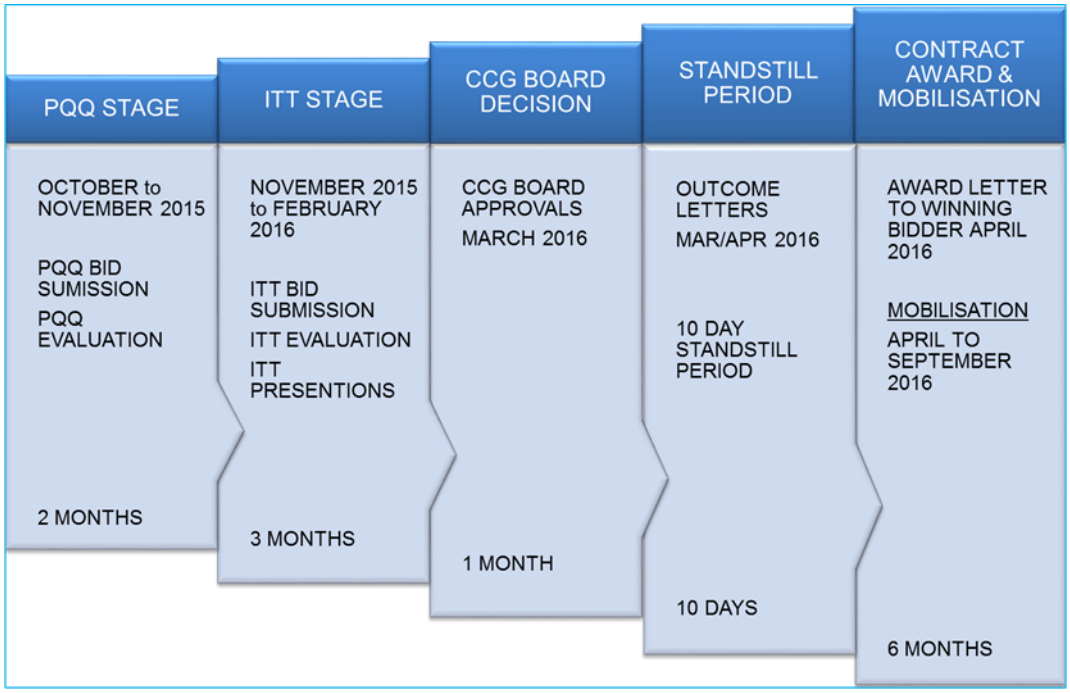
The NCL CCGs are commissioning NHS 111 and OOH as an integrated service across north central London, and this integrated service is expected to begin in October 2016.

[1] NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required.

3 Update on the procurement

3.1 Timeline

The procurement for the integrated NHS 111 and GP out-of-hours service remains in line with the timeline below:-



The Pre-Qualification Questionnaire (PQQ) stage, inviting expressions of interest, was opened on 1 October and closed on 2 November. We are currently in the process of evaluating the responses to the PQQ to determine which participants can be carried forward to the Invitation to Tender (ITT) stage. For reasons of commercial confidentiality, we are unable to give information about the identity of the potential bidders.

As has been discussed at previous meetings and consistent with standard procurement methods the evaluation of bids at the ITT stage will require a balanced scrutiny of quality and cost. The NCL CCGs have opted to weight the evaluation to favour quality in a ratio of 80:20. This means that 80% of the marking used to differentiate bidders will be assigned to quality questions and measures.

There are patient/public representatives - selected from members of the Patient and Public Reference Group (PPRG) which has been involved with the procurement process since April 2015 – on the Evaluation Panel, and we are planning to have additional representatives supporting the OSCE (Objective Structured Clinical Examination) stage, wherein bidders will be tested on their response to a range of specific, locally-devised scenarios.

3.2 Service specification

We engaged on the draft service specification for this service in July and August, and received hundreds of comments from our Patient and Public Reference Group, GPs and other clinical experts, specific interest groups, service users and members of the public in the five boroughs.

In light of these comments the specification was revised extensively. We are unable to include the final version in this paper as it remains a confidential document because of its commercial

sensitivity, until the Invitation to Tender (ITT) has been published. However, we have included a summary of the main changes as a result of our engagement, at Appendix A.

