NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Monday 31 October 2011 10:00 a.m.
Council Chamber, Enfield Civic Centre,
Silver Street, Enfield, Middlesex, EN1 3XA

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

Support Officers: Sue Cripps, Shama Sutar-Smith, Robert Mack, Pete Moore and Melissa James

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST (PAGES 1 - 2)

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

4. MINUTES (PAGES 3 - 10)

To approve the minutes of the meeting of 19 September 2011 (attached).

5. NORTH CENTRAL LONDON PRIMARY CARE STRATEGY (PAGES 11 - 102)

To consider the development of a primary care strategy for north central London.

6. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY (PAGES 103 - 118)

To note the response of the referral of the Barnet, Enfield and Haringey Clinical Strategy to the Secretary of State for Health by Enfield Health Scrutiny Panel.

7. STRATEGIC AND QIPP PLAN

To consider the Strategic and QIPP Plan for North Central London. (TO FOLLOW)

8. CANCER MODEL OF CARE (PAGES 119 - 126)

To consider the implementation of the new mode of care and, in particular, the development of integrated cancer systems.

9. FUTURE WORK PLAN (PAGES 127 - 128)

To consider the JHOSC's future work plan.

18 October 2011

Agenda Item 3

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

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

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

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

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

NO

NO

YES

You may have a **personal interest**

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

Prejudicial interest

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

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

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

NO

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

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

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North Central London Joint Health Overview and Scrutiny Committee
19 September 2011

Minutes of the meeting of the Joint Health Scrutiny Committee held at the Civic Centre, High Road, Wood Green, N22 8LE on 19 September 2011 at 9.30am.

Present: **Councillors:** Councillor Gideon Bull (Chair) (L.B.Haringey), Councillor John Bryant (Vice-Chair) (L.B.Camden), Councillor Alev Cazimoglu (L.B. Enfield), Councillor Alison Cornelius (L.B. Barnet), Councillor Kate Groucutt (L.B.Islington), Councillor Martin Klute (L.B.Islington), Councillor Graham Old (L.B. Barnet), Councillor Anne Marie Pearce (L.B. Enfield), Councillor Barry Rawlings (L.B. Barnet) and Councillor Dave Winskill (L.B.Haringey).

Officers: Rob Mack (L.B.Haringey), Peter Moore (L.B.Islington), Sue Cripps (L.B. Enfield), Melissa James (L.B. Barnet) and Shama Sutar-Smith (LB Camden)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)

Councillor Gideon Bull welcomed everyone to the meeting. Members of the Committee and officers introduced themselves.

Apologies for absence were received from Councillor Maureen Braun (L.B. Barnet), Councillor Peter Brayshaw (L.B. Camden) and Helena Kania (Haringey LINk).

Councillor Graham Old substituted for Councillor Maureen Braun (L.B. Barnet). Councillor Barry Rawlings also represented L.B. Barnet). It was noted that in the event of there being a need for a vote, each borough was entitled to one vote irrespective of the number of representatives that it had present at the meeting in question.

Apologies for lateness were received from Councillor John Bryant (L.B.Camden).

2 URGENT BUSINESS (Item 2)

None.

3 DECLARATIONS OF INTEREST (Item 3)

Councillor Gideon Bull declared an interest in that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Kate Groucutt declared that she was a governor at University College London Hospital but did not consider the interest to be prejudicial in respect of items on the agenda.

Councillor Alison Cornelius declared that she was an Assistant Chaplain at Barnet Hospital but did not consider it to be prejudicial in respect of items on the agenda.

4 MINUTES (Item 4)

In respect of the item regarding Out of Hours GP Services – Re-tendering of Contract, Councillor Winskill noted that it had been agreed to circulate the independent auditors report into the financial problems of Camidoc. Martin Machray reported that he had been awaiting a view from the Committee on how the report should be distributed. The Committee requested that the complete report plus summary be circulated to all Members.

RESOLVED:

1. That NHS North Central London be requested to circulate the full report and summary of the independent audit report commissioned by Camden PCT into the financial difficulties of Camidoc.

2. That the minutes of the meeting of 15 July 2011 be approved.

5 TRANSFORMING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN-PATIENT SERVICES FOR YOUNG PEOPLE LIVING IN BARNET, ENFIELD & HARINGEY (Item 5)

Emma Stevenson, Andrew Williams and Claire Wright from NHS North Central London, Maria Kane and Eric Karac from Barnet Enfield and Haringey Mental Health Trust and two young service users of the Northgate Clinic were present for the discussion of this item.

Ms Wright reported that the consultation period had been extended until 2 September. There had been concerns expressed about the fact that the consultation period had included August which it was felt might limit responses due to it being the peak holiday period. However, the consultation with young people that had taken place had proven to be effective. 10 focus groups had taken place with young people and parents. 263 responses had been received on behalf of individuals and 9 on behalf of organisations. This compared with only 80 that had been received at the time of the last meeting of the Committee. The report on the results of the consultation exercise had been submitted to NHS London and would be considered by the NHS North Central London board on 29 September.

Ms Kane reported that the Mental Health Trust (MHT) had been involved in responding to some of the issues that had been raised. In particular, they had further developed the clinical model that the proposals were based upon. Their view was that it was better to provide care in the community than in hospital and modern models of treatment were based on this principle. Mr Karac reported that the model used in the proposed restructuring had been reviewed and, in particular, phase 1 of the transition plan. Views that had been expressed during the consultation process to date had been incorporated and there would now be a single pathway model with service users only requiring a single referral. They would move through the pathway and back into the community when appropriate. There would be a small number of high dependency beds for those who needed them and these would be available for as long as required. There would be intense interventions by community teams available and a menu of different treatments. Community based patients could also join in with groups that would be based at the new unit. Education provision would be integrated into the daily programme. The model was tried, tested and cost effective. Young people had also been involved in helping to develop it. The number of high dependency beds would be subject to periodic review. If it was necessary to find in patient accommodation elsewhere, efforts would made to identify appropriate provision that was local.

It was noted that approximately 35% of expenditure by the Mental Health Trust was for in patient care, amounting to approximately £6 million per year. The budget for Northgate was £1.2 million per year. £650,000 of this would be re-invested in the development of community teams whilst the remainder would be used for QIPP savings. Whilst efficiency savings would be delivered, the main objectives of the proposals were clinical through the implementation of an improved service model.

In response to a question, Mr Karac reported that there were a range of views about the proposals amongst psychiatrists. The two psychiatrists from Northgate were understandably disappointed by the proposal to close it whilst several others based elsewhere were positive about the changes. A number of consultant psychiatrists were now reluctant to refer to Northgate.

It was noted that the reducing the number of beds from 24 to 15 was feasible because under the new arrangements patients would not stay in hospital as long. In addition, Northgate was frequently not full. Intensive community support would significantly reduce the demand for beds. The latest analysis suggested that even 15 beds might prove to be too many. One option that could be used if there was a need for additional beds would be to use Simmons House, which was based in Haringey.

Mr. Machray stated that the full report on the response to the consultation would be shared with members of the Committee. Ms. Wright reported that the Alliance model of care that was being piloted in Enfield appeared to be working. There had only been the need to admit three patients to hospital since the last meeting. However, it was noted that performance figures were only available until the end of March. She stated that the new arrangements were not entirely reliant on Alliance, which only currently operated in Enfield. Other community based measures were being operated in other boroughs. Simmons House represented the successful model of in patient care that the current proposals aimed to emulate. It was accepted that up to date performance figures for the Alliance model needed to be produced. Work was still being undertaken on educational provision, which would be integrated into the care of patients. Assessments would involve the mainstream schools of children and young people concerned. Provision would be dependent on their needs.

Members of the Committee were of the view that, based on the figures that were available for overnight bed days, it was not clear yet that demand for beds was going down and, even if they were, whether this was a long term trend. The figures that were available showed fluctuations in demand. They also needed more evidence to reassure them that people were getting better more quickly. It was noted that demand for bed days was not always determined by clinical need alone.

It was noted that referrals to Northgate had been stopped. Due to the long length of stay of patients, this was felt necessary to do this in order to avoid the possibility of their care being interrupted due to the clinic being closed. It would be possible to re-open the unit if necessary. 51% of respondents to the consultation had been in favour of the proposals with 43% against. Amongst service users, there were roughly equal numbers in favour and opposed to the proposals. Mr Karac reported that a report had been drafted that described fully the whole of the patient pathway, including phases 1 and 2.

The Committee received evidence from two service users. The following issues were raised:

- It would be difficult to re-open Northgate. Many of the staff had moved to new jobs elsewhere.
- The focus groups that they had attended involved a lot of questions being asked about the Alliance model that operated in Enfield which, as they were from Barnet, had not been relevant to them. The largest number of service users came from Barnet so it would have made more sense to pilot the new arrangements there.
- If some psychiatrists were reluctant to refer young people to Northgate, this was likely to have an impact on occupancy figures. The reduced number of in patient beds commissioned would lead to greater use of hospitals outside of the area which were more expensive and not as good.
- Some people required longer stays in hospital and could be at risk of relapse if discharged too soon. Problems at home could also make it difficult for some people to recover in the community.
- Some of the questions raised by service users had not been answered during the consultation. They had responded by letter to the consultation and had yet to receive a reply.
- Northgate had recently been refurbished. However, the premises had not been properly secured .
- A number of service users could not cope with mainstream schools. The school on the site addressed the needs of such young people very well and the closure of Northgate threatened its future.

The service users agreed to share their response to the consultation with the JHOSC. Members of the JHOSC were also invited to visit Northgate. It was noted that there were no plans to close the school on the site, which operated as a pupil referral unit.

Ms Stevenson stated that there was a need to ensure consistency in the questions that were asked in the focus groups and this was why not all of the questions would have seemed relevant to respondents from Barnet. Other service users had been satisfied with the engagement process

Ms Kane stated that the refurbishment had been necessary to maintain the high standards required for premises by the Care Quality Commission. No staff had from Northgate had left the Trust's employment yet. Responding to concerns expressed by the Committee that the proposed changes might lead to a greater use of expensive private sector provision, she stated that the Mental Health Trust was committed to working with commissioners to ensure that out of area provision was only used when absolutely necessary. It was noted that the site on which Northgate was located was leased by the Mental Health Trust from Barnet PCT.

Ms Stevenson stated that there were risks associated with delaying implementing the new model. Admissions to Northgate had stopped and therefore alternative provision outside the borough was having to be used. The Committee were of the view that the closing of Northgate had undermined the consultation and pre-empted the decision.

In conclusion, the Committee expressed its concern at the consultation process which they felt had not initially been adequate. The Committee had not yet received full details of the results of the process but noted that there was no evidence of their being overall support amongst service users. They were of the view that the evidence base in favour of the proposed changes was still unclear. In particular, the latest figures performance figures for the Alliance pilot in Enfield and overnight bed days only went to the end of

March 2011. The success of the proposals was at least partially dependent on there being a substantial drop in demand for beds and, if this was not achieved, there was likely to be an increase in the need for expensive out of borough placements which would put at risk the savings that were aspired to. The Committee also had not as yet received full details of the care pathway and its phases. The proposals required the de-commissioning of provision before the new service was fully in place and there were therefore potential risks. As yet, the Committee had not received the necessary assurances that these had been fully addressed as part of an effective transition process..

The Committee therefore concluded that it had still not received the evidence necessary for it to be convinced that the new arrangements were in the interests of the local health service.

RESOLVED:

1. That the Chair be requested to write to the NCL Board urging it not to take any final decision on the proposals until all the relevant information required for them to take an informed decision was available, namely:
- Up to date performance figures for the last two quarters on overnight bed days and the effectiveness of the Alliance pilot model in Enfield
- Clarity on the evidence base
- Full details of the consultation programme and response
- Clear details on the transition process and its phases

2. That NHS NCL be requested to circulate the full consultation report to Members of the Committee.

3. That a visit to Northgate Clinic be arranged for all Members of the Committee.

6 QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN - PERFORMANCE (Item 6)

Liz Wise from NHS North Central London was present for the discussion of this item.

Ms Wise outlined the current performance figures for the QIPP programme. It was noted that there had been a significant under performance against targets to reduce spending on acute care. It would be difficult to address this through slowing down referrals as patients had a constitutional right to receive treatments within a specific time frame. There were many and varied reasons why QIPP targets for acute services were not on track. GP referrals had increased in one PCT area whilst there had also been pressures from demand for emergency treatment. In addition, there were also issues arising from how some treatments were costed and charged. Analysis was being undertaken on the number of referrals that led to treatment. In some cases, there were charging issues to be resolved concerning how patients were dealt by hospitals after initial referral.

It was noted that efforts had been made to protect staffing levels in contract management and informatics. Consideration was being given to whether there was a need to strengthen officer support for a period of time as staff were currently very stretched in dealing with contracts. The acute portfolio of contracts amounted to over £1 billion. In the short term, consideration was being given to bringing in turnaround specialists.

Patients did not always get to see the right consultant first time and referrals from one consultant to another were quite high across the sector. There were 167 projects that were currently showing green. However, 80 were showing red and total QIPP slippage was currently forecast to be £30 million. The forecasts had been prepared using a worst case scenario. Each borough was now being asked to produce a recovery plan. £10.4 million of the slippage was from the stretch target and £22 million from acute productivity. This included £2 million over performance by UCLH on referrals from Islington. Savings on procedures of limited clinical effectiveness had proven difficult to realise. Expenditure on these was led by referrals and more work was needed with clinicians and the acute trusts. Part of the slippage was due to fact that the measures had been implemented later than planned. There had been some success in addressing the issue of medicines management although more could still be done. It was noted that it was not possible to mandate clinicians to only prescribe certain medicines. The

overspend on continuing care was currently being looked at as well as Islington PCT's budgetary position. Variations in GP referral rates across the cluster were also being analysed. In particular, referrals from Enfield PCT were 15% higher than elsewhere. 1200 referrals from Enfield had been processed in April and May rather than March and this had compounded the problem.

It was noted that patients still had the right to choose where they wished to be treated and that there were no plans to cut Islington PCT's budget by 12.5%, as had been suggested. Although it was proving very difficult to balance to books, failing to do so by the end of the financial year was not an option.

RESOLVED:

That the update on the performance of QIPP Plan be noted.

7. SAFE AND SUSTAINABLE – REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND (Item 7)

Simon Williams and Peter Kohn from the NHS London Specialised Commissioning Group was present for the discussion of this item.

Simon Williams outlined the work that had been undertaken to reconfigure congenital heart services in England. The aim of the review had been to ensure:

- Better diagnosis and follow-up care closer to patients' homes
- Fewer deaths and complications following the surgery
- Shorter waiting times for surgery
- Better trained surgeons
- Excellent care for all children with no postcode lottery.

A number of different options had been developed and consulted upon. The intention was that every centre chosen would have two full time surgeons and a throughput of around 500 – 600 procedures per year. In addition, it was intended that no centre would be more than four hours away from any patient by whichever mode of transport was the slowest.

Two centres were proposed for London. These were at GOSH and Evelina (Guys). This entailed services at the Royal Brompton/Harefield being discontinued. The forecasted number of procedures that would be undertaken in London was approximately 1250 per year. The minimum level that was required was 400 per unit per year and the ideal number 600. GOSH currently undertook over 500 per year. If three centres were maintained in London, the remainder would be split between Evelina and Royal Brompton. The numbers involved would mean that they were both beneath the threshold of 400. The intention was to increase work loads to ensure critical mass and, through this, improve outcomes, recruitment and retention of skilled clinicians and service development. A three centre model would not provide enough patients for all of the centres and result in an uneven distribution. In addition, the catchment areas would need to increased. However, the consultation had not finished and people were entitled to express a view contrary to this.

Concerns had been expressed that the discontinuation of services at the Royal Brompton might threaten the viability of other paediatric services there due to the absence of a paediatric intensive care unit. These services were children's respiratory services, including cystic fibrosis services and asthma. An independent review had been undertaken on this issues and had concluded that the services in question would remain viable. There were no significant concerns regarding the continuing viability of some other paediatric services at hospitals where it was proposed to discontinue surgery.

Ipsos Mori had undertaken a consultation exercise which had generated 70,000 responses. Strong support for two centres in London was expressed with only 12% against. There was some support for 3 centres for London as well as some for only 1. GOSH and Evelina were the two hospitals that were most strongly supported but there was a lot of support for all the units across the country. The Royal Brompton had been the 10th. best supported.

The Royal Brompton was mounting a legal challenge to the proposals through the judicial review process

and the verdict of this would be given in October. The expectation was nevertheless that the new configuration would become operational in April 2013.

It was noted that work was still continuing on the catchment areas for each hospital. Many hospitals had outreach services in other hospitals, including GOSH at Peterborough. However, patient choice had to be respected and many undertook considerable research before deciding which hospital to choose. The setting up of a single network of care for London was currently being considered by the Specialised Commissioning Group. Any changes to configurations within London were unlikely to have a significant affect on travelling times but it was likely to make a difference elsewhere.

Mr Williams stated that it was not expected that the changes would yield major improvements across the board. However, it was hoped to improve outcomes for cases where survival rates were currently very low. The longer term outcomes aspired to were concerned with a range of quality measures and not just mortality rates. Each of the units chosen would have 4 surgeons working together and undertaking approximately 125 operations per year. Services would be available 7 days per week. Some hospitals currently only had 2 consultants.

The Committee expressed their support for there being two centres for London and the two locations – GOSH and Evelina - that were proposed. However, they were mindful of the possible long term effects of the loss of services from some providers on their future viability and of the view that measures should be taken to minimise the impact of this. They were nevertheless supportive of the direction of travel and the development of more integrated patient pathways following surgery.

RESOLVED:

1. That the Chair be requested to write to the Specialised Commissioning Group with the Committee's views, as outlined above, in response to the consultation.

2. That copies of the health impact assessment and of the independent report reviewing if children's heart services and respiratory services could continue to be delivered safely at the Royal Brompton Hospital in the absence of an on-site paediatric intensive care unit be circulated to all Members of the Committee and

8 HEART FAILURE COMMUNITY CLINIC – PILOT (Item 8)

Caroline Cook and Dr Neel Gupta from North Central London Cardiovascular and Stroke Network were present for the discussion of this item and gave a presentation on the setting up of a pilot project to deliver a community based multi disciplinary integrated service in South Camden. This would be extended to the remainder of the cluster if successful.

Services were currently disjointed and there was often duplication of work. It was hoped that the new service would provide seamless care. The new model was based on NICE guidelines and was hoped to facilitate earlier diagnosis. All the necessary tests could be undertaken on the same day during one visit with a treatment plan sent to the GP, also on the same day. The specific venue for the location clinic had yet to be identified.

It was noted that there were a large number of people with heart failure who were not diagnosed. Although age was probably the most significant factor, the were a number of other risk factors including hypertension, diabetes, smoking and high cholesterol. Some communities had a slightly higher susceptibility, including the African Caribbean and South Asian communities. Diagnosis could be undertaken by blood test. However, increasing the percentage of those diagnosed was only one part of improving services. There was also a need to provide better care for those who were diagnosed.

In terms of location, various options were being explored. It was suggested that Stevenson House would be appropriate. It was noted that it was not clear where the service should best be located organisationally – whether in the acute or community sector. One option would be for it to be managed under a free standing n umbrella organisation.

It was noted that work was being undertaken by public health officers in NCL to address the low level of diagnosis and that they were also undertaking work on addressing low diagnosis rates for hypertension. One particular challenge that needed to be addressed as part of this was the transient population in many areas of the cluster.

RESOLVED:

1. That the pilot project be welcomed.

2. That the option of managing the service through the establishment of an umbrella organisation be supported.

3. That concern be expressed at the high numbers of undiagnosed patients in the community.

9 MEDICINES MANAGEMENT (Item 9)

The Committee noted the response received from the Secretary of State to the Committee's earlier letter regarding drug tariffs.

10 BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

Members from Enfield expressed their disappointment at recent decision by the Secretary of State in response to the referral by Enfield's Health Overview and Scrutiny Committee. The Council was now considering its options. The Secretary of State had nevertheless acknowledged that not all of the infrastructure required for the changes outlined in the strategy was in place. Enfield Council was of the view that primary care in Enfield was significantly underfunded and were looking for support from the JHOSC in pursuing this issue with the Secretary of State. Without the necessary investment in primary care, the over reliance on acute care could not be addressed successfully. The 15% increase in GP referrals from Enfield bore this out. They were also of the view that any money from the sale of land at Chase Farm should be re-invested in the infrastructure.

RESOLVED:

That the issue of Barnet, Enfield and Haringey Clinical Strategy be placed on the agenda for the next meeting of the Committee.

11 DATES AND VENUES OF NEXT MEETINGS (Item 10)

- Monday 31 October – Enfield
- Monday 5 December – Barnet
- Monday 16 January – Camden
- Monday 27 February - Islington

FINISH:
The meeting closed at 13:30 pm.

CHAIR:

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Agenda Item 5

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** [delete any that aren't relevant]: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Report on the development of NHS North Central London's Primary Care Strategy	
REPORT OF: Tony Hoolaghan Associate Director Primary Care NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 31/10/11**

SUMMARY OF REPORT:

The report tells the story of the identified need for a NHS NCL primary care strategy, the purpose of the strategy and the initial work which has taken place to begin the process to develop, and finally implement the strategy.

The report gives an update on the work which has taken place, thus far, to evaluate, analysis and assess the level and quality of primary care services across the five NCL boroughs, concluding with possible recommendations for a primary care strategy from this work.

Please see Appendix A for an overview of what patients and the public can expect from primary care services.

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

RECOMMENDATIONS: The Committee is asked to comment on the report and update

To note as part of the overall primary care item questions on Out of Hours process and CAMIDOC can be raised.

Tony Hoolaghan
Associate Director Primary care

DATE: 31/10/11

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North Central London

Development of NCL Primary Care Strategy

Report

7th October 2011

Contents

1. Introduction

The purpose of the project is to further improve quality, capability and productivity in primary care and to create capacity within primary care through transformational change. This will be through the joint development of borough plans to implement the **Primary Care Strategy for North Central London (NCL)**. The strategy will underpin the subsequent development of our five borough-based primary care plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. It will be a strategic shift from the previous premises-led to a quality-led agenda and will focus on:

- Promoting health, well being and illness prevention
- Addressing health inequalities
- Further improving the quality of primary care services, particularly in General Practice, to enhance the patient experience with better outcomes

The combined strategy and plans will determine how NCL will invest in primary care in each of the five boroughs over the coming years.

2. Programme of Work

In the project proposal, the following activities were set out for the initial four weeks:

2.1 Desktop research

- Reading existing documents (referenced earlier) provided by NCL
- Creating the macro picture by starting the first draft of the NCL Primary Care Strategy document
- Compare/contrast/challenge the five Primary Care Trust (PCT) borough strategies to inform the “Synopsis and Analysis” due at the end of week two.

