North Central London Sector Joint Health Overview and Scrutiny Committee
29 November 2013

Minutes of the meeting of the NCLS Joint Health Overview and Scrutiny Committee held at Barnet Town Hall on 29 November 2013

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Peter Brayshaw	LB Camden
Alison Cornelius	LB Barnet
Jean Roger Kaseki	LB Islington
Sury Khatri	LB Barnet
Graham Old	LB Barnet
Barry Rawlings	LB Barnet
Anne Marie Pearce	LB Enfield
David Winskill	LB Haringey

Support Officers

Rob Mack	LB Haringey
Andrew Charlwood	LB Barnet

1. WELCOME AND APOLOGIES FOR ABSENCE

An apology for absence had been received from Councillor Martin Klute.

2. DECLARATIONS OF INTEREST

Councillor Brayshaw declared a personal interest as a member of the governing body of University College of London Hospitals. Councillor Cornelius declared a personal interest as she was an assistant chaplain at Barnet Hospital. Councillor Bull declared a personal interest as an administrator for Moorfields Eye Hospital.

3. URGENT BUSINESS

None.

4. MINUTES OF THE 14 MARCH 2013

Resolved that:
The minutes of the meeting on the 4 October 2013 be approved.

Matters Arising:
The Chairman reported that he had received an e-mail from John Pelly (Chief Executive of Moorfields Eye Hospital) welcoming the session at the JHOSC on 4 October 2013.

Rob Mack undertook to re-circulate the response received from the Royal Free

regarding their statistics for waiting time in A&E, as reported at the last meeting.

The Committee requested that an additional visit to the 111 service be arranged as the previous visit had been arranged at short notice, which had not allowed some Members to attend. Councillor Bryant reported that the visit that had already taken place had been particularly useful in the context of a Camden review into out-of-hours GP service provision. He informed the Committee that the Camden review would be recommending that, in the future, out-of-hours GP services and the 111 service be commissioned together as an all through service. Rob Mack undertook to schedule another visit to take place in January 2014.

The Committee agreed that the Barnet, Enfield and Haringey Clinical Strategy Programme Office should be requested to provide a briefing to the Committee on changes to the Clinical Strategy since 2009. Enfield Members commented that the Enfield Health Overview and Scrutiny Committee had a standing item on Primary Care Development as this had been one of the key enablers in the Clinical Strategy. The Chairman undertook to circulate the response provided at Prime Ministers Question Time by the Prime Minister to the MP for Enfield, Southgate on this issue.

Members noted that at the JHOSC Seminar on the Francis Report, there had been discussion on the requirement for trusts to follow-up Care Quality Commission reports and for progress to be monitored by scrutiny committees. The Chairman undertook to revisit this issue at his agenda planning meeting.

5. SPECIALIST CANCER AND CARDIAC SERVICE RECONFIGURATION

Neil Kennett-Brown (Programme Director, Change Programmes, North and East London Commissioning Support Unit), Professor David Fish (Managing Director at UCL Partners), Dr Edward Rowland (Consultant Cardiologist and University College Hospital), Hilary Ross (Director of Strategy at UCL Partners) and Prof Muntzer Mughal (Consultant Surgeon and Head of Upper Gastrointestinal Services at University College Hospitals) updated the Committee on the proposed reconfiguration of specialist cancer and cardiac services in North and North East London.

The Committee noted that specialist services for five rare or complex types of cancer were in scope for reconfiguration which constituted 3-4% of all cancer cases. Treatment for most cancer conditions would continue to be provided at the same sites as now. Members noted that some district hospitals would see a decline in activity as a result of the reconfiguration and noted the impact that this may have on the longer-term viability of these hospitals.

Neil Kennett Brown reported that there had been very little feedback on the proposals to date despite engagement with individual NHS trusts, health and well-being boards and local healthwatch's. The Committee questioned whether acute trusts had managed to achieve the right levels of patient representation and sought assurance that commissioners would listen to and act on responses to the consultation. Hilary Ross reported that UCL Partners had provided support in bringing patients and clinicians together to develop the proposals.

Prof Muntzer Mughal reported that the reconfiguration was focused on improving cancer survival rates and improving patient treatment, with the changes delivering a world class service and system of care. Current specialist services were operating below national standards. Most services would continue to be delivered at a local level; the reconfiguration would result in improvements to services at a local level and improve patient pathways. It was noted that the reconfigurations were only expected to affect 10 – 15 patients per borough per year.

Responding to a question from the Committee regarding the selection of preferred locations for specialist services, Neil Kennett Brown reported that consultation had taken place with clinicians on specifications for local and specialist facilitates. All options had been evaluated, short-listed and appraised to consider clinical outcomes, strategic fit and links to research/education. The Committee were informed that Dr Claire Stephens from Barnet Clinical Commissioning Group was the Cancer Clinical Lead for London. UCL Partners had set up London Cancer and the Board comprised of clinical experts and patients. It was noted that individual bids had been submitted and evaluated. Proposals were only taken forward where there was a strong consensus amongst the Board.

