NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Monday 16 April 2012 10:00 a.m.
Haringey Civic Centre,
High Road, Wood Green, N22 8LE

Councillors: Maureen Braun and Alison Cornelius (L.B.Barnet), Peter Brayshaw and John Bryant (Vice Chair) (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Dave Winskill (L.B.Haringey), Martin Klute and Alice Perry (L.B.Islington),

Support Officers: John Murphy, Sue Cripps, Robert Mack, Pete Moore and Shama Sutar-Smith

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST (PAGES 1 - 2)

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

4. MINUTES (PAGES 3 - 10)

To approve the minutes of the meeting of 27 February 2012 (attached).

5. ORAL SURGERY (PAGES 11 - 16)

To report on proposals to move minor oral surgery from hospitals and into the community.

6. PROPOSAL FOR THE PROVISION OF A VASCULAR SERVICE FOR NORTH CENTRAL LONDON (PAGES 17 - 36)

To report on the outcome of the project to centralise complex arterial vascular surgery and develop new pathways and arrangements for centralisation and networking.

7. TRANSFORMATION OF CAMHS; UPDATE AND EDUCATION MODEL

To receive a presentation on the implementation of changes to CAMHS in-patient services in Barnet, Enfield and Haringey and to report on the education model (TO FOLLOW).

8. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST QUALITY ACCOUNT (PAGES 37 - 56)

To consider and comment on the Quality Account for Barnet, Enfield and Haringey Mental Health Trust.

9. ESTATES MANAGEMENT (PAGES 57 - 60)

To receive an overview of the changes that will be taking place in estates management as a result of the changes within the Health and Social Care Bill.

10. FUTURE WORK PLAN (PAGES 61 - 62)

To consider the JHOSC's future work plan.

05 April 2012

Agenda Item 3

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

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

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

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

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

NO

NO

YES

You may have a **personal interest**

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

Prejudicial interest

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

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

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

NO

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

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

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NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a meeting of the **JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **MONDAY 27 FEBRUARY 2012** at 10.00 a.m. in the Committee Room 1, Town Hall, Upper Street, N1 2UD

MEMBERS OF THE COMMITTEE PRESENT:
Councillors Alison Cornelius, Barry Rawlings and Graham Old (L.B Barnet), John Bryant (Vice-Chair) (L.B Camden), Alev Cazimoglu (L.B Enfield), Gideon Bull (Chair) and Dave Winskill (L.B Haringey), and Alice Perry (L.B Islington)

OFFICERS:
Hannah Hutter and Shama Sutar-Smith (L.B Camden), Melissa James (L.B Barnet), Rachel Stern (L.B Islington), Rob Mack (L.B Haringey), Linda Leith (L.B. Enfield)

ALSO PRESENT:
Jeremy Burden, Director of Contracts, NHS North Central London
Alastair Finney, Interim Programme Director, NHS North Central London
Martin Machray, Head of Communications and Engagement, NHS North Central London
Dr Douglas Russell, Medical Director, NHS North Central London
Liz Wise, Quality, Innovation, Productivity and Prevention Director, NHS North Central London

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the Joint Health Overview and Scrutiny Committee.

MINUTES

1 WELCOME AND APOLOGIES
Councillor Gideon Bull (Chair) welcomed all those present to the meeting.

Apologies were received from Cllr Martin Klute (L.B Islington) Cllr Anne-Marie Pearce (L.B Enfield).

2 URGENT BUSINESS
There was none.

3 DECLARATIONS OF INTEREST
Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda. Councillor Alison Cornelius declared that she was a Chaplain's assistant at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda

4 MINUTES

RESOLVED:
THAT the minutes of the meeting held on 16 January 2012 be agreed.

TO NOTE: All

Matters arising:

In response to a question regarding the delayed letter to the Secretary of State on behalf of the Committee regarding financial arrangements once NHS North Central London had been dissolved the Committee noted that the letter had now been sent. A copy of the letter had been circulated to members.

In respect of the work to implement the transformation of CAMHS (time 5), it had been suggested at the previous meeting that Councillors Alison Cornelius and Gideon Bull be invited to attend the next meeting young people's project board's as observers. The young people had indicated that they would be happy for the Members to attend a future meeting of their project board, once it was further established. The board was currently seeking a suitable venue for their meeting on 7 March. It was asked that the three Local Authority leads be invited from Barnet, Enfield and Haringey to attend the next meeting to present on education and CAMHS services (including new CAMHS model within the three boroughs.
ACTION BY: Rob Mack (Scrutiny Officer)

Statistics on the number of instances of maternity units at either Barnet or Chase Farm Hospital being temporarily closed had not yet been provided but a letter had gone to the Chief Executive of Barnet and Chase Farm Trust requesting these and emphasising the importance of this data. From next year, data on suspensions of maternity services would be available on a site by site basis rather then just by NHS trust, as was currently the case. The data on midwife to patient ratios would be chased up.
ACTION BY: Rob Mack (Scrutiny Officer)

It was noted that, as specified in the minutes, a letter had been sent to the Chief Executive of London Councils requesting that they take up the issue of the lack of an additional allowance for London CCGs to fund commissioning support services. Martin Machray reported that a letter had gone out to London NHS trusts on the indicative funding of £25 per head of population outlining management costs and that an additional communication had been provided outlining commissioning budgets.. A fuller briefing would be available later that week, on allocation of commissioning budgets.
ACTION BY: Martin Machray, NHS North Central London

5 NHS NORTH CENTRAL LONDON PRIMARY CARE STRATEGY 2012 TO 2016

Martin Machray, Head of Communications and Engagement and Dr Douglas Russell, Medical Director, NHS North Central London presented the report to the Committee.

Primary care was a fundamental part of the NHS and included self care, community services and social care. The British primary care system was seen as an international example of a care system that could be delivered in a cost effective way funded from taxation.
In the discussion the following points were made:

- There were still five individual borough work streams but NHS North Central London (NCL) did not operate in silos.
- NCL needed to speak on a level that local people could understand to ensure clear communication.
- The issue of CCGs commissioning services from themselves had been raised as a potential conflict of interest and it was clear that GPs did not want to be seen as serving their own self interest.
- It was clear that there needed to be greater capacity and improved capability at a local

level to enable truly integrated care.

- It was possible that some hospitals would lose income under the new arrangements.
- It was proposed that care packages would be delivered by one integrated team. The purpose of this approach was to utilise funds most effectively – so it was not about providing the team with more funding but more effective ways of working which therefore use funds more efficiently.
- Some of the existing regulatory functions would go to the National Commissioning Board.
- A specific Medical Director had been appointed to develop primary care in Enfield in recognition of the scale of improvements required within the borough. He/she would be in post from 1 April.
- Members welcomed the paper and noted that the Whittington Health had already taken over provision of community services for Islington and Haringey. They noted that not all acute trusts were proposing to develop their services in this particular way. They felt that consideration needed to be given as to how all hospitals within the cluster fitted into the model of integrated care.
- The IT system that the Whittington Health was developing in partnership with other partners were intended to integrate with existing systems.
- Members queried the process used to assess where the £47.5million should be spent. It was stated that there were gaps in data and NCL were aware of missing cases in some areas.
- CCG commitment to the strategy was needed. Members noted that the Joint Board of CCGs had committed to the document.
- In the event that the Bill was not passed by parliament, the cluster arrangement would continue and there would be a legacy for a successor organisation.
- The CQC had responsibility for regulating providers and the Department of Health and Commissioning Board would hold CCGs to account.
- The medical profession was largely self regulating and there were powers to find doctors in breach of their contracts if they did not meet their performance standards.
- GP practices' performance could be variable in their performance in correctly coding patients and population turnover was also an issue.
- If savings targets were met then there would be approximately £30-£40million available for reinvestment between primary and secondary care.
- Members expressed concern as to who would monitor the implementation of the primary care strategy and whether assurances could be given that it would continue after NHS NCL had ceased to exist. Members noted that the CCG had helped build the strategy and, as part of their authorisation procedure, they needed to be signed up to the strategy.
- A representative of the Local Medical Committee expressed concern that the CCGs did not represent GPs overall and that any legacy plan should be owned by those who would take over running of services.
- There was an existing NHS complaints system and all patients would still have the right to choose their registered doctor.

The Chair thanked Dr Douglas Russell and Martin Machray for their presentation.

RESOLVED:
That the report and presentation be noted.

TO NOTE: All

6 BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - IMPLEMENTATION

Alastair Finney, Interim Programme Director, NHS North Central London made a presentation to the Committee which gave an update on progress, details on a communications review and future developments on relation to the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

Primary Care was vital to future care planning and the PCTs had always agreed that the changes should not be made to the hospitals until the primary care changes were in place.

The advice from NHS London confirmed the risks that would arise were the A&E to close before the maternity unit. A capital business case needed to be submitted to the Department of Health and would require sign off before any works could proceed. The scheduled end date was Autumn 2013, provided there were no significant obstacles.

In the discussion the following points were made:

- The timeline had been drawn up in consultation with the trusts involved. It was a tight timescale and assumed the capital approval process was not held up. Once the Department of Health had approved the business case, work could start in three months time.
- There was a contingency plan that allowed for a delayed process of an additional 15 months. The fall back timetable gave a completion date of early 2015.
- A resident of Enfield reported that he had attended the North Middlesex Board meeting and they had stated that their outline business case had been submitted but Barnet and Chase Farm's (BCF) had not. In response the Committee were advised that Barnet and Chase Farm's outline documents were also due to be submitted that week and the changes would not take place until this was done.
- The JHOSC should consider the risk assessment documents. This could be arranged and the business case would also be available for viewing once it was complete.
  ACTION BY: Alastair Finney, NHS North Central London
- The spend for hospital works was around £100 million capital. The primary care spend would need to be assessed on a borough by borough basis.
- The details on spend would be included in the business case. An extra £12million of funding had been put into primary care that year and the majority of this had gone to northern boroughs to support the BEH plans.
- Although the cluster would not be around after 2013, the CCGs were part of the programme although the status of all organisations was subject to the Bill going through Parliament.
- The CCGs were at different stages of development and there needed to be awareness of how funding would be allocated.
- The need to address public transport when considering major service change was raised. It was the view of the Chair that there had been an inability on the part of TfL to engage effectively with the change programme. It was noted that the process for making transport link changes, even to move a bus stop, could never meet the pace of change required, even when TfL could see the need.
- Branding was not the key consideration for the process and it was more important that people were aware that provision of good quality primary care was the main message.
- It was important to recognise the efforts of staff in primary care services and the impact of negative messages regarding current provision.
- There should be better involvement of patients' and residents' groups.

- GPs in Enfield and Barnet had been marginally in favour of the proposals, with a clear split by borough.
- The Committee would like more information on proposals for the development of primary care services that would support the proposed changes.
- Councillor Cornelius reported an issue of concern regarding a neighbour who had been referred to A&E at Barnet. Officers noted the issue.
- It was suggested that the proposals should be considered by local health and wellbeing boards.
- The business case on this issue did not include land sales. The Committee would welcome an item on NHS Estates. **ACTION BY: Rob Mack (Scrutiny Officer)**

The Chair thanked Alastair Finney for attending.

RESOLVED:

1. That the risk assessment documents and business case be shared with the JHOSC
2. That the issue of how NHS estates will be managed and administered following the implementation of the Health and Social Care Bill be referred to a future meeting of the Committee.

TO NOTE: Martin Machray, NHS North Central London

7 FURTHER DEVELOPMENT OF THE NHS NORTH CENTRAL LONDON STRATEGY AND QIPP PLAN 2013/14 - 2014/15/MONTH 9 FINANCE UPDATE

Liz Wise, the Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the QIPP Plan Performance.

The JSNA case for change had been published in October representing the key points from all five borough JSNAs. The five borough JSNAs would be circulated to the Committee again. **ACTION BY: Liz Wise, NHS North Central London**

The financial position as of month nine was good with further savings of £3.8million secured taking the deficit to £11million. It was hoped that NCL would finish the year in balance.

All five boroughs were now forecasting that they would be able to achieve their total or better, with better than expected performance in Haringey. This was in part due to the receipt of returned top sliced funding of 2% from NHS London.

In the discussion the following points were made:

- Members highlighted that improvement in actual terms was £1.1million. Officers stated that this was against a very ambitious programme of savings and it was a vote of confidence from NHS London that they had released the additional funds.
- Some areas had experienced a high level of demand and activity, particularly around Barnet and Chase Farm and the Royal Free.
- There would be a raised QIPP challenge to come and it was linked to the Primary Care Strategy with a very strong multidisciplinary approach.
- Members expressed concerns about the capital programme underspend and the prospect that some of that funding may be lost if not spent. Officers recognised that there was a risk that the money may be lost and stated that the onerous approval process for works was a possible factor in this. An estates strategy was being drawn up but there was a debate on what would happen. The Committee noted that funds could not be used on GP premises.

- All capital spends required approval via the Department of Health and NHS London no matter how small they were.
- Members requested a briefing on the underspend and the capital needs.
  ACTION BY: Liz Wise, NHS North Central London
- The strategic financial objective was to have all Trusts in balance by 2012-13 with the cluster in as strong a financial position as possible by the end of 2012-13.
- Progress had been made on identifying the contribution savings from projects and programmes would make with a predicted figure of around £84million. That still left a gap and clarity was needed on what these projects would provide.
- The Operating Plan would be delivered by the end of March.
- The proposed capital spending was not outlined in the report and the members would like to see more information on this.
  ACTION BY: Liz Wise, NHS North Central London

The Chair thanked Liz Wise for attending.

RESOLVED:
That a briefing on the capital programme, its potential underspend and any measures to address this be circulated to the Committee.