2.2 Stakeholder engagement

As part of the scoping work, we provisionally identified 48 different organisational stakeholders, excluding the general public (See Stakeholder Model). In order to manage this number, we proposed that they should be divided into the following categories:

A. Essential to meet named individuals 1:1 (e.g. Clinical Commissioning Group, CCG, Chairs)
B. Essential to meet separately with organisation’s representative/s (e.g. Local Medical Committees, LMC)
C. To engage as representatives in locality-based plenary workshops (e.g. LINks)
D. Others to be engaged at least by correspondence

An early task was to agree the stakeholder list and to categorise, and to arrange meetings to discuss the strategic questions. We also agreed to run borough-based workshops at which the strategic questions will be posed to the attendees.

3. Progress to date

3.1 Desktop research

A suite of documents were provided by NCL but required validation as being both relevant and most recent. The suite contained a variety of differing documents from each PCT and it has been necessary to define the required minimum “core list” as being:

- PCT Commissioning Strategy Plan (CSP) – dated early 2010
- Primary Care Strategy – most recent } Check for inclusion/exclusion in CSP
- Polysystem Strategy – most recent }
- Joint Stratgeic Needs Assessment (JSNA) – most recent and under current review

- CIAMS Reports (Incomplete in some boroughs)
- Any other relevant and current documents for each borough PCT

The following NCL documents have been identified and reviewed:

- NCL Commissioning Strategy Plan (CSP) 2010/14 dated January 2010
- NCL Cluster Commissioning Strategy and QIPP Plan 2011/12 – 2014/15 dated June 2011
- "Refreshing the case for change" in NCL's QIPP plan 2012/13 – 2014/2015
- NHS NCL – "Health and Health Services in NCL. Now and in the future: Evidence pack" dated March 2011
- "Starter for 10" NHS North Central London case for a Primary Care Strategy – dated July 2011
- DRAFT "Case for Change Data Requirements" dated July 2011

In addition, some best practice research has identified the following documents:

- "Improving the quality of care in general practice" – The King's Fund March 2011
- "One in five GP practices are underperforming" – HSJ January 2011
- "Ten priorities for commissioners" – The King's Fund 2011
- Starfield Presentation – May 2008

3.2 Stakeholder engagement

In total we have identified 21 internal stakeholders for 1:1 interviews. It was not possible to complete all of them by the target date of 9th September due to annual leave, but all have now been completed.

The following internal NCL stakeholders have been identified and interviewed:

- Caroline Taylor – Chief Executive
- Helen Pettersen - Director of Transition & Corporate Affairs
- Jeremy Burden - Director of Contracts
- Liz Wise - Quality, Innovation, Productivity & Prevention (QIPP) Director
- Sarah Price - Director of Public Health
- Doug Russell - Medical Director (Primary Care)
- Tim Woodman - Deputy Medical Director (Primary Care)
- Julie Billet – Public Health Primary Care Lead

In the PCT boroughs the following stakeholders have been identified and interviewed:

Barnet	Alison Blair - Borough Director Sue Sumners – CCG Chair
Camden	Caz Sayer – CCG Chair Marek Koperski – PEC Chair David Cryer - Borough Director
Enfield	Sarah Thompson - Interim Borough Director Alpesh Patel – CCG Chair Janet High – PEC Chair
Haringey	Andrew Williams - Interim Borough Director Helen Pelendrides – CCG Chair Muhammed Akunjee – GP Rep on Project
Islington	Gillian Greenhough – CCG / PEC Chair Phil Orwin - Interim Borough Director

3.3 Independent Contractor Representatives
It is hoped that local LMC representatives will attend the Borough PCT workshops. No other arrangements have been made with LMC, LDC, LOP or LPC.

3.4 Borough PCT Workshops
This is proving to be the most difficult task to date. The time of year, short notice and existing events mean that it has been very challenging to identify suitable dates. The target date of completion by 30th September was not achieved. The Project Working Group (PWG) has agreed to extend to early October. The current situation is:

Barnet Arranged for 22nd September

Camden Arranged for 12th October

Enfield Arranged for 6th October

Haringey Arranged for 6th October

Islington Arranged for 5th October.

4. Literature research results (supported by interview feedback)
This document is an extract from the full "Synopsis and analysis of Borough Primary Care Strategies based on literature reading and initial stakeholder meetings as at 30th September 2011"

There are six extracts:

- "Starter for 10 NHS North Central London case for a Primary Care Strategy"
- Commentary and Questions on Barnet's Primary Care Strategy
- Commentary and Questions on Camden's Primary Care Strategy
- Commentary and Questions on Enfield's Primary Care Strategy
- Commentary and Questions on Haringey's Primary Care Strategy
- Commentary and Questions on Islington's Primary Care Strategy

4.1 "Starter for 10 NHS North Central London case for a Primary Care Strategy"

This document, written by Dr Douglas Russell, followed an introductory discussion at the Senior Leadership Team on 9th July 2011. He undertook to produce a very basic "starter for 10" document around which to frame a further discussion about the need to develop a primary care strategy. He sets out the argument for the definition and measurement of both activity and quality, prior to engaging in a developmental programme with primary care contractors.

Universal, accessible high quality general practice supported by well developed primary care teams integrated with social care and third sector is likely to be more capable of addressing the QIPP challenge than our current landscape.

We need to engage the clinical leadership with a new vision of a transformed supported developed high quality GP and primary care landscape across the whole sector attracting and retaining the highest quality staff, both clinical and support.

We need to be clear about what we mean by quality. The "Darzi" definition is still useful – with the 3 domains of Safety, Effectiveness and Experience, all predicated on cost.

There are a set of core documents published recently (circulated) that fill out a lot of background detail and evidence of the vision of what we would like to achieve over the next 5 years, from sources such as the RCGP, Kings Fund, Information Centre, Primary Care Commissioning.

Access is one dimension of care quality for the acutely ill but as important if not more so to patients with long term conditions is continuity.

Kings Fund report on improving quality in general practice is a key resource document. We should not simply measure process but also consider structure process and outcomes (Donabedian).

At the heart of the clinical contact is the consultation, with consultation skills, communication skills, diagnostic skills, skills in interventions such as high quality prescribing and appropriate and timely referral, team work, handovers, risk reduction, and clinical governance all important components of quality that are more difficult to measure.

Most difficult of all is one of the most vital – care and compassion. This starts from a sense of vocation but needs nurtured by a culture of professionalism and continuing professional development and support, peer comparison and personal reflection.

As a starting point we need data on what we currently have with benchmarking on matters such as have appeared on a number of "dashboards" – but these need to be developmental and implemented with collaboration of GP leaders and not used as a blunt managerial "stick" alone.

4.2 Commentary and Questions on Barnet's Primary Care Strategy (Shared/discussed with Borough Director and CCG Chair)

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield Haringey Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. There are repeated assertions that, "Without the strengthening of primary and community services, allowing the shift of care closer to home, the reconfiguration of acute services between the Barnet, Chase Farm and North Middlesex sites is not achievable."

The extent to which the strategic documents really address underlying issues and achieve changed health outcomes is difficult to assess and may be better reflected in outcome performance measures. Most of the focus has been on the health system infrastructure, yet little seems to have actually changed. The re-building of Finchley Memorial Hospital (due to open in 2012) is the most significant and tangible achievement. Along with the existing Edgware Hospital, the health economy will be unusual in London by having two community hospitals.

List size at July 2011 (Jan 2010)	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**	**Totals**
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered population	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**

The average number of patients per practice in NCL varies from under 5,000 to almost 6,500:

July 2011	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**	**Total**
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

Barnet has by far the largest registered patient population number (373,715 at July 2011), in NCL. Much of the demography of Barnet is closer to that of the Home Counties than to inner London Boroughs, although there are pockets of significant deprivation. However, this profile introduces different challenges. GPs report that their health-aware residents are very high consumers of any/all services offered. Additionally, there is anecdotal evidence to suggest that, with a generally older age profile, many retired residents have switched from using private insurance provision to NHS services; much of this workload is in general practice supporting long term conditions management.

In 2007, the primary care strategy stated that there were too many (then 73), and too small, practices - operating from unsatisfactory premises. The strategy set out plans to move to a "Hub and Spoke" model and to reduce both practices and premises:

How GPs are encompassed within this model may vary from area to area but there are three general options for practice configuration within a Primary Care Centre:

- *One large practice i.e. merging of several practices into a single contract. This contract could include the provision of other services within the Primary Care Centre as well as GP services*
- *Multiple practices co-located on one site. The PCT will accept this model only where it leads to shared management and administration / reception arrangements that take advantage of the opportunities co-location gives to sharing expertise and staffing costs*
- *Federal model with existing practices linked to a Primary Care Centre or community hospital. Federated practices will have to meet the criteria defined in section 7.1 of this document. All other practices will be expected to move to Primary Care Centres over time.*

The decision on which model to use for each Primary Care Centre will depend on the level of engagement of local practices, the service needs of the local population and the ability of local practices to meet these needs.

Question 1: Did these plans have sufficient support amongst GPs to be achieved?
By January 2010, the HUB and Spoke model was revisited and, with some modifications, rebadged as four polysystems – explicitly seeking to reduce the number of practice sites from 69 to 24, and naming the individual practices to be co-located.

Question 2: What has been the reaction of the GPs named to co-locate?
As at July 2011, there are 36 practices (53% of total) with less than 5,000 registered patients, covering a total patient number of 105, 000(28% of total). This compares with a total number of 39 and 38 practices in Camden and Islington respectively.

Question 3: With such a high number of practices, what do we know about the quality of primary care, by practice, in Barnet?
It is also notable that 62% of the practices (42) are on PMS contracts, and 12 of them are practices in the 2000 to 5000 range of registered patients.

Question 4: What are the pros and cons of having so many PMS contracts?
During the past year, post-Darzi, the plans have been modified to create there localities, supported by hubs in Edgware and Finchley hospitals. It is unclear to what extent the number of practices and sites will now be reduced.
The reality in 2011, is that Barnet still have 70 practices and too many of them are still in their unsuitable premises.

Question 5: So what has actually changed/been achieved in primary care in Barnet in the last five years.

Question 6: What now are the plans for General Practice numbers and sites?

Question 7: What are the implications for the BEH Clinical Strategy

The key challenges now facing primary care in Barnet would seem to be:
- To establish the re-built Finchley Memorial Hospital as a Neighbourhood Health Centre

- To demonstrate that the smaller practices are achieving equally high quality delivery as the larger practices
- Having defined the current quality standards, to achieve a sustainable improvement.
- At the same time to improve the overall premises standard
- To support the transfer of care arising from a decision to proceed with the BEH strategy

These are against the backdrop of rising referrals and a deficit budget.

4.3 Commentary and Questions on Camden's Primary Care Strategy (Not yet shared/discussed with BD/CCG/PEC)

The Camden documents refer to a strong reputation for innovation and for delivering continuous performance improvement. The CSP reflects broader whole system thinking and it introduces QIPP and robust performance management measurement. It is not just a GP premises strategy.

The polysystems planning, with the notable exception of Stephenson House, appears to have been incorporated into the April 2010 CSP.

In terms of general practice, the PCT always maintained that:

NHS Camden is committed to supporting and developing a diverse provider landscape for general practice and believes that patients want to see a mixed economy of small, medium and large practices.

List size at July 2011 (Jan 2010)	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**	**Totals**
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered population	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**

It is interesting to note that Camden has the highest number of registered patients per practice at almost 6,500 compared with Enfield, below 5,000, and the NCL average of 5,500.

July 2011	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**	**Total**
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The CSP notes that 80% of practices have received investment to improve premises over recent years, and that, although there are a few problem sites, the overall state of GP premises has been improved considerably.

Camden, along with Islington, is one of the few PCTs in the country to have published a GP balanced scorecard on their website. It is set out as a RAG-rated league table and has been a very effective performance improvement driver for all practices.

The current CCG thinking in Camden is that they recognise that primary care will be a key part of their whole system strategic planning and that they will have a vital role to play in raising standards in primary care. But they do not view the strategic performance management of independent contractors as their responsibility.

The growth of Haverstock Healthcare, the GP Provider Federation, means that there is now a single organisation through which NCL can communicate directly with most of their GP practices.

Camden is one of the few PCTs who agreed (three) APMS contracts with new providers.

Question 1: What plans are now in place to ensure additional provision in South Camden?

Question 2: How successful have the APMS contracts been?

Question 3: What progress has been made against the explicit targets in the April 2010 CSP?

Question 4: Has Haverstock been helpful to all parties and is it a model for the future?

4.4 Commentary and Questions on Enfield's Primary Care Strategy (Not yet shared/discussed with BD/CCG/PEC)

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet Enfield Haringey Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. There are repeated assertions in the strategic planning documents that, "Without the strengthening of primary and community services, allowing the shift of care closer to home, the reconfiguration of acute services between the Barnet, Chase Farm and North Middlesex sites is not achievable."

Enfield has the second largest registered patient population number (292,819 at July 2011) in NCL. The demography of Enfield is similar to much of Barnet in the West and more like the more deprived inner London Boroughs to the East.

With 60 practices, Enfield has the lowest average number of registered patients in NCL:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

Moreover, there is a significant domination of small and medium size practices:

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered patients	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**
Patients % change	+2.0%	+6.7%	+2.2%	-3.2%	+9.1%	+2.8%

This is an issue that is mentioned in all of the strategic planning documents and one that the strategies have sought to address. The previous strategies were heavily premises focused, but little seems to have changed in terms of numbers or premises conditions.

Given such a strong dependence on premises-led strategies, which have not been implemented, the primary care scene in Enfield seems to be the most under-developed in NCL.

The 2009/10 QOF scores reported 29 practices failing to achieve the London average.

The 2008 plan proposed a reduction to just 20 GP sites. The subsequent polysystem plan was not as explicit but clearly envisaged a significant overall reduction. As at July 2011, there are 39 practices, (65% of total), with less than 5,000 registered patients, covering a

total patient number of 128,000 (43% of total). This compares with a total number of 39 and 38 practices in Camden and in Islington respectively.

Question 1: Did these plans have sufficient support amongst GPs to be achieved?
Only 20% of the practices are served by the five practices of over 10, 000 compared to 46% and nine large practices in Camden.

Question 2: With such a high number of practices, what do we know about the quality of primary care, by practice, in Enfield?
It is also notable that 50% of the Enfield practices (31) are on PMS contracts, including 2000 to 5000 range of registered patients.

Question 3: What are the pros and cons of having so many PMS contracts?
The reality is that Enfield still has circa 60 practices and too many of them are still in their unsuitable premises.

Question 4: So what has actually changed/been achieved in primary care in Enfield in the last five years?

Question 5: What now are the plans for general practice numbers and sites?

Question 6: What are the implications for the BEH Clinical Strategy?

Question 7: How do we address the challenge of having so many small practices in sub-standard premises? Only then, can the real work of raising quality in primary care in Enfield be addressed

4.5 Commentary and Questions on Haringey's Primary Care Strategy
(Not yet shared/discussed with BD/CCG/PEC)

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield, Haringey Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. There are repeated assertions that, "Without the strengthening of primary and community services, allowing the shift of care closer to home, the reconfiguration of acute services between the Barnet, Chase Farm and North Middlesex sites is not achievable."

In the case of Haringey, there is an additional consideration in that it does not have a DGH site within the borough boundary. The demography places Haringey on the cusp of outer and inner London. The relatively well and wealthy west gives way to more areas of deprivation and inequality as you move eastwards.

Having been one of the early implementers of polysystems with plans for four clinics, Haringey then drew back to three localities based on Hornsey Central, The Laurels/St Ann's and Tottenham. Only the former is fully operational and there are major investment decisions to be made on the latter sites.

General Practice is still characterised by large numbers of small practices. The registered practice population has reduced by 7,500 (-3.2%) over the past year, mainly as a result of list cleaning. Average list size is just over 5,000

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered patients	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**
Patients % change	+2.0%	+6.7%	+2.2%	-3.2%	+9.1%	+2.8%

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

The overview in the January 2010 CSP still provides a good description of the primary care scene in Haringey:

3.6.1 Primary care services
Overview
Haringey has a diverse provider base with a large number of both GP and dental practitioners but the number and size of practices means this is a potentially fragmented system.

Budget

☐ £80million

Structure and providers

☐ GPs (£26million) plus other GP services (£18.5million)

☐ Of 57 practices, 50% are single provider GPs nearing retirement age.

☐ There are 50 dental practices which account for £14.2million of the primary care budget.

☐ Pharmacy and prescribing (£28.5million) operating from 56 outlets

Characteristics

☐ There are a large number of single handed GPs.

☐ Despite the introduction of the polysystem model there is a fragmented provider base

☐ There are 270,000 GP registrations in Haringey, higher than the estimated population figures of 226,000. This could mean that patients are registering from neighbouring boroughs.

☐ GP services vary significantly depending on the practice in terms of access, quality, and condition of premises and range of services available.

Question 1: Will the Tottenham redevelopment go ahead and will there be sufficient funding for health provision?

Question 2: The Laurels is not big enough. How will it share in the future redevelopment of St Ann's?

Question 3: How well will the large number of small/medium size of practices meet the quality of challenge?

4.6 Commentary and Questions on Islington's Primary Care Strategy (Not yet shared/discussed with BD/CCG/PEC)

The most significant demographic factor is the 9.1% growth of the registered population since January 2010:

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered patients	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**
Patients % change	+2.0%	+6.7%	+2.2%	-3.2%	+9.1%	+2.8%

This, combined with the low number of practices gives the 2nd highest average patient population per practice in NCL:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	**5,496**	**6,436**	**4,985**	**5,041**	**5,865**	**5,477**

The Primary Care SWOT analysis in the January 2010 CSP still provides a good description of the primary care scene in Islington:

General Practitioners (£31m) account for approximately 50% of the IPCT primary care budget. The majority of the 38 GP practices provide services in core hours. 12 single handed practices, five of which are within the central locality. Out of hours care is provided by CAMIDOC. (Now Harmoni)

Pharmacy and prescribing (£26m) accounts for 38% of the total budget and operates from 45 locations spread across the borough

Dental practices offer NHS treatment to Islington residents from 25 locations accounting for 13% of the overall primary care budget (£8.7m). 49% of residents access an NHS dentist

Optometrists 49 contracted optometrists operating in Islington operating from 27 practices. Services are centrally purchased and account for £1.5m of spend

Challenges

- Providing accessible and modern facilities
- Poor outcomes on patient experience
- Inequitable access to enhanced services for the population
- High proportion of single handed GP practices 12 out of 38 – now 10 out of 38
- Disparities in the quality of care across practices
- Limited capacity to respond to urgent care needs in and out of hours
- Multiple demands to respond to enhanced service requirements

- Attaining CQC registration status
- Improving the oral health of children
- Differentials in expected and recorded numbers on disease registers

Strengths

- Good coverage of GP and pharmacy services throughout the borough
- Mix of experienced and new GPs
- Offer a range of enhanced services
- Good QOF outcomes, but high levels of exception reporting

Implications for CSP/Choice

- Strengthen commissioning of GPs for quality, support access
- Tender for additional dentistry including oral health promotion focus
- Introduce services to provide more comprehensive urgent response

The long-standing 3-locality structure has continued, and is still moving towards hub and spoke models. South Locality still has the challenge of not having a suitable building to act as a hub.

Question 1: Finsbury Health Centre?

Question 2: Does South Islington need an alternative hub facility?

Question 3: If the high levels of exception reporting are addressed, what will be the impact on QOF scores?

Question 4: How well will the borough-produced primary care strategy fit with NCL strategy?

NCL Primary Care Strategy – Facts and figures

There are a total of 258 general practices with registered patients, excluding the three GP Led Health Centres and PCT Special Practice, where there are no lists.

Number of practices, by list size and by borough, at July 2011 (January 2010 figures in brackets).

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23 (21)	9 (13)	16 (16)	12 (14)	17 (15)	77 (79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68 (69)**	**39 (41)**	**60 (63)**	**54 (58)**	**37 (38)**	**258 (269)**
Total registered patients	**373,715 (366,367)**	**251,016 (235,187)**	**299,119 (292,819)**	**272,236 (280,887)**	**217,000 (198,993)**	**1,413,086 (1,374,253)**
Patients % change	+2.0%	+6.7%	+2.2%	-3.2%	+9.1%	+2.8%

The average number of **patients per practice** varies from under 5,000 in Enfield to almost 6,500 in Camden:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

A more detailed analysis shows the varying number of **patients registered by size of practice**:

Number of Patients by Practice Size at 1st july 2011	Barnet	Camden	Enfield	Haringey	Islington	Totals
Practices <2,000	16,148	4,541	6,878	8,424	3,959	39,950
% of registered patients	4%	2%	2%	3%	2%	3%
Practices 2,000-5,000	89,126	63,356	121,098	87,331	44,714	405,625
% of registered patients	24%	25%	40%	32%	21%	29%
Cumulative	28%	27%	43%	35%	22%	32%
Practices 5,000-10,000	158,129	68,078	112,386	82,142	120,588	541,323
% of registered patients	42%	27%	38%	30%	56%	38%
Cumulative	70%	54%	80%	65%	78%	70%
Practices >10,000	110,312	115,041	58,757	94,339	47,739	426,188
% of registered patients	30%	46%	20%	35%	22%	30%
Cumulative	100%	100%	100%	100%	100%	100%
Total registered patients	**373,715**	**251,016**	**299,119**	**272,236**	**217,000**	**1,413,086**

From the above analysis we can see that:

- Just less than 40,000 patients (i.e. three%) in NCL are registered in practices below 2,000 patients, with the largest number (16,000) in Barnet (but still only four% of Barnet total)
- 43% of Enfield patients are registered in practices with less than 5,000
- In Islington the comparable figure is only 22%
- In Camden 46% of patients are registered in the largest practices of over 10,000, compared with the NCL average of 30%.

General Practices (with lists) by type of contract

	Barnet	Camden	Enfield	Haringey	Islington	Total
GMS	26	20	28	23	35	**132**
PMS	42	16	31	30	2	**121**
APMS	0	3	1	1	0	**5**
Totals	68	39	60	54	37	**258**

Practice price per patient Budget 2011/12 (only available for Camden)

	Barnet	Camden	Enfield	Haringey	Islington	NCL
Min	n/a	£78.57	n/a	n/a	n/a	n/a
Max	n/a	£193.20	n/a	n/a	n/a	n/a
Ave	**n/a**	**£122.96**	**n/a**	**n/a**	**n/a**	**n/a**

GP prescribing costs per weighted average list size (rank order)

2010/11	Camden	Haringey	London Ave	NCL Ave	Enfield	Barnet	Islington
Cost per Astro PU	£21.94	£22.06	**£23.40**	**£24.15**	£25.33	£25.47	£25.93

Total investment in primary care by contractor/borough 2011/12 Budget

	Barnet	Camden	Enfield	Haringey	Islington	Total
GP	**Figures not yet obtained**					
Dentists						
Optometrists						
Pharmacist						

Overall QOF Scores by Borough PCT 2009/10 (2010/11 figures awaited)

Borough	Number	Exception	PCT Ave	Number of Practices by overall QOF scores 2009/10							
PCT	Practices	Reporting		<50%	50-80%	80-90%	90-92.3	92.4	92.4-93.6	93.7	>93.7
Barnet	68	4.49%	93.9%	0	1	6	9	London	6	England	46
								Ave.	9%	Ave	68%
Camden	40	5.76%	92.1%	1	1	5	3		7		23
									18%		58%
Enfield	63	4.19%	90.9%	0	5	14	10		9		25
									14%		40%
Haringey	52	5.33%	90.8%	1	3	11	7		6		24
									12%		46%
Islington	38	6.16%	93.9%	1	0	4	1		3		29
									8%		76%
London		5.13%									
England		5.41%									
	261			3	10	40	30		31		147
% of Practices by band				1%	4%	15%	11%		12%		56%

- 68% of NCL practices score above London average and 56% above England average
- Barnet, Camden and Islington are the highest scores, with Enfield and Haringey lowest
- Islington have very high exception reporting, with Barnet and Enfield both very low.