The service can be summarised as follows:

This service is designed for patients, carers and their families when:

- They need medical help fast, but it is not a 999 emergency.
- They do not know whom to contact for medical help.
- They think they need to go to A&E or another NHS urgent care service.
- They need to make an appointment with an urgent care service.
- They require health information or reassurance about what how to care for themselves or what to do next.

The integrated urgent care services which encompasses NHS 111 and the out-of-hours service must:

1. Be available 24 hours a day, 365 days a year (366 days in a leap year) for telephone advice;
2. Receive referrals through telephony and online channels;
3. Provide consultations with GPs and other clinicians during the out-of-hours period;
4. Connect service users to clinicians where indicated;
5. Provide access to health records and patient notes
6. Request an ambulance without delay where indicated; and
7. Provide a consistently high quality service irrespective of the geographic area served.

3.3 Commissioning Standards

NHS England published new Commissioning Standards for Integrated Urgent Care on 30 September 2015. These have been circulated to JHOSC already, and are available at https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf. As anticipated, and in part because NCL leads have taken a key role in steering their development, these standards are very much in line with the service model that NCL CCGs have been developing. E.g.

> (p10) The offer for the public will be a single entry point – NHS 111 – to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.
>
> Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists (GPs, dentists, pharmacists) and specialists.
>
> *(Note: It is important to note that the term 'Clinical Hub' (as used in the Commissioning Standards for Integrated Urgent Care) is a functional description, it being a joined up network of clinical support to be drawn upon depending on the person's need. It is not about a new building or a specific service.)*

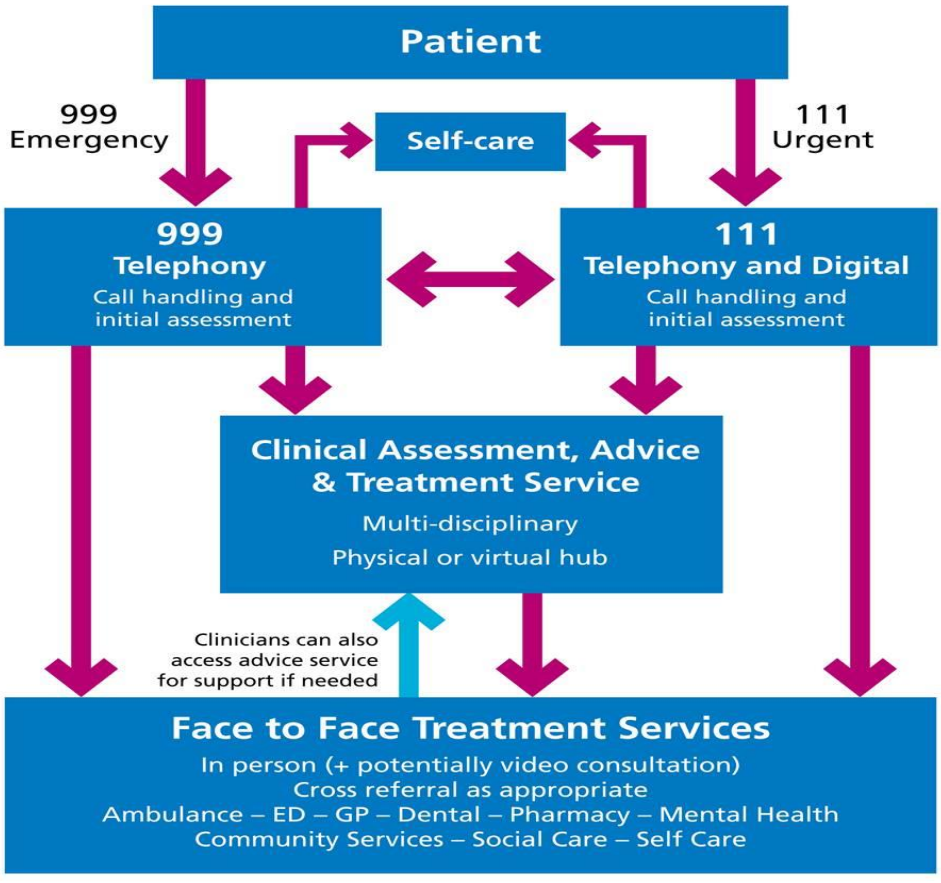
(p17) The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service.

(p17) It is envisaged that both large and small providers will have an important part to play in delivering a successful and Integrated Urgent Care service. Providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage current NHS 111 and Out-of-hours organisations to collaborate or work within a lead provider arrangement, to deliver the standards for an Integrated Urgent Care service.

