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THE CABINET

Wednesday, 10th July, 2013 at 8.15 pm in the Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Membership:

Councillors : Doug Taylor (Leader of the Council), Achilleas Georgiou (Deputy Leader), Chris Bond (Cabinet Member for Environment), Bambos Charalambous (Cabinet Member for Culture, Leisure, Youth and Localism), Del Goddard (Cabinet Member for Business and Regeneration), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health), Donald McGowan (Cabinet Member for Adult Services, Care and Health), Ayfer Orhan (Cabinet Member for Children & Young People), Ahmet Oykener (Cabinet Member for Housing) and Andrew Stafford (Cabinet Member for Finance and Property)

AGENDA – PART 1 TO FOLLOW PACK

11. BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY (Pages 1 - 34)

A report from the Director of Health, Housing and Adult Social Care is attached. This report sets out the context for local health services and appraises Cabinet of the outcomes of work undertaken across the Council to date. (Non key)

(Report No.26)
(8.50 – 8.55 pm)

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Agenda Item 11

MUNICIPAL YEAR 2013/2014 REPORT NO. 26

MEETING TITLE AND DATE:
Cabinet 10th July 2013

Agenda – Part:1	**Item:11**
Subject: **BEH Clinical Strategy** **Wards: all**	
Cabinet Members consulted: Cllr Doug Taylor, Cllr Hamilton, Cllr Orhan, Cllr McGowan	

JOINT REPORT OF:
Chief Executive, Director of Finance Resources and Customer Services and, Director of Health Housing and Adult Social Care

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1. EXECUTIVE SUMMARY

1.1 In September 2011, the Secretary of State for Health (SoS) approved the Barnet, Enfield and Haringey (BEH) Clinical Strategy which will remove 24 hour A&E and consultant-led maternity services at Chase Farm Hospital. Following legal correspondence about this decision (including a judicial review letter before action sent by the Council) the Council accepted assurances given by the SoS and NHS London over proposed improvements in primary care and community based services, namely, the BEH clinical strategy would not be implemented unless and until those improvements had been made. The NHS is working towards the date of November 2013 to implement the BEH Clinical Strategy and has announced that the formal decision will be made in September.

1.2 This report sets the context for local health services and appraises Cabinet of the outcomes of work undertaken across both the Executive and Scrutiny functions of the Council to date.

1.3 In order to obtain a level of clarity on the current position and plans, the Council commissioned independent clinical experts, Hygeian, to establish the current position of primary and community based services, the status of hospital services (in particular A&E and maternity) and provide a picture of what good primary and community based services should look like (see report attached at Appendix 1).

1.4 This is a joint report of the Chief Executive, Director of Finance Resources and Customer Services and Director of Health Housing and Adult Social Care. The report provides information on the current position of the BEH Clinical Strategy and draws on information from the Health and Wellbeing Scrutiny Panel.

1.5 The report provides Cabinet with a summary of the findings and concerns from the Hygeian report. Views of the Health and Wellbeing Scrutiny Panel and a current statement around health needs and health inequalities in Enfield from the Director of Health, Housing and Adult Social Care are included.

2. RECOMMENDATIONS

2.1 Cabinet notes the NHS timetable for decision-making in relation to the removal of A&E and Maternity services from Chase Farm Hospital and endorses the taking of all reasonable steps by the Council in that regard to safeguard health care services for Enfield residents, including urgent legal action if appropriate.

2.2 Cabinet delegates responsibility for any and all legal action, including urgent legal action to the Leader of the Council in consultation with the Chief Executive, Director of Finance Resources and Customer Services and Director of Health Housing and Adult Social Care

2.3 Cabinet is further asked to note that the work of the Council's appointed experts was hampered and constrained by a lack of data from the NHS bodies on activity in A&E, maternity and primary care.

3. BACKGROUND

3.1 In September 2011, the Secretary of State for Heath (SoS) approved the BEH Clinical Strategy which will remove 24 hour A&E and consultant-led maternity services at Chase Farm Hospital, with activity transferred to North Middlesex and Barnet Hospitals. The Council issued a judicial review letter before action challenging that decision and, in response, was given assurances by the SoS and the NHS in letters dated 23 November 2011 that the proposed improvements in primary care and community based services will be in place before services were removed from Chase Farm Hospital.

The Council is monitoring the progress of plans for implementation of the BEH Clinical Strategy. The NHS is due to take the formal decision on implementation of these changes in late September but have yet to publish the criteria they will use. The Council will wish to consider its options at that time and should be prepared to respond in a timely manner to any such decision. The purpose of engaging the independent expertise is to assist the Council in monitoring implementation and ensuring that sufficient and sustainable improvements to primary and community based health services have been made before services are moved from or reduced at Chase Farm Hospital, consistent with what local people were led to believe.

3.2 Hygeian, the authors of the report, were commissioned by the Council to provide an independent view with clinical expertise and additional capacity to support the authority in establishing:

- An agreed baseline;
- Agreement on the changes that need to be in place ;
- An analysis of the detailed NHS proposals and changes as they are made to establish the extent of progress.

3.3 The appointed independent expert (Hygeian) has completed Stage 1 of the work and is commencing Stage 2.

4. SUMMARY OF FINDINGS AND CONCERNS FROM HYGEIAN REPORT (STAGE 1)

4.1 The work by Hygeian on establishing a baseline position in 2007/08 was hampered and constrained by a lack of data on activity in A&E, maternity and primary care.

4.2 The range of data provided by the NHS to enable Hygeian to undertake a full assessment of acute, community and primary care activity in Enfield from the 2007 baseline through to the review date in early December 2012 has been wholly inadequate, particularly in respect of primary care activity. Where data has been provided, the entire period has not been covered, it has been at too high a level (e.g. total number of attendances rather than by site) or does not appear to reconcile with other, publicly available sources. This has restricted the expert's ability to assess expected progress e.g. an increasing proportion of urgent care rather than full A&E attendances at Chase Farm Hospital.

4.3 The forecast growth in Enfield's population at the time of the BEH Strategy was 1% for the ten years from 283,000 in 2005/06 to 286,000 by 2015/16. This forecast was soon overturned by actual growth to an estimated 296,000 in 2011, with a revised forecast by the NHS of 303,000 by 2021. Recent figures from the Office for National Statistics (ONS) (including Census figures) highlight an even higher baseline population of 313,935 for 2011 and a significant growth over the next ten years to 365,589 by 2021. (see paragraph 6.1).

4.4 There has been progress in respect of hospital services, and the planned developments in urgent care services. Further work, however, is required to deliver the planned improvements in primary care that have not materialised and there are on-going issues arising from previous failed primary care strategies.

4.5 The strategic approach to Primary and Community Care improvements changed part-way through the implementation process. Transfer of service into primary care settings seems to have changed and reversed. Additionally, the strategy changed from a premises-led strategy to the development of networks of GP practices.

4.6 Additionally, there are still issues regarding the standard of GP premises and further investment is required to bring GP premises up to a suitable level. Transport and the Ambulance Service continue to be issues of concern.

4.7 The conclusions shown in paragraphs 55 and 56 of the Hygeian report are shown below:

55. The NHS remains aligned to or has completed work on 11 (*out of 16*) of the recommendations made by the IRP in 2008, *on which the approval of the SOS was said (by him) to be conditional*. However, the NHS has failed to provide evidence to confirm the extent of progress made in two key aspects of primary care: the number of GPs and PCPs *(Primary Care Practitioners),* and the number of available appointments.

Note: wording in italics has been inserted for clarity.

56. Further progress is required before the proposed service changes can be made. The NHS needs to provide the appropriate empirical data to reassure the Council and public that the pre-requisite underpinning investments in primary care in particular have been made and are proving effective.