MORI Patient Survey March 2011 – Overall Satisfaction Levels by Borough PCT

MORI 2010/2011 Scores	Satisfaction with care received	Recommending a GP surgery to someone moved into area
Results England as a whole	89.00%	84.00%
London SHA	85.00%	77.00%
Barnet	85.00%	80.00%
Camden	83.00%	79.00%
Enfield	85.00%	77.00%
Haringey	81.00%	74.00%
Islington	85.00%	79.00%

- On the two overall satisfaction questions, none of the boroughs achieves the England average, but Barnet, Enfield and Islington all equal or better the London average.
- Haringey fail to achieve the London average on both questions.

Other independent contractors - Dental, Pharmacy and Optometry at April 2011

April 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Dental Practices	70	42	44	51	23	230
Optometrists	88	77	72	33	53	323
Pharmacies	71	65	61	56	46	299

There is more data available on contractors in each borough, but it is not in a standard format to enable comparisons to be drawn.

NCL Primary Care Strategy – Emerging Themes

Themes	Barnet	Camden	Enfield	Haringey	Islington
Previous/existing strategies	• There is a common theme that five years ago most strategies were looking to develop care pathways based on hub and spoke models. Healthcare for London led to most plans being re-packaged as "Polysystems" including new build locality centres. Over the past year, without any new build financing, plans have been modified to take account of the original hub and spoke model plus any polysystem developments that were approved. • Undoubtedly, the **strategic focus and planning** over the past five years has been premises-led. • However, despite the elaborate planning, implementation has been slow. Strategically the picture across NCL has not changed dramatically. • In Barnet, and Haringey there were detailed plans to reduce the number of practices substantially. But these plans generally did not have the support of GPs and were not implemented. • Enfield GPs had agreed to reducing practice numbers by relocations into new premises, but became disillusioned when the premises were not forthcoming. • Camden and Islington seem to have had most impact by focusing on implementing their local plans, irrespective of external drivers. • At its best, Practice Based Commissioning has tended to focus on pathway redesigns and has delivered improvements in some areas, but it has been variable across NCL.				
	Barnet's polysystem plan was to reduce from 69 to 24 GP sites within four polysystems, based on Primary Care Centres.	The Camden CSP reflects broader, whole system thinking than in some boroughs. It introduces QIPP and robust performance management measurement. It is not just a GP premises strategy.	Enfield's development of new NHCs (or hubs), GP led health centres and large GP practices based within fit for purpose premises and at the right locations. Some GPs are now sceptical about any premises development plans.	Haringey's "Going Local" vision, built three NHCs (polyclinics) to deliver local health services and reduce health inequalities. GP practices are based in the centres, with other nearby practices referring their patients to their local NHC.	"Transforming Primary Care" set out the vision for three polysystems with three polyclinics and associated practices.

Themes	Barnet	Camden	Enfield	Haringey	Islington
Current issues/drivers/focus	• BEH Clinical Strategy • FMH rebuild	• Developing an integrated care model • CCG development	• BEH Clinical Strategy • Poor morale amongst some GPs • Loss of PCT staff	• BEH Clinical Strategy • London Borough of Haringey partnership working • Tottenham site	• CCG development • Primary care strategy development
Number/Size of Practices	• Should a reduction in the actual number of practices be an <u>explicit aim</u>, or should quality be the determinant irrespective of size? • *"We are agnostic about the number of practices, but not about the quality of service and care" (Doug Russell)*				
	Largest number of practices, and the largest patient pop. Moving towards smaller practices working together	Close to optimum number with 6,436 patients per practice and 46% of patients registered in practices over 10,000	Lowest average patients per practice (4,985) and 43% of patients registered in practices with less than 5,000	Second owest average patients per practice (5,041) and 35% of patients registered in practices with less than 5,000	Average 5,865 patients per practice but some further reduction in practices possible
WICs and GPLHCs	• Have they proved to be effective? • Are they value for money?				
Quality of service and care	**<u>How we really measure true quality?</u>** • *"Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice"* (Improving the quality of care in general practice The King's Fund March 2011) • We previously have currently had Balanced Scorecards (five different), QOF (generally good), MORI Survey (not so good) and Prescribing Data. We will be implementing the London-wide GP Outcomes Framework from April 2012. • Anecdotally we know that there are issues in all boroughs and some more so than others • Access is a proxy indicator for outcomes				
Data	• Data rich, information poor. Data sets are often incomplete, inconclusive, different form, different content, hard to find, locally specific or non-existent. • We need both hard and soft data. • Islington Public Health Informatics team currently produce disease profiles by practice and have the ability, but not				

	the capacity, to extend across all practices in NCL.				
Themes	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**
Premises	• No single complete data set. CIAMS did not include primary care premises in four boroughs • Will there be funding for premises developments? How and how much? • NCL Estates Strategy report is now due, although it will not include non-PCT owned primary care premises.				
	• Estimated 30% unfit	80% of practices have had refurbs	Quantum Report February 2011	• Many small practices in unfit premises	Full CIAMS data available
IT	There are four dimensions to the lack of standardisation in IT systems: • Practices across NCL using different systems and suppliers • Practices within a Borough using different systems and suppliers • Practice systems not able to communicate with Community Services systems (Usually RIO) • The extent to which practices are (un)able to communicate with Acute and Mental Health provider systems				
GP Productivity	**<u>How we really measure productivity?</u>** • "2006/07 UK General Practice Workload Survey" is the most recent definitive study • See "Improving the quality of care in general practice" (King's Fund March 2011) for links between Quality and Productivity • Component elements of any productivity calculation will include, amongst others: o Weighted patient population o WTE GPs / Sessions / Hours o WTE Nurses / Sessions / Hours o WTE administrative staff o Numbers of appointments offered/attended o Practice cost per patient o Referrals				
			Commissioning referral data reported on BSC	Commissioning referral data reported on BSC	

Themes	Barnet	Camden	Enfield	Haringey	Islington
Future possible NCL strategy	**Acknowledging the transition phase** • Roles and relationships are evolving during the transition phase from PCTs to CCGs/NHS NCB and a high level of joint/collaborative working in this changing environment. • CCGs will be the commissioning strategic planners in the future. Primary care will be an essential component part of their strategy. • NCL, with a central and borough presence, currently has a dual role: o Performance managers of the whole health economies in each borough (to April 2013) o Management of primary care independent contractors (Ongoing through NCB) • The question then becomes: o "Who should lead on primary care strategy?" or do we now ask: o "Do we still need primary care strategies?" or, more fundamentally: o "What do we now mean by primary care?" or is it: o "Primary care contractor management strategy?" or, in reality: o "General Practice quality improvement strategy?" • Because of the differences in boroughs, any NCL strategy should be an underpinning set of aims, objectives, principles, targets, standards and guidelines to set the required standards across NCL but should not seek to get into the detail of each borough's specific issues. • NCL borough teams should then be asked to co-produce a plan to implement the NCL strategy. It is recognised that borough teams may need support to produce their plans. (Islington are piloting the production of a plan in tandem with this NCL strategy). • Improved performance will not come from stronger performance management alone. Some boroughs will require significant development support. **A vision for the NCL primary care strategy could therefore be:** o To shift from a premises-led focus to primary care based on prevention, health improvement and high quality services o To support CCGs to plan how to improve primary care services in each borough o To hand over to NCB in 2013 higher quality primary care contractual performance than inherited in 2011 o To use CQC registration as a quality marker o To use GP re-validation as a quality marker o To achieve greater service integration and smarter working across general practice and other independent contractors, Dentists, Optometrists and Pharmacists				

	A <u>strategy to achieve the vision</u> would be a comprehensive programme of development support combined with robust performance management. • The programme should be based on “Improving the quality of care in general practice” (King’s Fund March 2011) • Any such programme will require both **resource funding and development funding.** • This programme is not to be confused with the CCG development programme.

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The future landscape of Primary Care

A patient's view of primary care in North Central London in the Boroughs of Barnet, Enfield, Haringey, Camden and Islington in the year 20xx.

I've just moved into the area and I'd like to find out about what's available to me from the local NHS.

Welcome to North Central London from the primary care part of the NHS. Firstly, we want to get you registered as a patient in our area. We make it as easy as possible. You may already have had an information pack from your estate agent or letting landlord, but if not just call in at any of our NHS-signed premises – Doctors, Pharmacies or Clinics - or at your local council office. You'll need to bring with you a proof of your identity and of your new address and we'll get you signed up straight away. It will then take a few days for us to complete your registration and to send you full details of what we can offer you. This will include:

- Names and addresses and full information about local general practices who are ready, willing and able to offer you registration. You can then choose the one that best meets your personal lifestyle preferences. Be assured that the quality of care is uniformly high at all of our practices, and that the differences in location, premises, size, languages and gender are the criteria by which we want you to choose, according to what suits you. Some patients prefer a small practice where they will know, and be known by, all the staff. Sometimes this means that they may have to go to another nearby practice for care that cannot be safely delivered in a small practice. Other patients prefer a larger "one stop" centre where they may not know all the staff but a wider range of services will be available. It's your choice!

- An invitation to book a new patient health check at the practice of your choice. We want to ensure that the practice get to know about you so that they can offer you a total health service. This invitation will also be extended to your family members if you are also registering them.

- A list of pharmacies in your area, with opening times and additional services. Do note that our pharmacists are able to offer you advice and a wide range of services which could save you having to go to your doctor.

- An information pack on the full range of services we can offer and how to access them, for example, dentistry and optometry. Also it will explain how to find your way through the local NHS when you need us urgently. We offer a range of urgent care and the Hospital A&E Department is reserved for the most serious cases. Most urgent care can be delivered by your doctor or pharmacist. If you're not sure you can always phone us (see attached details) and we'll signpost you to the most appropriate care centre. Do be aware that if you do go straight to the Hospital A&E, they may re-direct you back to your local primary care service for the type of care that you need.

So, as a new patient, what can I expect from my general practice?

Firstly, we can assure you that the premises will be fit for purpose, irrespective of the age and type of building. We have a mix of new and old, large and small, buildings but they are all clean, bright, and tidy and will display only current relevant information about our services. The building will be accessible for all, including the disabled, and will conform to all health and safety and requirements and be a safe environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time.

All consulting and treatment rooms will be appropriate for their use, and there will be decent WC facilities should you need them.

The practice opening hours will be published and they will offer you a choice of pre-booked appointments or, if you are prepared to wait, a walk-in service. From the information we sent you, you will already be aware of your choice of clinician, including gender and language preferences.

On arrival, the practice reception staff will be welcoming and will offer you a confidential check-in process. As a new patient, you will be introduced to our health advisory service, either face to face or virtually, to guide you through the things that you may find useful including:

- How to get your personal health profile
- Self care and lifestyle advice
- Exercise on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Details of how to access all our services

Your practice health care team will view you as a member of the local health community and will provide you with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill health in a community and can advise you on healthy living, prevention and early diagnosis.

After my initial visit, how will I be able to contact the practice?

Between 8am and 6.30pm you can contact any of our practices by phone, e-mail or in person. Some of our practices are open until 8pm and on Saturday mornings. They will always respond to phone calls and e-mails within 2 hours and often immediately. Outside these hours, please ring the Out of Hours Doctor Service on the number that we have given you in our information pack.

We offer consultations with doctors and nurses by phone, by e-mail and face to face. When you phone or e-mail to make an appointment the practice will agree with you which is the most suitable option for you. If you prefer continuity, then practices will always try to offer you an appointment with the clinician of your choice. Sometimes, particularly if you require an urgent consultation, they will offer you a consultation with the first available clinician.

Whichever type of consultation you have, and whatever the time of day or night, with your permission, we can arrange for your medical records to be available to the clinician so that s/he can see all relevant information. If you have an out of hours consultation, we will ensure that your registered practice is aware of it, and they will update your records accordingly within 12 hours.

What services do you offer in your practices?

All of our practices work within a network of 15,000 to 30,000 patients across a number of practices. The network principle is that you will always be able to access the services that we offer as part of our guaranteed standard services list (see enclosed). If you are registered with a small practice, you may have to attend another nearby practice in the local network for some services.

Every practice offers, on-site, as a minimum the range of "core" services that you would expect from any general practice. Some larger practices offer a wide and growing range of additional services. Here are some examples of how the network functions:

- All practices offer a range of patient diagnostic tests in-house. If you need a blood test, then the sample will be taken in the practice and sent the samples away for analysis. The practice will advise you of the results within 72 hours.
- Some larger practices offer more specialised testing, such as ultrasound scanning, for their own patients and for those from nearby smaller practices in the network.
- If you require more specialist support and advice for a condition such as Diabetes, we may ask you to attend an appointment with a Diabetes GP or Nurse locally in the network.
- If you need an X-ray, there is a community-based X-ray service available in each borough.

Communication between practices is usually electronic. Most practices use the same computer system, but those who have a different system can still communicate with each other across the network. Practices are also able to communicate with other community based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

You will also be able to log on to check your own health record at any time. If you don't have a computer available to you, you can use the surgery patient computer to check your records, make future appointments or re-order your medication.

In addition to the above services, practices provide home visits for housebound patients. We can also offer these patients self-monitoring equipment to measure blood pressure, blood sugar levels and other routine regular monitoring tests.

Dentists, Pharmacists and Optometrists are all an important part of our primary care services. Our information pack will give you full details of your nearest practitioners and how to access them both routinely and in an emergency. Often, they will be co-located with our general practices or will be in nearby premises, and can offer a range of services to support your health and wellbeing.

Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer you for further advice or tests. Your GP will be able to offer you a consultation locally with a specialist consultant or will arrange a hospital appointment for you.

What if I need to go in to hospital for an operation?

Our GPs will do as much as they can in primary care to avoid hospital admissions. However, if they decide that an operation is necessary, they will:

- Advise you on what to expect
- Offer you a choice of hospitals
- Increasingly, arrange for you to be a day case patient without any overnight stay
- Ensure that, if you do stay in hospital, it will only be for the minimum time and get you discharged as soon as it is safe to do so
- Support your rehabilitation and convalescence at home or in a community setting.
- Arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician.

I've got what is known as a Long Term Condition – how will you manage that?

When a patient is first diagnosed with a long term condition, all our practices will:

- Provide you with full educational information about your condition soon after diagnosis
- Introduce you to our nursing team who lead much of our long term conditions management
- Advise you of additional support services, who will often be patient groups or charities, who are expert in the management of your condition
- Agree a package of care based on your needs. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.

If you need more specialist advice, all our practices work as part of a local network known as the Extended Primary Health Care Team. The team will service a population of 15,000 to 30,000 patients across a number of practices. The services include:

- District Nursing, including Community Matrons to plan and oversee your care
- Specialist nursing including School Nurses, Paediatric Nurses and other specialties
- Health Visiting
- Midwifery
- Physiotherapy
- Podiatry
- Speech and Language Therapy
- Occupational Therapy
- Primary mental health services, including psychology and a range of counselling and therapy services
- Social services care

If you have a complex condition, our team will appoint a named care co-ordinator, to work with you and the rest of the team. They will then work with you to implement your Care Plan.

All community members of our teams have modern technology, including telephones with GPS navigation, so that colleagues can locate them and they can locate you as quickly as is necessary.

What about my medications?

For those patients with long term conditions, we offer repeat dispensing from your named pharmacy without the need to request a repeat prescription from your practice. The pharmacist is an expert in medicines management and will advise when you need to see your doctor again for a review of your medications.

Your pharmacist will also advise you on any side effects or concerns that you have arising from your medication and will consult with your doctor about any recommended changes.

What services do your practices offer to pregnant women?

Hopefully, your practice will already know you and have offered you pre-conception advice as part of our normal service. The practice will seek to confirm your pregnancy as early as possible and offer you advice about your choice of birth settings. They will then offer you, and your partner, a range of ante-natal services including exercise and parenting classes. Our team of midwives will work closely with you and your GP to monitor your pregnancy and to support you in a safe birth.

After the birth, the practice team of doctors, nurses, midwives and health visitors will provide additional support services for the first two years. This will include:

- Immunisations
- Child development monitoring
- Parenting skills support
- Ongoing conception advice

What can you offer me if I am diagnosed with a terminal illness?

We will agree a Care Plan with you based on the MacMillan Gold Standard for end of life care. In addition to your GP, our extended Primary Health Care Team nurses will look after you and support and advise you on your options requiring decisions.

How do you assure the quality of your GPs?

All of our GPs are committed to ongoing professional development. They all have written personal development plans, and take part in an annual appraisal of their performance with a qualified GP appraiser. They attend regular education and development programmes on key GP skills.

All GPs are now required to apply for professional re-accreditation every 5 years.

GPs arrange for their practice staff to attend regular professional development training and education programmes suitable to their role. In addition to professional clinical training this includes customer care training for our reception teams. Our practices aim to build a culture of high standards of clinical care and service.

How do you know whether your GPs are doing a good job?

There are a number of statutory measures by which we can assess the overall quality of service provision by our primary care colleagues. In addition, we encourage a culture of incident reporting and group learning.

Our practices actively seek and welcome feedback from patients on their experience of our services, and view complaints as an opportunity to improve services.

Our aim, and that of all our practices, is to offer you a high quality primary care team service which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing.

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Date: **22 September 2011**

Cllr Bull
Chairman
North Central London Joint Health Overview and Scrutiny Committee
Haringey Council
7th Floor, River Park House
225 High Road
London N22 4HQ

Dear Cllr Bull

Re: Independent Business Review of Camidoc Limited

As promised please find attached a copy of the above report for circulation to Committee members. As you know the report was jointly commissioned by Camidoc Limited and the Commissioners representing the four Primary Care Trusts of Camden, City & Hackney, Haringey and Islington. The purpose was to explore the financial position of the company following their request for extra funding at the beginning of 2010. It did not look at broader issues such as service quality or the commissioning process.

I realise that members have waited a long time for this and it is now old but it is only recently that we have received permission form the authors to release this.

Yours sincerely

Martin Machray
Deputy Director – Governance and Communications

cc
Mr Rob Mack – JHOSC Committee Clerk, Haringey Council

Grant Thornton

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NHS Camden

Independent Business Review of Camidoc Limited

16 July 2010

Grant Thornton

Private and Confidential

Our reference: GN/BN

16 July 2010

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For the attention of Peter Buckman

Dear Sirs

Camidoc Limited ("Camidoc" or "the Company")

We refer to our engagement letter dated 24 June 2010 and have pleasure in enclosing our report.

Our conclusions and recommendations are included within the Executive Summary, but stress that for a full understanding it is necessary to read this in conjunction with our detailed commentary set out in Sections 2 to 5.

Your attention is drawn to our engagement letter in Appendix A which defines the scope of our work. This report is confidential and has been prepared exclusively for NHS Camden. Whilst other parties may be interested in receiving a copy of this report we stress that we cannot accept any responsibility whatsoever in respect of any reliance that these parties may place on our report in any decision that they may make in relation to the Company. We reiterate, therefore, that this report should not be used, reproduced or circulated to any other party in whole or in part, without our prior written consent.

Our work commenced on 26 June 2010 and our fieldwork was completed on 9 July 2010. We have not undertaken to update our report for events or circumstances arising after that date.

In preparing our report, our primary source has been information provided by the management of the Company listed in Appendix B and their representations made to us. We do not accept responsibility for such information which remains the responsibility of the Company.

The contents of this report have been reviewed by the management of the Company who have therefore confirmed in writing the factual accuracy of this report in Appendix D.

If you would like to discuss this report then please contact either Giles Newman (020 7728 3453) or Brian Ng (020 7865 2508).