In relation to competition, it was noted that consultation was taking place with Monitor, the regulator for health services, who were considering the proposals with the Office of Fair Trading.

The Committee questioned how pathways at district hospitals would be improved. Prof Muntzer Mughal reported that whilst there would be investment in and an increased focus on providing treatment in specialist centers, there would also be an increase in specialists visiting district hospitals to provide diagnosis and aftercare as part of the revised pathways.

Members noted the strong clinical case for the service reconfigurations and questioned whether a further phase of consultation would take place at the detailed proposals stage. It was also queried whether any financial liabilities would transfer along with services.

Neil Kennett Brown reported that a further meeting would take place with the Chairmen from the affected Joint Health Overview and Scrutiny Committee areas on 9 January 2014 to provide feedback on the engagement process and the options appraisal. He added the need of formal consultation would be defined by the requirements of the Health and Social Care Act 2006.

Professor David Fish undertook to circulate an e-mail that he had sent to Councillor Brayshaw regarding the impact of the proposed changes to the rest of the Committee.

Responding to question regarding funding for the service reconfigurations, clinicians reported that they expected 30% of funding to come from outside of the local health economy, adding that all funding issues would be addressed at the business modelling stage of the project. The Committee requested details relating to the financing of the scheme at a future meeting.

The Committee requested a submission from commissioners and clinicians on the benefits for patients as a result of the changes.

A Member questioned whether a London-wide commissioning strategy existed following the dissolution of NHS London. Neil Kennett Brown advised the Committee that, although clinicians and NHS England worked collaboratively, the system post April-2013 was now more distributed. He added that the Call to Action, which would be considered as a separate item on the agenda, set out NHS England priorities.

In relation to the timeline for implementation, it was noted that the critical issue was the move of The Heart Hospital to St Bartholomew's Hospital which was expected at the end of 2014 to be fully operational by April 2015.

Professor David Fish informed the Committee that 70-75% of cancer patients currently had poor outcomes. Investment in early detection was required to embed prevention across all clinical work streams.

Resolved that –
The North Central London JHOSC supports the proposed changes to cancer and cardiac services. The Committee would nevertheless welcome further engagement on them in order to address any outstanding issues and monitor development plans, but do not at this stage feel that a full public consultation is required on any or all of the proposals. The Committee look forward to further engagement and consultation once the business cases, financial arrangements and governance arrangements proposed are further developed

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SPECIALISED COMMISSIONING

Simon Williams from NHS England tabled a paper which detailed serviced priorities for specialist commissioning. He reported that there were 143 specialist services, with 48 contracts being led by London providers. 35 services had been identified as priorities in nine separate categories. It was noted that these would need to link into local service issues.

The Committee were advised that there had been too much emphasis on commissioning treatment rather than preventative measures, resulting in an 8% increase in commissioning of specialist services. To achieve change, a whole pathway review would be required. It was highlighted that HIV cases had increased 100% in the last 10 years following a tail-off in public health campaigns on this issue. Members emphasised that a joint NHS England, primary care and public health response was required to address this.

Simon Williams highlighted that a greater level of co-commissioning of pathways was required. It was noted that translating this into action across the health economy would be challenging.

At the request of the Committee, Simon Williams clarified that the definition of specialised service had been defined in the Carter Report and the number had been capped at 143. It was noted that some specialised services had been transferred

into specialist commissioning rather than clinical commissioning groups post April-2013.

The Committee thanked Simon Williams for his presentation to the Committee.

7. CALL TO ACTION

Neil Kennett Brown (Programme Director, Change Programmes, North and East London Commissioning Support Unit) presented the NHS England Call to Action which outlined structural and strategic challenges facing the NHS nationally and in London. He reported that the Call to Action was seeking to enable NHS England to work with clinical commissioning groups in the North Central London area to question: how resources should be deployed; how to make significant improvements to the management of long-term solutions; how to use technology to improve access to services and patient outcomes; and how services can be re-designed to meet patient needs.

Members were advised that the Call to Action had been a recent subject for discussion at the Greater London Assembly Health Committee and there was a drive for a more strategic London-wide approach to all elements of NHS service provision. The Committee noted that the Mayor of London had no statutory powers in relation to health.

Whilst the Committee noted the potential for the Call to Action to herald a significant change in the NHS, it was highlighted that a reform of GPs would be required to achieve this. It was noted that larger medical centres had better outcomes for patients, but 40% of GPs in London were single-handed practices. Under the previous primary care trusts system, some GPs had achieved transformational change whilst others had not. It was emphasised that a joined up approach (e.g. the alignment of all GP contracts) would be required to deliver transformational change.