Hygeian recommended metrics, proposed in the report, as a basis to monitor progress on hospital and primary care leading up to the proposed service changes in November 2013. Examples of these metrics for primary care include, the average list size per GP, the percentage of practices operating extended hours and the percentage of population registered with GPs and having access to out-of-hours primary care.

5. VIEWS OF THE HEALTH AND WELLBEING SCRUTINY PANEL

5.1 The Council's Health and Wellbeing Scrutiny Panel (H&WSP) has been charged by Full Council to maintain a close scrutiny of the BEH Clinical Strategy.

In addition to question and answer sessions at formal public meetings, Members and officers have visited the Accident and Emergency Department at Chase Farm and Barnet Hospitals. Members and officers have also visited the maternity units at Chase Farm, Barnet and North Middlesex Hospitals. The Panel additionally convened a special meeting on Monday 24th June 2013 to receive the report of the independent consultants. That meeting also heard from the London Ambulance Service and its commissioners and the BEH Transport Working Group, as set out below.

London Ambulance Service (LAS)

5.2 LAS and London commissioners outlined the current LAS call response procedures and the new commissioning following the 2012 review of services that will result in a 8% (241) increase in trained frontline LAS staffing (currently 2890) and fewer 'multiple vehicle allocations' at incidents. LAS stated that there will be two extra ambulances in the area but it was unclear how the new system would deliver this where ambulances are travelling throughout London (dynamic response system). It was stated that greater demand generated by the number of calls will automatically increase the number of ambulances in Enfield.

There was concern that increased demand for category A calls in Enfield is 16.8% compared to 8% in London. Population increase was, it was said, taken into account in the new commissioning report, as was the increase in category A calls.

The Panel also sought evidence on journey times to hospitals and health facilities in addition to the call response targets provided. The LAS agreed that better services are needed for non time-critical journeys. LAS has agreed to answer written questions post meeting, including on the issue of current private ambulance use.

In summary, although the LAS stated that Enfield would have 2 extra ambulances, when asked how many ambulances Enfield would have in total the LAS could not answer. The Government requires LAS to commission in such a way that it will be hard to establish exactly how many ambulances Enfield residents will have available. It is also clear that ambulance crews who work from Enfield bases will end up half way across London at the end of their shift and will have to drive their ambulance back to base before they can go home.

At the moment just over 50% of ambulances are staffed with paramedics. The LAS is recruiting and up-skilling present staff, but this programme will not be fully rolled out until 2015.

Enfield residents keep telling us that they are waiting longer and longer for ambulances. The Scrutiny Panel has heard of an elderly man who fell over on the pavement and was waiting for over one and a half hours in freezing temperatures until a district nurse who happened to be passing by intervened and phoned the LAS directly and told them they needed to come straight away.

5.3 **Transport**

The BEH Transport Working Group is now reconvened and meeting monthly.

In terms of achievements they cite the 307 bus route extension, the planned 202 extra parking spaces at Barnet Hospital, improvements to the underpass and Silver Street Station and a proposed bus countdown information system at each hospital. However, the updated Transport Impact Assessment report is still to be considered by the Health and Wellbeing Scrutiny Panel and the implications of HS-TAT modelling of the 5 most affected Enfield wards (Town, Chase, Enfield Highway, Enfield Lock and Southbury). Suggested mitigating actions appear weak and include that patients be given appointments outside of peak times or be given travel advice. A bus review is currently underway but provided no guarantee of any change to services. Staff car sharing schemes have been suggested to increase car parking spaces at hospitals and the suggested inter-hospital transport may incur licensing issues.

The Panel notes that whilst improvements to Silver Street Station are cited as achievements, the Transport Working Group seems unaware of access issues. The station can only be entered and exited by steep steps which will cause difficulties for many patients and women with children and babies visiting the North Middlesex.

Both Members and public raised concerns about the lengthy timescales needed to effect changes to transport and the apparent lack of urgency displayed.

Note

Cabinet is asked to note that the Transport Impact Assessment was only received on 24th June and the Scrutiny Panel is still awaiting the Equalities Impact Assessment which has been requested on a number of occasions since April 2013.

5.4 **BEH Clinical Strategy**

The Scrutiny Panel welcomed the report from the independent clinical experts.

5.4.1 The Panel noted but were not surprised at the difficulty in obtaining data for the report. They asked whether this was a common experience. The Hygeian representative commented that it had proved to be the most difficult project for obtaining information in 30 years experience. Panel members and the public mentioned earlier difficulties experience by the Kings Fund and the 4 borough Joint Health Scrutiny Committee in obtaining data and information.

Some Panel members were disappointed that IRP recommendations had not been met, evidenced for example by continuing sub-standard GP premises.

The Chief Officer of Enfield CCG stated there is no assumption in the Clinical Strategy regarding acute services moving to primary care. The Panel expressed some surprise at this statement. Since the inception of the BEH Clinical Strategy there have been

assurances provided by the NHS around improvements to primary and community based services and that this would be a pre-requisite to any changes in acute services.

The Panel remarked on the North Central London NHS description of primary care in Enfield (January 2012) that it

"seems to be the most underdeveloped in North Central London"

and was disappointed with the response from the local NHS who stated that they did not recognise this was the case. This underlines the lack of understanding and acceptance of the situation in Enfield.

The Panel also raised a concern over the number of changes of senior local NHS management and the lack of corporate memory in relation to the BEH strategy.

5.4.2 Concern was raised at the incorrect information provided regarding premises improvements (Highmead, Ordnance Road, Southgate and Enfield Town). The expected opening date of Highmead and Ordnance Road GP practices, which would post-date proposed changes in Clinical Services, was questioned. NHS has agreed to provide information post meeting.

The Panel noted the population figures and population growth which had repeatedly been raised by Scrutiny and the Council since 2007. The Chief Officer accepted that population numbers had been understated in the past. In addition, the independent experts raised the question of whether the current BEH strategy has the capacity to cope with the increasing population and increasing complexity of cases.

The Chief Officer of the CCG was confident that by September 2013 conclusions and recommendation of the IRP would be compliant. The Chief Officer added that Chase Farm Hospital would not be closing but changing its services and that 94% of residents who went to Chase Farm Hospital would continue to attend there after the change. In addition 40% of the 75,000 people per annum who would have gone to Chase Farm A&E will still be cared for at Chase Farm Urgent Care Centre.

The Panel asked the Chief Officer of the CCG and other NHS attendees to provide a definition and roles of Urgent Care Centres and Walk-in Centres. The GP Chair of Enfield CCG advised there were no clear definitions of either.

5.4.3 The Chief Officer of Enfield CCG stated that of the 75,000 patients who attend Chase Farm A&E at the moment 40% will continue to attend the Urgent Care Centre, Older People Assessment Unit and the Paediatric Assessment Unit. The remaining patients will have to go to Barnet or North Middlesex Hospitals' A&E departments. How patients will know where to go to be treated effectively is not clear given the confusion over what Walk-in Centres, Urgent Care Centres and A&E provide.

The local NHS stated they will not be assuming any of the patients noted in paragraph 5.4.3 will require capacity in primary care. The public pointed out that services in the community were at the heart of the original proposals in the BEH Clinical Strategy and the word Closer in the title of the public consultation 'Safer **Closer** Better' seemed to have been forgotten. Originally 72,500 appointments were to be moved to primary care.

5.4.4 When questioned, the decision timelines were re-stated by NHS representatives. It was not clear which measures the decisions of the CCG's would be based on. The Panel was informed that an NHS clinical assurance process was ongoing.