Yours faithfully

Grant Thornton UK LLP

Glossary

A&E	Accident and emergency
CAGR	Compound Annual Growth Rate
CEO	Chief Executive Officer
CHIP	Camden Health Improvement Practice, a service for homeless people commissioned by NHS Camden
EBIT	Earnings before interest and tax
EBITDA	Earnings before interest, tax, depreciation and amortisation
Financial Model	Full Camidoc Cash Flow March.xls
FYXX	Financial year ended/ending 31 March 20XX
GP	General Medical Practitioners
GT	Grant Thornton UK LLP
k	'000
KPIs	Key Performance Indicators
Management	Senior management and/or the directors of the Company
NHS Camden	Camden Primary Care Trust
OOH	Out of Hours
P&L	Profit and loss account
p.a.	per annum
PUCC	Primary Urgent Care Centre
the PCTs	Four Primary Care Trusts (i.e. NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney) which are the commissioners of the OOH Service
SLA	Service Level Agreement
SUI	Serious Untoward Incident
the Company or Camidoc	Camidoc Limited
WTE	Whole Time Equivalent (Staff)
Year 1	The first 12-month period from the date of commencement of the new OOH contract which is yet to be agreed between Camidoc and the consortium of four PCTs (NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney). The current expectation is 1 October 2010
Year 2 and 3	The second 12-month and third 12-month periods from the date of commencement of the new OOH contract
YTD	Year To Date

Contents

Grant Thornton

Section 1

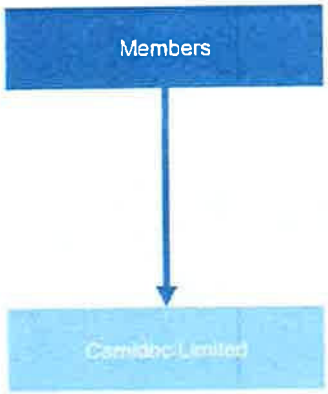
Executive summary

Headlines

Solvency	• Camidoc was technically insolvent as at 31 May 2010 as its total assets are less than total liabilities by £37k • The main liability, the amount owed to the NHS Pension Scheme in terms of top-ups for GP pensions totalling £797k at 31 May 2010 does not seem to have a due date. Total pension liability as at 31 March 2010 was £670k • Whilst the Company continues to use this as working capital, the PCTs need to understand the extent of this liability and agree its treatment prior to the commencement of the new contract
Ongoing contract	• The new contract does allow for the Company to make a small profit, however it is open to a number of different sensitivities • As a result, it is uncertain whether the new contract will enable Camidoc to trade profitably into the future without either additional payments or renegotiated contract terms • The PCTs should ensure that the risks highlighted in this report are considered before finalising the contract with Camidoc and, if necessary, redraft the contract to ensure there is scope for in year reviews to establish trading variations, especially activity
Key business drivers	• Camidoc needs to invest in its managerial capacity to ensure that it concentrates on productivity and profitability • The Company needs to agree with commissioners how productivity will increase over the first year/two years of the contract and recast its financial forecasts to take into account identified productivity gains • A considered cost improvement plan needs to be actioned including as a minimum agreed levels of productivity targets and the method by which the Company is going to achieve the required improvements, along with specific responsibility and dates and key milestones • Management should split out key contracts and report profitability for each contract to enable assessment of individual contract profitability and financial performance
Management and contractual interaction	• Currently the Company does not provide the PCTs with information of sufficient frequency and depth, other than the quarterly Performance Quality Report which provides activity trends and reports compliance of quality requirements • Monthly reporting packs should be agreed and put into the new contract, and a schedule of meetings agreed for regular (monthly, weekly if escalated) management meetings agreed • The PCTs should review the level of operational and financial controls and establish whether any further issues need to be reflected in the contract • Currently the Company does not have sufficient operational management capacity to ensure that the key issues are addressed

Overview of Camidoc Limited

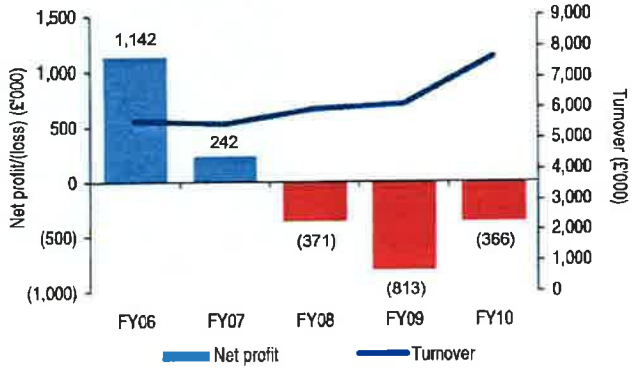
Legal structure



Key information

- a company limited by guarantee and not having a share capital
- standalone company with no parent company or subsidiary
- considered a social enterprise, not-for-profit organisation
- commenced trading from 1 April 2005 for the provision of out of hours (OOH) service
- prior to that, the provision of OOH Service was undertaken by a GP cooperative
- members comprise local GPs

Summary financial results from FY06 to FY10



Sources: 1. Audited accounts FY06-FY09; 2. Draft management accounts FY10

Business overview

- Camidoc is the provider of Out of Hours (OOH) Service to four local PCTs - NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney. Nearly 70% of the Company's turnover in FY10 relates to the OOH contract
- The Company provides telephone answering services and clinical cover for patients when their GP practice is closed, either during the day or at evenings and weekends
- The clinical services can take the form of:
  - telephone consultation by Camidoc doctors
  - provision of face-to-face services at Camidoc local centres where patients visit Camidoc doctors if required following a telephone assessment
  - home visits by Camidoc doctors if required after an initial telephone assessment
- The current OOH Contract, a block contract covering from 2005 to 2008, has been extended for no later than 30 Sept 2010 pending finalisation of the procurement process for the new OOH Contract (anticipated to commence from 1 Oct 2010) which will link payments to activity
- Other than the OOH Contract, the remaining 30% of income for Camidoc is from contracts for additional primary care services such as GP services to homeless residents in Camden, support to A&E departments at local hospitals, overnight GP cover and GP event cover

Statutory Directors

- There are currently 2 statutory directors based on the latest records obtained from Companies House:
  - Dr Mayur Gor
  - Dr Ivor Robinson
- Other than Dr Gor, none of the current leadership team (listed on Appendix B) are listed as statutory directors of the Company
- Based on the records obtained from Companies House, Michael Golding (the previous CEO) was the Company Secretary until his resignation on 31 March 2010

Key issues

Solvency

Camidoc was technically insolvent as at 31 May 2010 due to its total assets being less than total liabilities

- Based on management accounts as at 31 May 2010, total assets are less than total liabilities by £37k. The Company is therefore technically insolvent
- The reasons behind this financial difficulty include:
  - poor financial planning and management as well as lack of financial governance and focus
  - erosion of profitability due to increased expenditure and fixed costs e.g. salaries and overheads as the Company sought to increase its service quality and infrastructure capability. This is compounded by the block arrangement for the main OOH Contract in which unit price is based on population rather than activity volume. A benchmarking study carried out by the Primary Care Foundation indicated the current unit price at the lower quartile compared to other OOH providers
  - additional in session payments to doctors as activity increases
  - Camidoc is part of the NHS Pension Scheme, hence doctors and staff are entitled to additional 14% pension contribution by Camidoc. The outstanding contribution currently totals £797k at 31 May 2010. The PCTs need to ensure Camidoc agrees how this liability will be settled before signing the new contract
- Management believes this adverse financial position will be mitigated by moving to the new OOH Contract which will link income to activity. However, we note that the contract is significantly sensitive to activity volume in which case any significant decrease in volume will reduce the Company profitability and cash flows

Despite the positive cash position of the Company as at 31 May 2010, the directors of Camidoc should ensure that they take appropriate legal advice as to their current responsibilities under the Companies Act 2006 and the Insolvency Act 1986 and in particular provisions with respect to wrongful trading

Key issues (continued)

Trading performance

Camidoc has reported significant net losses over the last 3 years to FY10, resulting in a yearly reduction in reserves

Management considers the OOH Contract was under-funded as the unit price did not commensurate with the increased activity volume and additional investment in IT and resources by Camidoc which allows it to deliver a clinically better and higher quality of service

Summary P&L

£'000	FY09 Audited	FY10 Unaudited	% year-on-year
P&L			
Total income	**6,137**	**7,673**	**25.0%**
Cost of sales	(4,492)	(4,643)	3.4%
Gross profit	1,645	3,030	84.2%
Salaries and wages	(1,948)	(2,649)	36.0%
Other overheads	(493)	(720)	46.1%
EBITDA	**(796)**	**(338)**	**(57.5)%**
Depreciation, interest and tax	(17)	(28)	69.0%
Net loss	**(813)**	**(366)**	**(54.9)%**
Normalised EBITDA	(747)	(562)	(24.8)%
Normalised net loss	**(764)**	**(590)**	**(22.7)%**
KPIs			
Gross margin	26.8%	39.5%	12.7%
EBITDA margin	(13.0)%	(4.4)%	8.6%
Total activity (calls) ('000)	89	105	17.7%

Sources 1 FY10 draft management accounts; 2 FY09 audited accounts

- Camidoc made net losses of £813k and £366k in FY09 and FY10 respectively. Management has attributed the adverse trading performance to be due to:
  - significant under-funding of its OOH Contract by the PCTs as unit price was set at a constant/reduced rate per registered patient population which did not commensurate with the increased activity volume
  - higher pay costs and overheads as a result of:
    - investment in IT infrastructure
    - operational staff (call handlers, nurses)
    - clinical governance in order to provide better services and clinical quality in response to a past SUI incident
- The Company also ensures that all doctor pensions are topped up with additional 14% contribution as a result of activity undertaken by the Company. Management has accounted these pension payments as a liability due by the Company. However, it is unclear whether or not this pension contribution is effectively for distribution to the GPs
- The reduced net losses in FY10 from FY09 is mainly due to additional one-off income funding received as well as income generated from new contracts
- Camidoc received one-off income totalling £514k in FY10 in respect of swine flu funding (£114k) and additional income funding (£400k) to assist Camidoc for liquidity purposes

Key issues (continued)

Balance sheet and cash flow

May 2010 management accounts indicated that the Company is insolvent and therefore its going concern is dependent upon PCT support and the new OOH Contract in order to generate profit and sufficient cash headroom

Summary balance sheet and cash flow

£'000	FY09 Audited	FY10 Unaudited	% growth
Balance sheet			
Fixed assets	71	44	(38.1)%
Net current assets/(liabilities)	335	(5)	(101.4)%
Cash balances	357	387	8.4%
Retained profits	405	39	(90.3)%
Cash flow			
Operating cash flow	(546)	31	(105.7)%
Capital expenditure	(60)	(1)	(97.6)%
Net cash flow	(592)	30	(105.1)%

Sources: 1. FY10 draft management accounts 2. FY09 audited accounts

- The Company is currently insolvent. Management accounts as at 31 May 2010 indicated that total assets are less than total liabilities by £37k
- The Company's ability to continue as a going concern is heavily dependent upon the commencement of the new OOH Contract from which it needs to generate sufficient profit and cash headroom
- Camidoc currently has no overdraft facility or working capital facility and has sought assistance or support from the PCTs rather than other forms of support or debt
- At 31 March 2010, the Company had a total pension liability of £670k in relation to unpaid NHS Pension Scheme contribution for doctors. Total pension liability at 31 May 2010 was £797k. The Company has budgeted to repay the outstanding pension liability at an amount of £60k per month effective August 2010

- Latest cash flow forecast suggests that the Company will have insufficient cash to trade in September 2010 and is heavily reliant on cash flows from the new OOH contract

Key issues (continued)

Governance and financial control Weaknesses have been recognised in governance and financial control. Actions have been taken to address these. The service improvement plan has actions to further improve governance and financial control arrangements	• Historically, the Company has been reactive in improving governance arrangements and the control environment. Following an adverse SUI investigation in 2007, the Company improved clinical governance arrangements and introduced three new "lay" Board members • These Board members have been introducing improved corporate governance arrangements. It is recognised that further improvements can be made and reflected within the Service Improvement Plan • The Directors acknowledge that historic financial controls have been weak. In November 2009, the Company first started to use the Sage accounting package. Prior to this accounting records were held on Excel spreadsheets. The number of staff with finance experience and expertise has increased from 1 to 3 during the last year, including the recruitment of a qualified accountant as a "lay" Board member • Board meetings have not been held on a timely basis. The Company recognise that the frequency of Board meetings should increase, and this is due to improve in FY11. Performance reports will go to every Board meeting in advance of the meeting (whereas in the past this was not always the case), and in months where no Board meeting is scheduled, directors will receive a performance report • The focus of performance reporting to the Board has been on clinical governance and targets. Finances have been reported to the Board, but not in a way which informs evidence based decision making. Cost centre and service line reporting has not been in place. Productivity performance of the Company has been reported to the Board once in the last three years, and performance in this area does not compare well compared to other OOH providers

Key issues (continued)

Financials

Issues	Summary observations	Comment/recommendation
Pension liability	• Camidoc is liable to pay an additional 14% of doctor fees as pension contribution to the doctor pension scheme • As at 31 March 2010, the Company had £670k unpaid pension contribution for doctors. Total pension liability at 31 May 2010 was £797k	This suggests management reliance on not paying doctor pensions for working capital purposes We recommend that the PCTs seeking legal advice in relation the outstanding pension liability and to consider the impact to Camidoc
Management information	• Camidoc is a private business and was considered a small company which was exempted from statutory audit until FY07 • With no finance director, no requirement to report results to stakeholders, the quality of the accounting processes and monthly routines is not at the level that one might expect for a business of this size • Management has historically not maintained information to undertake analysis of contract performance	• The timeliness and quality of information available for our work has been an issue and we have had to spend time undertaking analysis work and data that we would normally have expected to be provided by the Company • The Company has recently recruited a part time Finance Manager to take responsibility of preparing monthly management accounts and financial planning Although the Company is a private limited company, management appeared to have considered it part of the NHS and not in a private sector. It should seek to adopt a more commercial approach in managing its finances with regular and vigour contract performance be undertaken to identify gaps and any material variances against expectation
Forecasts	• Our work on forecasts has been based on the three-year Financial Model prepared by management for the bid submission of the new OOH Contract • Management has recently revisited certain assumptions made in the model including activity volume, doctor rates and length of activity time (a productivity metric). We also understand that there are recent changes in other contracts e.g. increased income for District Nurse Messaging and cessation of John Howard contract • However, management has not yet updated these changes and consider their impact to other assumptions in the Financial Model	• Management needs to update the forecasts to reflect latest assumptions and recent changes to other contracts in order to produce an integrated financial model for Camidoc • In addition, the forecasts need to link to the current trading results and opening balances (assets and liabilities) which include the planned repayment of the unpaid pension liability for doctors

Key issues (continued)

Financial control environment

Issues	Summary observations	Comment/recommendations
Board reporting	• Board meetings in FY10 were held on a quarterly basis. The Company has recognised that Board meeting should be held more frequently • The Company has a service improvement plan drafted to deliver change. Actions to be taken to improve Board processes have been noted as: – Review information currently presented to the Board and its committees – Define roles for every Board member • Reports have not been made to the Board on company-wide productivity	• The Board should receive information on productivity metrics on a Company wide basis. This will identify areas for improvement which will help the Board deliver key contracts in a more efficient way
Financial reporting	• Historically, financial reporting has not been timely or presented in a clear way • Actions have been developed to improve financial reporting, such as migration of financial data onto the Sage system and having more frequent Board meetings • The finance capacity and capability has recently been improved, which gives some assurance that further improvements in the financial reporting arrangements can be made	• The Board should put in steps processes to ensure that finance information is reported to the Board taking into account: – timeliness of information including submission of monthly management accounts, rolling cash flow and forecasts – separate identification of significant contracts by income and costs – integration of finance and other performance information, such as productivity and clinical indicators
Board composition	• There is no current substantive CEO appointment. It is hoped that a CEO will be appointed on a permanent basis by January 2011. Currently one of the non-executive directors is filling this post on a part time basis. It is important that the Company consider the skill set of the CEO when making the appointment, especially with the changes expected within the NHS in the next 12-24 months	• The Board should draw up a job specification detailing the desired and essential skills and experience that is required for the CEO. This will help the Board in choosing the most appropriate candidate to be appointed to this position • The appointment will be an important step to the Company increasing its operational management capacity

Key issues (continued)

Financial control environment

Issues	Summary observations	Comment/recommendations
Governance structure	• The Company has a service improvement plan drafted to deliver change. Actions to be taken to improve Board processes have been noted as: – Review information currently presented to the Board and its committees – Define roles for every Board member	• The Company should ensure that the actions contained within the Service Improvement Plan are delivered. To achieve this reporting of performance against this plan should be made to the Board at each meeting

Grant Thornton

Section 2

Historical trading performance

Financial overview

Summary financials

£'000	<–Old OOH contract–> FY09 Audited	FY10 Unaudited	<———New OOH contract———> Year 1 Forecast	Year 2 Forecast	Year 3 Forecast
P&L					
Total income	**6,137**	**7,673**	**6,929**	**6,933**	**6,938**
Cost of sales	(4,492)	(4,643)	(3,396)	(3,401)	(3,405)
Gross profit	1,645	3,030	3,533	3,533	3,533
Salaries and wages	(1,948)	(2,649)	(2,528)	(2,579)	(2,629)
Other overheads	(493)	(720)	(650)	(658)	(666)
EBITDA	(796)	(338)	355	296	238
Depreciation, interest and tax	(17)	(28)	(24)	(32)	(39)
Net (loss)/profit	**(813)**	**(366)**	**330**	**265**	**199**
Balance sheet					
Fixed assets	71	44	n/a	n/a	n/a
Net current assets/(liabilities)	335	(5)	n/a	n/a	n/a
Cash balances	357	387	n/a	n/a	n/a
Retained profits	405	39	n/a	n/a	n/a
Cash flow					
Operating cash flow	(546)	31	(99)	298	239
Capital expenditure	(60)	(1)	(30)	(30)	(30)
Net cash flow	(592)	30	(129)	268	209
KPIs					
Gross margin	26.8%	39.5%	51.0%	51.0%	50.9%
EBITDA margin	(13.0)%	(4.4)%	5.1%	4.3%	3.4%
Total activity (calls) ('000)	88.9	104.6	70.0	70.0	70.0

Notes 1. Management has not updated the 3 Year Financial Model with the opening balance sheet as the start date for the new OOH Contract was unknown at the time of preparing the model. We have therefore not included the balance sheet forecast within the table above
2. Total activity (calls) is for the calendar year basis (i.e. 1 January to 31 December)

Sources 1. Management information 2. Financial Model

Overview

- Since FY08, Camidoc is reporting net losses for the year, most recently amounted to £813k and £366k in FY09 and FY10 respectively
- Management has attributed the adverse trading performance to be due to:
  - significant under-funding of its OOH Contract by the PCTs as unit price was set at a constant/reduced rate per registered patient population which did not commensurate with increased activity volume
  - higher fixed overheads as a result of investment in IT infrastructure, operational staff (call handlers, nurses) and clinical governance in order to provide better services and clinical quality in response to a past SUI incident
- The Company is technically insolvent at present and its going concern is dependent upon granting of the new OOH Contract which it needs to generate profit and improve cash in Year 1 to 3 of operation

New OOH Contract

- Camidoc is currently in negotiation with the PCTs in relation to the new OOH Contract
- Management has considered the Company financial forecast on the assumption that the new OOH Contract is to start from 1 October 2010
- Under the new contract, Camidoc is forecasting to achieve net profit of £0.3 million in Year 1, reducing to £0.2 million in Year 3
- When sensitised, the contract may not provide sufficient headroom for ongoing trade, especially if activity levels decrease (see Section 4 of this report)

Update to the Financial Model

- Year 1 to 3 forecasts presented in the table opposite was derived based on management assumptions made for the purpose of its bid submission
- Management has recently revisited certain assumptions made in the bid including activity volume, doctor rates and length of activity time (a productivity metric). We also understand that there are recent changes in other contracts e.g. increased income for District Nurse Messaging and cessation of John Howard contract. However, management has not yet updated these and consider their impact to other assumptions in the Financial Model

FY10 trading performance against estimated outturn

FY10 trading performance - actual versus estimation

£'000	FY10 Actual	FY10 Estimated	FY10 Variance
Total Income	**7,673**	**5,935**	**1,738**
Cost of sales			
Doctors' Fees	(4,405)	(3,267)	(1,138)
Medical Supplies	(136)	(128)	(8)
Others	(102)	(116)	14
Gross profit	**3,030**	**2,424**	**606**
Salaries and wages	(2,649)	(2,047)	(602)
Rent	(102)	(84)	(19)
Overheads	(617)	(265)	(352)
EBITDA	**(338)**	**29**	**(367)**
Depreciation	(28)	(25)	(3)
Net (loss)/profit	**(366)**	**4**	**(370)**
KPIs			
Gross margin	39.5%	40.8%	(1.4)%
EBITDA margin	(4.4)%	0.5%	(4.9)%
Total activity (calls) ('000)	104.6	92.3	(12.3)
Doctors' Fees as % of Income	57.4%	55.0%	(2.4)%

- £400k one-off income funding from the four PCTs to improve Camidoc liquidity position
- £114k one-off income to address the impact of swine flu on activity
- £1,224k new income streams not previously estimated i.e. CHIP contract (£768k), provision of GP services at A&E department at North Middlesex Hospital (£227k), Whittington Hospital (£120k) and John Howard Care Centre (£109k)

- higher expenditure on doctor fees to meet higher demand from swine flu (£103k) and general increase in activity volume for the OOH Contract
- provision of new contracts as discussed above (e.g. CHIP and hospital support)

- recruitment of new Medical Director and clinical governance lead who joined part year through in FY10
- additional headcount (nurses, call handlers, salaried GPs) to meet new contracts obtained

- back-pay of rent and service charges for premises (£116k) relating to the previous two years
- IT-related expenditure i.e. system maintenance, website development and upgrade
- higher than expected legal fees, professional fees

Sources 1 Management information; Budget Proposal 09-10 (2).xls

Overview

- The Company does not undertake annual budgeting process nor does it monitor its performance against budget on a regular basis
- The FY10 estimated outturn in the above table represents breakeven financial forecast estimated by the previous CEO
- The lack of sufficient financial monitoring has left the Company dependent on subsidy from the PCTs
- Whilst greater levels of financial management are put in place, the Company has yet to provide confidence that the finances are being managed robustly enough to avoid future cash flow problem

Quality of earnings and cash

Management identified normalisation adjustments

£'000	FY09 Audited	FY10 Unaudited
EBITDA		
Reported EBITDA	(796)	(338)
Income:		
Swine flu one-off income funding	-	(114)
One-off additional income funding	-	(400)
Expenditure:		
Additional costs due to swine flu	-	114
Back pay of rent	-	116
Consultation events	49	-
Bid costs	-	60
Total management adjustments	49	(224)
Normalised EBITDA	(747)	(562)
Cash balance		
Reported cash balance	357	387
Total management adjustments	49	(224)
Normalised cash balance	406	163

Sources: 1. Management information

- Income support from the PCTs to address the step increase in activity relating to swine flu epidemic between April-July 2009 prior to the start of the National Flu Helpline and website. Camidoc has quantified the cost associated to swine flu to be £114k, which was largely made up of additional doctor fees and call handlers
- Further funding from the PCTs to assist Camidoc improving its liquidity position
- Back payment of rent expense for the premises at St Prancas Hospital in which Camidoc operates (administration and clinics)
- Costs incurred in relation to the preparation and submission of Camidoc bid for the new OOH contract
- Consultation events to seek feedback from general public regarding Camidoc service and operational matters

Income

Income analysis by contracts

Service	Commissioners	Contract type	FY10 income £'000	% of income
OOH contract (existing)	NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney	Block	4,784	68.5%
Other recurring contract				
CHIP	NHS Camden	Block	768	11.0%
Practice income	166 surgeries at present	Hybrid	600	8.6%
North Middlesex Hospital support	North Middlesex Hospital	Block	287	4.1%
PUCC overnight care	NHS City and Hackney	Block	280	4.0%
Whittington Hospital suppport	NHS Islington	Block	120	1.7%
District Nurse Messaging	NHS Camden, NHS Islington and NHS City and Hackney	Block	75	1.1%
Safe Haven	NHS Camden and NHS Islington	Block	30	0.4%
Dental triage	NHS Camden, NHS Islington and NHS Haringey	Block	23	0.3%
OOH prison cover	NHS Islington	Block	15	0.2%
PCT event cover	NHS Camden	Block	8	0.1%
Subtotal			**6,989**	**100.0%**
Non-recurring and a ceased contract				
Additional funding for Swine Flu	NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney		114	n/a
One-off additional funding	NHS Camden, NHS Islington, NHS Haringey and NHS City and Hackney		400	n/a
John Howard support	North East London Mental Health		170	n/a
Total income in FY10			**7,673**	**n/a**

Sources: 1. Management information

Overview

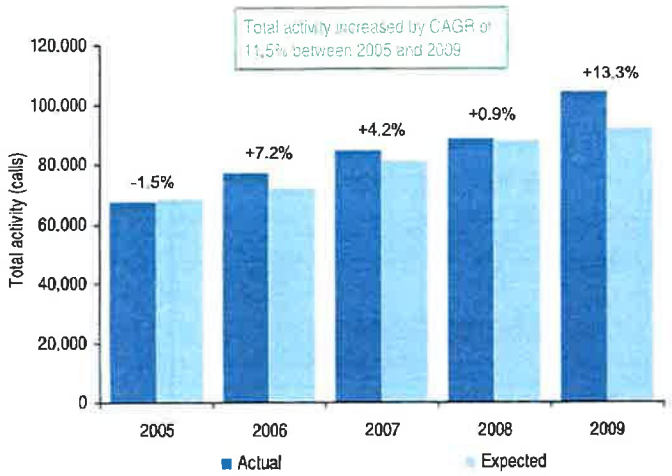
- The table opposite provides the list of Camidoc's contracts and income breakdown for FY10 based on discussion with management