TO NOTE: Liz Wise, NHS North Central London

8 CONTRACT MANAGEMENT OF ACUTES

Jeremy Burden, Director of Contracts, NHS North Central London gave a presentation to the Committee.

The team managed 17 contracts many of which operated on standardised specifications. Although specifications could be varied, the majority were mandated by the Department of Health. Although acute services had started to lower bed numbers, there had been a rise in consultant to consultant referrals.

In the discussion the following points were made:

- Coding charges and out of contract services were a monthly challenge
- Payment by results had created a coding issue. Whilst there was guidance on how trusts should code activity, this could also sometimes allow them to code in a way that maximised their income.
- It was recognised that payment by results had helped to lower patient waiting times and meet other performance targets
- In response to a question about the implications of early discharge from hospital, officers advised the Committee that the clinically right approach for the patient was the focus. For example, some stroke pathways led to early discharge but it had to be right for the patient in their individual case.
- Where Barnet and Chase Farm had struggled with A&E targets, they had received support from an urgent care support team who had helped to review discharge planning and reach a system-wide multi-agency solution. The problem in that instance had been down to diversions from other hospitals and issues about how the hospital was working. Now that the hospitals and social services were working better together, patients could be discharged more efficiently.
- There had been an increase in the number of ambulances arriving at both Barnet and

Chase Farm hospitals and both had seen a significant drop in performance. However, Barnet had recovered more quickly.
- The contracts covered were not outside of main providers, for example hospices were not covered.
- The Committee would like to see the activity data for each site of Barnet and Chase Farm hospitals.
  ACTION BY: Jeremy Burden, NHS North Central London

The Chair thanked Jeremy Burden for attending.

RESOLVED:
That activity data for each site of Barnet and Chase Farm hospitals be shared with the Committee.

TO NOTE: Jeremy Burden, NHS North Central London

9 NHS NORTH CENTRAL LONDON TRANSITION UPDATE REPORT

Martin Machray, Head of Communications and Engagement, NHS North Central London gave an update to the Committee.

In the discussion the following points were made:
- Barnet and Islington CCGs had received authority for medicines management to be delegated. Enfield would have the slowest possible transition as they had the largest deficit.
- Members queried whether the CCG per capita amounts were calculated on past figures or if they could be revised in the light of changes to deprivation levels.
- There was an assumption in the Bill that public health would move over to local authorities. However other bodies were also asking for additional funding to cover these responsibilities.
- The baseline estimate spend for public health had been made by the Department of Health according to PCT spend in 2010/11. Barnet had been more disadvantaged by the settlement than most other boroughs, having the lowest amount per head of population of any borough other than Bexley. The settlement was decided at national level so any lobbying would need to be targeted there. There was a significant gap between the top and bottom settlement with a range of 3% to 50% across the boroughs. The Committee would like to compare per capita settlements against the current spend so they could assess the drift. They requested a specific briefing on the issue.
  ACTION BY: Martin Machray, NHS North Central London

The Chair thanked Martin Machray for attending.

RESOLVED:
That a briefing be submitted to a future meeting of the Committee on the baseline funding estimates for local authorities in the cluster.

TO NOTE: Martin Machray, NHS North Central London

RESOLVED:

10 FUTURE WORK PLAN

The Committee gave its consideration to a report outlining its future work plan.

The issues around vascular surgery had been the subject of a number of presentations. The end of process report would be for information only.

The indicative timings for the next meeting were as follows:
CAMHS – 45 minutes
QIPP Performance – 10 minutes
Estates management – 45 minutes
Oral Surgery – 10 minutes
Vascular Surgery – 10 minutes
BEH MHT Quality Account – 30 minutes

Martin Machray stated that there may not be enough information available about estates management to progress the item at the next meeting.

It was proposed that the risk register item should come to the meeting on 28 May. It was suggested that this be circulated in advance so that members could take a view on the agenda.

The Committee would write to the Chair of the GLA Transport Committee querying the proposed placed on ambulances using the designated Olympic lanes and asking that they raise the concerns of the Committee in their meeting with Transport for London on 13 March. Councillor Winskill agreed to draft a letter on behalf of the Committee.

ACTION BY: Councillor Winskill

The future meeting dates were as follows:

16 April – Haringey

28 May - Enfield

9 July (moved from 16 July) – Barnet

RESOLVED:
THAT subject to the above amendments, the report be agreed.

TO NOTE: All

The meeting ended at 1.25pm

CHAIR: Councillor Gideon Bull

MINUTES END

North Central London

CLUSTER-LED ORAL SURGERY PROCUREMENT

Briefing for Joint Overview And Scrutiny Committee
Tina Raphael, March 2012

Background

This procurement is part of a wider project to reroute minor oral surgery out of the hospitals and into the community. There are significant costs associated with oral surgery, particularly day case activity and this activity is increasing.
Based on work done in London and nationally, it is estimated that 50% of the daycase activity can be provided in the community with a significant cost saving.

The first aspect of this project was to ensure that referrals for non-urgent minor oral surgery go to referral management services rather than the hospital for all NCL boroughs. This allows for clinical triage to identify those referrals which

- are suitable for Intermediate Minor Oral Surgery (IMOS),
- require hospital treatment
- should have been within the competence of a general dentist.

From 1st October 2011, all dentists across NCL have been asked to refer non-emergency oral surgery referrals via the relevant referral management centre for their borough using a standard referral form. Barnet, Enfield and Camden are each using their GP referral management service for these dental referrals (Barndoc, SCAS and CCAS respectively) while Haringey and Islington use the Haringey Dental Referral Management Service.

The second aspect of the project has been to ensure that there is IMOS provision across the cluster. The present position in each borough is as follows:

Haringey - An IMOS provider has been in place since April 2010. They were contracted on a pilot basis which has been extended. Their dental referral management service handles the majority of oral surgery referrals for Haringey dentists.

Barnet - Two IMOS providers are in place, who were formally procured in 2010, and are contracted until 2013. As at April 2011 they were only receiving a small proportion of referrals since most Barnet GDPs were continuing to refer directly to hospital.

Enfield - Two IMOS providers (contracted on a pilot basis) had been in place until December 2010 when the service had been suspended to reduce costs. The providers have now been recomissioned up to April 2012.

Islington - Established an IMOS pilot in April 2011 provided by their community dental service

Camden – The Islington pilot has been extended to cover Camden until April 2012

An NCL service specification has been agreed which takes account of NCL's policy on treatments of limited clinical effectiveness. Borough leads are working with their current IMOS providers to ensure that they are providing the service in line with the agreed specification.

Reason for the Procurement

IMOS providers now need to be formally procured for all boroughs where there has not been a formal procurement process (ie all but Barnet) for the following reasons

1. To allow all those who are interested to put themselves forwards to ensure that the service is provided at the highest quality and the best value for money

2. To ensure that contracts are consistent across the cluster and contain the appropriate mechanisms for the service to be properly monitored.

Referrals will continue to go via the referral management service of each borough and it is likely that clinical triage will in the future be provided by one provider across the cluster.

Current Position

The procurement was advertised in January on Supply2Health and in the British Dental Journal. Camden advertised for one provider, Islington and Haringey for two and Enfield for three. 48 expressions of interest were received and the applicants were sent pre-qualification questionnaire documentation. These were considered by a panel made up of

- primary care commissioning leads from each of the four boroughs,
- senior managers from NCL,
- a dental advisor,
- a local dental committee representative
- an oral surgeon

The panel was co-ordinated by a member of the NCL procurement team.

22 of the applications from whom pre-qualification questionnaires were received have now gone through to the Invitation to Tender Stage.

PROCUREMENT TIMETABLE

ORAL SURGERY CARE CLOSER TO HOME PROJECT

	STEP	NO. DAYS	DATE START	DATE END	TIME/ PLACE
	Procurement Process Phase	*115 days*	*04/01/2012*	*11/06/2012*	
	CCGs of all boroughs advised of procurement	12 days	04/01/2012	19/01/2012	
	Advert approved by Comms Team	5 days	16/01/2012	20/01/2012	
	Advertise Procurement on Supply2Health and BDJ and inform all existing GDPs and salaried services.	*1 day*	*23/01/2012*	*23/01/2012*	
	Period for expressions of interest	15 days	23/01/2012	09/02/2012	
	PQQs issued	0 days	09/02/2012	09/02/2012	
	Period for submission of PQQs	15 days	09/02/2012	02/03/2012	
	Initial Financial Assessment of PQQ submissions (Ian and Sunil)	1 day	02/03/12	02/03/12	
	Panel evaluation period of PQQs	5 days	06/03/2012	12/03/2012	
	Moderation Meeting	0 days	12/03/2012	12/03/2012	2-4pm Stephenson House
	ITTs sent out	0 days	13/03/2012	13/03/2012	
	Period for submission of ITTs	24 days	14/03/2012	13/04/2012	
	Bidders day	0 days	19/03/2012	19/03/2012	1-3pm Stephenson House Room 6LM1
	Panel evaluation of ITTs	10 days	16/04/2012	27/04/2012	
	Moderation meeting of ITTs and preparation for interviews	0 days	30/04/2012	30/04/2012	2-5pm Stephenson House
	Presentation Days	2 days	9/05/2012	10/05/2012	NB Enfield presentations on Thurs if poss
	Final Panel evaluation	1 day	11/05/2012	11/05/2012	TBC
	Award report paper prepared for board				

	Board sign off on process				
	Notify applicants of result				
	Alcatel Period				
	Sign contract with agreed providers				
	Mobilisation Phase	*30 days*	*18/06/2012*	*30/07/2012*	
	Work with providers to mobilise service 6 wks Thu 09/02/12 Wed 21/03/12	6 wks			
	Notify RMS	30 days			
	Prepare paperwork for patients	30 days			
	Commence referrals to new providers	10 days	09/07/2012	20/07/2012	
	On-Going monitoring commences	0 days	23/07/2012	23/07/2012	

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NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, ENFIELD, HARINGEY, ISLINGTON, CAMDEN **WARDS:** ALL
REPORT TITLE: Proposal for the provision of a vascular service for North Central London	
REPORT OF:	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 08/01/12**

SUMMARY: The centralisation of complex arterial vascular surgery is a key strand of the London Cardiovascular Project. Commissioners were asked to lead implementation of this within clusters, and have been working with providers to develop new pathways and arrangements for centralisation and networking. The aim is to improve quality and outcome through increased critical mass. A local solution, satisfactory to commissioners has been agreed and is endorsed by the Chief Executives of the five North Central London Acute Providers. In the proposed solution emergency vascular, aortic aneurysm, carotid endarterectomy and complex lower limb bypass surgery will be provided from a new vascular hub based at the Royal Free Hospital who will also support an improved vascular network. Implementation will commence in April 2012. The local solution broadly achieves the aims of the cardiovascular project, though containing some important variation.

CONTACT OFFICER:

RECOMMENDATIONS: To endorse the proposal from The Royal Free Hospital

DIRECTOR Dr Nick Losseff, Medical Director Secondary Care

DATE:

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Proposal for Provision of a Vascular Service for North Central London

"National guidance on the organisation of vascular services identifies that clinical outcomes will be improved if patients are cared for by an appropriately staffed and equipped specialist vascular service."
(North Central London Arterial Vascular Services Commissioning Intentions – May 2011)

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1. Declaration of Institutional Commitment

In collaboration with our partners in North Central London (NCL), The Royal Free Hampstead NHS Trust is committed to leading the development of a world-class North Central London Vascular Care Service for the benefit of the population and patients of North London, Essex and Hertfordshire.

This is a seminal opportunity for North Central London to deliver world class vascular care, with a specialised treatment centre based at the Royal Free site and vascular assessment and treatment units at each of the partner sites. Our proposal is to provide the sector with a truly integrated managed service, and this proposal is fully endorsed by our partners University College Hospitals NHS Foundation Trust, Barnet and Chase farm Hospitals NHS Trust, North Middlesex University Hospital NHS Trust and Whittington Health NHS Trust.

The Royal Free facilities have benefitted from over £13 million investment in the last two years to build state of the art facilities and equipment which are fit for purpose for delivering complex surgical and interventional care. The Royal Free has the infrastructure, capacity and capabilities as the central unit to deliver all complex vascular surgery on site whilst maintaining specialist interventional support at the HASU and Heart Hospital and supporting network partners to maintain local services as appropriate.

This proposal to establish the NCL Vascular Care Service under the leadership of The Royal Free Hampstead NHS Trust which embraces the principles of inclusivity and has been developed with and has the support of the clinical vascular community across North Central London and the medical directors and chief executives of UCLH Foundation Trust, Barnet and Chase Farm NHS Trust, the North Middlesex University Hospital NHS Trust and Whittington Health. It also has the support of University College London Partners.

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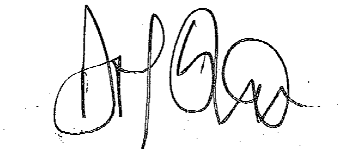
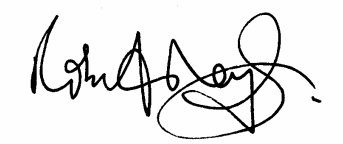


David Sloman,
Chief Executive Officer
The Royal Free Hampstead NHS Trust

Claire Panniker
Chief Executive Officer
North Middlesex University Hospital



Robert Naylor
Chief Executive Officer
University College Hospital Foundation Trust

Yimien Koh
Chief Executive Officer
Whittington Health

Mark Easton
Chief Executive Officer
Barnet and Chase Farm NHS Trust

2. Introduction

The *Cardiovascular Project: The case for change*, the Vascular Society, and NCEPOD all identified a need to redesign the way that vascular surgery is delivered in London and concluded that the best outcomes are delivered in specialist units with dedicated teams available 24 hours a day, seven days a week. All parties advocated the coming together of hospitals to provide higher volume units and emphasised the importance of equal access to care for patients.