5.4.5 The NHS England representative discussed the on-going Hunt review of Urgent and Emergency services in England, published June 2013. The Panel notes that attempts to reduce demand on A&E departments by improving primary care have failed to deliver. The Panel's view is that changes to A&E should not take place until the review has been completed and the results understood.

6 HEALTH NEEDS AND HEALTH INEQUALITIES IN ENFIELD

6.1 Enfield is an area with significant and increasing levels of deprivation and high health need. The ONS released their latest mid-year estimates on the 26th June. Their estimate of the Borough population, as of 30th June 2012, was 317,287 - an increase of 3,352 (1.1%) from 2011. This is lower than the ONS projected figure of 324,773 for 2013/2014 but higher than the GLA projection of 316,499. The forecast growth in population at the time of the BEH Clinical Strategy was originally 286,000 by 2015/16 revised to 296,000 in 2011.

6.2 Enfield remains London's fourth most populated Borough. Whilst Enfield ranks 32nd out of 150 local authorities for premature deaths, a particular issue for Enfield remains health inequality with a significant gap in life expectancy for men and women between deprived and more affluent wards. There is evidence that this gap is widening.

6.3 Enfield Primary Care Trust (PCT) was replaced on April 1st 2013 by Enfield Clinical Commissioning Group (ECCG). The PCT spend in 2011/12 was £512.8m. The budget for the CCG for 2013/14 is significantly less at £352.7m. This is because some services – including the GP's own contracts, are now commissioned nationally.

The majority of the CCG budget (62%) is for acute services – hospital services. The majority of the remainder is for community services, mental health services and primary care excluding GP contracts. Demographic changes leave this budget under pressure now and into the future.

6.4 Key health needs have been identified through the development of the Enfield Joint Strategic Needs Assessment and include:

<u>Health Inequality</u>

Life expectancy varies substantially from west to east for men (7.7 years) and women (13.4 years) best to worst wards. This is compounded by average income levels in Enfield being £60 below London and England averages with the overall rate of employment at 64%, the fifth lowest in London. Deprivation in Enfield is increasing with the 3 Edmonton wards within the 10% most deprived in England. Child poverty is an increasing problem and is at the 8th highest rate in London and significantly worse in the east of the Borough. In addition, 12% of Enfield households are living in fuel poverty (13,124 households) the 5th highest in London.

<u>Health and Wellbeing of Children, Young People and their Families</u>

Improvements are still needed to the timeliness of women accessing maternity services. Infant mortality rates are still higher than London and England averages and childhood immunisation is below London and England averages. We continue to see childhood obesity rates as a particular concern. There has been a recent increase in hospital admissions for under 19s, including asthma, diabetes and epilepsy.

Health and Wellbeing of Adults

Enfield has high rates of people recorded as living with long-term conditions, including 7,611 with coronary heart disease, and 15,065 with diabetes. However, estimates suggest significant number of people may be living with long-term conditions, but are yet to be diagnosed. Approximately one quarter of adults in Enfield are thought to be obese, with the impacts of obesity being estimated to cost Enfield £84.1 million by 2015. It is estimated that about 74,000 adults in Enfield drink above recommended levels and that nearly 3,648 adults in Enfield are alcohol dependent. Enfield's alcohol-related admission rate has continued to rise, and is close to both the London and England rates which were 1,985 and 1,974 per 100,000 respectively.

The HIV prevalence in Enfield has continued to rise, with Enfield being one of 58 English local authorities (30 of which are London boroughs) where the prevalence rate is greater than 2 per 1,000. Over 50% of people diagnosed with HIV in Enfield in 2009-11 were diagnosed at a late stage of infection.

Enfield has the 3rd highest rate of excess mortality amongst adults who have serious mental health problems when compared to the general population. Mental ill health has considerable negative impacts on people's physical health. The number of adults accessing community mental health services has continued to rise, with the number of patients accessing in-patient care remaining relatively stable between 2006 and 2011. Enfield GP registers suggest that 17,508 adults suffer from depression, equating to nearly 8% of Enfield's adult population. Many more people may be suffering from depression, but are not known to their GP.

In respect of the health and wellbeing of older people, the Joint Strategic Needs Assessment tells us that the number of expected cases of dementia is significantly higher than the number of cases diagnosed, with only 39.9% of people living with dementia thought to have been formally diagnosed in 2011/2012 compared to the estimated England average diagnosis rate of 44.2% and London average of 44.6 %.Of the total deaths of over 65 year olds recorded in 2008/2010, 67.9% took place in hospital (3,380 deaths over the two years). This compares unfavourably with both London (61%) and England (54.4%).

7 ALTERNATIVE OPTIONS CONSIDERED

To do nothing and allow the BEH Clinical Strategy to proceed without external scrutiny.

8. REASONS FOR RECOMMENDATIONS

8.1 The Council is seeking to act in the interest of local people, to ensure their needs and very real concerns are represented in respect of the provision of safe and accessible health care services in Enfield.

8.2 Should circumstances arise in which legal action is considered appropriate in relation to Chase Farm Hospital, it will be essential for the Council to act promptly. In this context, promptness will require a challenge to be brought very quickly once a decision has been made by the NHS (i.e. within a week or two). Even a relatively short delay could risk jeopardising the success of any legal challenge. As such, there will not be time to seek approval from Cabinet with the necessary flexibility to take an urgent decision if the situation warrants it.

9. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

9.1 **Financial Implications**

Any external legal costs that may arise from a decision to challenge can be met from the Council's central fund. It is recommended that any expenditure is reported to the panel suggested in paragraph 2.2 and decisions surrounding the level of expenditure are subject to the Council's financial regulations and governance procedures.

9.2 **Legal Implications**

The Council has a statutory power to review and scrutinise matters relating to health services in its area by virtue of s190 Health and Social Care Act 2012, and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The report recommends that Cabinet note the timetable for withdrawal of acute and maternity services from Chase Farm Hospital and endorses the taking of reasonable steps, including legal action if necessary, to safeguard healthcare services for Enfield residents.

Under section 222 Local Government Act 1972 the council has the power to institute legal proceedings if it considers it expedient for the promotion or protection of the interests of the inhabitants of its area. Under the Council's Constitution, the power to initiate legal action is delegated to the Assistant Director of Legal Services.

9.3 **Property Implications**

None

10. KEY RISKS

10.1 The greater risk would seem to lie in if the Council did nothing, and fails to act in the community's best interests, by failing to attempt to secure improved public health outcomes.

11. IMPACT ON COUNCIL PRIORITIES

11.1 **Fairness for All**

Approval of the recommendations will help the Council monitor the development of primary and community care and secure improved health services for the benefit of all residents.

Accessible, effective health services for all residents are vital in improving the health of vulnerable groups and reducing inequalities in the more deprived parts of the Borough.

11.2 **Growth and Sustainability**

It is important that appropriate, sustainable health services, responsive to the changes in population and Enfield's major regeneration initiatives are provided to current and future residents in Enfield.

11.3 **Strong Communities**

Effective health services contribute to the Council's priority of making Enfield a safe and healthy place to live and are an important factor in building and maintaining strong communities in Enfield.

12. EQUALITIES IMPACT IMPLICATIONS

Excellent health services are fundamental to delivering the Council's equality agenda. The Council has requested a copy of the latest Equality Impact Assessment carried out by the NHS into their BEH Clinical Strategy proposals but this has yet to be supplied.

13. PERFORMANCE MANAGEMENT IMPLICATIONS

The development of effective primary and community care will contribute to the achievement of the Council's health and community priorities and effective monitoring of the implementation of the NHS reconfiguration timetable is essential to ensure that viable health services are maintained for Enfield's residents.