OOH Service with four local PCTs

- The current OOH Service is contracted under block contract arrangement
- Income is based on a standard unit price of £5.31 per registered population within the area, generating a total revenue of £4.8 million in FY10 irrespective of the actual activity volume
- The contract was originally awarded to Camidoc covering a period of three years from 1 April 2005 to 31 March 2008. However, the provision of OOH Service has been extended at the PCTs request pending conclusion of the procurement process for the new OOH contract which will be driven by activity demand rather than a block contract. At present, the extended contract will end by 30 Sept 2010
- The Company invoices on a quarterly basis in advance until January 2010 when invoices were raised on a monthly basis in advance to assist Camidoc liquidity
- Analysis on activity is provided overleaf

Income (continued)

OOH Contract - activity trends



Note: Total activity shown in the chart above is for the calendar year basis i.e. 1 January to 31 December to exclude the timing difference and impact from Easter weekend each year. Total activity relates to the OOH Contract only and excludes daytime calls

Source: 1. Management information

OOH Service with four local PCTs (continued)

- The chart above shows the total activity for the OOH Contract over the last five calendar years in comparison to the level expected by Camidoc at the beginning of the year
- Camidoc has experienced an increase in activity year-on-year since the contract commencement with a CAGR of 11.5% between 2005 and 2009
- Total activity generally exceeded expectation with over-activity ranging from +0.9% and +13.3% per year. The highest over-activity in 2009 of 13.3% is mainly caused by exceptional demand relating to the swine flu epidemic

Other key contracts

CHIP

- This relates to provision of GP service to homeless residents in Camden
- The service was commissioned by NHS Camden from 1 June 2009 for a period of 5 years on a block contract arrangement

Practice income

- These are income from GP surgeries which have not opted out from the OOH Service commissioned by the PCTs. At present, Camidoc generates income by way of a standard price per patient list for call handling arrangement plus additional income from additional clinics provided by Camidoc doctors

North Middlesex Hospital support

- This relates to provision of Camidoc's doctors to support the A&E department at North Middlesex Hospital in delivery of A&E activity and meeting the hospital 4-hour A&E target

PUCC overnight care

- This is an additional service in addition to the existing OOH Contract with NHS City and Hackney where Camidoc provides overnight GP support and receptionist at Homerton Hospital

Other key contract

- Camidoc provides GP support for A&E department at Whittington Hospital

Cessation of a contract in June 2010

- The provision of primary care service to John Howard Centre in Hackney has recently been terminated in June 2010

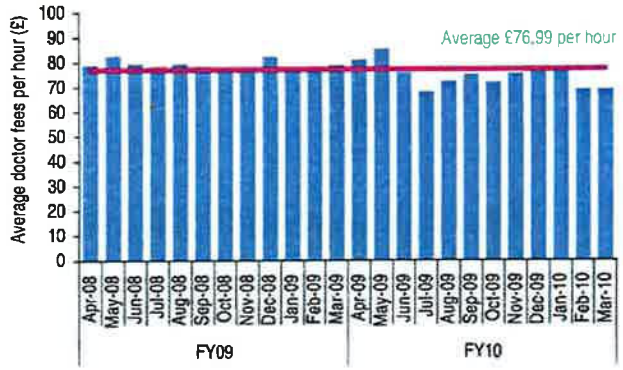
Gross margin

Gross profit analysis

£'000	FY09 Audited	FY10 Unaudited
Total Income	**6,137**	**7,673**
Cost of sales		
Doctors' Fees	(4,266)	(4,405)
Medical Supplies	(130)	(136)
Motor Expenses and Travel	(36)	(23)
Telephone and internet charges	(60)	(78)
Total cost of sales	(4,492)	(4,643)
Gross profit	**1,645**	**3,030**
KPIs		
Gross margin - as reported	26.8%	39.5%
Gross margin - excludes one-off income	26.8%	36.6%
Doctors' fees as % of income - as reported	69.5%	57.4%
Doctors' fees as % of income - excludes one-off income	69.5%	61.5%
Average doctor fees per hour (£)	£79.25	£74.73

Sources: 1. Management information 2. FY09 audited accounts and FY10 draft management accounts

Doctor fees per hour



Sources: 1. Management information 2. GT analysis

Overview

- The Company has shown an improved gross margin from 26.8% in FY09 to 36.6% in FY10 predominantly driven by a net decrease in doctor fees per hour

Doctors Fees

- Doctors fees are the largest variable costs for the Company, representing 95% of cost of sales in both FY09 and FY10

Doctor rates per hour

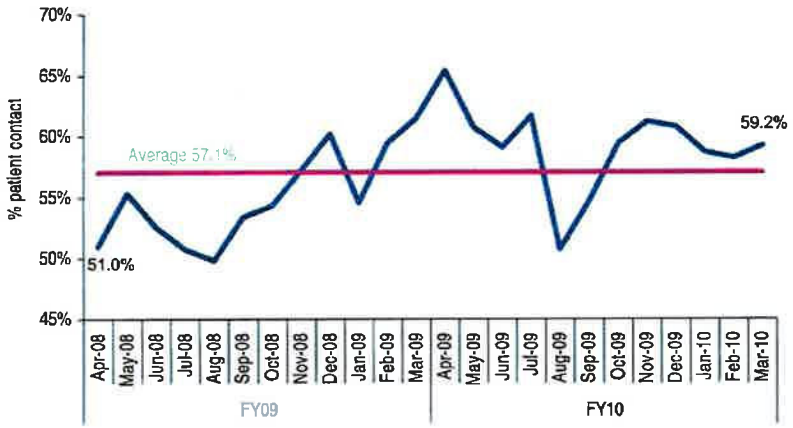
- Below are the doctor rates payable by Camidoc at present in 2010:

	Pre-May 2010	May-June 2010	From July 2010
– Monday to Friday evening:			
from 7.00 pm to midnight	£60	£55	£60
from midnight to 8.00 am	£76	£70	£75
– Saturday and Sunday			
from 7.00 am to midnight	£70	£60	£70
from midnight to 7.00 am	£82	£70	£80

- Doctor fees per hour for the last 2 years to March 2010 averaged at £77 per hour which is closer to the highest rates for shifts after midnight
- In response to financial pressures experienced by the Company, management has reduced the hourly rates paid to doctors at the beginning of 2009 and again in May 2010. This contributes to the overall decrease in doctor fees per hour which resulted in improved profit margin in FY10 compared to FY09
- Management has recognised the need to increase doctor rates to mitigate against the risk of doctors not willing to fill shifts and has brought forward the increase from 1 October 2010 to 1 July 2010. We have considered the financial impact of further increase of doctor rates in Section 4 of this report

Gross margin (continued)

% of patient consultation per doctor allocated hours



Sources | Management information 2 GT analysis

Doctors Fees (continued)

Productivity

- The Company does not currently report or analyse the level of doctor productivity in delivery of the demand activity
- The chart opposite analyses the extent of doctors time spent to deliver patient consultation for a period of last 2 years to March 2010 on a monthly basis
- In the absence of other data, this measurement represents a proxy of doctors productivity and how well the Company manages its doctors time in accordance with activity pattern within the OOH shifts
- Based on the analysis presented opposite, an average of 57% of doctors' paid hours were spent to deal with patient consultation with an overall improvement from 51% in April 2008 to 59% in March 2010
- In addition, our analysis from the data suggests that Camidoc has an average of 2 calls per doctor hour in 2009 (calendar year basis). This is in line with the benchmarking study carried out by the Primary Care Foundation which put Camidoc productivity level at the lower quartile of other OOH providers
- Management ability to increase the productivity of its doctor workforce would allow Camidoc to become increasingly competitive and profitable

Expenditure

Expenditure summary

£'000	FY09 Audited	FY10 Unaudited
Salaries and wages		
Salaries and wages	Not available	(363)
Administrative	Not available	(340)
Call Handlers	Not available	(646)
Management	Not available	(263)
Supervisors	Not available	(176)
Board	Not available	(189)
Drivers	Not available	(290)
Receptionists	Not available	(230)
Nursing	Not available	(124)
Healthcare Assistant	Not available	(1)
Subtotal	(1,923)	(2,622)
Directors' Emoluments	(25)	(27)
Total salaries and wages	**(1,948)**	**(2,649)**
Overheads		
Rent	-	(102)
Service charges	(18)	(99)
IT related expenditure	(152)	(155)
Advertising	(26)	(44)
Public and patient external consultancy	(55)	(39)
Consultation events	(49)	-
Course and training	(35)	(37)
Legal and professional fees	(19)	(32)
Depreciation charge	(35)	(28)
Other overheads (individually below £28k)	(140)	(211)
Total overheads	**(528)**	**(748)**
Total expenditure	**(2,476)**	**(3,397)**
% of Total Income	40.4%	44.3%

Sources: 1 FY09 audited accounts and FY10 management accounts

Pay costs

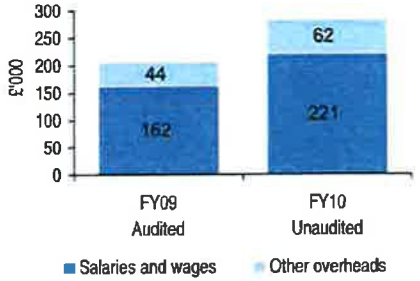
- Payroll accounted for c.78% of total expenditure in FY09 and FY10
- The increase in pay costs from £1.9 million in FY09 to £2.6 million in FY10 is mainly due to the following:
  - additional staff resources such as call handlers and nurses to deal with both increasing demand in activity for the OOH Contract and provision of new services/contracts e.g. CHIP, hospital support
  - new Medical Director and clinical governance lead during FY10
- Analysis of headcount/WTEs is currently not readily available for our work

Other overheads

- Total overheads increased from £528k in FY09 to £748k in FY10 mainly as a result of additional premises costs relating to back payment of rent and service charges for the previous two years for the premises at St Pancras Hospital

Average monthly expenditure

- The average monthly expenditure has increased between the last two years to FY10 as shown in the chart below:



Sources: 1 FY09 audited accounts and FY10 management accounts

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Section 3

Historical cash flow and balance sheet

Cash flow overview

Summary cash flow

£'000	FY09 Audited	FY10 Unaudited
EBITDA	**(796)**	**(338)**
Working capital movement		
Stock	(5)	-
Debtors	107	(108)
Creditors	148	477
Operating cash flow	**(546)**	**31**
Interest income	24	0
Tax	(9)	-
Capital expenditure	(60)	(1)
Net cash flow	**(592)**	**30**
Opening cash balance	950	357
Closing cash balance	**357**	**387**

Sources: 1. FY10 draft management accounts; 2. FY09 audited accounts; 3. GT analysis

Basis of preparation

- The Company's audited and management accounts did not contain a cash flow statement
- The table opposite shows the cash flow summary of the Company derived based on information available from the accounts

Commentary

- The Company had a cash balance of over £350k as at the last two balance sheet dates

FY09

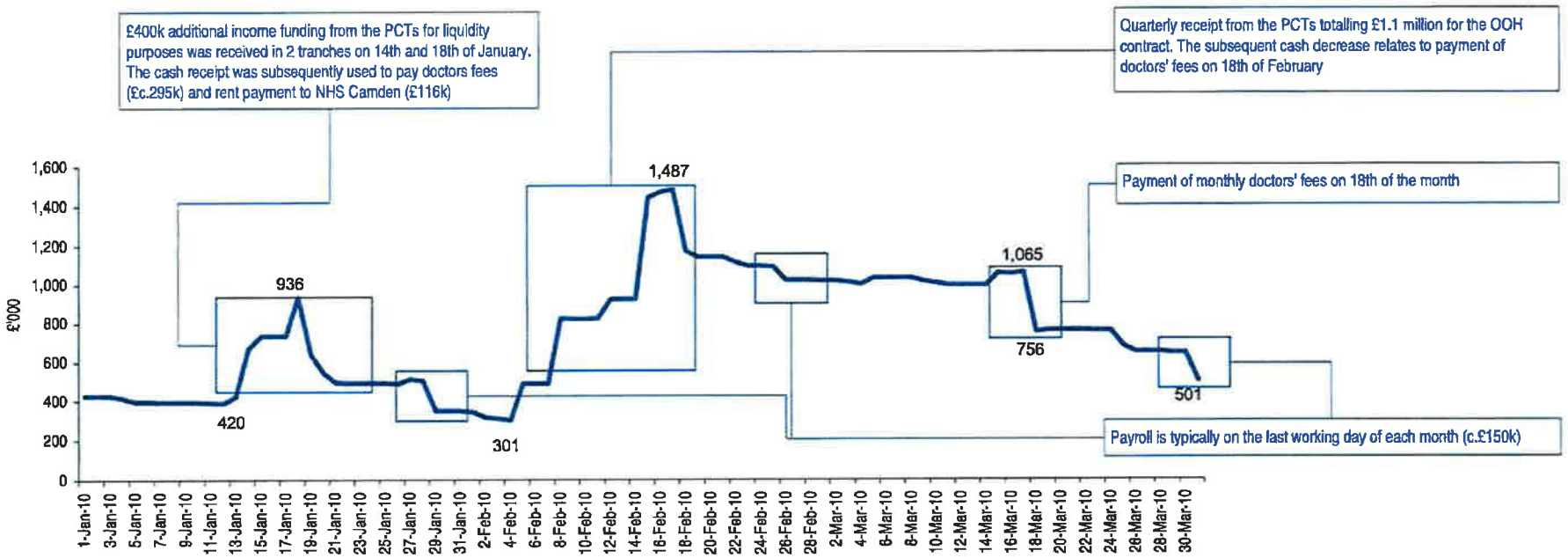
- The negative cash flow of £592k is mainly caused by the Company recording losses at the operating level (EBITDA)

FY10

- A marginal positive operating cash flow of £31k was recorded in spite of operating losses due to cash released from working capital
- This is largely due to the Company using the increase in doctor pension liability owed by the Company (c.£300k) as working capital in FY10
- Total doctors pension liability as at 31 March 2010 was £670k. This has still not been paid

Cash flow overview (continued)

Intra month cash analysis from January - March 2010



Note The chart above represents total cash balances in three bank accounts ; i.e. the main current account deposit account and CHIP bank account
Sources 1 Bank statements

Monthly cash flow forecast outturn to December 2010

Summary cash flow forecast from July to December 2010

£'000	Jul-10 Forecast	Aug-10 Forecast	Sep-10 Forecast	Oct-10 Forecast	Nov-10 Forecast	Dec-10 Forecast
Cash inflows						
OOH Contract - old contract	258	406	406	406	-	-
OOH Contract - new contract	-	-	-	451	451	451
CHIP	64	64	64	64	64	64
Practice Income	50	50	50	50	50	50
Other	14	14	14	14	14	14
Total receipts	**387**	**534**	**534**	**985**	**579**	**579**
Cash outflows						
Doctors Fees	(273)	(270)	(270)	(270)	(270)	(270)
Doctors' pension contribution	-	(120)	(120)	(120)	(120)	(120)
Salaries and wages	(286)	(140)	(140)	(140)	(140)	(140)
PAYE	(70)	(70)	(70)	(70)	(70)	(70)
Staff pension	(25)	(25)	(25)	(25)	(25)	(25)
Medical Supplies	(12)	(12)	(12)	(12)	(12)	(12)
Premises Rent & Service Charges	(5)	(23)	(18)	-	-	-
Telephone and travel costs (fuel)	(8)	(7)	(7)	(7)	(7)	(7)
IT equipment	-	-	-	(30)	-	-
IT Licenses	-	-	-	(8)	-	-
IT Support/Development	(24)	(25)	-	-	(25)	-
Staff training and welfare	(2)	(2)	(2)	(2)	(2)	(2)
Recruitment	(6)	-	-	-	-	-
Membership fees and subscriptions	(2)	(2)	(2)	(2)	(2)	(2)
Insurance	(3)	(3)	(3)	(3)	(3)	(3)
Office Supplies	(4)	(3)	(3)	(3)	(3)	(3)
Cars maintenance	(2)	(2)	(2)	(2)	(2)	(2)
Board Meetings	(1)	(1)	(1)	(1)	(1)	(1)
Legal/Professional/Accounting	(5)	(2)	-	(2)	(2)	(2)
Marketing materials and website	(3)	(1)	(1)	(1)	(1)	(1)
Total payments	**(729)**	**(707)**	**(675)**	**(697)**	**(684)**	**(659)**
Net cash flow	**(342)**	**(173)**	**(141)**	**288**	**(105)**	**(80)**
Opening cash balance	528	186	13	(128)	161	56
Closing cash balance	**186**	**13**	**(128)**	**161**	**56**	**(24)**

Commentary

- The table opposite summarises management forecast of monthly cash flow to 31 Dec 2010 from the actual cash balances as at 30 June 2010
- Management has not prepared a cash flow statement to bridge the balance sheet as at 30 June 2010 from the year end position at 31 March 2010. We are therefore unable to consider the impact of this to the monthly cash flow forecast provided opposite
- The cash flow forecast opposite is prepared by management based on the following assumptions:
  - that the existing old OOH contract is extended up to 30 Sept 2010. The new OOH contract is assumed to start on 1 Oct 2010
  - the Company had an opening cash position of £528k as at 1 July 2010
  - there are no material changes in the Company's trading performance and cash flow profile for the period from 31 March 2010 to 30 June 2010 including unwinding of working capital balances
  - forecast repayment of the existing pension liability for doctors by an amount of £60k per month from August 2010 onwards

It is assumed that the new OOH contract will commence from 1 October 2010. High cash inflow of £857k is made up of the following:
- £406k cash receipt relating to Sept 2010 billing under the old contract (monthly in advance)
- £451k cash receipt relating to October 2010 billing under the new contract (monthly in arrears)

Management has included in the cash flow forecast the impact of increase in doctor rates with effect from 1 July 2010

The Company expects to pay pension contribution for doctors in arrears. The payment of £120k in Aug 2010 comprises pension contribution for July 2010 of £60k and settlement of existing liability amounting to £60k per month. Monthly doctors pension is made up of 14% pension contribution by the Company and voluntary contribution by the doctors

The lowest cash headroom is expected at the end of August 2010 with lowest cash balance of £13k

Source CFF v Actuals July 10 onwards 050710 xls

Balance sheet overview

Summary balance sheet

£'000	31-Mar-09 Audited	31-Mar-10 Unaudited
Fixed assets		
Computer Equipment	51	30
Office Equipment	20	14
Total fixed assets	71	44
Current assets		
Stock	29	29
Trade debtors	680	679
Other debtors	7	119
Prepayments and accrued income	21	17
Cash at bank and in hand	357	387
Total current assets	1,094	1,232
Current liabilities		
Trade creditors	(305)	(392)
Doctors pension liability	(370)	(670)
Other taxes and social security costs	(43)	(99)
Other creditors	-	(10)
Accruals and deferred income	(37)	(60)
Corporation Tax	(5)	(5)
Total current liabilities	(760)	(1,237)
Net current assets/(liabilities)	**335**	**(5)**
Net assets	**405**	**39**
Capital & Reserves		
Share Capital	-	-
Retained profits - opening balance	1,218	405
Net loss for the year	(813)	(366)
Shareholders' funds	**405**	**39**
KPIs		
Trade debtor days	40.4	32.3
Trade creditor days	24.8	30.6

Sources: 1 FY10 draft manage rent accounts; 2 FY09 audited accounts

Overview

- The Company had a low level of reserves as at 31 March 2010 with retained profits of £39k which represents 11% of its current year loss
- As at 31 May 2010, the Company is technically insolvent as its total assets are less than total liabilities by £37k

Working capital

- As at 31 March 2010, a high proportion of trade debtors (53%) are owed more for than 3 months. Management has stated that long outstanding debtor balance is one of the factors which resulted in the Company not paying the doctor pension liability (further explained below)
- Other debtors as at 31 March 2010 includes £90k amount owed by Laurels Healthcare Limited which is the joint-partner of GP-led health centre in Haringey
- The Company has a high outstanding liability relating to doctors' pension contribution by Camidoc (i.e. 14% contribution on top of doctor fees) totalling £670k as at 31 March 2010 (31 March 2009: £370k). Management has advised that the outstanding pension liability did not include the voluntary pension contribution by doctors

Movement in reserves

Movement in reserves

£'000	31-Mar-05 Audited	31-Mar-06 Audited	31-Mar-07 Audited	31-Mar-08 Audited	31-Mar-09 Audited	31-Mar-10 Unaudited
Retained profits						
Opening balance	211	412	1,346	1,589	1,218	405
Net profit/(loss) for the year	201	1,142	242	(371)	(813)	(366)
Distribution to members	-	(207)	-	-	-	-
Closing balance	**412**	**1,346**	**1,589**	**1,218**	**405**	**39**

Sources: 1. FY10 draft management accounts 2. FY05-FY09 audited accounts

Commentary

- As at 31 March 2010 the Company has a low level of reserves with retained profits of £39k, equating to 11% of its FY10 net losses
- The erosion of reserves over the years since FY08 was due to losses made by the Company
- Camidoc had £412k retained profits as at 1 April 2005 when the current OOH contract commenced
- The Company made a £0.2 million distribution of reserve to its members in FY06 and managed to increase its retained profits to £1.6 million as at 31 March 2007
- No further distribution to its members was made subsequent to FY06

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Section 4

Projections for Year 1 to Year 3

Forecast P&L for Year 1 to Year 3

Forecast P&L for Year 1 to Year 3 under new OOH contract

£'000	Year 1 Forecast	Year 2 Forecast	Year 3 Forecast
		<——New OOH contract——>	
Income			
OOH contract	4,381	4,385	4,390
Incentive income	400	400	400
CHIP	768	768	768
Practice income	600	600	600
Other contracts	780	780	780
Total Income	**6,929**	**6,933**	**6,938**
Cost of sales			
Doctors' Fees	(3,177)	(3,177)	(3,177)
Medical Supplies	(132)	(135)	(137)
Others	(88)	(89)	(91)
Gross profit	**3,533**	**3,533**	**3,533**
Salaries and wages	(2,528)	(2,579)	(2,629)
Rent	(84)	(85)	(87)
Overheads	(566)	(573)	(579)
EBITDA	**355**	**296**	**238**
Depreciation	(24)	(32)	(39)
Net profit	**330**	**265**	**199**
KPIs			
Gross margin	51.0%	51.0%	50.9%
EBITDA margin	5.1%	4.3%	3.4%
Total activity (calls) ('000)	70.0	70.0	70.0
Doctors' fees as % of income	45.8%	45.8%	45.8%

Sources: 1. Financial Model

Based on assumed total activity volume of 70,000 per annum in each of the three-year forecast. The year-on-year increases are due to a marginal inflation of 0.1% per annum

Management has assumed a 2% pay increase year-on-year on payroll which largely result in erosion of EBITDA margin and net profit over the 3-year forecast

Overview

- The table opposite shows the Company's forecast P&L for the first to third year of operating under the new OOH contract based on the 3-year Financial Model used by Camidoc for the bid purposes
- Management has recently revisited certain assumptions made in the bid including activity volume, doctor rates and length of activity time (a productivity metric). We also understand that there are recent changes in other contracts e.g. increased income for District Nurse Messaging and cessation of John Howard contract. However, management has not yet updated these and consider their impact to other assumptions in the Financial Model