3. Summary of Proposal

Building on the lessons learned from the existing vascular service, and the wider vascular group discussions our value proposition is to provide a North London vascular managed service which fully incorporates UCLH and BCF.

Complex vascular surgery will be centralised at The Royal Free providing a centre of excellence for complex vascular treatment and vascular assessment with the principle of inclusivity central to service delivery.

Carotid artery surgery associated with the Hyper Acute Stroke Unit (HASU)[1)] will continue to be provided at the UCLH site. All interventions will be performed by designated carotid specialists jointly appointed by UCLH and RFH working to common governance, audit and MDT. The Royal Free will provide vascular support to the Heart Hospital (see co-dependency section below). In addition, networked support will also be provided to the locally based Vascular Assessment and Treatment units (VATUs) at our four partner Trusts.

This proposed service will be underpinned by a single governance structure that will assure quality of service, ensure compliance with the service standards, and deliver equality of access for all North London residents. Adherence to quality standards will be monitored by the NCL Cardiovascular and Stroke network on behalf of the NCL commissioners.

4. The Current Service

The Royal Free

Currently serves a population of 1.3 million within the M25 and provides tertiary vascular care to Hertfordshire and parts of Essex. Since 1999 The Royal Free Hampstead NHS Trust (RFH) has delivered a well established vascular care service to North London incorporating the Whittington Health NHS Trust (WHT) and The North Middlesex University Hospital NHS Trust (NMUH). The service provides a networked on call arrangement for vascular emergencies that extends across NCL as well as an on-call interventional radiology service that serves NCL and beyond for complex interventional treatment. In addition to providing complex tertiary treatments and an emergency vascular service, RFH is also home to the North London aneurysm screening service and has a well established vascular research programme with core projects looking at vascular tissue regeneration, biomaterials and skeletal muscle ischaemia.

The service is currently delivered by seven Consultant vascular specialists, three of whom are joint appointees with NMUH (2 consultants) and WHT (1 currently with a 2nd proposed in next 6 months). The surgical team is supported by six consultant interventional radiologists providing specialist vascular treatments and cross-sectional radiology, in addition to supporting the regional liver and kidney centres and the multi-unit gastrointestinal bleeding service based at RFH.

The local hospitals provide patient-centred care with inpatient vascular review. RFH and NMUH have two joint consultant vascular surgeon appointments and complex vascular surgery is performed at RFH. The consultant vascular surgeon at WHT has one operating session per week at RFH and currently delivers arterial vascular surgery locally.

University College London Hospitals
UCLH currently provides a fully comprehensive regional and national vascular service including a range of specialist tertiary services with a strong emphasis on minimally invasive endovascular treatments. The service provides approx 400 elective and 175 non elective inpatient episodes per annum as well as day case and outpatient care. The Trust currently serves as a national centre for complex aortic aneurysm repair and in conjunction with the Heart Hospital provides vascular support to complex thoracic aortic treatments. The vascular service is also collocated with the Hyper Acute Stroke Unit on the UCH site providing carotid endarterectomy surgery and thus contributing to the excellent results of this acclaimed unit. A growing diabetic foot service provides specialist care integrated with podiatry community services. In addition vascular clinicians provide critical support to codependent services including trauma, GI bleed, women's health and oncology
The service is currently staffed by four dedicated specialist vascular surgical consultants and five vascular interventional radiologists. These staff work in a multidisciplinary team with colleagues in vascular anesthesia, neurology, cardiology and cardiac surgery. The consultant surgical oncall arrangements are delivered jointly with The Royal Free.

Barnet and Chase Farm
BCF currently has 4 Vascular Surgeons supported by 5 Interventional Radiologists. There are clinics, day surgery, main theatre and angio suites on both sites. A full range of procedures including endovascular aneurysm repair (EVAR), carotid endarterectomy and peripheral vascular surgery are carried out within The Trust. These activities are supported by a functioning vascular lab at Barnet General Hospital (BGH).

The above services are in the process of consolidation onto the BGH site. The Vascular Unit is supported by 3 Registrars, 2 SHO's, a Staff Grade and 5 FY1's. The unit also provides elective and emergency vascular cover for complex orthopaedic procedures at RNOH Stanmore.

5. The Proposed Service

The proposal in this document is for a 'Hub and Spoke' model which fully incorporates the services currently delivered at UCLH and BCF. Complex vascular surgery will be centralised at The Royal Free Hospital. This will be referred to in this paper as the Centre for Complex Vascular Treatment (the CCVT).

Carotid artery surgery associated with the Hyper Acute Stroke Unit (HASU)[1)] will continue to be provided at the UCLH site. All interventions will be performed by designated carotid specialists jointly appointed by UCLH and RFH working to common governance, audit and MDT. The Royal Free will provide vascular support to The Heart Hospital (see co-dependency section below). In addition, networked support will also be provided to the locally based Vascular Assessment and Treatment units (VATUs) at our four partner Trusts.

This proposed service will be underpinned by a single governance structure that will assure quality of service, ensure compliance with the service standards, and deliver equality of access for all North London residents. Adherence to quality standards will be monitored by the NCL Cardiovascular and Stroke network on behalf of the NCL commissioners.

6. Proposed Service Design for the Centre for Complex Vascular Treatment

The proposal is for a hub site – the Centre for Complex Vascular Treatment based at the Royal Free site, to provide the following services:

Service Delivered	Description
Complex inpatient arterial vascular activity	• Abdominal and thoracic aortic surgery • *Complex Peripheral Vascular Disease (see definition below) • Other complex vascular cases i.e vascular malformations, Lymphodema surgery, ischaemic upper limb) • Non-HASU carotid endarterectomy • Emergency (out of hours) vascular surgery
Single specialty vascular care ward with rapid access tertiary service for network partners	• 32-bedded ward staffed by nursing team with competencies in vascular care • Emergency transfer bed available 24/7 • Designated vascular high dependency beds
Vascular critical care	• ITU staffed by Consultants with expertise in caring for complex vascular patients • "elective" high dependency beds for major surgery in the Overnight Intensive Recovery Unit
24/7 vascular surgery on call	• 24/7 consultant and registrar grade cover will be provided at the hub
24/7 specialist vascular interventional on call	• On call for emergency vascular intervention at RFH staffed by designated vascular interventionalists • Separate from general interventional on call at BCF and RFH • UCLH to retain its own Interventional on call arrangements staffed by UCLH consultants
Specialist complex vascular outpatient clinics	• Vascular malformation clinics** • Specialist vascular anaesthetic assessment clinics • Thoraco-abdominal assessment service • Joint radiology/surgery clinics
Renovascular centre	• Acute kidney injury unit • Hub site for vascular access surgery • Acute dialysis beds
Out of hours vascular studies	• Vascular studies available at evenings and weekends as well as Mon-Fri
Specialist vascular rehabilitation programme	• Specialist amputee rehabilitation hub • Vascular rehabilitation unit
Host to regional specialist vascular MDT	• Provided on site with video-linked access for remote participation
Host to pathway co-ordination and database team	• Team based on site but working across NCL to support patient pathways and collection of required data.
Host to specialist nurses	• Home site for specialist nursing team working across NCL

** Vascular Malformation : On the basis that there is a spectrum of Vascular malformations not all of which are considered 'complex' it is proposed that all cases must be subject to MDT review, common audit and governance processes. Where the expertise exists and with prior MDT agreement, non-complex vascular malformations can be treated at a spoke but all complex cases must be treated at the hub.

*Definition of complex PVD for transfer from spoke to hub hospital

The differentiation of peripheral vascular cases into simple and complex depends on local factors and co-morbidities. These risk factors may summate to warrant a definition of "complex" and treatment in the hub.

Patients shall be deemed as complex for a particular spoke hospital and meriting transfer to the vascular hub if the former institution does not possess the requisite specialised skill set or services to safely and successfully manage the patients' primary presentation and or associated co-morbidities. This definition may therefore vary with hospitals, local resources and individual patients.

Co- morbid risk factors include:

1. Age
2. Co-morbidities such as severe renal impairment requiring dialysis, severe cardiac and or respiratory compromise, liver failure
3. Facilities e.g. CO2 contrast angiography, hybrid operating facility for concomitant extensive endovascular and open procedures
4. Co-dependent services e.g. cardiology, cardio-vascular anaesthesia, neurological & neurosurgical services.
5. Increasing complexity of intervention.

The decision to deem a patient complex rests with the local MDT and will be documented following their discussions.

7. The Vision for Interventional Radiology

The Royal Free will provide specialist vascular interventional radiology services for work being carried out at the CCVT. The proposal is to develop a network specialist vascular interventional radiology out of hours on call service. It is also envisaged that there will be joint specialist interventional clinics at the centre. It is important to note that we propose to deliver this without compromising existing vascular and general interventional services supporting each of the partner Trusts which will continue to be managed by the partner Trusts. This will need to be developed further through the Interventional Radiology implementation group.

8. Proposed Service Design for Vascular Assessment and Treatment Units.

These will be based at Barnet & Chase Farm, UCLH, the Whittington and the North Middlesex. These units will provide the following services:

Service Delivered	Description
Ambulatory assessment, diagnostics and ongoing care service	• Outpatients services for new referrals • Post-op care for all patients treated at the VATU and for complex patients that have been referred to the CCVT and repatriated back to the VATU as appropriate. • Post-discharge follow-up for all patients treated at the VATU and for complex patients that have been referred to CCVT in accordance with agreed protocols. • Cross-sectional imaging • Vascular studies with GP direct access • Protocol-delivered vascular pre-op assessment for patients having their procedure at the VATU • Outpatient-based diabetes service • Foot and wound care service • Outpatient rehabilitation, PT, OT and dietetics. • Vascular malformation clinics
Day case and short-stay elective treatment	• Varicose vein • Non complex PVD (see definition in section 6 of complex PVD.) • Non-complex vascular surgery as defined by MDT
On-site Vascular Surgeon Mon-Fri 9-5	• Designated vascular surgeon available on-site • For inpatient referrals and on site assessment • Undertakes elective operating and sees outpatients
Access to well-being services	• Smoking cessation • Lifestyle guidance • Welfare guidance
Integrated “virtually” with Centre	• Networked via N3 server • Videoconferencing facilities • Remote access to IT systems at centre (details and timescales to be agreed) • Image transfer via IEP
Key-workers and specific administration on site	• CNS available on-site to see patients • Service supported by local admin support • Designated pathway co-ordinator

** ** Vascular Malformation : On the basis that there is a spectrum of Vascular malformations not all of which are considered ‘complex’ it is proposed that all cases must be subject to MDT review, common audit and governance processes. Where the expertise exists and with prior MDT agreement, non-complex vascular malformations can be treated at a spoke but all complex cases must be treated at the hub.

8. Local implementation of the Case for Change – NCL specific changes:

8a. Hyper Acute Stroke Unit

The excellent outcomes achieved by the HASU at UCLH are recognised and must be preserved. By its nature there will be a group of patients whom are higher risk in whom better outcomes for carotid endarterectomies would be expected from surgery at the HASU itself. This relates to the fact that these high risk patients may benefit from the hyperacute stroke support provided at the HASU. Carotid artery surgery associated with the Hyper Acute Stroke Unit (HASU)[1)] will continue to be provided at the UCLH site. All interventions will be performed by designated carotid specialists jointly appointed by UCLH and RFH working to common governance, audit and MDT. All other patients will have their interventions at the hub. Specialists performing carotid endarterectomies will be fully accredited vascular surgeons with a special interest in carotid surgery and will be core members of the network vascular MDT. The service will undergo rigorous audit and will further strengthen the potential for clinical research across the two disciplines to ensure better outcomes for stroke patients.

Activity projections indicate there are in the region of 76 HASU high risk patients requiring carotid endarterectomy in 2012/13 and 50 low risk patients. Whilst this will be a deviation from the case for change, it is compliant with the specified activity levels and will be subject to continuous review. In addition to this, we propose a single, evidence-based NCL protocol for operating on asymptomatic patients.

Ongoing audit and review of this service will be necessary to assure the best model of care.

8b. Cardiothoracic Surgery

Cardiothoracic surgery in NCL will continue to be provided within the UCL Partners academic health science centre by the Heart Hospital. The centre at RFH will support the Heart Hospital 24/7 for acute aortic dissections, vascular complications arising at the Heart Hospital and with general vascular support and will have joint clinics at the Heart Hospital where indicated. All thoracic surgery will be undertaken at the Heart Hospital. The centre at RFH will make special arrangements for those very rare cases needing open thoraco-abdominal surgery without impacting upon services at the Heart Hospital. Procedures requiring heart Lung bypass will only take place at The Heart Hospital.