14 PUBLIC HEALTH IMPLICATIONS

Public Health implications are detailed in section 6 of this report.

Background Papers

None

Barnet, Enfield and Haringey Clinical Strategy Review

Stage One Summary Report

Enfield Council

8th May 2013

Glossary of Terms

Abbreviation / Term	Full Name / Explanation
A&E	Accident and emergency
BCFHT	Barnet and Chase Farm Hospitals NHS Trust
BEH Strategy	Barnet, Enfield and Haringey Clinical Strategy
CFH	Chase Farm Hospital
COPD	Chronic obstructive pulmonary disease
DNA	Did not attend
DVT	Deep vein thrombosis
EqIA	Equality Impact Assessment
EWTD	European Working Time Directive
FBC	Full Business Case
GP	General Practitioner
IIP	Integrated Implementation Plan
IRP	Independent Reconfiguration Panel
JHOSC	Joint Health Overview and Scrutiny Committee
NCL	NHS North Central London
NHS	National Health Service
NMUH(T)	North Middlesex University Hospital (Trust)
ONS	Office for National Statistics
PCP	Primary Care Practitioner
PCT	Primary Care Trust
RAG	Red, Amber Green
RCGP	Royal College of General Practitioners

Background

1. In 2007 the Barnet, Enfield and Haringey Clinical Strategy (BEH Strategy) was published for public consultation. Proposals within the consultation included two options for changes to women and children's services, urgent care and planned care. Both options in the consultation document included the same primary care proposal: "strengthening of services available in a community setting", to include "extending GP practice hours, expanding intermediate care, and creating new primary care centres for diagnostic and out-patient services".

2. In particular, implementation plans for the strategy would require significant changes to services provided from the Chase Farm Hospital (CFH) site. 24 hour accident and emergency provision would be replaced by a 12 hour Urgent Care Centre, consultant-led maternity services would no longer be available on site and the hospital would specialise in the delivery of planned and intermediate care. All hospital services would, in future, be provided in the context of a well-developed programme of services available in primary and community care.

3. Since 2007 proposals included in the strategy have been subject to a number of challenges including that from the local Joint Health Overview and Scrutiny Committee (JHOSC). Reviews of the strategy have been carried out by the Independent Reconfiguration Panel (IRP) in 2008 and 2011, a Clinical Review Panel in 2010 and against the Secretary of State's "4 Tests" in 2010.

4. The Secretary of State for Health has been involved on two occasions, in 2008 and most recently in 2011 the Secretary of State wrote to Enfield Council supporting the case for changes in services to be in the best interest of local people but directing the NHS to respond fully to the IRP recommendations.

This review

5. In October 2012 Enfield Council engaged the services of Hygeian Consulting, a specialist healthcare consultancy, to support its scrutiny of the implementation of the BEH Strategy, as it relates to the reconfiguration of services currently provided at Chase Farm Hospital and changes to primary care.

6. Stage 1 of this work is to establish a baseline of hospital, primary and community services against which changes can be measured. The primary focus is on accident & emergency and maternity services and the development of services in primary care. The approach to the review has included a desktop review of key documents, literature, health statistics and correspondence (see Appendix A). Stage 2 will be a periodic monitoring of implementation from April 2013.

7. Meetings and interviews have been held with a wide range of stakeholders including NHS managers, clinicians, Council staff, commissioners and members of the community. Site visits have been made to Barnet, Chase Farm and North Middlesex University hospitals (see Appendix B). We would like to thank all of those individuals and teams that have taken time to meet with members of the review team and provided documentation and information.

8. The range of data provided by the NHS to enable us to undertake a full assessment of the situation from the 2007 baseline through to the review date in early December 2012 has been limited, particularly in respect of primary care activity. Where data has been provided, the entire period has not been covered, it has been at too high a level (e.g. total number of attendances rather than by site) or does not appear to reconcile with other, publicly available sources. This has restricted our ability to assess expected progress e.g. an increasing proportion of urgent care rather than full A&E attendances at Chase Farm Hospital.

9. It should also be noted that the Barnet and Chase Farm Hospitals NHS Trust (BCFHT) Full Business Case, approved by NHS London at end of November 2012, has recently been published. However, the document does not contain detailed activity and capacity projections, nor does it address the development of services in primary care. The document therefore fails to provide reassurance in two key areas covered by this review.

10. Against that background, this report:

- Outlines the original case for change.
- Outlines the approved strategy.
- Summarises the subsequent challenges and changes in NHS thinking.
- Describes the baseline position in 2007/08.
- Outlines the provision of services in autumn 2012.
- Provides a gap analysis of further work to be undertaken to prepare for the reconfiguration of services in November 2013.
- Provides a set of milestones and measures against which further progress can be monitored by Enfield Council.

The case for change

11. The BEH Strategy proposed a case for change based on:

- Growing concerns regarding the safety and quality of care provision and the ability to maintain safe and effective staffing to support clinical services in BCFHT arising from duplication of services across multiple sites, the introduction of the European Working Time Directive (EWTD) and Royal College guidance on the consultant staffing for maternity and A&E services.
- Developments in the clinical evidence base informing new models of care and patient pathways and increasing specialisation of acute services including major trauma, stroke and cardiac care, maternity, neonates and children's services, together with the move to more care being provided in community settings.
- National policy supporting a new direction for community services, signalling a move away from care in secondary and acute settings and into community and primary care.
- The poor state of the infrastructure at Chase Farm Hospital and underlying financial position of the health economy as a whole, and Barnet and Chase Farm Hospital in particular.

The approved strategy

12. The approved BEH Strategy, ratified after consultation in 2007, would have the following specific implications for the population of Enfield (predicted to increase from 283,000 in 2005/06 to 286,000 by 2015/16):

- Concentration of 24 hour A&E services at Barnet Hospital and the North Middlesex University Hospital (NMUH), closure of the 24 hour accident and emergency department at Chase Farm Hospital and provision of urgent care centres at all three hospitals.

- Concentration of consultant-led maternity services, neonatal and children's services at Barnet Hospital and NMUH following the closure of consultant-led maternity services at Chase Farm Hospital. Planned capacity is 13,000 deliveries per annum at those two hospitals: Barnet (7,000) and North Middlesex (6,000).
- Midwife-led antenatal and postnatal clinics would remain at Chase Farm Hospital. The original plan to keep the midwife-led delivery suite at Chase Farm was to be reconsidered once the changes had bedded in.
- Provision of a paediatric assessment unit and an older people's assessment unit on the Chase Farm site.
- Development of planned elective in-patient and day care at Chase Farm and movement of some of this work from Barnet Hospital, freeing up capacity for the additional emergency admissions resulting from changes to A&E services.
- Provision of planned care activity and intermediate care beds on the Chase Farm site.
- Transformation of primary care to improve patient experience and outcomes, and in particular extending GP practice hours, expanding intermediate care, and creating new primary care centres for diagnostic and out-patient services, together with the development of urgent care centres.

13. There were several key capital developments planned for the hospital sites:

- Completion of new build Women's and Children's Centre at NMUH.
- Completion of an A&E extension/reconfiguration and new build Women's and Children's Unit at Barnet Hospital.
- Upgrading and refurbishment of the current A&E, Urgent Care Centre and out-of-hours primary care centre at Chase Farm Hospital to produce a modern facility for urgent care, paediatric resuscitation and out-of-hours primary care services. A phased upgrade, whilst services continue to be delivered, is due to commence after the 24 hour A&E has ceased, planned for mid-November 2013.