Commentary

- We have considered the assumptions within the financial model and stress tested to identify assumptions which are most sensitive to Camidoc profitability and cash flow. These assumptions are:
  - activity volume
  - incentive payment
  - doctor rates per hour
  - length of activity type (measured in minutes)
- Our summary findings are provided in tables that follows later part of this section

Forecast cash flow for Year 1 to Year 3

Forecast cash flow for Year 1 to Year 3 under new OOH contract

		<——New OOH contract——>	
£'000	Year 1 Forecast	Year 2 Forecast	Year 3 Forecast
Cash inflows			
OOH Contract	4,016	4,385	4,390
Incentive income	240	400	400
CHIP	768	768	768
Practice Income	505	600	600
Other	611	780	780
Total receipts	**6,140**	**6,933**	**6,938**
Cash outflows			
Doctors Fees	(2,938)	(3,177)	(3,177)
Salaries and wages	(1,837)	(1,871)	(1,905)
PAYE	(634)	(707)	(723)
Medical Supplies	(124)	(134)	(137)
Premises Rent & Service Charges	(84)	(85)	(87)
Telephone and travel costs (fuel)	(80)	(89)	(91)
IT equipment	(160)	(163)	(166)
IT Licenses	(40)	(41)	(42)
Staff training and welfare	(41)	(46)	(47)
Recruitment	(22)	(24)	(25)
Membership fees and subscriptions	(5)	(5)	(5)
Insurance	(46)	(50)	(50)
Office Supplies	(28)	(30)	(30)
Cars maintenance	(26)	(29)	(29)
Board Meetings	(28)	(30)	(30)
Marketing materials and website	(28)	(30)	(30)
Consultation event	(10)	(10)	(10)
Sundries	(41)	(45)	(45)
Contingency	(69)	(69)	(69)
Capital expenditure	(30)	(30)	(30)
Total payments	**(6,269)**	**(6,665)**	**(6,728)**
Net cash flow	**(129)**	**268**	**209**

Sources : 1 Management information 2 Financial model

Commentary

- The table opposite shows the Company's forecast cash flow for the first to third year of operating under the new OOH contract based on the 3-year financial model used by Camidoc
- The forecasts did not include consideration of opening balances (assets and liabilities) as the timing of the commencement of the OOH Contract was unknown. Hence the forecast represents cash flow generation from the new OOH Contract
- In Year 1, Camidoc expects to experience a cash shortfall of £129k due to the assumption of cash collection and payment
- The cash flow forecast opposite does not include payment for outstanding pensions liability

Key assumptions

Key assumptions - income

Area	Assumptions for Year 1	Previous year's track record	Extent of sensitivity	GT comment
OOH contract • Activity volume	• Total activity volume of 70,000 per the bid submission is made up of: – Phone: 29,000 (41%) – Clinic: 32,000 (46%) – Home visits: 9,000 (13%)	• Total activity in 2008 calendar year (the recent year with no impact of swine flu) was 88,880, made up of: – Phone: 39,405 (44%) – Clinic: 37,845 (43%) – Home visits: 11,629 (13%)	• A 10% increase in activity volume will: – increase net profit by £327k in Year 1, i.e. doubling from the base case – increase cash balance by £300k at the end of Year 1 • A 5% decrease in activity volume will: – decrease net profit by £117k in Year 1 – decrease cash balance by £107k at the end of Year 1	• The results suggest that activity volume is a highly sensitive assumption to profitability and cash • Lower activity volume is based on assumption that overall activity will reduce following initiatives around GP extended hours, walk-in-centres and GP led health centres • Management's assumed types of activity is based on historical trends. However, we note the assumed ratio of clinic (46%) is higher than actual in 2008
• Tariff	**Unit price per activity** Unit price (£) **Phone** Above 29,001 39.95 Between 27,001-29,000 36.99 Below 27,000 48.75 **Clinic** Above 25,001 71.28 Below 25,000 84.95 **Home Visits** Above 5,501 114.16 Below 5,500 133.48	• Based on Camidoc bid price	• Not applicable	• The unit price set by Camidoc reflects management assessment of the complexity and time taken for activity type

Key assumptions (continued)

Key assumptions - income (continued)

Area	Assumptions for Year 1	Previous year's track record	Extent of sensitivity	GT comment
OOH contract • Incentive payment	• £400,000 income per annum	• There were no incentive payment under the existing OOH Contract	• Removal of incentive payment will: – take Camidoc into loss position by reducing net profit by £396k in Year 1 – reduce cash balance by £236k at the end of Year 1	• The assumed incentive payment is highly sensitive and critical to Camidoc profitability and cash • Camidoc should assess the likelihood of meeting the criteria for incentive payment and consider taking mitigating actions in the event of non-compliance • In addition, we understand from management that there is a risk of penalty of up to £200k per annum being imposed by the PCTs in the event Camidoc fails to meet the performance targets in accordance with the current terms for the new OOH Contract
Other contracts • CHIP	• £64,000 per month, equating to £768,000 per annum	• In line with FY10 turnover	• A 10% decrease in income is expected to result in a marginal impact to profitability and cash	
• Practice income	• £50,000 per month, equating to £600,000 per annum	• In line with FY10 turnover	• A 10% decrease in income is expected to result in a marginal impact to profitability and cash	
• Other income	• £65,000 per month, equating to £780,000 per annum	• In line with FY10 turnover	• A 10% decrease in income is expected to result in a marginal impact to profitability and cash	

Key assumptions (continued)

Key assumptions - cost of sales

Area	Assumptions for Year 1	Previous year's track record	Extent of sensitivity	GT comment
Doctors' fees • Doctor rates per hour	Weekdays • 1900 hours to midnight: £62.70 • midnight to 0800 hours: £79.80 Weekends • 0700 hours to midnight: £68.40 • midnight to 0700 hours: £79.80	• The assumed rates are in line with the doctor rates applicable in May -June 2010 (before the recent increase from 1 July 2010) • The rates are inclusive of 14% pension contribution by Camidoc	• A 5% increase in doctor rates will: – reduce £100k net profit in Year 1 or 30% – reduce cash by £92k at the end of Year 1	• The results suggest that doctor rates are highly sensitive to profitability and cash • Management should model any future changes in doctor rates and assess the implication to the Company's profitability and liquidity position
• Length of activity type (measured in minutes)	• Phone: 10 minutes per call • Clinic: 25 minutes per clinic visit (including 10 minutes call) • Home visits: 60 minutes per home visit (including 10 minutes call)	• The assumed 10 minutes per call suggest the Company is assuming 6 calls per hour • Based on activity data for 2009 and the benchmarking study by the Primary Care Foundation, the Company was operating at an average of 2 calls per hour • Management considers the benchmarking data not to be a like-for-like comparator as it includes time taken by doctors undertaking face-to-face consultations and home visits	• A 5 minutes increase in time per activity will: – take Camidoc into loss position by reducing net profit by £429k in Year 1 – reduce cash by £394k at the end of Year 1	• The results suggest that time per activity is highly sensitive and critical to Camidoc profitability and cash position • Management should undertake detailed assessment of its productivity to identify areas where productivity can be improved • Productivity indicators should be regularly monitored and reported together with action plans to address any adverse variance

Key assumptions (continued)

Key assumptions - expenditure

Area	Assumptions for Year 1	Previous year's track record	Extent of sensitivity	GT comment
Expenditure • Salaries and wages	• £211k per month, equating to £2.5 million per annum	• £221k per month in FY10	• A 5% increase in payroll will: – reduce net profit by £126k in Year 1 – reduce cash by £124k in Year 1	• Pay costs are largely fixed in nature and any incremental cost will broadly result in an equivalent reduction in profit and cash • Management has stated that the current operational workforce (nurses, call handlers) is to remain broadly static due to previous investment made on human resources
• Other overheads	• £56k per month, equating to £674k per annum	• £62k per month in FY10	• A 5% increase in overheads is expected to result in a marginal impact to profitability and cash	• Overheads are largely fixed in nature and any incremental cost will broadly result in an equivalent reduction in profit and cash

Key assumptions (continued)

Key assumptions - cash flow

Area	Assumptions for Year 1	Previous year's track record	Extent of sensitivity	GT comment
Collection • OOH Contract	• Monthly billings in arrears with collection within 30 days upon invoice	• In line with the current OOH contract		• The assumption appears in line with current contract terms
Payment • Doctor fees	• Monthly payment in the following 1 month	• In line with FY10		• The assumption appears in line with current cash pattern
• Salaries and wages	• In the current month	• In line with FY10		• The assumption appears in line with current cash pattern

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Section 5

Financial control environment

Governance Structure

Financial Control Environment

Area of focus	Exception commentary
Comment on the procedures adopted by the Board to ensure the effective management and control of the business • The Company has an informal Board of Directors which includes executive and non-executive directors. Only 1 Executive Director is the statutory director of Camidoc based on records obtained from Companies House • The split of directors is roughly equal between clinicians and non-clinicians. The Company's articles determine that there must be a majority of clinicians on the Board. This majority is currently one • The Board is supported by sub-committees: – Finance and Corporate Governance – Clinical Governance – Information Management and Technology • Each sub-committee is chaired by a non-executive director who is a non-clinician • There are a sub-set of working groups that support the Board including: – Clinical audit – Service quality and improvement – Medicines management – Community and public engagement	• During FY10 the Board of Directors met on a quarterly basis. We understand that meeting frequency was the same in prior years • The Company plans to hold meetings of the Board every other month in FY11. In the months where a Board meeting is not due to be held, the Company plans to issue Directors with finance and performance information for service and comment • Sub-committees to the Board have been used to deal with specific risks facing the Company. In response to a critical SUI report in 2007, the Company used a Clinical Governance committee to address improvement points arising from this report. To address non-clinical governance concerns the Finance and Corporate Governance committee has been meeting monthly. These concerns arose from a deterioration in the cash position of the Company in 2008 • The Company has a service improvement plan drafted to deliver change. Actions to be taken to improve Board processes have been noted as: – Review information currently presented to the Board and its committees – Define roles for every Board member • Management has commented that information presented to the Board has often been late and not necessarily presented in a format that is user-friendly. Aligned with meetings being held infrequently in the past, this would suggest that there was a high risk that Board actions to address concerns would be reactive and not timely • Some Board members have clearly defined responsibilities already. For example, Mariette Davies has an oversight for improving the control environment and finances although she is not a statutory director of Camidoc according to records from Companies House. Responsibilities should be clearly defined for all Board members. The Company recognises this and have committed to complete this action in the Service Improvement Plan by August 2010

Management team

Financial Control Environment

Area of focus	Exception commentary
Comment on the Board composition • The split of directors is roughly equal between clinical and non-clinical staff • There is currently no substantive CEO appointment. It is hoped that this post is filled by January 2011. Currently one of the non-executive directors is filling this post on a part time basis • Board members have experience of the NHS both within the local economy and with other NHS organisations	• The current Board appears to be highly experienced within the NHS. This includes Board members with non-executive roles within other NHS organisations, including at a large London acute provider trust and a local primary care trust • The Board has good local health economy connections, including with local GPs and commissioners • Over time the Company has recruited non-executive directors to fill skill gaps within the organisation. In response to criticism in a SUI report issued in 2007 the Company recruited three non-executive non-clinical directors. This was to increase the corporate governance skill set of the Board of Directors to improve the governance arrangements of the Company. Historically, the Company has been clinically able at the Board level due to the strong doctor representation on the Board • During 2009 the Board first recognised that there may be a potential problem with cash flow. This could have led to the Company trading whilst insolvent. As a result of this, the Board established that there were weaknesses in financial controls (evidenced through late and inadequate reporting of financial information to the Board). An additional Board member with finance and audit experience was recruited with remit to improve the financial control environment of the Company • The Board has recognised that they were over dependent on the previous CEO. This has led to the senior management team being under utilised. Also, the potential of the clinical workforce to play a role in wider service improvements has yet to be fully realised • There is no current substantive CEO appointment. It is hoped that a CEO will be appointed on a permanent basis by January 2011. Currently one of the non-executive directors is filling this post on a part time basis. It is important that the Company considers the skill set of the CEO when making the appointment, especially with the changes expected within the NHS in the next 12-24 months • Also it has been recognised that a substantive operational director may be needed. However, there are currently no plans in place to recruit such a person
Comment on whether the Finance Department is fit for purpose • The Company has a small finance team of two people • A new Finance Manager was recently recruited who is working part-time on 3 days a week	• The Company has a small finance team of two people. Both of these have been recruited in June 2010 • This represents an increase in numbers of the finance team. Furthermore, both recruitments have experience of using the Sage accounting system. The Company migrated to Sage in November 2009 • Neither member of the finance team is an exam qualified accountant. However, there is a qualified accountant within the non-executive directors • The Company should consider whether the finance team has the capacity and capability to deliver timely finance information to the Board in a format that the Board can use to understand the financial position of the Company

Reporting to the Board

Financial Control Environment

Area of focus	Exception commentary
Comment on quality of reporting to the Board • The Company has recognised that improvements can be made in financial reporting. We have commented on this on the next page • Clinical governance and performance reporting has been the focus on the Company, more so since a critical SUI report in 2007 • Since this report the Company has improved clinical outcomes and is recognised as a high quality OOH provider • However, benchmarking reports suggest that the Company does not compare well with other OOH providers when reviewing productivity metrics	• Board reporting packs are made on clinical performance and governance to the Clinical Governance committee and to the Board. These would cover quality and performance against standards and targets. A report is made to each committee meeting and the Board consider that the Company's clinical performance is effective. These reports were first made to the Board in 2008 • The Company has arrangements in place to review the productivity of individual doctors, for example through reviewing calls made on shift or patients seen in a shift. These reviews will be conducted on a sample basis • The outcomes of these reviews will be reported to the Clinical Governance committee and action taken against individual doctors if they do not achieve desired productivity levels. However, this process does not appear to be integrated to give a Company-wide view on productivity • Reports have not been made to the Board on productivity, apart from a recent benchmarking report which showed that the Company performed poorly against other OOH providers when using productivity metrics. Performance reports to the Board should build on the reported concerns and integrate finance, productivity and clinical performance • We note that in FY09 the Company saw activity levels increase significantly due to swine flu. The Company was able to quantify increased costs as a result of swine flu following additional doctor shifts and resources to meet additional activity demand. This enabled the Company to seek additional funding for this activity from the PCTs

Financial reporting

Financial Control Environment

Area of focus	Exception commentary
Comment on the financial reporting arrangements of the Company • Historically, financial reporting has not been timely or presented in a clear way • Actions have been developed to improve financial reporting, such as migration of financial data onto the Sage system and having more frequent Board meetings • The finance capacity and capability has recently been improved, which gives some assurance that further improvements in the financial reporting arrangements can be made	• The Company employs external accountants to produce year end accounts. Prior to the Company migrating to the Sage accounting system the external accountants helped produce management accounts • Although management accounts were produced, the Board were not satisfied with the financial reports received by the Board. Criticisms included: – Timeliness of finance reports. Often they were tabled at Board meetings rather than in advance of the meeting. Late tabling of finance reports would make it difficult for effective Board challenge and decision making on the Company's financial position – Clarity of finance reports. Finance reports were often presented in a format convenient for the preparer, rather than giving the Board the information in a format they needed – Style of reporting. Cost centre reporting is only just being established in the Company. The Board do not have the information on the profitability of services or contracts. Therefore decisions on which services to provide are made on intuition rather than on evidence • We understand that Sage has capacity for cost centre reporting. This will require costs and income to be accurately recorded within the Sage system so that the Board can more accurately report and manage on a contract by contract basis. For Board reporting to be timely, accounts will need to be closed down soon after each month end. Historically, month end accounts have not been closed down in a timely way • FY11 will be the first full year that accounts will be prepared on the Sage system • Historically, the Board has not had financial information sufficient to make operational decisions. Decisions on operations (e.g. cutting doctors fees, closing services at the Royal Free) have been made intuitively, rather than on evidence. Introducing cost centre accounting and service line reporting will provide the finance department with the information to make decisions based on service level performance • Again, an investment in senior operational management will be key to driving productivity and profitability going forward

Audit arrangements

Financial Control Environment

Area of focus	Exception commentary
Comment on audit arrangements • No internal audit function as expected for a small Company • External limited assurance audit until FY09 due to small size • No adverse comments on the control environment • "Except for" audit opinion on accounts due to going concern	• Prior to FY09 the Company was subject to a limited assurance audit regime. This was due to turnover being below the threshold for a full audit • This changed in FY09 due to the increase in turnover above the audit threshold • Despite this the external auditors have not provided the Company with a written Report to those Charged with Governance. This is not unusual for an audit of a Company of this size • Discussions with management has established that an "except for" opinion was issued on the FY09 accounts. The "except for" was in respect of going concern due to the OOH contract not being renewed, but rather extended for a short period • External audit of FY10 accounts expected to take place in July 2010 • The external auditors did not comment adversely on the control environment of the Company • There is no internal audit function due to the size of the Company

Grant Thornton

Appendices

A. Letter of engagement
B. Principal sources of information
C. Monthly cash flow forecast from July 2010 to December 2010
D. Factual accuracy confirmation letter

A. Letter of engagement

Grant Thornton

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For the attention of Peter Buckman

24 June 2010

Dear Sirs

Independent Business Review of Camidoc Limited, the Out of Hours Provider Service for NHS Camden

1 Introduction

1.1 Further to Liz Clark's email on 22 June 2010, we are writing to confirm our understanding of the work Grant Thornton UK LLP will undertake in relation to the Independent Business Review ("IBR") of Camidoc Limited, the Out of Hours Provider Service ("the Company"), for NHS Camden ("the PCT").

1.2 This letter, together with the attached Appendix A of our standard terms and conditions sets out the basis on which Grant Thornton UK LLP will provide the services set out below to you. It also summarises the respective areas of responsibility of your directors and of ourselves.

2 Scope of work

2.1 We will prepare a report to provide an IBR of the Company that cover the scope of work set out in Appendix B.

2.2 Our work may be based on internal management and external information. Where this is the case an audit examination of the management and external information and accounts is not required. The PCT confirms that we shall have unrestricted access to the books and records of the Company and the full co-operation of its directors and senior management, who will keep us informed of any matters that they consider are relevant to our work.

2.3 The scope of our work will be limited both in terms of the areas of the business and operations which we review and the extent to which we review them.

2.4 Our report will be in powerpoint format and addressed to the PCT.

2.5 During the course of the engagement we may show drafts of our report to you. This is done on the basis that they are subject to revision and alteration and no reliance should be placed on any draft document without our prior written consent. A document remains 'draft' for these purposes until it has been manually signed by a Grant Thornton UK LLP partner.

2.6 Draft copies of our report will be provided to the directors of the Company to confirm the factual accuracy of the information contained therein.

2.7 We will require a written representation from the directors of the Company to confirm the factual accuracy of the information contained in our report.

2.8 During the period of this assignment we shall not be required to undertake any responsibility for directing or making decisions about the PCT's affairs, sole responsibility for which remains with the management of the PCT. Any decisions made as a result of our work will be the sole responsibility of the directors of the PCT.

3 Tax advice

3.1 For the avoidance of doubt the scope of our work does not include the provision of any tax advice. Should you require additional tax advice then this will be the subject of a separate letter of engagement. Additional tax advice work may be subject to amended terms.

4 Fees

4.1 In accordance with normal professional practice, our fees are based upon the degree of responsibility and skill involved and the time necessarily occupied on the work. Our total fees will be fixed at £36,630 and are based on our assessment of the actual time we will need to spend on the engagement and a 10% discount as set out below:

Breakdown of fee	Cost per day	No. of days	Total (£)
Partner	2,800	1.5	4,200
Manager	1,900	10.0	19,000
Executive	1,750	10.0	17,500
Subtotal		21.5	40,700
10% discount			(4,070)
TOTAL			36,630

4.2 VAT and out of pocket expenses will be added to these fees at standard rates.

4.3 In the event that the engagement is terminated for any reason, other than completion, you agree to pay us an abort fee. The abort fee will be calculated as our actual time incurred at the discounted rates set out above up to the point at which the engagement is terminated.

Assumptions

4.4 Our fees are based on the following assumptions:

- we will have disclosed to us all relevant accounting records and related information, and the information we require will be reliable and will be provided to us without undue delay;
- we will receive full co-operation from all relevant personnel at the Company and the PCT, and their other professional advisers;
- there is no delay in the date we agree with you to commence our fieldwork;

- there are no periods during the engagement where it is necessary for all or part of our team to stop their work due to information unavailability or inaccuracy (in such circumstances we will discuss this with you in advance of suspending our work).

4.5 If these assumptions are not met, we reserve the right to charge an additional fee for any extra work involved in carrying out the engagement or to compensate us for our staff being inefficiently utilised. Additional fees will be charged at the discounted rates set out above. We will endeavour to mitigate the cost to you arising from delays in the commencement of our fieldwork/temporary suspension of our work by reassigning staff to alternative engagements if we consider this to be a reasonable course of action, unless you request us not to.

5 Payment of fees

5.1 Our fees are payable on presentation of our invoice and this will be issued once you have received our final report, or on termination of the engagement.

5.2 We reserve the right to add an interest charge at a rate of 1% per month simple interest on any bills that remain unpaid 10 days after presentation.

5.3 Our invoice will be addressed and sent to the PCT. The invoice will be payable direct to Grant Thornton UK LLP's account, details of which are as follows:

Barclays Bank plc
Sort code: 20-11-39
Account no: 00811297
Account name: Grant Thornton UK LLP

6 Timetable

6.1 In accordance with your timetable, we expect to commence our work on 24 June 2010.

6.2 Assuming that information is available on a timely basis, we will prepare a draft report for your consideration on or before 9 July 2010 in advance of your reporting deadline of 23 July 2010.

7 Other matters

7.1 This engagement will terminate, unless previously terminated or mutually extended by agreement, on completion of the engagement. We reserve the right at any time and without any liability or continuing obligation to you to terminate this engagement if:

- you are in material breach of any of the terms of this engagement;
- you fail to accept our advice on a material regulatory or professional matter concerning the engagement; or,
- we are not satisfied that we can proceed with the engagement without being in default of applicable laws and/or ethical guidelines.

7.2 In any circumstances where this engagement is terminated (including those set out in paragraph 7.1 above), save on completion of the engagement, any short fees as set out in paragraph 4.3 of this engagement letter and all fees and expenses incurred by and due to us or to which we may be committed in connection with this engagement to the date of termination will be payable by you immediately after termination of the engagement.

7.3 The expiry or termination of this engagement will not affect the respective rights and obligations of the parties which may have already accrued to, or been incurred by, any one of us prior to such date (including in particular our rights to remuneration) nor any representations, confirmations or indemnities given by you herein, including the provisions of sections 4 and 5 which will continue in full force and effect notwithstanding such termination.

7.4 Any amendment or modification to the terms herein shall be agreed in writing and signed by the PCT and Grant Thornton UK LLP.