(p20) Integrated Urgent Care will have the capability to make an electronic referral to the service that can best deal with a patient's needs as close to the patient's location as possible.
 Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service whenever this is supported by local agreement.

(p31) The clinical workforce will be comprised of generalist clinicians (paramedics, nurses and GPs) who have specialised skills and competences in remote and telephone assessment and management, supported by specialised clinicians from a range of professions cover specific clinical areas, including mental health, dental health and paediatrics.

The model for Integrated Urgent Care services as described by NHS England is illustrated below:



3.4 Contract management

We will establish a governance structure within which a lead CCG will be responsible for the overall contract management. The contract will however be overseen by representatives of all five CCGs, who will hold the future provider/s to account, through regular quality review meetings and ongoing monitoring to ensure all aspects of the service adhere to the highest of standards and meet the needs of service users in each of the five boroughs.

As at present, there would be monthly meetings involving representatives of both providers and commissioners. These involve a Contract Technical Group looking at financial and similar aspects of the provider's performance, and a Contract Quality Review Group (CQRG) looking at performance data, serious incidents, complaints and service user feedback.

The Patient and Public Reference Group, with input from local Healthwatch, is currently considering how best to involve service users in the contract review process – one suggestion is that there will be one or more public or Healthwatch representatives on the CQRG, who will in turn feed back to a broader patient/public group who may have a role in oversight of the whole NCL Urgent and Emergency Care Network.

Outside of these monthly meetings, commissioners and relevant bodies (i.e. Healthwatch) will have the right to make unannounced inspections of NHS 111 and GP out-of-hours sites, as part of best practice, information sharing and a collaborative approach to joint working. During the mobilisation period the CCGs will continue to work with public and patient representatives to develop the quality and activity reports that can be shared more widely.

Taken together, these approaches will give us early insight into any issues which may arise, and enable us to work with the providers to ensure these are addressed and do not have a significant impact on patients.

If commissioners continue to have concerns about a provider's performance, they will be subject to the terms for financial penalty and ultimately suspension or contract termination, as set out in the NHS standard contract[2]. Relevant excerpts from this are included at Appendix B.

3.5 Quality requirements and key performance indicators

Monthly reporting on a detailed set of performance measures will provide the CCGs with early notice should the provider struggle to meet the expected standards. As at present, there will be a published set of National Quality Requirements (NQRs) allowing for comparability between the local service and those elsewhere, as well as some measures reflecting local priorities. The contract will be flexible, allowing measures to change over time, so we can be sure we are checking the right things.

The current NQRs for NHS 111, published on the NHS England website[3], collect performance data in areas such as:-

- Percentage of calls answered within 60 seconds
- Percentage of calls transferred to a clinical advisor

[2] https://www.england.nhs.uk/nhs-standard-contract/15-16/

[3] https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2015-16/

- Percentage of call-backs with 10 minutes
- Percentage of calls resulting in ambulance dispatch
- Percentage of callers recommended to attend primary or community care.

These measures are intended to assess whether the NHS 111 service is fulfilling its role within the broader urgent and emergency care system, and operating in a sufficiently robust way so that service users can have confidence in it.

The out-of-hours service is subject to the same reporting mechanism, so that we will have comparable service-appropriate data, locally derived and compared month by month, but also benchmarked to regional and national metrics. An important measure in this section, in terms of demonstrating the benefits of service integration will be the number of callers whose issue is dealt with wholly within the integrated urgent care service, without onward referral.

There is also a set of patient experience indicators, based on regular surveys sent out to callers. This data records patients' satisfaction with the service, their outcomes (i.e. whether they complied with the advice from the integrated urgent care service, and whether their problem was resolved) and what service they would have used had 111 not been available – again, this is a way of checking that service users have confidence in the service, and that it is diverting patients from A&E and other parts of the system that are under pressure.

The provider/s will also be required to have processes in place that allow patients and carers to share experiences and provide feedback about the service on an ongoing basis. This patient feedback will form part of the monthly reporting to CCGs.

There is also a mechanism for doctors and other clinicians to submit feedback forms on an ongoing basis as part of Clinician Feedback. There will be regular commissioner-provider meetings to review clinical interactions from initial call to ultimate disposition. This will enable qualitative assessment of contacts on a case-by-case basis, and provide a much richer sense of how the service is performing. All calls in the integrated urgent care service are also recorded – commissioners will listen to a selection of recordings to ensure the quality of this part of the service, and this is also a useful tool for assessing any complaints that are received.