14. In terms of the shift of activity from secondary care, the strategy assumed:

- 2,173 fewer emergency admissions per annum to CFH (1,851) and NMUH (322) for Enfield residents, but only 7 per day being treated instead within a primary care setting.
- 72,314 out-patient appointments moving from CFH (48,962) and NMUH (23,352) to a primary care setting, of which 136 were related to accident and emergency.

15. In terms of the development of primary care, Figure 10 of the Abridged Pre-consultation Business Case for the BEH Strategy summarises the key initiatives for Enfield PCT, using over £8.5m between 2008/09 and 2012/13 (reproduced in Figure 1 below).

Figure 1 - Planned developments in primary and urgent care from 2008/09 to 2012/13

New primary care centre in Freezywater/Enfield Highway area *(NB: Now Ordnance Road to open in July 2014)*
New practices in Evergreen and Forest primary care centres *(NB: Completed)*
Extended hours in GP practices across Enfield
New primary care centres in Enfield Highway/Wash and Ponder's End/Enfield Lock with additional practitioners *(NB: Now Moorfields Road under tender and Ordnance Road as above)*
Reduced GP average list size across Enfield
New primary care centre in Upper Edmonton *(NB: Now Highmead planned for 2014)*
New primary care centre at Arnos Grove *(NB: Replaced by a planned scheme in Southgate)*
24 step up and step down beds at Chase Farm Hospital
Creation of a 24/7 rapid response team
Home based rehabilitation with supporting beds and 7 day care centre
Single point of contact telephone number for access to GP and community services
LAS emergency care practitioners to be introduced in Enfield, if pilots successful elsewhere
Easier access to diagnostic services such as MRI scanning, CT scanning and ultrasound
Rehabilitation beds and centre

16. Paragraph 2.2.3 of Enfield PCT's "Care Closer to Home Investment Plan 2008 to 2013", published in June 2007, refers to the difficulties that arise from high list sizes in parts of Enfield. The plan cites the maximum list size recommended by the Royal College of General Practitioners (1,800), and a Department of Health definition of "under-doctored" (1,500). The conclusion reached was that the PCT should work towards the 1,500 standard, an increase of 42 Primary Care Practitioners (PCPs) based on the estimated population at that time.

17. While the BEH Strategy clearly includes the parallel development of primary care services and reconfiguration of acute hospital services, there is no specific reference to which aspects of one component are directly dependent on which aspects of the other.

Subsequent challenges and policy changes

18. The BEH Strategy has been the subject of a number of significant challenges since its publication in 2007.

19. In March 2008, the Chair of the Barnet, Enfield and Haringey Joint Health Overview and Scrutiny Committee exercised the power of referral of services under the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002.

20. The Secretary of State asked for advice on the referral from the Independent Reconfiguration Panel (IRP). Following a full review of the proposed changes, the IRP concluded that it accepted the need for change as set out in the BEH Strategy, to ensure the provision of safe, sustainable and accessible services. However, the IRP made a number of recommendations or conditions that should be met before the service changes took place. The Secretary of State noted that "the three PCT Boards had agreed that the planned developments in primary care must be in place before any services are moved out of a hospital setting".

21. In May 2010, the Secretary of State for Health issued a national moratorium on reconfigurations and, after further consideration, directed those NHS organisations engaged in reconfigurations to meet four further tests. On 26 January 2011, the Board of NHS London concluded that the four new tests for reconfiguration had been met.

22. Each of the above challenges resulted in the conclusion that, subject to the assurance that certain recommendations are accepted, the implementation of the BEH Strategy is in the best interests of the local population.

23. Since consultation on the original BEH strategy, there has been a significant shift in thinking around the development and provision of primary care services. The NCL report "Transforming the primary care landscape in North Central London", published in January 2012, pointed to a shift away from the "premises led approach" to an "integrated care network approach".

24. While this change in emphasis does not eliminate the need to improve the quality of the infrastructure within which primary care services will be delivered, it does signal two significant changes which have a material impact on how services are now being planned: plans for local urgent care centres have been dropped, and a more selective approach to the transfer of out-patient activity to primary care settings has been adopted. Furthermore, NCL stated in a clarification letter dated 21st January 2013 that "there are no assumptions from the implementation of the acute changes in the BEH clinical strategy that there will be an activity shift from acute to primary care". This is a clear change from the assumptions in the original plans – see paragraph 14 above.

25. The current primary care plan, arising from the 2012 "Transforming the primary care landscape in North Central London" document, includes investment in the following:

- An increased number of appointment slots: 76,896 through expansion of the Local Enhanced Service and 20,566 through extended hours.
- Completion of four schemes – Highmead (in 2014), Moorfields Road (at tender stage), Ordnance Road (in July 2014) and Southgate (lease under discussion) – and identification of a site in Enfield town.
- Recruitment of 4 additional GPs in conjunction with University College London, contributing a further 17,472 additional appointments per annum.
- A COPD primary care pathway, with more services available in GP surgeries (£628k);
- Investment in information technology to increase the number of appointments by reducing DNAs and improve the overall patient experience (£1m);
- Improvement of facilities in GP surgeries to provide more treatment space (£526k);
- Introduction of a minor ailment scheme to reduce GP workload (£400k);
- Development of the anti-coagulation service to provide services to create increased patient choice and reduce travel times (£97k);
- A DVT pathway for patients to be treated in the community and avoid A&E (£12k).

Baseline position in 2007/08

26. A full description of healthcare provision in 2007/08 when the BEH Strategy was ratified has been constrained by the lack of data on activity in A&E, maternity and primary care.

27. 24 hour A&E services were provided at each of the three hospitals – Barnet, Chase Farm and NMUH. In 2008/9, the total number of attendances for BCFHT was approximately 152,000 (total for Chase Farm and Barnet Hospitals) and approximately 110,000 for NMUH. [Source: *NHS Information centre Hospital Episode Statistics*]. We are advised by the Council that there were around 74,000 attendances at the CFH A&E and out-of-hours unit in that year.

28. All three hospitals provided antenatal, postnatal and in-patient consultant-led maternity services, with midwifery-led units at Chase Farm Hospital and Edgware Hospital. In 2008/09, there were 10,360 deliveries across the four units: Barnet (3,143), Chase Farm (3,265), Edgware (430) and North Middlesex (3,522).

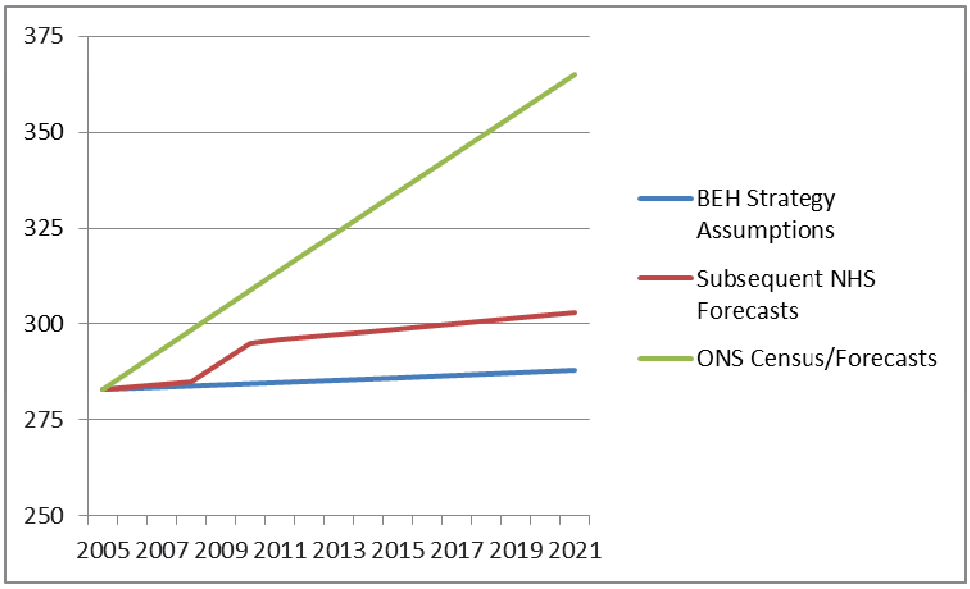
29. Primary care in Enfield was served by a total of 62 GP practices with (on average) a higher than recommended list size per professional. A high proportion of practices operated from premises which required up-dating (66% according to Enfield Council).