Resolved that –
The Committee receive a full report at the March 2014 meeting on NHS England's Call to Action in relation to GPs.

8. DENTISTRY

The Committee received an update from Alice Benton (NHS England) and Rita Patel (North East London Dental Commissioning Lead) on dentistry in North Central London. They advised the Committee that whilst they were in the Primary Care Directorate at NHS England, they commissioned dentistry in primary care settings, acute hospital trusts, specialist and out-of-hours services.

Members noted that oral health promotion (adults and children) were services that were now commissioned by local authority public health functions.

It was acknowledged that out of hours dentistry provision was a major issue and the Committee were informed that steps were being taken to address this through the establishment of triage services and an urgent referral pathway.

The Committee highlighted that NHS dentistry was only serving approximately 50% of the population and expressed concern regarding the accessibility and affordability of private dentistry.

Resolved that:
The Committee consider this as a substantive item of business at a future meeting to include submissions from individual borough clinical commissioning groups and public health, with specific reference to oral health promotional activity.

9. RECOVERY OF COSTS BY NHS TRUSTS FROM NON UK NATIONALS

The Committee welcomed Simon Blazer (University College Hospital London NHS Foundation Trust) and Lubna Dharssi (Barnet and Chase Farm Hospitals NHS Trust) who were in attendance to outline the approach of the two trusts to recovering costs from non UK nationals. Dr Wagman, a former NHS consultant, was also in attendance to address the Committee on this item.

Lubna Dharssi reported that Barnet and Chase Farm Hospitals NHS Trust had two overseas officers in post. The officers had interviewed over 400 patients and had recovered £200K from 200 overseas visitors in the last year. Where patients had absconded without payment, debts were pursued and in some cases the Home Office were advised resulting in some overseas visitors being denied entry back into the UK. It was highlighted that the Trust had to operate within Department of Health guidelines which meant that some treatments (such as emergencies or clinically urgent) could not be denied even if there were questions regarding the patients eligibility.

Simon Blazer reported that University College Hospital London NHS Foundation Trust had a similar structure in place regarding overseas visitors. A team of four overseas officers were in place and £1.9 million had been invoiced by the Trust across all six hospital sites from overseas visitors and private patients. It was noted that of the £1.9 million invoiced, approximately 50% had been collected which compared favourably to the national average of 35%. £200K had been written off at the advice of the debt collection agency and £100K was being paid in instalments. He added that his collection team operated Monday to Friday 9am–5pm and acknowledged that some presentations of overseas visitors could be missed due to these staffing limitations.

Simon Blazer added that all presentations at A&E were treated without charge, with charges only applying if the patient was admitted. Issues included failed asylum seekers due to them having no return date to their native country which made clinical decisions difficult and patients having communicable diseases meaning that there was a public interest in treating them to minimise the impact on the wider population.

The Committee requested statistics from both trusts on presentations of overseas visitors at A&E and maternity.

The Committee questioned how ward staff checked eligibility. Simon Blazer

reported that staff would review their records and if there was any query regarding the status of the patient, an interview would be conducted. EU citizens would be treated and costs recovered in accordance with reciprocal arrangements in place with EU Member States.

Dr Wagman informed the Committee that the current system was open to abuse and estimated that the cost of health tourism to the NHS was in the region of £2 billion a year. He considered that a system review, including changes to the Department of Health guidelines, was required to address this issue effectively.

The Committee noted that the government were currently consulting on a proposal to introduce a £200 visa levy.

Resolved that:
The minute extract above be referred to the Chief Executives of NHS trusts operating in North Central London and that they be requested to provide a response to the Committee on the issues raised, with their submissions reported to the March 2014 meeting.

10 JHOSC SEMINAR ON IMPLICATIONS OF THE FRANCIS REPORT

The Committee considered a paper which detailed the outcome of the North Central London JHOSC on the implication of the Francis Report for Health Scrutiny.

Members noted that access to complaints information and having guidance and support on how to access and interrogate effectively performance data that was available were some of the key themes emerging.

The Committee commented that there was a lack of coordination between the different monitoring agencies. It was also suggested that there needed to be an appropriate balance between performance targets and patient outcomes.

Resolved that:
The findings from the North Central London JHOSC on the implication of the Francis Report for Health Scrutiny be referred to the London Scrutiny Network for further discussion.

11 WORK PLAN AND DATES FOR FUTURE MEETINGS

The Committee noted the future meeting dates and work programme.

Members were informed that the Chairman would be holding a work programming workshop and that any updates to the work programme would be reported to the Committee in due course.

Resolved that:
The following items to be added to the Forward Work Programme:

- Mental Health
- Cancer and Cardiovascular Service Reconfigurations

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