8 Limitation of liability

8.1 Our liability in connection with this engagement shall be limited, on the basis set out in the additional terms and conditions of engagement in Appendix A, to a maximum aggregate amount of £2,000,000 and, subject to that cap, to the part of any loss suffered which is proportional to our responsibility.

9 Conflicts of interest and independence

9.1 The rules governing our profession restrict the extent to which we can deal with companies in certain circumstances if they or any of their directors have been our clients at any time during the previous three years. There are also restrictions if there is any other relationship between us that could prejudice our objectivity or could be seen to do so.

9.2 It should be noted that Grant Thornton UK LLP was engaged by the PCT to undertake work on information provided by two candidate organisations for the Out of Hours Service and to provide high level commentary on their financial health and risks to the PCT in contracting with these organisations. That assignment was subject to a separate engagement letter dated 6 October 2009 and we reported to you on 12 October 2009.

9.3 Save for those set out in paragraph 9.2 above, our internal enquiries indicate that neither the PCT nor any of its directors have been our client or a client of RSM Robson Rhodes LLP within the last three years. We have not identified any other relationship that could prejudice the objectivity of Grant Thornton UK LLP or be seen to do so in undertaking the assignment to which this letter of engagement relates.

9.4 By agreeing to the terms of this letter you confirm your understanding of the roles Grant Thornton UK LLP is undertaking and you consider that there are neither any conflicts of interest nor any independence issues in relation to these roles. Should a conflict of interest or an independence issue arise then this shall be promptly disclosed to the other party and

appropriate safeguards discussed If it is not possible to put appropriate safeguards in place, either party may terminate this engagement

10 Additional terms and conditions of engagement

10.1 Our report is confidential and will be prepared exclusively for the PCT with a copy to the directors It should not be used, reproduced or circulated in whole or in part for any purpose without our written consent Such consent will only be given after full consideration of the circumstances at the time

10.2 The additional terms and conditions included in Appendix A to this letter apply to this engagement as if they were set out in this letter. They should be read and understood in conjunction with this letter as they form an important and integral part of the overall terms of engagement.

11 Acceptance of terms

11.1 Once agreed, this agreement/contract with you sets out the entire terms agreed between the parties relating to this engagement/contract and supersedes all previous representations, warranties and terms (whether in writing or not) previously made between the parties Any amendments, additions or alterations to this agreement shall not be effective unless in writing and signed by a duly authorised representative of each party.

11.2 We should be grateful if you would confirm our understanding of your instructions and your agreement to the terms of this letter, including those contained in Appendices A and B by signing and returning the enclosed copy of this letter

Yours faithfully

GRANT THORNTON UK LLP

Terms of engagement acknowledged and agreed by:

Signed *Peter Beaumont* ...... Date *12/July/10* ......

On behalf of NHS Camden, Camden Primary Care Trust (PCT)

These additional terms and conditions of engagement should be read together with the accompanying letter from Grant Thornton UK LLP which identifies the engagement to which they relate (the 'engagement letter').

1 LIMITED LIABILITY PARTNERSHIP

1.1 Grant Thornton UK LLP [illegible] responsibility

2 VERIFICATION

2.1 [illegible] engagement.

2.2 Our review of the affairs of the Company will not constitute an audit in accordance with Auditing Standards and no verification work will be carried out by us. Consequently we will not express an opinion on the financial statements and management accounts which we discuss in our reports

2.3 [illegible]

3 LIMITATION OF LIABILITY

3.1 The aggregate liability of this firm, its partners, agents and employees or any of them (together referred to in this and subsequent clauses as the 'Firm') for the Total Damage will be limited to the amount of [illegible] as set out in our engagement letter to which these additional terms and conditions of engagement are appended.

3.2 For the purposes of this engagement letter 'the Total Damage' shall mean the aggregate of all losses or damages [illegible]

3.3 Where there is more than one Addressee the limit of liability specified in paragraph [illegible]

PROPORTIONALITY

3.4 In respect of all services, the liability of Grant Thornton UK LLP [illegible] Civil Liability (Contribution) Act 1978.

CLAIMS

3.5 You agree not to bring any claim in respect of loss or damage suffered by you out of or in connection with the services [illegible] Third Parties) Act 1999

SCOPE OF LIMITATION OF LIABILITY

3.6 The limitation of liability referred to in paragraph 3.1 of this appendix refers to all assignments undertaken by us that are covered by this engagement letter. Our maximum liability for all assignments undertaken by us in relation to this engagement letter is [illegible] as determined by section F of it.

4 OWNERSHIP OF BOOKS AND PAPERS

4.1 All documents in whatever form, paper, electronic or otherwise such as (for example, but without being an exhaustive list) working papers, letters (including without limitation e-mails), memoranda, file notes of meetings and telephone calls, draft computations and returns etc and copies of other original documents which we create or which we receive either as principal or in our own right or as agent for you belong to Grant Thornton UK LLP. For the avoidance of doubt, we do not assert such ownership rights to documents such as, for example, title documents, original invoices and other original primary accounting records, tax deduction certificates etc belonging to you, but we may retain possession of them by exercising a lien because our fees remain outstanding after becoming due for payment.

5 RESPONSIBILITY FOR LEGAL DOCUMENTS

5.1 For the avoidance of doubt, although you may wish us to comment on the commercial aspects of legal documents that may be drawn up by lawyers in connection with the engagement, we will not be involved in their drafting and/or preparation as we believe that is within the realm of the professional business of lawyers. Further, whilst every care will be taken in the advice we give in relation to any information contained in such documents, such advice and/or comment should not be taken as verifying the documents, which will have been drafted by your lawyers. Accordingly, we cannot accept any liability or responsibility for any loss or damage suffered as a result of any defects in such documents arising from their drafting, preparation, completion or the mechanics of putting them into effect.

6 STAFF

6.1 Our staff are assigned to you on the mutual understanding that neither party will offer employment to, nor employ, the staff of the other who have been involved during our engagement, or dealing with you, within twelve months unless written consent has been obtained from either party. If such consent is given either party reserves the right to bill an appropriate fee of 20% of the initial salary on appointment plus VAT.

7 CLIENT FUNDS

7.1 Whilst you may not have asked us to do so, from time to time some clients request us to hold monies on their behalf and the following paragraphs provide information on the current basis of these arrangements if you choose to ask us to hold such monies at some time in the future and we agree to do so.

7.2 i) Agreement for payment of interest

The Clients' Money Regulations of the Institute of Chartered Accountants in England and Wales require us to write to you to confirm [illegible]

All client monies held on the PCT's behalf which are in excess of £10,000 and are unlikely to be reduced below that amount within three days of receipt, will be placed in an interest bearing designated deposit account in the PCT's name. All client monies held on the PCT's behalf, other than amounts stated above, will be held in trust for the PCT in our general clients' bank account for which no interest will be accountable to the PCT. However, such monies may be transferred to a designated deposit account where it is considered appropriate, or as a result of specific instructions to that effect being received from the PCT. All interest received on designated deposit accounts will be credited thereto and will be accounted for as belonging to the PCT.

ii) Operation of bank accounts holding client funds

As a matter of best practice and internal control no single partner or member of staff is permitted by the rules of Grant Thornton UK LLP to be a sole signatory on a client's bank, building society or similar account other than for sums of £5,000 or less in respect of each transaction. No partner or member of staff at Grant Thornton UK LLP, whether singly or jointly, is permitted to receive in his/her/their own name monies due and payable to or from a client.

8 OUR SERVICE

8.1 If at any time you would like to discuss with us how our service to you could be improved, or if you are dissatisfied with the service you are receiving, please let us know by contacting Roy Welsby at our London office. We undertake to look into any complaint carefully and promptly and to do all we can to explain the position to you. If we have given you a less than satisfactory

service, we undertake to do everything reasonable to put it right and, if you are still not satisfied, you may of course take up matters with the Institute of Chartered Accountants in England and Wales.

9 GOVERNING LAW

9.1 This engagement letter shall be governed by and construed in accordance with UK and European Law and you hereby agree with us to submit for all purposes in connection with this engagement to the exclusive jurisdiction of the UK Courts.

10 CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

10.1 In the course of our work for you under this contract/engagement we may obtain advice and/or other services from one or more member firms of Grant Thornton International. You and we agree that in that event, the terms of the contract/engagement will apply for the benefit of each member firm of Grant Thornton International with respect to any work that they carry out in respect of or in relation to this contract/engagement. Other than in relation to the advice and/or services provided by the said member firm(s) of Grant Thornton International, and except for the benefit of partners and employees of Grant Thornton UK LLP as set out below it is hereby agreed between us that the Contracts (Rights of Third Parties) Act 1999 does not apply to the terms of this contract/engagement or any subsequent amendment to it unless expressly confirmed in writing that the said Act does apply.

10.2 Except to the extent that our partners and employees can benefit from the provision "Claims" herein, it is hereby agreed between us that the Contracts (Rights of Third Parties) Act 1999 does not apply to the terms of this engagement or any subsequent amendment to it unless expressly confirmed in writing that the said Act does apply.

11 FORCE MAJEURE CLAUSE

11.1 No party to this agreement shall be liable in any way responsible for any failure to fulfil its obligations under this Agreement if such failure has been caused (directly or indirectly) by circumstances beyond the control of the defaulting party. This shall include war, riot, acts of terrorism, industrial action, accident or equipment failure (except where such accident or equipment failure has been caused by the negligence of the defaulting party, its employees, sub-licensees, subcontractors, agents or otherwise).

12 CIRCULAR TRANSACTIONS AND INPUT TAX AT RISK

12.1 For the avoidance of doubt, unless specifically indicated in the agreed Scope of Work, the work that we will undertake under this engagement is not intended to consider or identify any possible VAT liability arising from 'Carousel Fraud' (where goods are repeatedly traded within a group of companies without being sold to an end user), or from the provisions of Section 77A of the VAT Act 1994 whereby businesses in a supply chain may be held jointly and severally liable for the VAT debts of any other party involved at any stage in the supply of the goods specified in that section.

13 INTERNATIONAL STATUS

13.1 For the avoidance of doubt please be aware that Grant Thornton International is not an international/global/worldwide partnership or limited liability partnership either in relation to all of the members collectively or any two or more members together. In particular, Grant Thornton UK LLP does not carry on business in the United States of America or Canada and is a separately owned and managed business from entities known as Grant Thornton LLP carrying on business in those territories.

14 TERMINATION CLAUSE

14.1 In the event of non-payment of any bill rendered by us in accordance with our terms for payment, we reserve the right to unilaterally suspend or terminate our engagement/contract with you and the services provided under it. Any such suspension or termination of our engagement/contract with you will be communicated to you in writing and sent by post or by facsimile transmission or e-mail.

14.2 Such Notice shall be deemed to be delivered to you two days after posting. If the Notice is sent to you by facsimile transmission or e-mail it shall be deemed delivered to you at the date and time of transmission or sending. Following any such suspension or termination our contractual or tortious duty of care to you will cease for any future actions or advice required under our engagement/contract with you. You will remain liable for all fees and disbursements and VAT arising together with interest chargeable thereon.

15 DISPUTES AND MEDIATION

15.1 In the unlikely event of a dispute arising out of or relating to this contract/engagement it is mutually agreed that before embarking on litigation proceedings we will attempt to resolve it through negotiation between senior executives of our respective organisations, who have authority to settle the same. If the matter is not resolved through negotiation, we shall endeavour to agree upon the nomination and appointment of an independent Mediator upon receipt of a written notice, by

[illegible]

DATA PROTECTION ACT

[illegible]

[illegible]

[illegible]

[illegible]

Scope of Work

We set out below the scope of work and the headline content of our report.

1 Executive Summary

1.1 We will provide a summary of key issues arising from the course of our work, most particularly

- historical trading results for the year ended 31 March 2010 and year to date performance in the current financial year ending 31 March 2011
- key drivers of the financial projections for the years ending 31 March 2013 and consideration of key risks to the delivery of these projections
- funding requirements based on these projections and sensitivity analysis

2 Historical trading results for the year ended 31 March 2010

2.1 High level comment on the historical trading performance of the financial year ended 31 March 2010, commenting on material variances to budget and specific commentary on the most significant client accounts

2.2 We will consider the quality of earnings to analyse the underlying EBITDA and cash generation for the year to 31 March 2010.

2.3 Comment on key drivers and contributing factors for any material variances in EBITDA and cash generation against budget for the financial year ended 31 March 2010 and year to date performance in the financial year ending 31 March 2011

2.4 Comment on key drivers and contributing factors to any under-performance, highlighting between externally driven factors (i.e. market factors, etc) versus internal (i.e. Company specific factors). Specifically:

- GP cost/hour
- GP availability rates
- other KPIs as determined by the Company.

2.5 Comment on actions taken by management to deal with any under-performance, including timing and depth of measures taken.

3 Current outturn for the year ending 31 March 2011 and two-year projections for the years ending 31 March 2012 and 2013 (the projections)

3.1 We will review the Company's projections and report by exception on the following:

- correct compilation on the basis of the stated assumptions
- consistency with the accounting policies normally adopted by the Company, as amended by known future changes in accounting standards.

3.2 We will analyse the projections for each of the years ending 31 March 2013 (profit and loss, balance sheet and cash flow, including working capital) by commenting on key underpinning assumptions. We will analyse and comment on the following:

- turnover revenue and margin for significant clients
- new revenue streams and assumed new wins of key clients, and associated implementation costs
- seasonality
- analytical review of overheads, corporate costs, capital expenditure and exceptional costs
- cost saving initiatives (both implemented and any further planned)
- conversion of EBITDA to cash, to the context of the cash profile of new contracts
- commentary on the working capital requirement of these contracts

3.3 Comment on the annual budget of EBITDA and cash from 31 March 2010 to 31 March 2013

3.4 For the avoidance of doubt we will not review the calculations or assumptions in respect of any taxation numbers included in the projections.

4 Cash flow and liquidity

4.1 We will consider vulnerabilities and upsides to the projections, and comment on the sensitivity of the projections to changes in underlying assumptions and estimates. We will test any sensitised forecasts for correct compilation and comment thereon

4.2 We will analyse the estimated impact of loss of a key client, including the viability of other services if a contract was to be lost

4.3 We will consider mitigating actions available to management in the event of underperformance, to achieve projections and the cost and timing for implementation.

4.4 We will analyse the monthly cash position and liquidity in the financial year ended 31 March 2010, including nine-month positions. We will consider the Company's funding requirements and required bank facilities based on the projections and sensitivity analysis thereon

4.5 We will comment on further funding requirement that could be needed, in the event of vulnerabilities to the projections

4.6 We will analyse the movement in reserves including distributions in the financial year ended 31 March 2010

5 Financial control environment

5.1 High level comment based on discussions with management of the Company on the current financial controls in place. We will summarise and comment on areas of concern around financial controls

5.2 We will consider areas for improvement in the current financial control environment solely based on the high level discussions

5.3 We will report instances of any recent audit qualifications. We will report on audit management letters issued by the Company's auditors in the last 12 months by summarising the key points included and steps that management have taken to address the issues

6 Strategy

6.1 Based on our discussions with the Company's management and our work on the projections as set out above, we will provide a high level commentary on management's strategy to meet the Company's budget for the 3 years ending 31 March 2013.

7 Other

7.1 Based solely on our interaction with the management team during the course of our work, we will provide observations, if relevant, on key strengths and perceived weaknesses of the management team of the Company. We will comment in our report on areas where additional resource or expertise may be required, if relevant.

7.2 We will summarise the current legal and ownership structure of the Company (for the avoidance of doubt legal due diligence may be required in this area).

B. Principal sources of information

In conducting our work we held discussions and/or exchanged correspondence with the following individuals:

Camidoc Limited

Leadership team

- James Hood, Interim Chief Executive
- Dr Mayur Gor, Executive Director
- Mary Elford, Chair
- Mariette Davies, Finance and Corporate Governance Committee
- Michael Golding, former Chief Executive

Management team

- Stephen Grant, part time finance manager

NHS Camden

- Mike Gill, Project Manager

Ineum Consulting

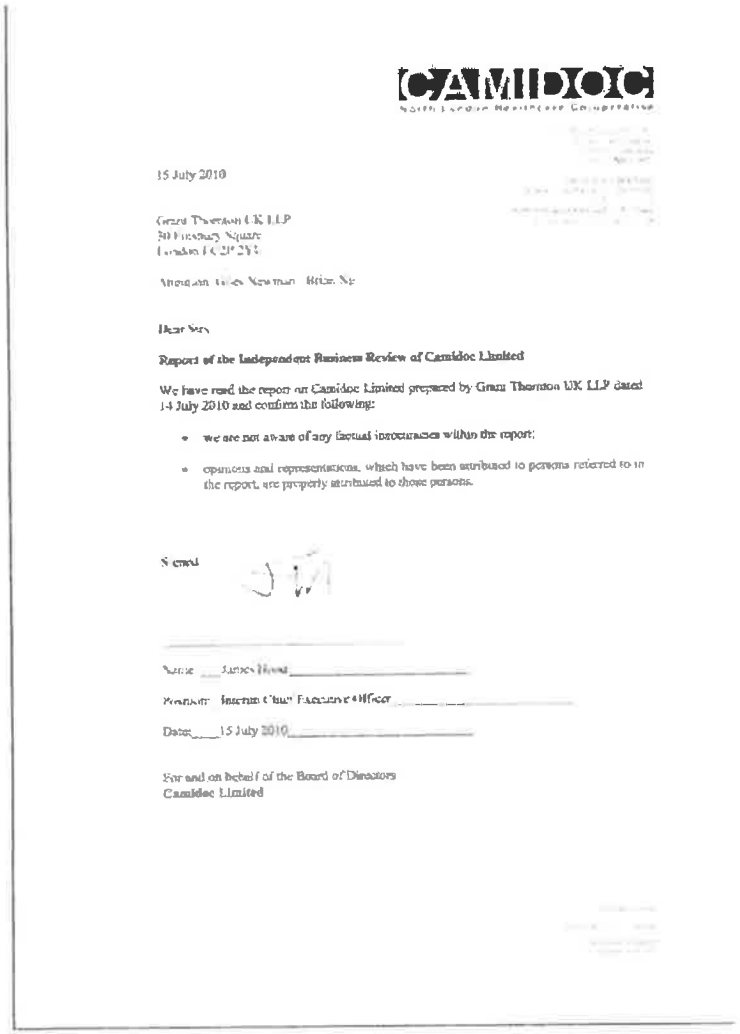
- Morag Inglis, Senior Manager

C. Monthly cash flow forecast from July 2010 to December 2010

Summary cash flow forecast from July to December 2010 assuming new OOH contract start date of 1 October 2010

£'000	Jul-10 Forecast by weeks Week 1	Week 2	Week 3	Week 4	Jul-10 Forecast	Aug-10 Forecast	Sep-10 Forecast	Oct-10 Forecast	Nov-10 Forecast	Dec-10 Forecast
Cash inflows										
OOH Contract - old contract	6	253	-	-	258	406	406	406	-	-
OOH Contract - new contract	-	-	-	-	-	-	-	451	451	451
CHIP	-	64	-	-	64	64	64	64	64	64
Practice Income	-	20	20	10	50	50	50	50	50	50
Other	0	-	12	2	14	14	14	14	14	14
Total receipts	**6**	**337**	**32**	**12**	**387**	**534**	**534**	**985**	**579**	**579**
Cash outflows										
Doctors Fees	(3)	-	(270)	-	(273)	(270)	(270)	(270)	(270)	(270)
Doctors' pension contribution	-	-	-	-	-	(120)	(120)	(120)	(120)	(120)
Salaries and wages	(156)	-	-	(130)	(286)	(140)	(140)	(140)	(140)	(140)
PAYE	-	-	(70)	-	(70)	(70)	(70)	(70)	(70)	(70)
Staff pension	-	-	-	(25)	(25)	(25)	(25)	(25)	(25)	(25)
Medical Supplies	(0)	(6)	-	(6)	(12)	(12)	(12)	(12)	(12)	(12)
Premises Rent & Service Charges	(5)	-	-	-	(5)	(23)	(18)	-	-	-
Telephone and travel costs (fuel)	(1)	(0)	(7)	(0)	(8)	(7)	(7)	(7)	(7)	(7)
IT equipment	-	-	-	-	-	-	-	(30)	-	-
IT Licenses	-	-	-	-	-	-	-	(8)	-	-
IT Support/Development	(24)	-	-	-	(24)	(25)	-	-	(25)	-
Staff training and welfare	-	-	(2)	-	(2)	(2)	(2)	(2)	(2)	(2)
Recruitment	-	-	(6)	-	(6)	-	-	-	-	-
Professional membership fees and subscriptions	-	-	-	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Insurance	(1)	-	-	(2)	(3)	(3)	(3)	(3)	(3)	(3)
Office Supplies	(0)	-	(3)	-	(4)	(3)	(3)	(3)	(3)	(3)
Cars maintenance	-	-	(2)	-	(2)	(2)	(2)	(2)	(2)	(2)
Board Meetings	-	-	-	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Legal/Professional/Accounting	(5)	-	-	-	(5)	(2)	-	(2)	(2)	(2)
Marketing materials and website	(2)	(0)	(0)	-	(3)	(1)	(1)	(1)	(1)	(1)
Total payments	**(197)**	**(6)**	**(360)**	**(166)**	**(729)**	**(707)**	**(675)**	**(697)**	**(684)**	**(659)**
Net cash flow	(191)	330	(328)	(154)	(342)	(173)	(141)	288	(105)	(80)
Opening cash balance	528	337	667	340	528	186	13	(128)	161	56
Closing cash balance	**337**	**667**	**340**	**186**	**186**	**13**	**(128)**	**161**	**56**	**(24)**

D. Factual accuracy confirmation letter



CAMDOC

15 July 2010

Grant Thornton UK LLP
30 Finsbury Square
London EC2P 2YU

Attention: Helen Newman Ref: Nr

Dear Sirs

Report of the Independent Business Review of Camidoc Limited

We have read the report on Camidoc Limited prepared by Grant Thornton UK LLP dated 14 July 2010 and confirm the following:

- we are not aware of any factual inaccuracies within the report;
- opinions and representations, which have been attributed to persons referred to in the report, are properly attributed to those persons.

Signed

Name James Hood

Position Interim Chief Executive Officer

Date 15 July 2010

For and on behalf of the Board of Directors
Camidoc Limited

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Barnet, Enfield and Haringey Clinical Strategy	
REPORT OF: Rob Mack, Joint Health Overview and Scrutiny Committee Support Officer	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 31/10/11**

SUMMARY OF REPORT:
Attached is the Secretary of State's letter regarding the Independent Review Panel's (IRP) recommendations and decision on the Barnet, Enfield and Haringey Clinical Strategy, along with the IRP's recommendations to the Secretary of State.

CONTACT OFFICER:
Rob Mack
Joint Health Overview and Scrutiny Support Officer
Haringey Council

RECOMMENDATIONS:
The Committee is asked to note:

The recommendations from the Secretary of State's and the IRP report.

The JHOSC will be looking at how these areas can be explored at an additional meeting on 14th November. The purpose of this meeting is to examine the plans for implementation.