9. Codependencies

Our proposal addresses the co-dependency framework in the following ways:

Co-dependency	**How it is delivered**
Cardiothoracic medicine	• 24/7 cardiac intervention available on RFH site • PCI beds available on RFH site • Specialist cardiothoracic diagnostic service on RFH site
Cardiothoracic Surgery	• Aortic dissection and joint cardiovascular cases to be performed at the Heart Hospital (within UCL Partners) • Vascular support for Heart Hospital provided by CCVT
Hyper Acute Stroke Unit	• High risk HASU TIA or stroke patients requiring immediate carotid surgery will have their operation at HASU at the UCLH site. All interventions will be performed by designated carotid specialists jointly appointed by UCLH and RFH working to common governance, audit and MDT • All other carotid activity will be undertaken at the CCVT
General Surgery	• Acute general surgical cover and acute surgical beds available on RFH site • Trusts will collaborate on job planning to ensure adequate support for these services continue
Renal Services	• RFH is hub site for renal medicine and surgery

	• Acute dialysis beds on site at RFH • RFH is hub site for vascular access surgery
Plastic Surgery	• RFH is hub site for plastic surgery for NCL and Mount Vernon networks • Acute plastic surgery beds and 24/7 cover available on site at RFH
Vascular Anaesthetics	• All complex vascular anaesthesia undertaken by Consultant staff with expertise in vascular anaesthetics • CCVT with work with CVS Network and partner Trusts to integrate pan-NCL expertise
Gatrointestinal Bleed Service	• 24/7 Consultant-delivered GI bleed rota based at RFH supported by 24/7 acute interventional radiology service • GI Bleed rotas at UCLH and BCF will continue to be provided and managed by those Trusts.
Diabetes Medicine	• On site diabetes service at RFH • Linked to community diabetes services • On site multidisciplinary diabetic foot team
Microbiology	• Full-spectrum diagnostic labs on site at RFH
Neurology	• Neurology is based at RFH with 24/7 cover on site

10. Working with clinical support services

Clinical support services (diagnostics, radiology, etc) will continue to be provided locally to the levels required to support the agreed pathways for in-scope activity.

11. Repatriating post-operative patients to their local site

Draft protocols have been developed and are under discussion with network sites to ensure efficient transfer of patients between hospital sites at the earliest clinically appropriate opportunity where necessary and in the best interests of patients. RFH currently has protocols in place for the treatment and return of tertiary patients functioning for a variety of tertiary surgical specialties such as complex vascular surgery. Availability of beds at the VATUs and double charging commissioners are the biggest risks associated with repatriation. Options to split the tariff are being considered which will assist in expediting necessary repatriations and prevent double charging. The agreed repatriation model will be underpinned by on-site vascular consultant cover Monday to Friday and fully integrated local multi-disciplinary vascular and rehabilitation teams working with NCL partners to improve patient flow and ensure timely, safe discharge. Key workers at both the CCVT and at the VATUs will be allocated to all patients to act as ‘patient concierge’, enhancing the patient experience, whilst ensuring excellent communication with partner organisations and relatives, further assisting the seamless transfer between sites.

Each VATU will be subject to the same quality standards as the CCVT. The compliance of the service will be monitored by the Cardiovascular and Stroke Network. In terms of ensuring equity of service of access, service delivery, rehabilitation and quality of care. Throughout the implementation process analysis will need to be conducted on current levels of service and provision mapped against the standards in collaboration with our partner Trusts and the Cardiovascular and Stroke Network.

12. Delivering a community service and the Wellbeing Suite

The RFH vision is to support and expand upon how care is currently delivered in the community. The central site will provide the base for community outreach services including vascular nurse specialists, social work support and rehabilitation support. There will be close working with local end of life and TIA services. The local sites will form the base for community outreach services linked with diabetes and renal services.

RFH has a strategy for the development of integrated care and a proven track record for delivery of innovative service models in this area with five integrated pathways already managing patients under care and a further 14 under development. These pathways are built on mature and productive relationships with partners. We will apply the lessons learned to date to ensure every opportunity is taken both at the central and local sites to deliver seamless, integrated pathways of care across primary, secondary, community and social care, in partnership with the third sector wherever possible.

The proposed service will build and develop relationships with Clinical Commissioning Groups, GPs and third party providers with scheduled meetings to develop services and monitor performance.

In order to facilitate and deliver an enhanced community-facing service RFH is developing a public health lifestyle services intervention and Prehabilitation[1] model to serve the needs of vascular patients their families and the wider community. Plans are underway to establish a Wellbeing Suite at the RFH site. This seeks to develop a sustainable evidence-based opportunistic health promotion and improvement offer for patients and their families. Vascular patients will be referred to the service by clinicians initially from outpatient clinics. Interventions will include integrated care referrals into community services (using a community-facing Health and Wellbeing Passport) and a holistic multi-disciplinary approach to condition-specific management and prevention e.g. smoking cessation, psychological assessment. This development will be cost neutral to commissioners.

13. Research and Development

The establishment of this NCL-wide vascular service will permit potential access to a higher volume of patients (subject to consent) for translational research programmes. Furthermore, by delivering a fully-integrated service, more patients can be offered the opportunity to participate in these clinical trials.

Research is currently based at individual hospitals under the UCL umbrella and will continue to be so. UCL based research will remain under the auspices of UCL and full support will be given to research projects based at all network Trusts. Should a research team wish all their research to be based from the hub the Royal Free is committed to provide full support to the research projects and project teams.

14. Clinical Structure

In the proposed model, the clinical structure will be changed to manage the provider network alliance vascular service and the delivery of a new governance framework. This structure will assure appropriate governance of the service and professional leadership for the multidisciplinary team as well as providing clear lines of accountability for quality, safety and service delivery.

Best practice learning from previous service integrations is being applied and this structure will be appointed to by competitive process to underpin each leadership role with the legitimacy and mandate of a formal appointment and will be open for any team member eligible according to the essential requirements of each role (which will be specified during the implementation process). Furthermore, each lead will be supported with formal leadership training as part of the UCL Partners clinical lead programme.

The role of the NCL Cardiac and Stroke Network appointed clinical lead for vascular will remain unchanged for its duration. This valuable role will maintain its quality assurance requirement, will remain a spokesperson for the collected vascular team and represent the service at a Cardiovascular and Stroke network / NCL level and sit on the vascular management group. The NCL Cardiac and Stroke Network vascular lead is distinct from but complementary to the provider network alliance vascular clinical lead role. The latter, appointed by the RFH hub, will be the lead

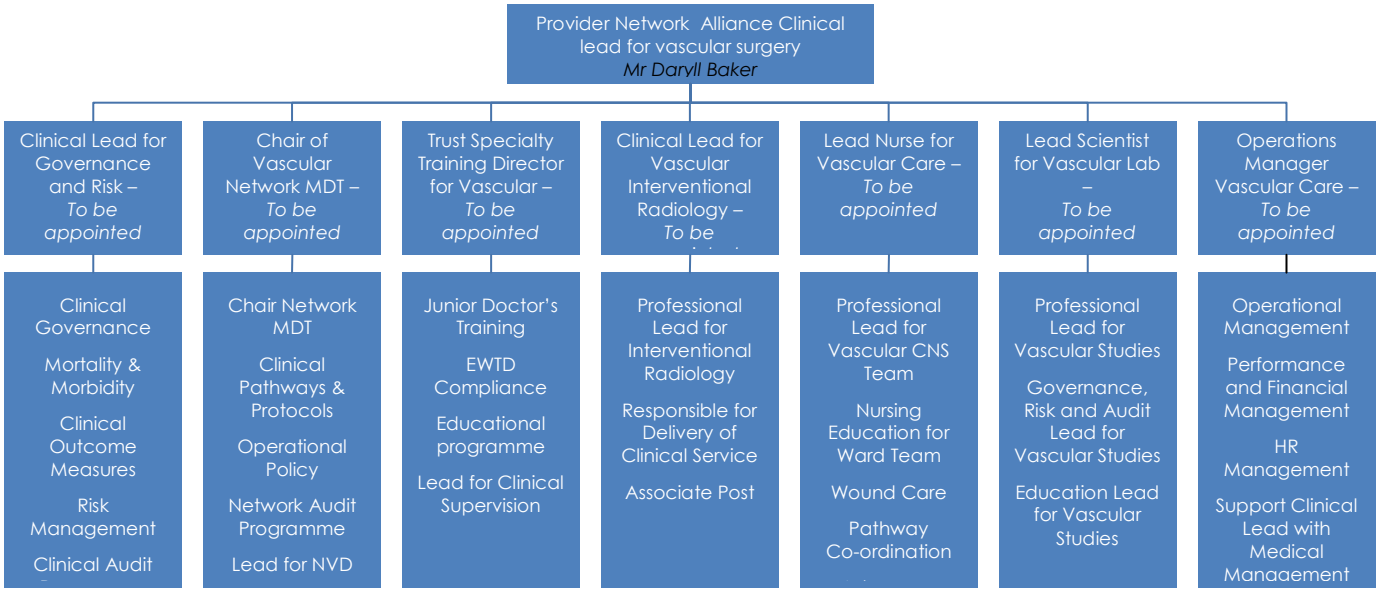
[1] Prehabilitation is the delivery of exercise and other lifestyle regimes with a view to limiting the impact of surgical or medical procedures. Examples include tendon strengthening prior to knee surgery, core strength and fitness sessions prior to chemotherapy, smoking cessation and weight loss prior to anaesthesia and surgery.

medical manager and will clinically lead the implementation, chair the management group, and be accountable to the Trust for the delivery of the service.

The NCL Cardiovascular and Stroke Network will provide oversight on the implementation of the new model of care and will advise the commissioners and NHS London on progress.

15. Governance Framework

The existing governance framework at RFH provides a robust structure for risk management, clinical governance and measuring performance against quality outcome measures. The proposed provider network vascular service will incorporate five specific entities to assure quality, safety and clinical performance – these are outlined below.



Proposed Clinical Structure of Vascular Care. Each lead is given a clear, designated role in the delivery of networked services.

The clinical structure will be updated to manage the expanded network and the delivery of a new governance framework. The proposed structure detailed above will allow the network model to be compliant with the NCL service specifications, appropriate governance of the provider network and professional leadership for the multidisciplinary team as well as providing NCL commissioners, the provider network and the Trust with clear lines of accountability for quality, safety and service delivery.

It is proposed that this structure is appointed to by competitive process to underpin each leadership role with the legitimacy and mandate of a formal appointment and will be open for any team member eligible according to the essential requirements of each role (which will be specified during the implementation process). Furthermore, each lead will be supported with formal leadership training as part of the UCLPartners clinical lead programme.

16. Pathways

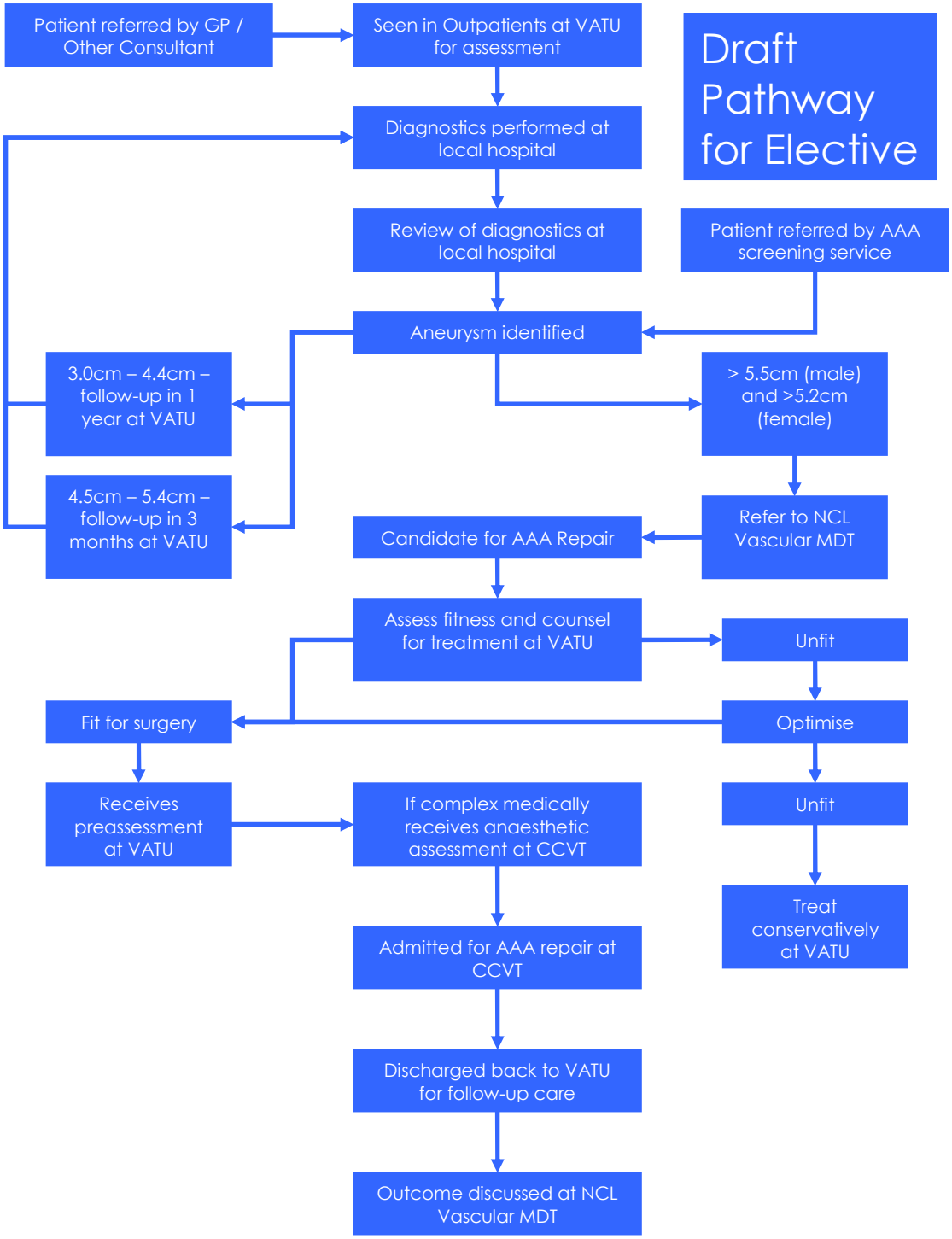
Below are the three main clinical pathways for complex vascular activity. These illustrate that diagnostics, assessment and consultation and non complex procedures and intervention will be provided at local hospitals, whereas complex intervention will be provided at the centre for complex vascular treatment.

