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).

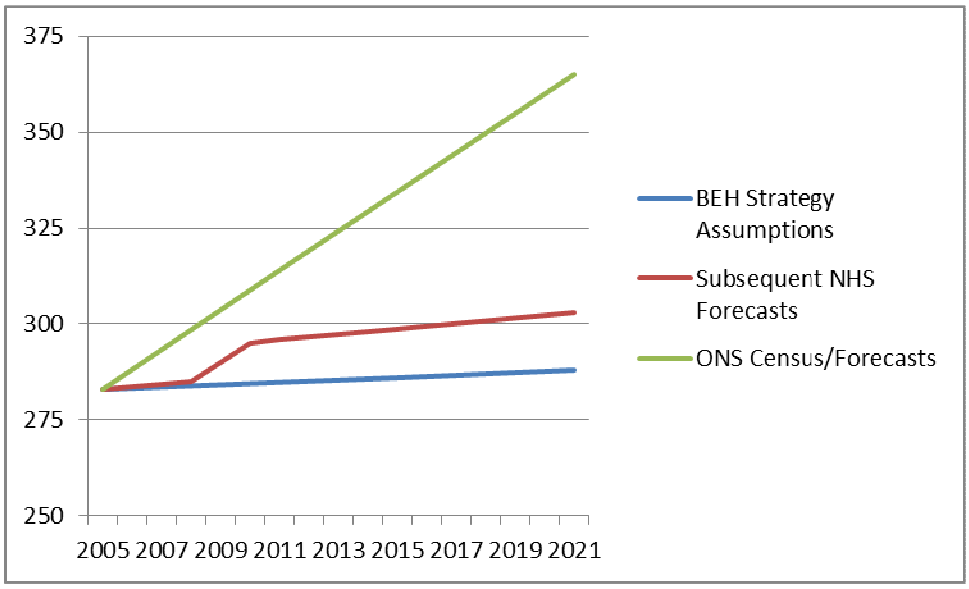
29. Primary care in Enfield was served by a total of 62 GP practices with (on average) a higher than recommended list size per professional. A high proportion of practices operated from premises which required up-dating (66% according to Enfield Council).

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

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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

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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.