30. The average list size per Primary Care Practitioner (GPs and nurses with extended skills) was 1,923, higher than the 1,800 recommended by the RCGP. A target GP list size of 1,500 was set out in Enfield PCT's "Care Closer to Home Investment Plan 2008 to 2013" published in June 2007.

31. The forecast growth in Enfield's population at the time of the BEH Strategy was 1% for the ten years from 283,000 in 2005/06 to 286,000 by 2015/16. This forecast was soon overturned by actual growth to an estimated 296,000 in 2011, with a revised forecast by the NHS of 303,000 by 2021. Recent figures from the Office for National Statistics (ONS) (including Census figures) highlight an even higher baseline population of 313,935 for 2011 and a significant growth over the next ten years to 365,589 by 2021.

32. The various changes in Enfield's forecast population are highlighted in Figure 2 below.

Figure 2- Population forecasts: 2005 to 2021 (000)



33. We are also advised that changes in the qualification for housing benefits will continue to drive a population shift from inner to outer London, bringing a younger, mobile population to Enfield.

Assessment of progress

34. The NHS remains aligned to or has completed work on 11 of the IRP's 16 conclusions and recommendations. Work on the remaining 5 is underway, and is largely expected to be completed in line with the timetable for service changes in November 2013. The areas for most concern are the improvements in primary care (IRP recommendation 9) and transport (IRP recommendation 12).

35. With regard to the changes in hospital services, the evidence available demonstrates that progress has been made to prepare for the implementation of the strategy, with all of the capital developments expected to be completed on schedule. Measures implemented since 2008 designed to stem the flow of patients to the A&E departments include increasing capacity in general practice, improved utilisation of available capacity in general practice and demand management. Total attendances have grown by less than 2% overall, with a small reduction in attendances at Chase Farm balanced by small increases at Barnet and North Middlesex. [Source: *NCL provided data November 2012]*.

36. However, with regard to maternity services, the NHS has yet to confirm that the planned capacity at Barnet and North Middlesex is for 13,000 births and that this will be sufficient for the needs of the significantly increased population.

37. Although there has been positive progress in respect of hospital services, and the planned developments in urgent care services have largely already been delivered, further work is required to deliver the planned improvements in primary care where progress is patchy and there are "on-going issues arising from previous failed primary care premises strategies". [Source: "Transforming the primary care landscape in North Central London, July 2012].

38. Progress on the four new primary care centres has been slower than originally anticipated, and the contract for the Ordnance Road development had not been signed at the time of the review.

39. Many of the smaller GP practices remain in sub-standard premises, and consequently the primary care scene in Enfield as described by NCL "seems to be the most underdeveloped in North Central London". 33 of the GP practices in Enfield scored less than the London average on overall Quality and Outcomes Framework (QOF) scores in 2010/11. [Source: NCL- Transforming the primary care landscape in North Central London, January 2012].

40. No evidence has been provided to demonstrate an increase in the number of GPs and PCPs, a reduction in average list sizes or an increase in the number of appointment slots in primary care.

41. Despite the paucity of evidence to demonstrate quantitative improvements, increases in the level of patient experience have been reported. Recently published results of a Clinical Commissioning Group (CCG) patient satisfaction survey on GP out-of-hours services show 68.04% of Enfield respondents reporting a good experience in the period July 2011-March 2012, slightly below the average of 70.3% across results from 212 CCGs. However, we are advised that there are still high levels of health inequalities and the Council's view is that these are increasing.

42. Quality and Outcomes Framework results for 2011/12 also show a significant increase in scores across the Enfield PCT area from previous years. The average points per practice were 934.9 in 2011/12 compared to 904.4 for 2010/11. The improvement was most marked in the scores for patient experience which increased to 94.5% in 2011/12 from previous scores of around 65%. There is still room for further improvement in comparison with other PCT areas but the direction of the results is encouraging.

43. The principal outstanding issues that require clarification from the NHS are:

- By how much and by when are GP and PCP numbers increasing.
- By how much average list sizes per GP and PCP are falling, despite the higher than expected increase in population.
- By when the planned increase in appointment slots in primary care will be delivered.
- By when the four new primary care centres will be operational.

44. In addition to current plans, several other risks that must be considered are:

- Implementation of the BEH Strategy could be delayed by changes in NHS organisational structures taking place on 1st April 2013.
- Given that the service transfers will take place a few weeks ahead of seasonal winter pressures, the preparedness and resilience of primary care, urgent and emergency care and the London Ambulance Service must be tested to identify risks, associated mitigation and develop business continuity plans.
- Due to recent material changes at Board level in both Trusts and the wider organisational changes within the NHS on 1st April 2013, working relationships between

the Council and the NHS could be impacted and "corporate memory" within the NHS could be reduced even further.

- The potential impact in terms of possible further service changes arising from the proposed merger of BCFHT with the Royal Free NHS Foundation Trust.

45. It is likely that some of the detail to evidence achievements to date and to forecast the effects of further progress is included in the business cases for BCFHT and NMUHT – the contents of which are not yet in the public domain. These details have been requested but have not been released at the time of preparing this report.

Further progress required

46. The developments in both primary and secondary care that need to be in place before the changes to service provision take place at Chase Farm are embedded in the BEH Strategy Integrated Implementation Plan (November 2012) and can be summarised as:

- Completion of capital developments at Barnet Hospital, Chase Farm Hospital and NMUH.
- Implementation of process improvements planned for the urgent care centres at Chase Farm Hospital and NMUH to underpin the move from a triage based service to 'see and treat'.
- Full implementation of the Transport Working Group's work programme including processes and systems for joint working and communication between Barnet, Chase Farm and North Middlesex hospitals to ensure people are able to access the right service, first time.
- Continued work with the London Ambulance Service to design and implement safe and efficient transfer protocols and service developments that support primary care services to manage more patients within community and primary care settings.
- The community midwifery and primary care services models need to be settled by early spring to ensure women are clear about their choices and where they can choose to deliver in advance of the service changes in November 2013.
- Mental health pathways need to be reviewed to assure safe services once the Chase Farm 24 hour A&E is removed and with it a formal ' place of safety' regularly used by people with mental health conditions who can't access immediate support from the mental health services located on the Chase Farm site.
- Further premises development and improvement plans are to be implemented – with four new premises being available during 2014/15: Southgate, Ordnance Road, Moorfields Road and Highmead.
- Full realisation of additional primary care appointment slots has still to be achieved, to provide additional capacity.
- Delivery of the full impact of the four new GP posts is to be achieved to demonstrate a reduction in list sizes.
- The latest information available confirms 85% extended hours coverage across Enfield. Although no target was given, the Abridged Pre-consultation Business Case infers 100%.

Milestones and metrics leading up to November 2013

47. There are a number of milestones between March 2013 and spring 2014 against which further progress can be monitored under Stage 2. In addition to monitoring whether the event has met (or is likely to meet) the planned date, the impact of these key events on associated activity levels should be also monitored on an on-going basis, particularly during the early months/years following the milestone.