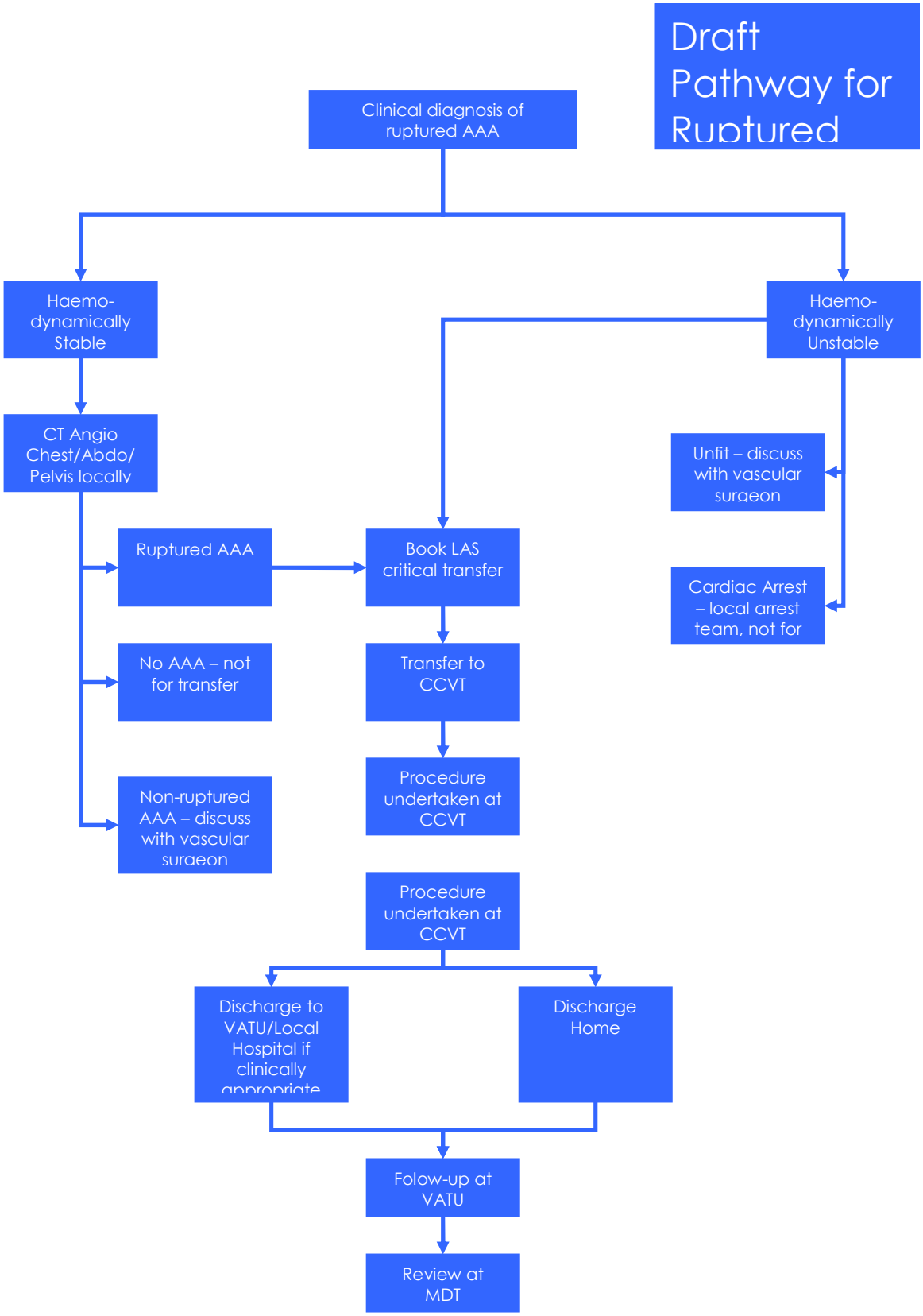
These pathways are aspirational at this stage, and will require working through in detail with the clinical teams. In essence, they provide for specialist care at the centre and outpatient, diagnostic and clinically appropriate inpatient

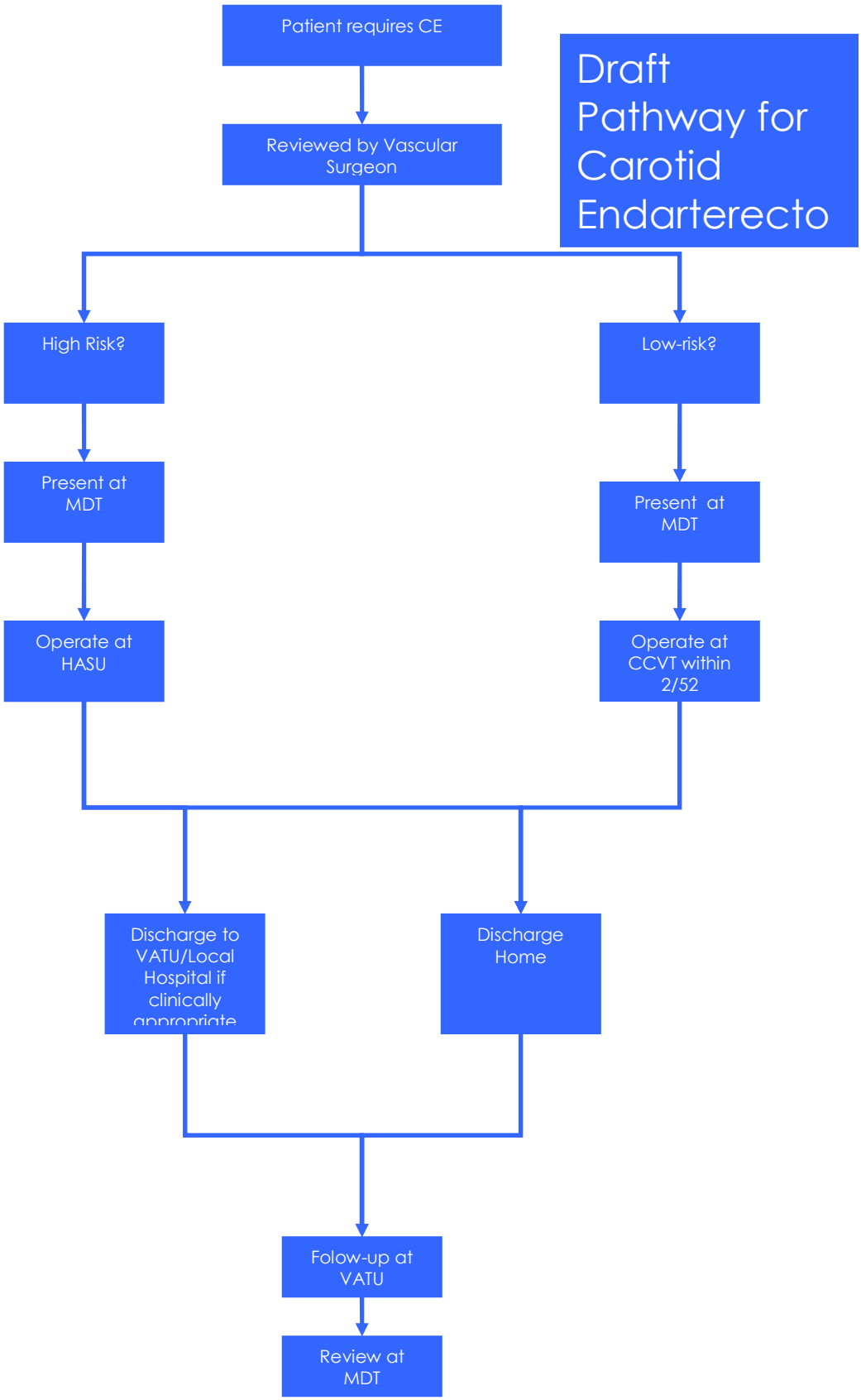
care at local hospitals. These pathways will reduce duplication of services, maintain as much activity as is appropriate locally and allow scope for increasing co-ordinated care across the sector.

The opportunities here are manifold: at present, the sole specialist amputation rehabilitation service resides at the Royal Free. With the acceptance of this proposal, we will be enabled to adopt a sector-wide aspect to our service planning and look to provide protocol-driven specialist rehabilitation across NCL. This will be delivered through enhanced professional training and analysis of service models.

By providing a co-ordinated model of care, we will be able to reduce duplication and improve efficiency across the pathways. By standardising protocols of care and having a single governance structure we can ensure and measure equality of service across the sector.


Draft Pathway for Elective
Patient referred by GP / Other Consultant
Seen in Outpatients at VATU for assessment
Diagnostics performed at local hospital
Review of diagnostics at local hospital
Patient referred by AAA screening service
Aneurysm identified
3.0cm – 4.4cm – follow-up in 1 year at VATU
4.5cm – 5.4cm – follow-up in 3 months at VATU
> 5.5cm (male) and >5.2cm (female)
Refer to NCL Vascular MDT
Candidate for AAA Repair
Assess fitness and counsel for treatment at VATU
Unfit
Optimise
Fit for surgery
Receives preassessment at VATU
If complex medically receives anaesthetic assessment at CCVT
Unfit
Treat conservatively at VATU
Admitted for AAA repair at CCVT
Discharged back to VATU for follow-up care
Outcome discussed at NCL Vascular MDT


Draft Pathway for Ruptured
Clinical diagnosis of ruptured AAA
Haemo-dynamically Stable
Haemo-dynamically Unstable
CT Angio Chest/Abdo/ Pelvis locally
Unfit – discuss with vascular surgeon
Ruptured AAA
Book LAS critical transfer
Cardiac Arrest – local arrest team, not for
No AAA – not for transfer
Transfer to CCVT
Procedure undertaken at CCVT
Non-ruptured AAA – discuss with vascular surgeon
Procedure undertaken at CCVT
Discharge to VATU/Local Hospital if clinically
Discharge Home
Folow-up at VATU
Review at MDT


Draft Pathway for Carotid Endarterecto
Patient requires CE
Reviewed by Vascular Surgeon
High Risk?
Low-risk?
Present at MDT
Present at MDT
Operate at HASU
Operate at CCVT within 2/52
Discharge to VATU/Local Hospital if clinically
Discharge Home
Folow-up at VATU
Review at MDT

17. Capacity Plan

Activity in scope (calculated from projected outturn for 2011-12, this is total activity at all centres in NCL and includes both NCL and non-NCL patients):

17a. Complex Activity Delivered at the Centre (CCAT)

Procedure to be carried out at the CCAT	**Complex activity to be carried out at the CCAT** (per year based on 2011/12 activity)				**Endovascular Theatre Sessions Required (Per Week)**	**Endovascular Interventional Suite Sessions Required (Per week)**	**Inpatient Beds Required (Per week)** [based on 85% utilisation]
	RFH	**BCF**	**UCLH**	**Total**			
Aortic aneurysm repairs	53	43	88	**184**	6.6	0	8
Lower Limb Interventions	154	17	20	**191**	3.2	0.7 – 0.9*	9
Carotid endarterectomy	7	27	10	**44**	1.2	0	2
TOTAL					**11**	**0.7 – 0.9***	**19**

* Data illustrated as a range to ensure capacity at the CCAT is adequate.

17b. Resources Required at the CCAT

Resource	**Current weekly vascular requirement at RFH**	**Additional weekly complex vascular Requirement**	**Total**
Endovascular theatre sessions per week	9	11	20
Endovascular Interventional Suite sessions per week	2	0.7 – 0.9	2.7 – 2.9
Inpatient Beds	11 beds (including 8.1 complex beds)	10	21

17c. Activity Delivered at the HASU

Activity	**Projected Outturn**	**Endovascular Theatre Sessions Required (Per Week)**	**Endovascular Interventional Suite Sessions Required (per week)**	**Open vascular theatre sessions required**	**Inpatient Beds Required**
Carotid endarterectomy	55	0.8	0	0	1.21

18. Financial & Staffing Model

Vascular is a loss making service, currently losing over £2m at the Royal Free alone. The greater the service consolidation, the greater the opportunity for service synergy efficiency savings, which will assist in reducing the deficit. This loss will increase by an estimated £0.5m as complex work transfers over. We have estimated that, if the whole service transferred in line with the model of care, the overall loss could be mitigated to around £1m by making cost savings across the whole service. Clearly, we would need commissioner support to give this practical effect.

It is acknowledged that the Commissioners expect the implementation of the integrated vascular service model to be cost neutral in terms of not costing more than current services that are commissioned. It is also recognised that repatriations must be managed without incurring additional costs to the commissioners. Further discussion with commissioners and providers regarding commissioning arrangements and transitional funding agreements are underway to ensure the financial viability of the new service.

19. Activity Forecasting

Based on the actual activity data submitted by RFH, BCF and UCLH for Q1, Q2 and Q3 for 2011/12, the activity forecast (NCL and non NCL) is as follows:

Financial Year	FY2012/13	FY2013/14	FY2014/15
Aortic Activity	200	220	225
Lower Limb Interventions	200	220	240
Carotid	50	50	50
Carotid (HASU)	55	55	55

Growth is anticipated in aortic activity and lower limb through non-NCL referral, through increased activity via AAA screening programme and improved access to services for PVD. This activity is distinct from commissioner-derived activity as it includes non-NCL activity and activity from spells where a vascular procedure was not the dominant code.

20. Timescales

Our proposal is to consolidate vascular services across North London to create a genuine North London provider network from **April 2012.** A detailed implementation plan of how the service shifts and develops from April 2012 is currently being prepared.