Clinical audit of all cases is a requirement of the continuous quality improvement element of this service. Commissioners will require the provider to undertake clinical audit at a local level. Commissioners will review data on all referrals that are made within the integrated urgent care system –this means we can ensure that providers are making appropriate referrals for all callers, and that different providers within the system are working together in an integrated fashion, in the best interests of patients and the health system as a whole.

The provider/s will also be required to meet any changing quality requirements established by NHS England for NHS 111 and OOH services.

3.6 Local service developments and indicators

Representatives of all five NCL CCGs have been involved in developing the service specification and procurement model for this service. To a large extent, therefore, the new service model is intended to meet all the service needs of all the population – where one CCG has proposed improvements to the model based on local experience, these have been applied across all five CCGs, so that all our service users will benefit.. An example of this is the requirement to adopt

end of life care plans within the service for Haringey patients; this has been adopted for all boroughs involved in this service.

As has been discussed previously, the local approach to integrating NHS 111 and the out-of-hours service came out of local work in Camden and Islington with The Primary Care Foundation (PCF). The PCF observed in detail the exact ways in which the disconnect between the services impacted on patients, and made recommendations about the importance for patient safety of having an integrated service and removing unnecessary delays in call transfer between services.

It is this work, and the model that has evolved out of it, that has gone on to inform NHS England's approach to commissioning integrated urgent care. Since then, we have conducted a huge amount of local engagement, and local residents and commissioners have been involved at every stage to inform the development of the specification.

There are many service requirements included in the specification to reflect input from local patients, public and clinicians. These broadly fall into the following areas (see Appendix A):-

1. Clinical quality and safety
2. Clinical Governance and Integrated Governance
3. Operational
4. Technical
5. Patient and Public Involvement
6. Social Marketing and Communication
7. Performance and Contract Management
8. Workforce
9. Access and Availability

The performance indicators described above will be reported on a borough-by-borough basis (based on the location of the caller so that individual CCGs can continuously monitor whether the provider is meeting local variations in need and providing a consistently good service.

Local needs vary between (and within) the NCL boroughs. There are variations in the types of people who use our services, in terms of age, ethnicity, levels of deprivation and prevalent conditions. The future providers will be expected to flex their service delivery to ensure they meet all these needs – for example to adjust the numbers, skill mix and shift hours of staff at the out-of-hours bases to fit with local demand – exactly as already happens. The key principle is that there should be equity of access and service delivery for patients across the whole of NCL. Equity of access is not the same as services being identical.

There is also local variation in the other services commissioned by the NHS or local authorities. For example, a mental health crisis hotline is currently commissioned for patients in Camden and Islington and will be a referral point used by the integrated urgent care service in those boroughs – elsewhere the equivalent patients will be supported in a different way.

Similarly, while all NCL CCGs are developing extended GP services, these projects are at different stages, will offer different services in different areas, and will continue to develop over the five-year lifetime of the urgent care contract and beyond. These developments will clearly have a big impact on 111/OOH referrals during the 8am-8pm period and at weekends, and the volume of calls received from different areas at different times – the new providers will need to be sensitive to this variation, and adapt their service accordingly. The specification makes this requirement clear.

North central London CCGs have commissioned a comprehensive Directory of Services to ensure that, outside the scope of NHS 111/OOH itself, there is comprehensive understanding of what local services are available when. This will greatly enhance the quality of advice and referral provided by NHS 111. One of the significant benefits of the new model, as we track patient pathways through and out of the urgent care service, is that we will be equipped to assess where needs are or are not being met across the whole health system. For example if referrals in a particular area or for a particular service type are not working smoothly or proving satisfactory for patients, this is where it will show up, and how CCGs will be alerted that there are changes that need to be made.

4 Recommendations

- JHOSC members are asked to consider and comment on the information provided.
- The JHOSC is asked to consider at what stage they would like a further update on this programme, bearing in mind the projected milestones which should see the contract awarded in April 2016, and the new service beginning in October 2016.