48. As far as hospital services are concerned, progress between now and the transfer of services in November should be compared on a quarterly basis against the agreed timetable for the construction of new buildings, redesign of care pathways and revised workforce plan. The impact on patterns of activity in A&E, urgent care and maternity services should also be monitored on a quarterly basis.

49. With regard to primary care services, between now and the transfer of services in November, progress needs to be monitored in terms of the number of GPs and PCPs, the number of appointment slots and the percentage of practices operating extended hours.

50. The NHS will need to provide the requisite data on a timely basis to inform this monitoring process, without which the Council will be unable to monitor progress in any meaningful way.

Primary care in the longer term

51. Demonstrating improved patient outcomes is key to judging the overall success of the evidence-based Primary Care Strategy, but achieving these outcomes depends on having appropriate infrastructure and processes in place. For this reason, in order to judge accurately the effectiveness of the Barnet, Enfield and Haringey primary care transformation programme, measures of improvements need to include elements of structure (e.g. facilities) and process (e.g. ways of working) as well as outcome.

52. Based on the review of recently published literature and evidence gathered during this project, we would suggest there are eleven key quantitative measures which can be used as part of an overall framework to assess the quality of primary care services in Enfield, namely:

- The average list size per Primary Care Practitioner (Enfield PCT standard of 1,500).
- The average list size per GP (RCGP target of 1,700).
- The average list size per practice (no lower than the average for London).
- The percentage of practices operating extended hours (target of 100%).
- The percentage of the population registered with GPs and having access to out-of-hours primary care.
- The number of appointment slots available with GPs and other primary care staff.
- The percentage of GP practices in sub-standard accommodation (no higher than the average for London).
- The number of attendances at A&E and the Urgent Care Centre.
- The quality of primary care services, in terms of patient safety, clinical effectiveness and patient experience.
- Access to a wide range of health and care professionals in the community.
- The shift from “triage and wait” to “see and treat”.

53. It is also important to focus on the qualitative aspects of primary care, in terms of both process and patient satisfaction. Appendix C contains a summary of "what good looks like" for both primary care and urgent care services.

54. It is also advisable to monitor trends in patient experience information for primary care, maternity services and emergency and urgent care. The 'Friends and Families test' for maternity and emergency care specialties are available now, and 'Net promoter scores' are being considered for primary care from April 2013. National Patient Survey feedback is also available annually and the monitoring of resulting action plans may also provide an opportunity for monitoring patient experience.

Conclusions

55. The NHS remains aligned to or has completed work on 11 of the recommendations made by the IRP in 2008. However, the NHS has failed to provide evidence to confirm the extent of progress made in two key aspects of primary care: the number of GPs and PCPs, and the number of available appointments.

56. Further progress is required before the proposed service changes can be made. The NHS needs to provide the appropriate empirical data to reassure the Council and public that the pre-requisite underpinning investments in primary care in particular have been made and are proving effective.

Recommendations

57. The following actions are recommended to Enfield Council in terms of information and reassurances required from the NHS in broad order of priority:

- Confirmation of the scale and timing of the increase in GP and PCP numbers since 2007/08 and planned to 2015/16.
- Confirmation of the scale and timing of the increase in appointment slots in primary care since 2007/08 and planned to 2015/16.
- Confirmation of when the four new primary care facilities will be operational: Highmead, Moorfields Road, Ordnance Road and Southgate.
- Reassurance that capacity within the new building developments will be adequate for the needs of an increased population, as the recently published Full Business Case does not provide the information required to confirm this now.
- Reassurance that the Transport Group will deliver against its objectives before the November 2013 deadline.
- Reassurance on plans to maintain focus and progress during the NHS re-organisation transition phase during 2013 that will help reduce risks to implementation and service availability and delivery.
- Confirmation as to how and when the impact of increased population growth will be reflected in investment plans from 2013/14 onwards, monitoring progress against the existing Primary Care Plan in the meantime.

58. The following actions are recommended to Enfield Council in terms of the monitoring of future progress:

- Use the milestones and metrics proposed within this report as the basis to monitor progress on all areas of the Integrated Implementation Plan – covering both hospital and primary care - that clearly sets out the programme of work leading up to the proposed service changes in November 2013.

- Liaise with the NHS to determine the precise data to be used for further monitoring of progress between the Council and the NHS as part of the formulation of the Stage 2 monitoring process, building on the recommendations in this report and NCL's draft benefits realisation plan.

- Undertake further reviews of progress being made on a quarterly basis, at the end of March, June and September and then immediately before the timing of the final decision to transfer A&E and maternity services (in line with the proposals in paragraphs 48-50 above).

Appendix A

Documents Reviewed

Hospital Reconfiguration: An IPPR briefing, Institute for Public Policy Research, September 2006
The Future Hospital: The progressive case for change, Institute for Public Policy Research, January 2007
Maternity Matters, Department of Health, April 2007
The Future Hospital: The politics of change, Institute for Public Policy Research, May 2007
Barnet, Enfield & Haringey clinical Strategy ABRIDGED Business Case 26th July 2007
Barnet, Enfield and Haringey Clinical Strategy Draft Programme Brief 08.02.2008
Advice on Proposals for Changes to the distribution of Service Between Barnet, Chase Farm and North Middlesex Hospitals and the Associated Development of Primary Care Services, Independent Reconfiguration Panel, 31 July 2008
Secretary of State's letter to Barnet Enfield & Haringey Clinical Strategy Joint Scrutiny Committee, 3 September 2008.
Implementing the Barnet, Enfield and Haringey Strategy, Nigel Beverly, SRO, 1 December 2009
Barnet, Enfield and Haringey Clinical Strategy Review of Evidence (2007-2010), UCL Partners, October 2012
Barnet, Enfield and Haringey SAFER, CLOSER, BETTER HEALTH CARE, Clinical Strategy Implementation Programme. Test 4 Patient Choice, 10.11.2010
Independent Reconfiguration Panel Report to Secretary of State, 8 July 2011
Improving the Quality of Care in General Practice, Kings Fund 2011
Secretary of State's letter to Health and Wellbeing Scrutiny Panel 12 September 2011
Report on the development of NHS North Central London's Primary Care Strategy 31 10 2011 JHOSC
The State of Maternity Services, Royal College of Midwives, 2011
NHS NCL Primary Care Strategy 2012-16 January 2012 (Transforming the primary care landscape in North Central London)
Report from a Clinical Review of the Barnet, Enfield and Haringey Strategy, NHS London, February 2012
Barnet, Enfield and Haringey Integrated Implementation Plan (Draft), NHS North Central London, May 2012
Primary Care Strategy 2012/16. Enfield Primary Care Development Strategy Implementation Programme High Level Implementation Plan, NHS North Central London, 1 June 2012
Getting to grips with 24/7 emergency and urgent care, NHS Clinical Commissioners, October 2012
The New Chase Farm Hospital, Barnet and Chase Farm Hospitals NHS Trust, October 2012 ([public information leaflet)

‘Review of Urgent Care Centres - A discussion paper from the Primary Care Foundation’, October 2012
Barnet, Enfield and Haringey Integrated Implementation Plan, NHS North Central London, November 2012
General practice in London: Supporting improvements in quality’ commissioned by NHS London from The King's Fund and Imperial College London, December 2012
Various minutes of Health and Wellbeing Scrutiny Panel meetings
Various minutes of Joint Overview and Scrutiny Panel