21. Implementation

We envisage that the implementation will be undertaken from 1st April 2012 when the complex services will transfer. There is a significant level of detailed work that needs to be undertaken and a dedicated project manager has been appointed to deliver this.

It is proposed that the NCL Core Vascular group would transition into the implementation project board which will be chaired by the Provider network vascular lead alongside the RFH Executive Director of Operations working in collaboration with the NCL commissioner vascular lead and supported by the project manager. This board will have Vascular and Interventional Radiology consultant representation from partner trusts, and representation from NCL, the CVS network to provide NCL with assurance.

22. Gap analysis and Risk mitigation

In terms of challenges facing the Trust within scope, these can be summarised as follows:

1. Length of stay reduction for vascular patients: this is the key challenge across the network as lengths of stay are high. Simply ensuring patients get transferred out of the CCVT in a timely fashion to ensure throughput is not enough.

2. Access to Specialist Amputation Rehabilitation: this is currently limited to the services available at RFH, which will be expanded to meet the additional demand presented by the consolidation of services.

3. Bringing in scaled service improvement: if this RFH bid is successful, there will be a need for focused work implementing pathways between sites, improving efficiency and monitoring success against the agreed performance indicators.

4. The lack of cardiothoracic surgery on site is one area where we are challenged. However, the guidance from Commissioning Support for London is clear that this is a) not an absolute requirement for complex vascular surgery[2] and b) can be provided within the same Academic Health Science Centre, which it is at the Heart Hospital within UCL Partners. As noted above we will continue to provide vascular surgical support for the Heart Hospital.

5. Agreeing a financial model which supports innovation, productivity and cost reductions.

23. Conclusion

We have proposed a solution for delivering centralised complex vascular services that is acceptable to all partners, is cost-neutral to commissioners and requires minimum infrastructure investment to enable as the capacity to provide the complex centre exists already at RFH. The pathways included in this document seek to ensure there is no service duplication and patients will receive as much of their care as is clinically appropriate close to home.

[2] Cardiovascular Project Co-dependency Framework, Commissioning Support for London, 2010, Appendix 4

Barnet, Enfield and Haringey
Mental Health NHS Trust

Quality Account

2011 - 2012

CONTENTS

SUMMARY OF PRIORITES

Where were we last year? Follow-up on our 2011 - 2012 priorities

Priorities for 2011-12 were developed with input from staff, service users, carers, partnership organisations and members of the public in our Stakeholders Workshop in 2011. We set demanding targets for these improvements. While much work has been carried out in these areas, it is unlikely that we will fully meet our target of 25% improvement in communication with GPs.

Priorities for 2011- 2012	
Patient Experience - Improve and monitor therapeutic engagement (pg 15)	**Partially met**
Safety - Improve communication with GPs (pg 9)	**Not Met**
Clinical Effectiveness - Improve focus on patient identified care goals (pg 13)	**Met**

Priorities for 2012- 2013
TBA

Where are we going? Our priorities for 2012-13

Priorities to be agreed in collaboration with stake-holders at the BEH Quality Account workshop on 8 May at St. Ann's Hospital.

Where are we now?
SUMMARY OF 2011- 2012 PERFORMANCE

Patient Safety	2010 - 2011	2011 - 2012 To date	National
7-day follow up after discharge from inpatient care (pg *8*)	99.98%	100%	Target 95%
Risk assessment carried out within 7 days of admission to inpatient care (pg *8*)	99%	98%	N/A
Number of safety incidents reported (pg *7*)	369 PM	402 pm	tba

Patient Experience	2010 - 2011	2011 - 2012	National
Patient Environment Action team (PEAT) (pg *16*)	Good	Good	Good
Patient Experience (pg *17*)	81%	77%	77%
Carers experience (pg *15*)	n/a	60%	n/a
Staff would recommend this trust (pg *16*)	3.33	3.27	3.42

Clinical Effectiveness	2010 - 2011	2011 - 2012	National
Service users are assessed using mandatory HoNOS PBR clustering tool (pg *11*)	97%	91.6%	tba
Mental health service users are offered physical health checks on admission (pg *12*)	99%	99%	N/A
Outcome measures are implemented to measure effectiveness of treatment (pg *11*)	partial	Met	N/A
Readmission within 28 days (pg *12)*	tba	4%	tba

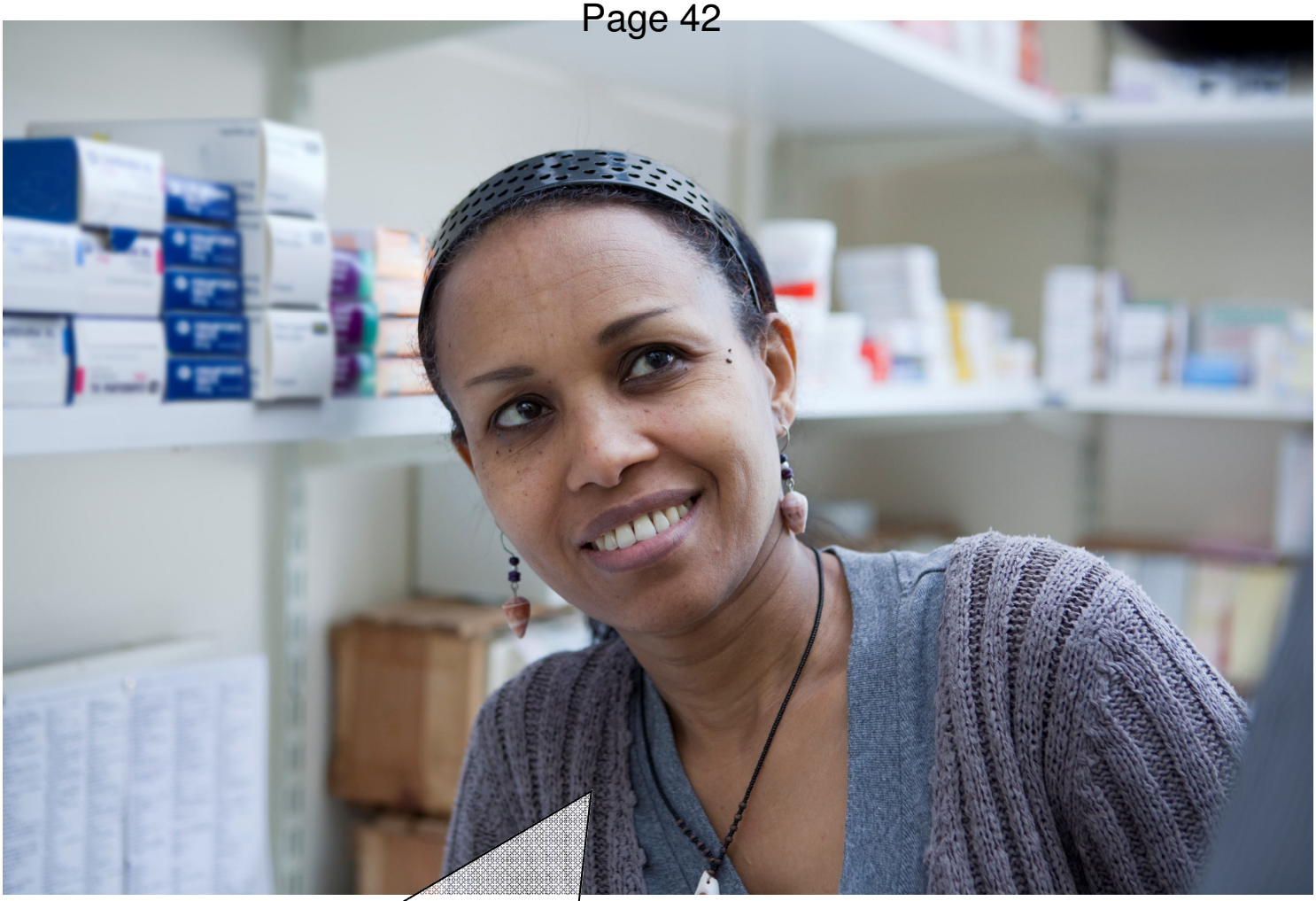
SERVICE USER INVOLVEMENT IN PLANNING AND DELIVERY OF SERVICES

Listening Event

The Trust held a 'listening event' with support from our local service user groups to provide a different type of opportunity for an honest and open two-way line of communication between service users and carers and mental health staff and for staff to hear first hand accounts about the experience of being on the receiving end of the services they provide. The aim of the event was for staff to better understand what is working well and where improvements should be made and to take this into account in their own individual practice and in the teams they work in.

Service users and carers gave positive feedback and said they valued the opportunity to be listened to in this way and hoped that staff would take what they had said into account in the way that they deliver services.
Nurses, occupational therapists and psychiatrists who made up the staff group commented that the experience had a hard-hitting impact and they had heard strong messages particularly about issues around customer care, communication and the provision of the right information at the right time.

A six month follow-up review is planned to take place in April to measure the impact on clinical teams.



Hourly Rounds (intentional rounding):

Staff were interested to find out if making contact with each service user on the ward on an hourly basis to ask how they are feeling and if they need anything would provide more opportunity for service users to get the information they want and result in a reduction of visits to the nursing office, improved satisfaction and a reduction in incidents of violence and aggression. Since August 2011 staff on Dorset and Thames Wards have been working to implement this change to the established process of hourly checks.

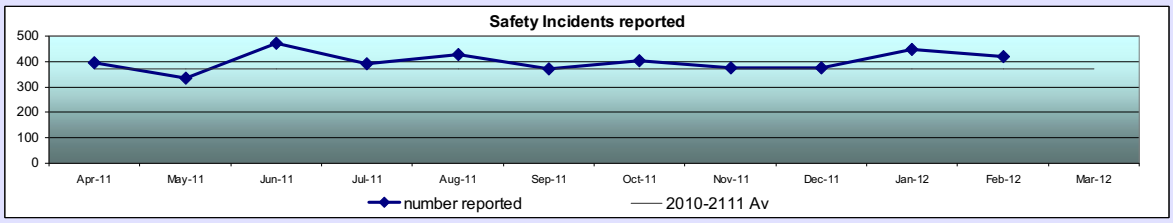
In November both wards reported that there has been a largely positive response to the hourly rounds. Service users have said that the rounds make them feel staff are caring and looking out for them and staff report that they are learning more about service users quicker and are able to identify their needs sooner than before. Anecdotally staff report that service users are making less visits to the nursing office with queries and that there has been less violence and aggression and less complaints. Staff are continuing to adapt the methodology in response to comments from service users and staff to ensure it fully meets the needs of mental health service users.

In view of the positive findings so far it has been decided that all wards in the Crisis and Emergency service line will implement intentional hourly rounds over the coming months.

PERFORMANCE REVIEW

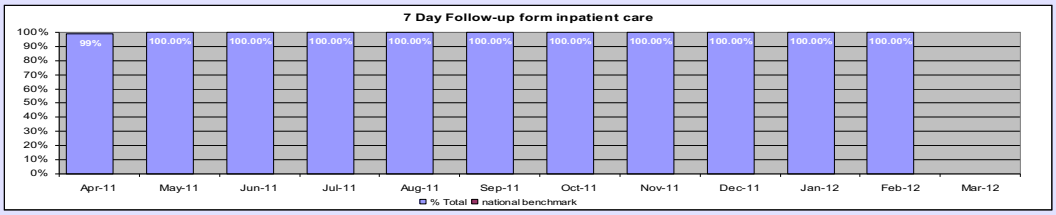
Patient Safety

Improving incident reporting and reviewing

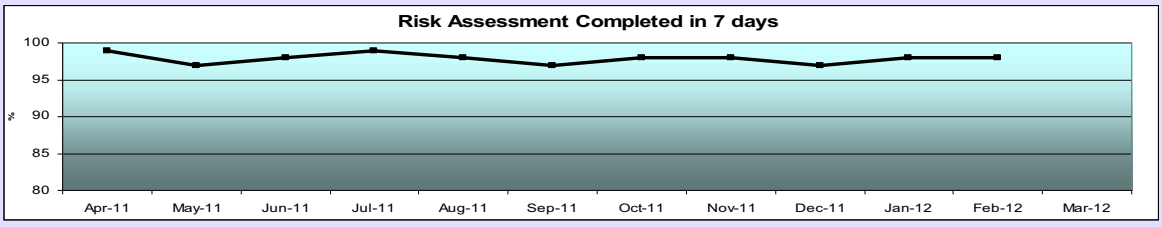
Why did we choose to focus on this?	All NHS Trust are required to report incidents of harm, violence, or errors which could have a potentially negative impact on patients, visitors or staff. Whilst our target improvement for 2010-11 was partially met, BEH remained in the lower reporting scale in comparison to other mental health trusts and it was identified that we needed to continue to improve the culture of identifying and learning from incidents.
What was our target?	To achieve a further 30% improvement on 2010-11 rates of reporting.
What did we achieve?	To Date: We are reporting approximately 400 incidents per month. Although this shows an improvement on our average monthly reporting seen in 2010-11, we recognise this falls below the improvement target we set for ourselves. 
What needs to improve?	We will continue to ensure staff report all incidents throughout the trust, and improve staff awareness that all incidents, however small, should be reported in order that the Trust can learn from them and implement preventative action. Reviewing of incidents and lessons learnt, within agreed timescales needs to be a focus for all team managers.
How will we continue to monitor and report?	Incident performance reports are continually monitored through Trust and Local clinical governance committees. The Trust's incident reporting system has been upgraded and has enabled more robust reporting. Service Managers are now able to review and reflect on their individual service lines and monitor both the recording and the reviewing of incidents which are then discussed during meetings and in supervision.