5 Appendices

Appendix A: Principal changes to 111/OOH service specification following public engagement

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

Appendix A: Changes to the Service Specification

Structure

As a result of the feedback from patients and the public we have edited the structure of the service specification and reorganised the presentation style. A summary has also been included to assist audiences that may not be familiar with the technical detail. The terminology has been modified to add clarity where providers are required to deliver functions, for example changes from 'should' to 'must'. A diagrammatic summary has been added to assist readers with the type of service to be delivered and to help reflect where the service fits into the rest of the system.

1. Clinical quality and safety

The commissioners and members of the governance committees will be able to enter the provider's premises for governance purposes and to check on service delivery. This group will also include patient representatives.

The clinical quality of the service will be monitored using regular clinical audit; this will operate at a borough level and also based on the professional group for clinicians in the service. The audit standards will include the professional standards that have been set by the relevant Royal College or Professional Body, for example the Royal College of GPs audit standard will be a requirement within this service.

2. Clinical Governance and Integrated Governance

The information security requirements have been refined so that it is clear that data cannot be shared outside of the permitted use for this service and certainly cannot be used for any commercial purposes.

3. Operational

The role of the clinical hub within the service has been clarified so that providers are aware of the precise scope of the service within north central London, to reflect the integration with local services in each of the boroughs. For example, with care homes in Barnet and mental health services in Camden and Islington.

The location of call centres is also specified with the added desire to make this close to the boroughs of north central London. The location of bases for out-of-hours GP appointments must be within the boroughs of north central London.

The minimum data requirements for service users have been changed to remove ethnicity, based on the public feedback.

Callers will have more direct access to clinicians and this will be based on any care plans that have been agreed with a patient's GP. This function has been introduced following feedback from NCL residents.

Callers falling into a number of categories will now have more direct access to a clinician including the following, these have been added following feedback from patients and the public in NCL

- Patients that are not happy with the initial advice given
- Patients who may want an ambulance but are unsure
- Those patients that want support with self-care or home care but do not want to visit an Emergency Department
- Patients with multiple symptoms and those patients who also have complex medical

histories
- Patients with clinical care plans including those who have an end of life care plan

The public wanted a more responsive service when seeing a GP in the out-of-hours period, therefore the time periods for responses have been shortened to improve the patient experience.

4. Technical

The online access to this service has been expanded for north central London.

The clinical decision support system will be more flexible so that it can be changed in the future to meet the needs of users in north central London.

Patients will be able to consent to record sharing when they call and will be able to make individual decisions on access to their patient record.

Telephone call routing has been improved so that calls for certain patients in north central London such as under 5s and over 85s will be routed to a clinical advisor more rapidly rather than being first managed by a health advisor.

5. Patient and Public Involvement

The provider will be required to involve the public and patients on an ongoing basis with service development.

The provider will need to develop their patient feedback techniques to reflect the local needs of each borough in north central London.

6. Social Marketing and Communication

As a result of very specific feedback from NCL residents the commissioners will require the provider to work with local organisations and groups within each borough to promote the service and help promote access.

7. Performance and Contract Management

The specification sets out that payment model and the performance indicators will be refined during the course of this contract and that the provider will be required to move to the new payment system.

The contract model will use the NHS standard contract but will include an annual review process that will enable the opportunity to agree any contract variations and changes that need to be made in response to developments in primary care and other parts of emergency care.

Public representatives will be part of the group that oversees the contract and will have an opportunity to provide ongoing recommendations for service development.

Contract monitoring data will be presented at an individual borough level which is a requirement that has resulted from public feedback.

Outcomes: The service will have a balanced set of key performance indicators which will include clinical outcomes and operational outcomes (e.g. where a patient was referred to)

The KPIs will be monitored monthly to start with, however north central London will be moving towards real time reporting so that outcomes can be more closely monitored. North central London is now a pilot site for real time reporting.

8. Workforce

The workforce component has been modified to ensure that the service includes clinicians that are familiar with local pathways, services and protocols such as local borough level formularies and services that exist in each borough. The clinicians will be supported with a local directory of services but will need to be familiar with the local services that they may be referring to and will need to demonstrate how they will integrate with local services in each borough, including local GP services.

The training requirement has also been expanded to ensure that the service is connected to local practices through the training of GP registrars in order to help improve the number of local GPs working in the service that are familiar with the needs of patients in each borough in NCL.