Appendix B

Key Staff Interviewed

Enfield Council

- Rob Leak, Chief Executive
- Ray James, Director of Housing, Health and Adult Social Care
- Mike Ahuja, Head of Corporate Scrutiny and Community Outreach
- Kate Wilkinson, community representative, Enfield
- Dr Shahed Ahmad, Director of Public Health
- Bindi Nagra, Assistant Director of Housing, Health and Adult Social Care and joint commissioner with NHS NCL
- Councillor Alev Cazimoglu, Chair of Enfield Health and Wellbeing Scrutiny Panel

NHS North Central London

- Caroline Taylor, Chief Executive
- Siobhan Harrington – Director of Implementation (BEH Strategy)
- Dr Angela Lennox – Assistant Medical Director, Primary Care
- Sean Barnett, Primary Care Development lead

Enfield Clinical Commissioning Group

- Dr Alpesh Patel, Chair
- Dr Mo Abedi – currently PEC Chair and has just been appointed as CCG Medical Director
- Liz Wise, Accountable Officer

Barnet and Chase Farm Hospital Trust

- Mark Easton, Chief Executive (to 23 November 2012)
- Dr Adam Rodin, Clinical Director Women's services
- Carol Littlehales, Head of Midwifery
- Elizabeth Raidan, General Manager for Women and Children
- Mary Joseet, Director of Performance, Planning and Partnerships
- Sarah Perry, Director of Operations Emergency care
- Rachel Kambambe, Emergency Care Manager
- Dr Turan Huseyin, Clinical Director – Emergency Medicine

North Middlesex University Hospital Trust

- Lance McCarthy, Interim Chief Executive

Appendix C

"What Good Looks Like"

Overview

This is a review of the literature to outline "what good looks like". This is important as although the immediate priority is to ensure the NHS has delivered on its plans and complied with the recommendations of the IRP, there is also a longer term need to ensure that the residents of Enfield receive a "good" quality of service compared to their neighbours.

'What good looks like' can be based on the definition of quality in the NHS contained within the Darzi NHS Next Stage Review, Department of Health, 2008. The three core measures are: patient safety, clinical effectiveness and the experience of patients.

The BEH Strategy fits within this framework, as it focuses on:

- Consolidating specialist expertise, facilities and equipment for some of the more acute and higher risk services to improve outcomes and patient experience, specifically maternity services and 24 hour accident and emergency services.
- The availability of accessible high quality 'core' general practice services and wider primary care services including:
    - Consistent, high quality diagnosis, referral and prescribing
    - Efficient and effective management of acute illness
    - Proactive management of people with long term conditions
    - Consistent approach to promoting health and preventing ill health

Donabedian (1988) also provides a helpful framework that includes key elements regarding:

- Structure; facilities, equipment, administration, personnel and protocols.
- Process; records, diagnosis, treatment plan, sequencing of activities.
- Outcomes; patient satisfaction, health status, completion of treatment, recall patterns and needs of recall.

'What good looks like' - primary care

A recent report regarding primary care commissioned by NHS London and published by the King's Fund in December 2012 identifies that some practices in London are not equipped to meet this challenge, finding:

- While there has been investment in new facilities, some practices continue to operate from premises that are not fit for purpose.
- The GP workforce is older in London than elsewhere, with a quarter of GPs aged over 60 in some areas - this raises staff recruitment and retention issues.
- Smaller practices tend to employ fewer practice staff. Almost 20 per cent of London practices are single-handed, compared with just 13.8 per cent across the rest of England. While this does not mean patients receive a poorer service it may limit what the practice can offer.

The report argues that major changes are needed to the organisation and delivery of primary care to meet these challenges including:

- Working with a wider range of health and social care professionals to deliver more integrated care for patients with complex health and social care needs.
- Working with hospitals and community service providers to develop models of shared care that ensure timely and appropriate access to urgent care for patients 24/7.
- Be more proactive in reaching out to high-risk groups and working with local authorities to promote health and prevent disease.
- Making better use of data to understand and act on local variations in performance.
- Creating new models of service provision in which GP practices work together in local networks from which improvements in primary care can be delivered and sustained.

Good primary can be measured and monitored through a number of dimensions, set out in *'Improving the Quality of Care in General Practice*', The Kings Fund, 2011.

Access

- Access to a range of services and health and care professionals in the community – may include nurses, midwives, health visitors, mental health workers, benefits advisors, staff to support diagnostic tests such as phlebotomy. The federated practice model established in Enfield during 2012 provides for this.
- A range of methods to access assessments and advice including telephone triage, email and face-to-face appointments.
- Easy to access appointments, including 'self-service' bookings for routine non-urgent matters via telephone or e-channels.
- Appointments available with the most appropriate health or care professional.
- Enough contact slots (including face-to-face appointments) to meet assessment needs of the population.
- Enough slots at times people can access them. For example working people often find appointments before or after work or at the weekend more convenient especially in the current economic climate and not wanting to take time off work.

Diagnosis, referral and prescribing

- Did the patient get a timely diagnosis and on-going treatment with the right person to resolve their immediate and on-going needs?
- Did prescribing meet the approved guidelines and protocols and secure the best outcome for the patient?

Long term conditions management

- Are all patients with long term conditions on the appropriate practice register?

- Does the patient have an on-going management plan and 'rescue remedies packs' (antibiotics, steroids etc.) as needed?
- Are there planned review arrangements?
- Are early-warning indicators identified?
- Does the patient know who to contact if they have a change in their condition?
- Have carer's needs been assessed, planned and provided for?

Promoting health and preventing ill health

- Are there proactive and transparent arrangements in place for promoting health and preventing ill health on a community, family and individual basis?
- Are staff appropriately skilled?
- Is information available?
- Is there a network and a range of support and motivational service options available e.g. pharmacists, schools and colleges, charities, third sector organisations to people regarding healthy lifestyles and making healthy choices e.g. smoking cessation safe drinking weight management, blood pressure and cholesterol management?

'What good looks like' - urgent care

A recent review of 15 urgent care centres and a literature review has led the Primary Care Foundation to conclude that a good urgent care service is one in which:

- Care is provided promptly – using 'see and treat' rather than 'triage and wait'.
- The scope of the service is clear – articulated by commissioners and described clearly for patients and the 111 service.
- There is clear governance and management responsibility for improving quality and cost effectiveness.
- The environment is appropriate for the provision of good quality care and supports integration with other services – integrating urgent care to wider primary care and secondary care systems.
- The process used supports these objectives.
- There are mechanisms for capturing and acting on patient experience and other feedback.

Review of Urgent Care Centres, Primary Care Foundation, October 2012

Patients want to access a service that is easy to get to and will provide the care and treatment they need in a safe, clean environment, delivered by competent and skilled staff. If their needs cannot be fully met at the urgent care centre they want to be confident of safe and timely referral and transfer to the most appropriate place e.g. a specialist centre.

All other service providers in the system need to know what can be done where, and in Enfield the London Ambulance Service is working closely with primary care and the acute hospitals to ensure protocols are in place to get patients to the right service first time. The urgent care centre service will be included in the 111 service information that will commence in March 2013.

The planned provision of urgent care centres at Chase Farm, Barnet and North Middlesex hospitals is in line with these principles. All three hospitals are having new or upgraded facilities. A full workforce review is being undertaken across accident and emergency and the urgent care centres to ensure competent staff are in the right place when the service changes take place. Chase Farm and the North Middlesex hospitals are changing their urgent care service models to 'see and treat' and it is understood that the new centre in Barnet will operate this model from April 2013. When work is complete in 2014, the urgent care centre at Chase Farm will be co-located with the out-of-hours primary care service in enhanced facilities.

NHS London is working with commissioners and providers to secure an information solution that will enable appropriately shared data and information flows across the system, enhancing communication and decision making. This will help to improve the safety and continuity of care.

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