Patient Safety (continued)

7 Day follow-up

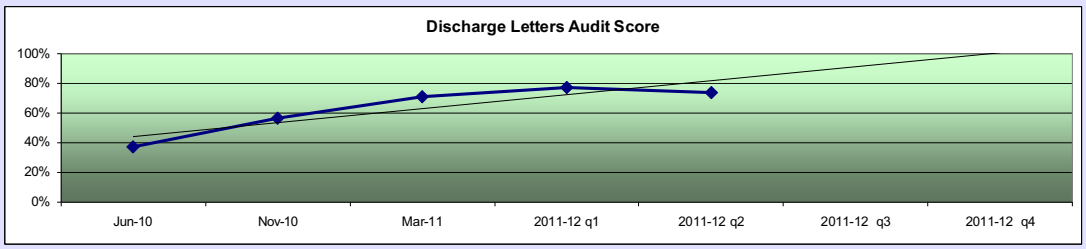
Why did we choose to focus on this?	Service users are at the greatest risk of relapse and or self harm in the first seven days following discharge. The Trust planned changes in services to facilitate and maintain the high level of compliance achieved in 2010-11 and to reduce readmissions.
What was our target?	Our target is to provide follow up care within 7 days of discharge to 100% of patients.
What did we achieve?	The following chart is based on performance data including all patients discharged from inpatient services in 2011-12. 
What needs to improve?	Continue to maintain high levels of compliance. All teams and individual clinicians to continue monitoring up to date progress on performance targets for all patients on their caseload.
How will we continue to monitor and report?	7 day follow-up is being actively managed and monitored by teams through the daily review of discharge activity. Performance is also monitored through the weekly exception reports, monthly service line performance meetings and at Board Committee level.

Quality of Risk Assessments

Why did we choose to focus on this?	All of our patients are required to have an assessment of past and current risk behaviour carried out within seven days of admission. It was identified that these need to be thorough, and that they inform decisions about the care provided to the patient. Risk assessments should reflect a continuous process, updated with new information as it becomes available and as the patients' conditions improve.
What was our target?	Target has been set at 95% to account for potential delays due to compliance with assessments. Monitoring of the risk assessments and related documents has been expanded to encompass an evaluation of the quality and continuity of risk assessment.
What did we achieve?	The target has been maintained with an average rate of 98% compliance. This figure is based on self assessment audits on a sample of patients each month through the Quality Assurance Audit. 
What needs to improve?	To continue monthly monitoring at team level and maintain current standards.
How will we continue to monitor and report?	This will continue to be monitored through the ward and community quality assurance process. Results and reports will be presented to individual teams and to all clinical governance and scrutiny meetings.

Patient Safety (continued)

Communication with GPs

Why did we choose to focus on this?	Feedback from our stakeholders focused strongly on the need to improve communication with GPs. Collaborative provision of health care between all providers is essential to ensure better health for our service users.
What was our target?	The Trust is working to ensure that communication at the point of discharge or transfer of care is both timely and meets the needs of other care providers. Target: 25% improvement in compliance with discharge and transfer standards.
What did we achieve?	To date an audit of quarter 1 and 2 discharge letters has shown that compliance levels achieved at the end of 2010/11 have remained stable. However, we recognise we did not meet the level of improvement we set for ourselves. Further details will be provided with data from the end of year audit.  The Trust has run a series of workshops for GPs, in order to develop the primary care strategy. Following this, the Medical Director launched an exercise with local GPs, asking for accounts of service problems, based around the experience of the GP and patients, and using this to make changes to the way the Trust communicates with GPs. In addition, the Medical Director has engaged with clinical commissioners in a review of the delivery of primary care mental health services, and the working of the interfaces between primary and secondary care. We continue to work with our community partners to manage patients' conditions within the community and prevent acute hospital admissions where possible.
What needs to improve?	Our commissioners have been working with the Trust to improve collaborative working with GP partners. The Trust will continue to work with commissioners and GPs to develop agreed standards of physical health information to be shared between the Trust and GPs at the point of referral, at care reviews and at discharge.
How will we continue to monitor and report?	Compliance with communication of discharge and transfer arrangements will be audited on a quarterly basis.


Toilet
Growing

Clinical Effectiveness

Patient Reported Outcomes

Why did we choose to focus on this?	In 2009 the Trust considered three different assessment tools to evaluate the effectiveness of treatment modules. Clinical Outcomes for Routine Evaluations (CORE) was finally chosen as the Trust's assessment tool as this provided the most standard, well validated tool to compare local service provision and benchmark our services nationally. This tool was adopted by three of our seven service lines with implementation to be considered in other service lines throughout the year. ECS uses patient reported outcomes at discharge to assess improvement in self management of symptoms and other aspects of improvement in condition. Outcomes are measured in other service lines using CORC in CAMHS and an outcome framework agreed for Dual Diagnosis.
What was our target?	That CORE Net be considered for implementation in other service lines in 2011-12. That Enfield Community Services develop the use of PROMS across other services within the ECS Service Line.
What did we achieve?	Data from CORE to be provided in final draft. ECS has incorporated PROMS in their Key Performance Indicators and has monitored outcomes through quarterly performance meetings.
What needs to improve?	Collection of PROMS data to be incorporated into Trust wide survey system and made available to further services.
How will we continue to monitor and report?	CORE net and PROM results will be available to individual clinicians and managers, and will be reported through clinical governance groups.

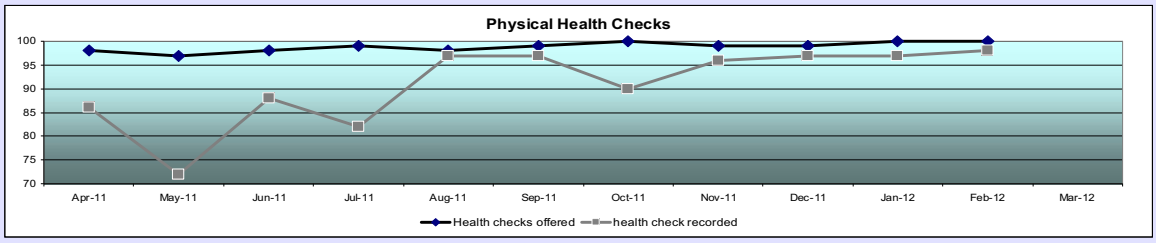
ECS Patient Reported Outcomes	2011-2012	2010-2011
Symptoms Improved	94%	96%
Resume Daily Routine	98%	91%
Manage Symptoms	99%	97%
Understanding of Condition	99%	97%

HoNOS PBR

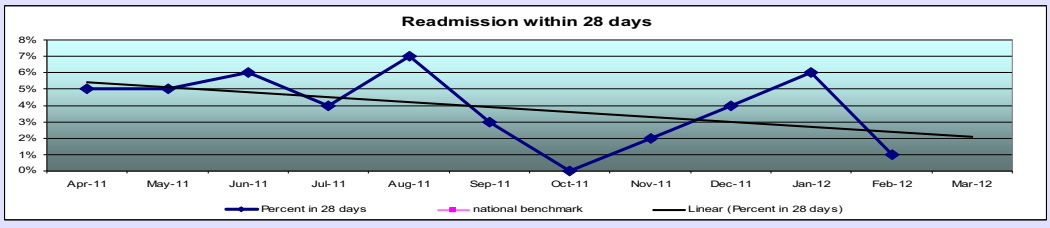
Why did we choose to focus on this?	All Mental Health NHS Trusts are now part of a system of payment by results. The Trust must assess each patient using HoNOS, which demonstrates change in a patient's overall functioning after treatment. This assessment leads to a designated "care cluster" for each patient. The cluster designates the level and number of interventions provided to our clients.
What was our target?	Our target is to achieve 100% compliance with HoNOS PbR clustering.
What did we achieve?	As of November, 91.6% of patients have been clustered using HoNOS PbR.
What needs to improve?	Work is in progress to complete the clustering of all patients registered with mental health services.
How will we continue to monitor and report?	The completion of HoNOS assessments will continue to be monitored through performance reports.

Clinical Effectiveness (continued)

Improving Physical Health

Why did we choose to focus on this?	Physical health was identified as having a major bearing on a patients' mental health. The Trust made this a priority in 2010-11 and it was decided to continue to focus on this important issue as there were further areas for improvements identified.
What was our target?	To improve communication with GPs, not only on admission but at discharge and to build on the previous year's success in maintaining the physical health and overall wellbeing of our community clients. All teams to achieve 95% compliance with awareness of recent physical health check outcomes.
What did we achieve?	Monitoring of physical health has been added to the community mental health teams monthly self assessment audit. The figure below shows that while inpatient teams have maintained compliance with this target, community teams have shown marked improvement over the year, and are currently meeting the target. 
What needs to improve?	To continue monthly monitoring at team level and maintain current standards.
How will we continue to monitor and report?	This will continue to be monitored through the ward and community quality assurance process. Results and reports will be presented to individual teams and to all clinical governance and scrutiny meetings.

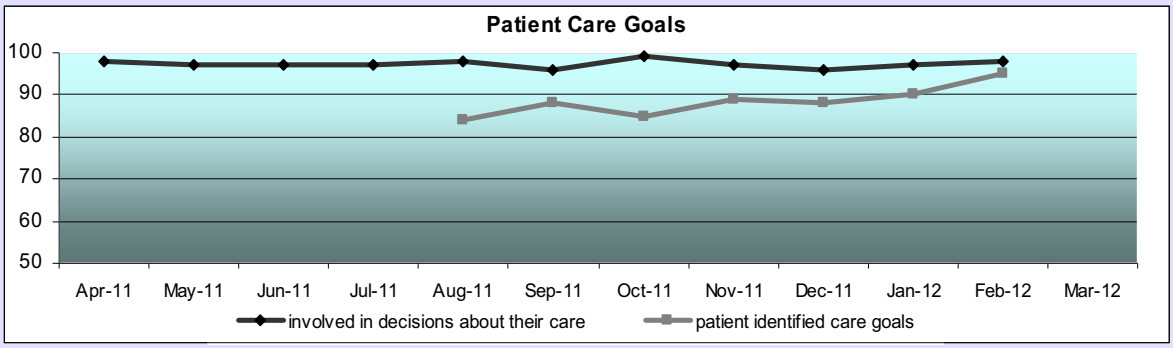
Readmission within 28 days

Why did we choose to focus on this?	This standard will become a national mandatory standard in all quality accounts from 2012-13. This standard is measured to address potentially avoidable readmissions into hospital. The Trust may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from incidents of readmission.
What was our target?	National benchmark data for acute trusts is readily available, but mental health benchmarks have not yet been sourced. Further details to be included in the final draft of this document..
What did we achieve?	The figure below shows the rate of readmission within 28 days. While the figures vary, an overall reduction is shown. 
What needs to improve?	Further work is needed to establish benchmark data and set targets for improvement in 2012-13.
How will we continue to monitor and report?	Performance is monitored through monthly service line performance meetings and at Board Committee level.

Clinical Effectiveness (continued)

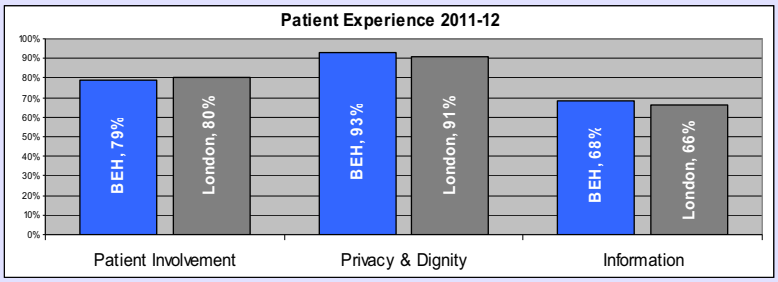
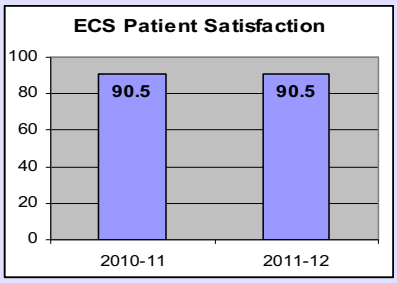
Patient identified care goals

Why did we choose to focus on this?	To improve the focus on patient centred care, it has been agreed that goals should be set on an individual level by users of mental health services. Every care plan should include at least one personal goal identified by the service user.
What was our target?	90% of service users to have individually identified care goals addressed in their care plans.
What did we achieve?	The development of patient identified care goals has been added to the monthly team level self assessment to promote awareness. It has been noted in spot checks of these self assessments that interpretation of this standard varies widely between clinicians. As this standard represents a new way of developing care plans, it was anticipated that it would take some time to implement this and develop a consistency of clinical approach. Wellness and Recovery packs are currently offered to all service users and can be used to help identify personal goals. The figure below shows consistent compliance with involving service users in decision making. The development of specific goals set by the service user has been monitored since August, and shows an improvement. The average compliance rate for the year is 88%.
What needs to improve?	As spot checks have identified variation in the practical application of this target, further work in clinical team and clinical supervision will address this issue.
How will we continue to monitor and report?	This will continue to be monitored through the ward and community quality assurance process. Results and reports will be presented to individual teams and to all clinical governance and scrutiny meetings. Spot checks will continue to evaluate the variation in clinical practice.