9. Access and Availability

The population that the service is being delivered for and the specific needs of each of the local boroughs is cited in the specification to reflect the local authority health profiles for each borough. This includes the need for specific accessible service locations within each of the boroughs of north central London. The times of operation of the service are clearly set out in the service specification. The performance indicators for north central London will include access and availability of the service to ensure that residents for each borough receive an equitable service.

Access to the service will be expanded to ensure that all people in north central London irrespective of where their GP is will be able to access this service.

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

GC9 Contract Management

9.4 If the Co-ordinating Commissioner believes that the Provider has failed or is failing to comply with any obligation on its part under this Contract it may issue a Contract Performance Notice to the Provider.

9.6 Unless the Contract Performance Notice has been withdrawn, the Co-ordinating Commissioner and the Provider must meet to discuss the Contract Performance Notice and any related issues within 10 Operational Days following the date of the Contract Performance Notice.

9.11 If a Remedial Action Plan is to be implemented, the Co-ordinating Commissioner and the Provider must agree the contents of the Remedial Action Plan within:

9.11.1 5 Operational Days following the Contract Management Meeting;

9.12 The Remedial Action Plan must set out:

9.12.1 actions required and which Party is responsible for completion of each action to remedy the failure in question and the date by which each action must be completed;

9.12.2 the improvements in outcomes and/or other key indicators required, the date by which each improvement must be achieved and for how long it must be maintained;

9.12.3 any agreed reasonable and proportionate financial sanctions or other consequences for any Party for failing to complete any agreed action and/or to achieve and maintain any agreed improvement (any financial sanctions applying to the Provider not to exceed in aggregate 10% of the Actual Monthly Value in any month in respect of any Remedial Action Plan).

9.16 If, 10 Operational Days after notifying the Governing Bodies, the Co-ordinating Commissioner and the Provider still cannot agree a Remedial Action Plan due to any unreasonableness or failure to engage on the part of the Provider, the Co-ordinating Commissioner may recommend the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), up to 2% of the Actual Monthly Value for each further month a Remedial Action Plan is not agreed.

9.19 If either the Provider or any Commissioner fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan, then the Co-ordinating Commissioner or the Provider (as appropriate) may, at its discretion apply any financial or other sanction agreed in relation to that failure.

9.20 If a Party fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan and does not remedy that failure within 5 Operational Days following its occurrence, the Provider or the Co-ordinating Commissioner (as the case may be) may issue an Exception Report:

9.20.1 to the relevant Party's chief executive and/or Governing Body; and/or

9.20.2 (if it reasonably believes it is appropriate to do so) to any appropriate Regulatory or Supervisory Body,

in order that each of them may take whatever steps they think appropriate.

9.21 If the Provider fails to complete an action required of it, or to deliver the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan:

9.21.1 (if the Remedial Action Plan does not itself provide for a withholding or other financial sanction in relation to that failure) the Co-ordinating Commissioner may, when issuing an Exception Report, instruct the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), in respect of each action not completed or improvement not met, a reasonable and proportionate sum of up to 2% of the Actual Monthly Value, from the date of issuing the Exception Report and for each month the Provider's breach continues and/or the required improvement has not been achieved and maintained, subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value;

9.22 If, 20 Operational Days after an Exception Report has been issued under GC9.20, the Provider remains in breach of a Remedial Action Plan, the Co-ordinating Commissioner may notify the Provider that any sums withheld under GC9.19 or GC9.21.1 are to be retained permanently. If it does so having withheld those sums itself on behalf of all Commissioners, the Co-ordinating Commissioner must distribute the sums withheld between the Commissioners in proportion to their respective shares of the Actual Monthly Value for each month in respect of which those sums were withheld.

GC16 Suspension

16.1 If a Suspension Event occurs the Co-ordinating Commissioner:

16.1.1 may by written notice to the Provider require the Provider with immediate effect to suspend the provision of any affected Service, or the provision of any affected Service from any part of the Services Environment, until the Provider demonstrates to the reasonable satisfaction of the Co-ordinating Commissioner that it is able to and will provide the suspended Service to the required standard;

16.8 Following and during the suspension of a Service the Provider must:

16.8.1 not accept any further Referrals of Service Users who require the suspended Service;

16.8.2 at its own cost co-operate fully with the Co-ordinating Commissioners and any interim or successor provider of the suspended Service in order to ensure continuity and smooth transfer of the suspended Service and to avoid any inconvenience to or risk to the health and safety of Service Users, employees of the Commissioners or members of the public including:

16.8.2.1 promptly providing all reasonable assistance and all information necessary to effect an orderly assumption of the suspended Service by any interim or successor provider; and

16.8.3 ensure there is no interruption in the availability of CRS or Essential Services including, where appropriate, implementing any Essential Services Continuity Plan.

Termination: Provider Default

17.10 The Co-ordinating Commissioner may terminate this Contract or any affected Service, with immediate effect, by written notice to the Provider if:

17.10.1 any Condition Precedent is not met by the relevant Longstop Date; or

17.10.2 the Provider ceases to carry on its business or substantially all of its business; or

17.10.3 a Provider Insolvency Event occurs; or

17.10.4 the Provider is in persistent or repetitive breach of the Quality Requirements; or

17.10.5 the Provider is in breach of any regulatory compliance standards issued by any Regulatory or Supervisory Body or has been issued any warning notice under section 29 or 29A of the 2008 Act, or termination is otherwise required by any Regulatory or Supervisory Body; or

17.10.6 two or more Exception Reports are issued to the Provider under GC9.19 (*Contract Management*) within any rolling 6 month period which are not disputed by the Provider, or if disputed, are upheld under Dispute Resolution; or

17.10.8 there is:

17.10.8.1 a Provider Change in Control and, within 30 Operational Days after having received the Change in Control Notification, the Co-ordinating Commissioner reasonably determines that, as a result of that Provider Change in Control, there is (or is likely to be) an adverse effect on the ability of the Provider to provide the Services in accordance with this Contract; or

17.10.8.3 a breach of GC24.9.2 (*Change in Control*) and the Provider has not replaced the Material Sub-Contractor within the relevant period specified in the notice served upon the Provider under GC24.10 (*Change in Control*);

GC18 Consequence of Expiry or Termination

18.2 If, as a result of termination of this Contract or of any Service following service of notice by the Co-ordinating Commissioner under GC17.4 or 17.10 (*Termination*), any Commissioner procures any terminated Service from an alternative provider, and the cost of doing so (to the extent reasonable) exceeds the amount that would have been payable to the Provider for providing the same Service, then that Commissioner, acting reasonably, will be entitled to recover from the Provider (in addition to any other sums payable by the Provider to the Co-ordinating Commissioner in respect of that termination) the excess cost and all reasonable related administration costs it incurs (in each case) in respect of the period of 6 months following termination.

18.3 On or pending expiry or termination of this Contract or termination of any Service the Co-ordinating Commissioner, the Provider, and if appropriate any successor provider, will agree a Succession Plan.

18.4 For a reasonable period before and after termination of this Contract or of any Service, and where reasonable and appropriate before and after the expiry of this Contract, the Provider must:

18.4.1 co-operate fully with the Co-ordinating Commissioner and any successor provider of the terminated Services in order to ensure continuity and a smooth transfer of the expired or terminated Services, and to avoid any inconvenience or any risk to the health and safety of Service Users or employees of any Commissioner or members of the public; and

18.4.2 at the reasonable cost and reasonable request of the Co-ordinating Commissioner:

18.4.2.1 promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the terminated Services by a successor provider;

18.5 On and pending expiry or termination of this Contract, or termination of any Service, the Parties must:

18.5.1 implement and comply with their respective obligations under the Succession Plan; and;

18.5.2 use all reasonable endeavours to minimise any inconvenience caused or likely to be caused to Service Users or prospective service users as a result of the expiry or termination of this Contract or any Service.

18.7 On expiry or termination of this Contract or termination of any Service:

18.7.3 subject to any appropriate arrangements made under GC18.4 and 18.5, the Provider must immediately cease its treatment of Service Users requiring the expired or terminated Service, and/or arrange for their transfer or discharge as soon as is practicable in accordance with Good Practice and the Succession Plan.

18.8 If termination of this Contract or of any Service takes place with immediate effect in accordance with GC17 (*Termination*), and the Provider is unable or not permitted to continue to provide any affected Service under any Succession Plan, or implement arrangements for the transition to a successor provider, the Provider must co-operate fully with the Co-ordinating Commissioner and any relevant Commissioners to ensure that:

18.8.1 any affected Service is commissioned without delay from an alternative provider; and

18.8.2 there is no interruption in the availability to the relevant Commissioners of any CRS or Essential Services.