Patient Experience

Patient Experience

Why did we choose to focus on this?	All mental health trusts are required to participate in the national mental health service users survey. While the Trust carries out internal surveys on an ongoing basis, the national survey provides a benchmark with other service providers. ECS carries out a twice yearly postal survey as agreed with service commissioners.
What was our target?	Our target for the mental health survey was to maintain scores at the average for mental health services in London. ECS target was set at 90% satisfaction.
What did we achieve?	The first figure below shows BEH and London scores for questions relating to patient involvement, privacy and dignity, and provision of information for the current and previous year. The Trust has maintained scores in line with London average. The second figure shows ECS patient satisfaction scores in 2010-11 and 2011-12. Satisfaction rates remain consistently compliant with our target.  
What needs to improve?	CQUIN targets in 2012-13 require that ECS implement new patient innovative ways of capturing real-time patient stories through a range of multi -media options using discovery interview methodology. Training will commence in quarter 1, with interviews to be conducted in quarter 4.
How will we continue to monitor and report?	Ongoing patient experience reporting is conducted via local surveys and interviews. Reports are circulated through clinical governance groups and scrutiny meetings.

Carers survey

Why did we choose to focus on this?	The Trust aims to involve carers in developing and improving our services. In 2011 we engaged carers in a series of focus groups to identify how best to achieve this.
What was our target?	As this was a new method of collecting feedback, no benchmark was available. Our aim was to engage a wider proportion of our carer population and establish an action plan for implementing change.
What did we achieve?	Three focus groups were held in the individual boroughs with collaboration from the local mental health carers groups. Over 150 comments and individual experiences were received through the focus groups.
What needs to improve?	Areas for improvement identified included lack of clarity regarding care pathway and admission criteria, insufficient support after discharge from mental health services, a need for carers to be supported with crisis management and coping skills, and undefined roles around carers assessments.
How will we continue to monitor and report?	An action plan has been developed to address the needs identified. Collaborative work with the local authority and commissioning colleagues is underway to develop training programme for carers and clarity on carers assessments.

Patient Experience (continued)

Patient Environment Action Team

Why did we choose to focus on this?	This standard will become a national mandatory standard in all quality accounts from 2012-13. Patient Environment Action Team (PEAT) is an annual assessment of inpatient healthcare to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.
What was our target?	To maintain scores in line with national average.
What did we achieve?	Assessments were carried out by NHS staff, patient representatives and members of the public on inpatient wards across all trust sites. Results for BEH over the past 3 years can be seen in the table below. Trusts are each given scores from 1 (unacceptable) to 5 (excellent) for standards of environment, food and dignity and privacy. BEH scores are in line with national average.
What needs to improve?	The inspection identified a few immediately rectifiable issues regarding cleanliness. For other issues regarding grounds or maintenance an action plan is in development.
How will we continue to monitor and report?	The Trust will continue to participate in the annual PEAT inspections.

	ENVIRONMENT	FOOD	PRIVACY AND DIGNITY
2011 National Average	GOOD (4.26)	GOOD (4.63)	GOOD (4.49)
2011 Trust Average	GOOD (4.11)	GOOD (4.62)	GOOD (4.83)
2010 Trust Average	GOOD	EXCELLENT	GOOD
2009 Trust Average	GOOD	GOOD	GOOD

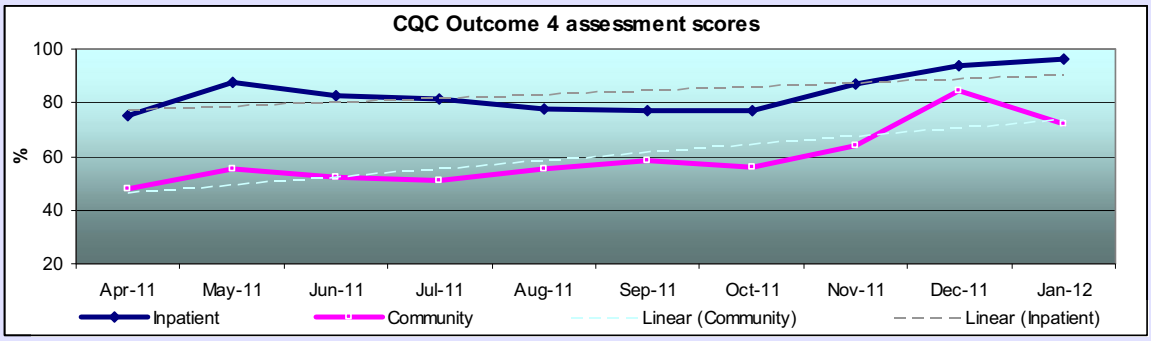
Would staff recommend this trust?

Why did we choose to focus on this?	This standard will become a national mandatory standard in all quality accounts from 2012-13. This question is a part of the national staff survey carried out annually in all trusts.
What was our target?	To achieve scores within the nation median.
What did we achieve?	The table below shows that the Trust score was below the threshold for the lowest percentile of trusts.
What needs to improve?	The Trust aims to involve carers in developing and improving our services. In 2011 we engaged carers in a series of focus groups to identify how best to achieve this.
How will we continue to monitor and report?	As this was a new method of collecting feedback, no benchmark was available. Our aim was to engage a wider proportion of our carer population and establish an action plan for implementing change.

	BEH 2011	Lowest 20%	National average	Highest 20%
Staff recommendation of the trust as a place to work or receive treatment	3.27	3.30	3.42	3.56

Patient Experience (continued)

Therapeutic Engagement

Why did we choose to focus on this?	Therapeutic engagement is core to the development of positive working relationships between clinicians and service users. By developing better communication and understanding, service users and their care team can work more effectively toward improved health outcomes.
What was our target?	Our aim was to improve therapeutic engagement in both inpatient and community mental health teams through implementation of Productive Community and continued work with Productive Ward. Our target was 80% compliance with standards relating to therapeutic engagement.
What did we achieve?	Lead nurse inspections carried out in community and inpatient teams have assessed the quality of therapeutic interaction between patients and staff based on CQC standards for outcome 4: Care and welfare of people who use services. The figure below shows compliance rates with this standard. Inpatient services have maintained compliance levels at or above our target of 80%. While community teams have shown improvement and at present are approaching the target, we recognise this falls below the improvement target we set for ourselves.  Productive Community has been implemented in a phased approach across service lines. Psychosis community teams have participated in a project to improve the amount of therapeutic time spent with patients. This project is currently being rolled out to Common Mental Health community teams.
What needs to improve?	A concern has been identified within two inpatient wards regarding the level of therapeutic activities and engagement. The Trust has put in place new programmes of therapeutic activities tailored to the needs of this client group and has developed monitoring structures using dementia care mapping to ensure that needs are being met. The Trust has also provided staff development and training programmes to strengthen staff understanding of meaningful engagement with their patients or users.
How will we continue to monitor and report?	We will continue to monitor through practice standards leads inspections undertaken with input from peer colleagues.

QUALITY STATEMENTS

During 2011 - 2012 Barnet Enfield and Haringey Mental Health NHS Trust provided eight NHS services in seven service lines. BEH has reviewed all the data available to them on the quality of care in all eight of these NHS services. The income generated by the NHS services reviewed in 2011 - 2012 represents 100% of the total income generated from the provision of NHS services by BEH for 2011-12.

National Audits

During 2011 - 2012 Barnet Enfield and Haringey Mental Health NHS Trust participated in all national clinical audits applicable to the services provided by the Trust. Details and outcomes of national clinical audits and national confidential enquiries that BEH was eligible to participate in during 2011-2012 are as follows:

- **Psychological Therapies** – Data collected for 94 cases.
- **Schizophrenia** – Data collected for 100 cases.
- **Prescribing Observatory for Mental Health:**
- **Topic 1 and 3: Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards and forensic wars** - Data collected for 168 cases
- **Topic 6: Assessment of side effects of depot antipsychotic medication** - Data collected for # cases.
- **Topic 7: Monitoring of patients prescribed lithium** - Data collected for 73 cases.
- **Topic 9: Use of antipsychotic medicine in people with Learning Disabilities** - Data collected for 67 cases.
- **Topic 10: Use of antipsychotic medicine in CAMHS** - Data collected for 17 cases.
- **Topic 11: Prescribing antipsychotics for people with dementia** - Data collected for 180 cases.

Local Audits

The reports of 32 local clinical audits were reviewed by BEH in 2011– 2012. For full reports of local audits visit our website by following the link below:
(site in development - to be inserted before publication

BEH intends to take the following actions to improve the quality of healthcare provided (examples):

- Patient experience - medical staff to discuss medication options with patients and monitor through quality assurance.
- Safeguarding children - procedural quick reference guide to be developed by safeguarding lead and distributed to all teams. - IT procurement to ensure scanners are provided to all clinical teams for uploading of documents.
- Health records - crisis planning to be added to quality assurance audit for continued monitoring though clinical supervision.
- Carers survey - Joint training to be developed for carers coping skills - new carers assessment policy to be developed and ratified.

CQC

Barnet Enfield and Haringey Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is currently registered. BEH has no conditions to its registration.

The Care Quality Commission has not taken enforcement action against BEH during 2011 – 2012.

BEH is subject to periodic reviews by the Care Quality Commission.

BEH has not participated in any special reviews or investigations by the CQC during the reporting period.

Research

The number of patients receiving NHS services provided or sub-contracted by Barnet Enfield and Haringey Mental Health NHS Trust **in 2011-2012 that were recruited during that period to participate in research approved by a research ethics committee was [to be provided prior to publishing].**

CQUIN

A proportion of Barnet Enfield and Haringey Mental Health NHS Trust income in 2011 -

2012 was conditional on achieving quality improvement and innovation goals agreed between BEH and NHS North Central London through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011-2012 and for the following 12 month period are available in the following document on our website: link to new website

Hospital Episode Statistics

Barnet Enfield and Haringey Mental Health NHS Trust submitted records during 2011 - 2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: **XX%** for admitted patient care; and **XX%** for out patient care. The percentage of records in the published data which included the patient's valid General Medical Practice Code was **XX%** for admitted patient care; and **XX%** for out patient care. **(figures not yet available)**

Information Toolkit

Barnet Enfield and Haringey Mental Health NHS Trust score for 2011 - 2012 for Information Quality and Records Management, assessed using the Information Governance Toolkit was level **2**.

Payment By Results

Barnet Enfield and Haringey Mental Health NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were **XX%. (figures not yet available.)**

Monday - Friday
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Agenda Item 9

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, ENFIELD, HARINGEY, ISLINGTON, CAMDEN **WARDS:** ALL
REPORT TITLE: Estates Management Update: 4 April 2012	
REPORT OF: Martyn Hill, Associate Director – Estates and Facilities	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** 04/04/12

SUMMARY: An introductory briefing on Estates Management, within NHS, at the current date.

Please note this is a brief update on Estates, at the following meeting the subject will be looked at in further depth.

CONTACT OFFICER:
Elizabeth Stimson
Senior Communications and Strategic Engagement Officer
NHS North Central London

RECOMMENDATIONS: To note the briefing.

DIRECTOR
Martyn Hill
Associate Director – Estates and Facilities
NHS North Central London

DATE:

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NHS
North Central London

Estates Management Update
4 April 2012

Transfers to Providers

The Government in August last year issued a guidance document on the Primary Care Trust (PCT) Estate that provides for the:

- Transfer of PCT properties delivering community healthcare via provider NHS Trusts (including Foundation Trusts) to those Trusts.
- PCTs (before the transfer date) to enter into formal property agreements with minority occupiers of these transferred properties and via existing directions to occupiers of retained properties. Leases with GP's are being co-ordinated with the LMC and we are seeking to adopt a joint approach with the LMC and other Clusters. All other leases are in the process of being agreed or issued to tenants.

Lists of properties that could transfer were agreed in principle with the Providers and submitted to the Department in October 2011. Since then further initial advice has been received on the transfer documentation and accounting principles. The timeline for the transfers has now been aligned with the transfer of other properties and will take place at Midnight 31 March 2013.

The transfer of property will also include transfer of the associated estates staff and termination or novation of the relevant property service contracts. The staff and contracts are currently being mapped by Cluster Estates to determine precise numbers and the appropriate transfer strategy. These transfers will generate further contract amendments.

NHS Property Services Ltd

NHS Property Services Ltd (or PropCo) was announced by Andrew Lansley on 25 January 2012 as a government owned limited company to take ownership and manage that part of the PCT estate not transferring to the NHS community care providers. Properties will include some operational estate, estate with multiple occupiers, office and administration spaces, and surplus estate. Existing contractual arrangements with service providers that deliver and maintain NHS Properties will remain in place to support the needs of this property. The Companies objectives are to:

- Hold property for use by community and primary care services
- Deliver value for money property services
- Consolidate management of the Estate
- Deliver and develop cost effective solutions for community health services
- Dispose of property surplus to NHS requirements
- Drive greater efficiency into the Estate
- Manage PCT Property worth £6.6 billion (£4.6 billion is freehold

It is intended that Staff will know their destination within NHS Property Services by 31 December 2012 and all properties are intended to transfer at midnight 31 March 2013.

However, we still cannot be certain about:

- Organisational structure, it is intended that it will have regional structure with London being one of the regions. The process of making senior board appointments is underway
- Numbers of Staff within scope, we have no information as yet on this
- Organisational design, work started on this in Spring 2012

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

27 February 2012

Future Work Plan

1. Introduction

1.1 This report outlines the work plan for future meetings of the JHOSC.

28 May (Enfield):

1.2 Items for the next meeting of the Committee are currently as follows:

- QIPP outturn
- BEH update
- Estates Management
- Acute Commissioning
- Primary Care including generic borough level implementation plans
- Transition including Clinical Commissioning Groups (CCGs) and NHS Commissioning Board

1.3 Items for future meetings are currently as follows:

9 July (Barnet)

- Integrated Care
- Transition
- CAMHS - Transformation of In Patient Services

1.4 Further agenda items for these meetings will be agreed in due course.

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