Rob Mack, Joint Health Overview and Scrutiny Committee Support Officer

DATE: 31/10/11

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From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

POC1_625192

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Councillor Alev Cazimoglu
Chair, Health and Wellbeing Scrutiny Panel
Enfield Council
Scrutiny Services
PO Box 50
B Block
Civic Centre
Silver Street
Enfield EN1 3XA

12 SEP 2011

Dear Councillor Cazimoglu,

BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY ALTERNATIVE PROPOSALS REPORT AND REFERRAL FROM ENFIELD COUNCIL AND INITIAL INDEPENDENT RECONFIGURATION PANEL ASSESSMENT

Further to your Scrutiny Panel's referral letter of 20 February 2011 and your Council's report and supporting documents of 14 April 2011 concerning the Barnet, Enfield and Haringey Clinical Strategy, I asked the Independent Reconfiguration Panel (IRP) for its advice on this matter.

The Panel has now completed its initial assessment and shared its advice with me.

A copy of the Panel's initial assessment is appended to this letter.

The Panel will publish its advice on 12 September 2011 at www.irpanel.org.uk

In order to make a decision on this matter, I have considered the concerns raised by your Scrutiny Panel, the contents of your Council's report to me and have taken into account the IRP's advice.

Grounds for referral by Enfield Council's Health Scrutiny Panel

Essentially, your referral to me was made on the grounds that:

- the four key tests designed to build confidence within the service, with patients and communities have not been met; and

- the variation to the provision of local services is not in the best interests of the residents of Barnet, Enfield and Haringey.

I will now take each of the points you have raised in turn and set down undercover of this letter my response to your Council's report to me of 14 April 2011 in the context of the Panel's advice to me.

The four tests for service change

I know we all share a commitment to improving health and healthcare.

Where this requires change in the configuration of services, I believe the local NHS in conjunction with its partners needs to lead these processes to build confidence within the service and with the patients and communities we all serve.

As an integral part of its assessment, the Panel considered the documentation provided by NHS London regarding its application of the four tests to the BEH clinical strategy.

This consideration was taken in the context of the relevant guidance to the NHS and that the four tests are being applied retrospectively in this case.

In the Panel's opinion, the process appears to have been robust and the consideration of the evidence compiled thorough and well balanced.

The Panel acknowledges that sections of the clinical and wider community in Enfield are unhappy with aspects of the proposals that will see some services consolidated away from Chase Farm.

The Panel goes on further to say that was always the case and remains so. Nevertheless, the Clinical Strategy is designed to best meet the needs of the wider population across the whole of Barnet, Enfield and Haringey.

Representations seen by the IRP from Haringey GP commissioners and councillors in Barnet and in Haringey have stressed this point.

Proposals not in the best interests of the local NHS

As part of its initial assessment, the Panel also looked closely at the impact of the proposed changes under the BEH clinical strategy, and how these might affect local patients.

The Panel is clear that the case for change is the right one. No viable alternative clinical proposals have been put forward since NHS London undertook its own assurances against the four tests for service change, taking into account current and prospective patient choice (a key component of those four tests).

I understand the local NHS believes the drivers for change under the BEH clinical strategy are centred on getting the best outcomes for patients across both primary and secondary care with the development of primary care services already having been introduced in each of the boroughs of Barnet, Enfield and Haringey.

Future of Enfield hospital (report from Enfield Council)

At our meeting on 10 March 2010, I offered the Local Authority, GP commissioners and the local NHS the opportunity to work up alternative proposals against the current BEH clinical strategy.

Your report to me of 14 April 2011 sets down ten recommendations, which are not as I am sure you will agree alternative clinical options for service change.

Your report says, "at this time, the Council states Enfield GP Consortium is unable to offer any guide to what is their preferred option.

Instead, the Council believes Enfield GPs will simply support any decision I as Secretary of State for Health might take and do not want to support any particular options in advance of that decision".

Further, your report goes on to say, "we [Enfield Council] believe there is no single alternative option to the BEH clinical strategy that will deliver

viability, but that I as Secretary of State for Health, following the Council's ten recommendations, can achieve clinical safety, meet local taxpayers' demands and secure long term viability.

In its advice to me, the Panel states that the report submitted by your Council understandably highlights local concerns and calls for a retention of the status quo with a similar level of clinical services at North Middlesex and Chase Farm as at present.

However, it does not, in the Panel's view, provide any credible alternative to the current proposals or address the increasing and real concerns about the safety and sustainability of current services that underpin the clinical case for change.

I am sure you will agree with me that the safety of patients is paramount.

This is one of the reasons why I believe that in supporting the Panel's advice, the case for change should proceed.

I believe that any further delay to implementing change may be detrimental to patients and the services they access.

Initial IRP advice

Essentially, the Panel believes your Scrutiny Panel's referral is not suitable for full review.

I support the Panel's advice to me in full.

I am satisfied the IRP's advice on this important issue is in the interests of the local health service and I do hope your Committee will continue to work with local NHS partners in the best interest of patients.

Next steps

Having covered off issues concerning the IRP, I will now turn to the important themes of organisational change and the future commissioning of acute hospital services for the Barnet, Enfield and Haringey geography.

Organisational change

In accepting the Panel's advice, I am today writing separately to NHS London to issue a direction using the powers in section 8 of the NHS Act 2006.

I am directing NHS London to work with Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust to assess the feasibility of transferring Chase Farm Hospital to the North Middlesex University Hospital NHS Trust with a view to ensuring this happens if the assessment of the merits of doing so supports this.

I have asked NHS London to report back to me with the findings of its feasibility study no later than 16 December 2011.

Future commissioning arrangements

I have discussed issues of organisational change and future commissioning arrangements with NHS London.

It is clear to me the most effective way to deliver services will change over time.

For example, as new models of service delivery for urgent and emergency care networks are brought forward, clinical techniques and new approaches to clinical staffing and IT are developed and the needs of the local population change.

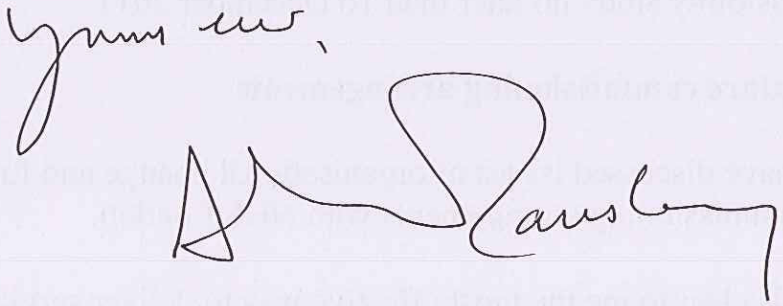
I believe it is right that if in future, local Clinical Commissioning Groups assess that a need for services at Chase Farm is unmet, then it will be within their gift to commission new services on that basis.

As part of any new local management structure following future organisational change, I would in any case expect that organisation to review its future clinical service provision to ensure it meets the needs of its local population.

I am copying this letter to:

Dame Ruth Carnall, Chief Executive, NHS London

Dr Peter Barrett, Chair, Independent Reconfiguration Panel
Councillor Doug Taylor, Leader, Enfield Council
Baroness Wall, Chair, Barnet and Chase Farm Hospitals NHS Trust
Mark Easton, Chief Executive, Barnet and Chase Farm Hospitals NHS Trust
David Hooper, Chair, North Middlesex Hospitals NHS Trust
Clare Panniker, Chief Executive, North Middlesex Hospitals NHS Trust
Councillor Gideon Bull, Chair, North Central London Joint Health Overview and Scrutiny Committee
Councillor Dilek Dogus, Cabinet Member for Health and Adult Services, Haringey Council
Councillor Helena Hart, Public Health, Barnet Council
John Lynch, Chair, Enfield LINk
Paula Khan, Cluster Chair, NHS North Central London
Caroline Taylor, Cluster Chief Executive, NHS North Central London



ANDREW LANSLEY CBE

IRP

6th Floor
157-197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Andrew Lansley CBE MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

8 July 2011

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Enfield Council Health Scrutiny Panel
Barnet Enfield Haringey Clinical Strategy

Thank you for forwarding copies of the referral letter and supporting documentation from Cllrs Mike Rye and Christine Hamilton, Chair and Vice Chairman, Enfield Health Scrutiny Panel (HSP). NHS London provided initial assessment information. Letters were also received from Nick de Bois MP and David Burrowes MP and from Mr Kierran McGregor, Secretary, *Save Chase Farm*. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. The IRP considers each referral on its merits and its advice in this case is set out below. **The Panel concludes that this referral is not suitable for full review.**

Background
Between June and October 2007, Barnet, Enfield and Haringey PCTs undertook public consultation on proposals for changes to local healthcare services, in particular the distribution of services between Barnet, Chase Farm and North Middlesex Hospitals. The proposals related to a wide range of existing hospital-based services including accident and emergency services, inpatient and day surgery, maternity and paediatric services. The proposals would also allow for the strengthening of local primary and community services, including the creation of new primary care centres for diagnostic and outpatient services.

The public consultation document, *Your health, Your future, Safer Closer Better,* set out two options for a future model of services:

- *Planned Care is concentrated on the Chase Farm site*
- *Chase Farm becomes a community hospital*

The Joint Scrutiny Committee of the London Boroughs of Barnet, Enfield and Haringey and the Hertfordshire County Council responded to the consultation in October 2007 expressing

major concerns about the deliverability of the proposed changes and stating that it was unable to support either option.

The Barnet Enfield and Haringey Clinical Strategy Project Board responded to the Joint Scrutiny Committee's concerns in November 2007. In the same month, the Project Board advised the Boards of the Barnet, Enfield and Haringey PCTs that Option 1 was its recommended option. The three PCT Boards met on 11 December 2007 and accepted the recommendation.

At its meeting in January 2008, the Joint Scrutiny Committee considered the PCTs' decision and referred the matter to the Secretary of State for Health on 31 March 2008. Following an initial assessment, the IRP undertook a full review of the proposals - known as the Barnet Enfield Haringey (BEH) Clinical Strategy - and submitted its report to the Secretary of State on 31 July 2008. The Panel concluded that change was essential to ensure high quality health services for local people. It supported the proposals but made sixteen recommendations, that must be adhered to, to ensure safe, sustainable and accessible services. The Panel supported proposals for the centralisation of A&E services and consultant-led maternity care at Barnet and North Middlesex Hospitals, an urgent care unit and planned care based at Chase Farm Hospital and endorsed the intention to improve primary care services throughout the locality. The Secretary of State for Health accepted the IRP's advice in full on 4 September 2008.

Since the Secretary of State's decision in 2008, work has continued to implement the BEH Clinical Strategy. Developments to primary care services have been introduced in each of the boroughs of Barnet, Enfield and Haringey. Urgent Care Centres have opened at Chase Farm and North Middlesex Hospitals and walk-in centres in Finchley and Edmonton (though the latter is due to reduce its opening hours from 1 October 2011). Some clinical services have been consolidated within Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust.

Implementation of the BEH Clinical Strategy was halted in the summer of 2010 when a moratorium on all significant service changes was introduced pending review against four tests for service change identified by the Secretary of State. *The Revision to the Operating Framework for the NHS in England 2010-11* and a letter to the NHS dated 29 July 2010 from the NHS Chief Executive on service reconfiguration provided guidance on how this should be approached.

A Strategic Co-ordination Group (SCG) – comprising representatives from relevant local authorities, LINks, local GPs, acute trust clinicians and PCTs - was formed to assess the BEH Clinical Strategy against the four tests and to report to a London-wide review panel (that included external input and membership) established by NHS London. The SCG commissioned UCL Partners to provide an independent analysis of whether the four tests had been met. It also convened a Clinical Review Panel to review the clinical evidence for the service changes envisaged in the BEH Clinical Strategy and to ascertain whether any change in circumstance or evidence had taken place in the three years since the original consultation.

The SCG met on 30 November 2010 to consider the evidence provided by UCL Partners and others. It agreed with the Clinical Review Panel's conclusion that the case for change had increased since 2007. The SCG submitted its report to NHS London on 6 December 2010 concluding "*that the balance of evidence and stakeholder views is in favour of the Strategy. We have reached a consensus and would wish to recommend to you* [NHS London] *that, from the evidence provided to us, the four tests laid down by the Secretary of State…have been met.*"

The NHS London review panel affirmed that the materials submitted by the SCG reflected a true assessment and that on balance the tests had been met. On 26 January 2011, a Board meeting of NHS London confirmed that the BEH Clinical Strategy had met the four tests and noted the implication of its decision that implementation of the Strategy would re-commence.

Prior to this, Enfield HSP met on 24 November 2010 to consider its own view of the application of the four tests and on 26 November 2010 wrote to the Chair of the BEH Co-ordination Group to advise that in the HSP's view the tests had not been met. HSP members met representatives of UCL Partners on 19 January 2011 to discuss its findings and requested further information, which was provided on 28 January 2011. At a meeting on 1 February 2011, Enfield HSP resolved to refer the BEH Clinical Strategy to the Secretary of State.

On 10 March 2011, the Secretary of State met a cross-party delegation of local MPs and Enfield councillors to discuss the BEH Clinical Strategy. At the meeting, the Secretary of State invited local stakeholders to submit to him alternative options to the Strategy. Enfield Council submitted a report, *Future of Enfield Hospitals: Report to the Secretary of State for Health*, on 14 April 2011.

The Secretary of State sought initial assessment advice from the IRP on 11 May 2011 requesting that the Panel's advice should incorporate the IRP's views about NHS London's application of the four tests in this case and the contents of the report submitted by Enfield Council. The Secretary of State also requested that, in considering options for service change, the Panel's advice should not be restricted by current organisational boundaries.

Basis for referral

The HSP's letter of referral of 20 February 2011 states that:

"On Tuesday 1 February 2011 Enfield Health Scrutiny Panel agreed to exercise its power of referral to the Secretary of State for Health pursuant to Section 7 of the Health and Social Care Act 2001.

The Health Scrutiny Panel noted the decision of NHS London at their Board meeting on 26 January 2011 to recommend that the Barnet Enfield and Haringey Clinical Strategy had met the four new tests for reconfiguration based on the BEH Strategic Co-ordination Group's assessment and that the BEH strategy should recommence.

The Health Scrutiny Panel considers that the four key tests designed to build confidence within the service, with patients and communities have not been met and is referring the matter as the proposed variation to the provision of services is not in the best interests of the residents of Barnet, Enfield and Haringey."

IRP view

The Panel notes:

- Guidance on the application of the four tests for service reconfiguration was issued to the NHS on 29 July 2010 (letter from Chief Executive of the NHS in England, Gateway ref 14543)
- Following the issue of that guidance, NHS London, together with the local NHS, has put in place a robust process for the assessment of relevant reconfiguration schemes and conducted a thorough retrospective assessment of the BEH Clinical Strategy against the four tests that incorporated external input
- Enfield HSP, at its meeting on 24 November 2010, concluded that the four tests had not been met – this conclusion was reached without reference to the detailed analysis conducted by UCL Partners which was not available until 1 December 2010 (after the deadline by which stakeholders had been asked to respond)
- Further to a meeting with UCL Partners, on 19 January 2011, Enfield HSP remained unconvinced that the tests had been met
- Since the Secretary of State's invitation to local stakeholders to submit alternative strategies (at the meeting of 10 March 2011), no new evidence has been presented that constitutes a substantive alternative to the BEH Clinical Strategy
- The Clinical Review Panel, in offering its advice to NHS London, concluded that *"the clinical case for change has in fact increased over the past few years"*
- A Strategic Options Appraisal prepared by Barnet and Chase Farm Hospitals NHS Trust (dated 14 January 2011) set out a contingency plan should the BEH Clinical Strategy not be approved for continued implementation – the options considered by the Trust in the paper are not in preference to the original strategy, nor has their impact been assessed against the needs of the overall population in Barnet, Enfield and Haringey
- Representations made to the IRP by Enfield MPs have suggested that changes to the existing organisational structures of local hospital trusts could facilitate better options for services serving Enfield residents
- Because of the locations of the hospitals, the services they provide and the populations they serve, collaboration across PCT and local authority boundaries is essential to deliver any major change
- Enfield HSP, in its letter of referral of 20 February 2011, states *"It is our view that primary care must be in place and seen to be working before withdrawal or changes occur at the* [Chase Farm] *hospital"*

IRP

Conclusion
The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral.

In requesting initial assessment advice from the IRP, you asked that the Panel incorporate views about NHS London's application of the four tests in this case and the contents of the report submitted by Enfield Council. You also requested that, in considering options for service change, the Panel's advice should not be restricted by current organisational boundaries.

The Panel has considered the documentation provided by NHS London regarding its application of the four tests to the BEH Clinical Strategy. This consideration is in the context of the relevant guidance to the NHS and that the four tests are being applied retrospectively in this case. In the Panel's opinion, the process appears to have been robust and the consideration of the evidence compiled thorough and well-balanced. It is true that sections of the clinical and wider community in Enfield are unhappy with aspects of the proposals that will see some services consolidated away from Chase Farm Hospital. That was always the case and remains so. Nevertheless, the Clinical Strategy is designed to best meet the needs of the wider population across the whole of Barnet, Enfield and Haringey. Representations seen by the IRP - from Haringey GP commissioners and councillors in Barnet and in Haringey - have stressed this point.

Serious concerns have also been raised about the implications of not completing the implementation of the strategy for services at the North Middlesex Hospital following its refurbishment under a PFI scheme. Indeed, Enfield Council itself agreed a motion in November 2010 that no decisions should undermine the quality and viability of the North Middlesex Hospital. The adverse service and financial consequences of a change in direction at this stage are a legitimate concern that would be felt by residents of Enfield and Haringey. The report submitted by Enfield Council understandably highlights local concerns and calls for a retention of the status-quo with a similar level of clinical services at North Middlesex and Chase Farm Hospitals as at present. However, it does not, in the IRP's view, provide any credible alternative to the current proposals or address the increasing and real concerns about the safety and sustainability of current services that underpin the clinical case for change.

The status quo has real downside risk in terms of the current safety and sustainability of local services. The ongoing safety and quality of these services must be the highest priority for all concerned. The implementation of the BEH Clinical Strategy requires close co-ordination of effort across two providers. Representations made to the IRP have suggested that the needs of Enfield residents might be better served by the separation of the Barnet and Chase Farm NHS Trust allowing for the creation of a new foundation trust comprising North Middlesex and Chase Farm hospitals. The IRP was not presented with evidence to assess the possible benefits of this organisational change on service configuration. It is for local commissioners and providers of the services to explore this matter further, under the guidance of NHS London, to establish how it might help deliver the safe and sustainable services that local residents need. For reasons of clinical risk management, effective

IRP

engagement of all relevant parties and financial viability, these issues should only be explored within the existing framework for implementation of the BEH Clinical Strategy.

The IRP does not consider that a full review would add any value in this instance. There are no new substantive proposals or decisions to be reviewed. Concerns raised by Enfield HSP, such as its wish to see appropriate primary care services in place and working before changes are made to services at Chase Farm Hospital, were covered in the IRP's recommendations in 2008 along with other actions that were required. They remain as relevant now as then.

Yours sincerely

Dr Peter Barrett CBE DL
Chair, IRP

Independent Reconfiguration Panel
Tel: 020 7389 8045/6
E Mail: info@irpanel.org.uk *Website:* www.irpanel.org.uk

IRP

APPENDIX ONE

LIST OF DOCUMENTS

Enfield Council Health Scrutiny Panel

1 Letter of referral and attachments from Cllr Mike Rye, Enfield HSP Chair, to Secretary of State for Health, 20 February 2011
Attachments:
2 Letter to Chair of Co-ordination Group, NHS Enfield, from Enfield HSP Chair, 26 November 2011
3 Extract from UCL Partners Barnet, Enfield and Haringey Clinical Strategy Report assessing the level of support for the Strategy amongst General Practitioners
4 Letter to HSP Chair from BEH Clinical Strategy Senior Responsible Officer, 1 December 2010
5 Letter to Chief Executive, NHS London, from BEH Clinical Strategy Senior Responsible Officer, 6 December 2010
6 Letter to Chair and Vice Chairman, Enfield HSP, Chief executive, NHS London, 13 December 2010
7 Response to questions from Enfield HSP following presentation by Dr Helen Barratt, UCL partners and Prof Hilary Pickes, member of Clinical Review Team, 28 January 2011
8 Enfield LINk response to Barnet, Enfield and Haringey Clinical Strategy Clinical Review Panel Report, November 2010
9 Letters to IRP Chair from Cllr Alev Cazimoglu, Chair, Enfield Health and Wellbeing Scrutiny Panel, 19 May and 16 June 2011
10 Letter to IRP Chair from Cllr Doug Taylor, Leader of the Council, Enfield Council, 6 July 2011

NHS London

1 NHS London Board paper *NHS London's assurance review of Barnet, Enfield and Haringey Clinical Strategy against the four new tests for reconfiguration*
2 Strategic Co-ordination Group submissions
3 BEH Strategic Co-ordination Group meeting papers, 30 November 2010
4 NHS London Board paper *Quality Assurance Framework for reconfiguration Schemes*, 19 October 2010
5 *Future of Enfield Hospitals: Report to the Secretary of State for Health submitted on 14 April 2011*
6 *Future of Enfield Hospitals: Report to the Secretary of State for Health submitted on 14 April 2011 – Record of Submissions*
7 BEH Clinical Strategy Update for IRP, 24 February 2011
8 NHS Comments on Enfield Council's report to the Secretary of State for Health on the Barnet, Enfield and Haringey Clinical Strategy, 23 June 2011

IRP

Other information received

1 Letter to Joint Director of Commissioning, NHS Enfield and London Borough of Enfield, from Haringey GP Commissioning Consortium, 13 April 2011
2 Letter to Secretary of State for Health from Chair, Haringey Council shadow Health and Wellbeing Board, undated
3 Letter to IRP Chair from Nick de Bois MP and David Burrowes MP, 14 June 2011
4 Letter to IRP Chair from Mr Kierran McGregor, Secretary, Save Chase Farm, 10 June 2011
5 Letter to IRP from Mr John Sturman, 9 June 2011
6 Emails and attachments from Mr Donald Smith, 27 June and 7 July 2011
7 Letter to Secretary of State for Health from Cabinet Member for Public Health, London Borough of Barnet, 22 June 2011

London cancer services:
Implementing the model of care

London Borough of Camden, Islington, Barnet, Haringey and Enfield

North Central London Joint Health Overview and Scrutiny Committee

31st October 2011

Developing the model of care

- 45 clinicians working over 12 months
- Three work areas: early diagnosis; common cancers and general care; rarer cancers and specialist care
- Patient panel to ensure strong patient voice
- Case for change: December 2009
- Model of care: August 2010
- Extensive 3-month engagement on proposals – over 85 per cent of survey respondents supportive
- London GP Council has endorsed the recommendations

LondonHealth PROGRAMMES

NHS London

The case for change

- Later diagnosis has been a major factor in causing poorer relative survival rates
- There are areas of excellence in London but inequalities in access and outcomes exist
- Treatment and care should be standardised
- Specialist surgery is taking place on too many sites: common treatments are available on too few
- Comprehensive pathways should be commissioned; organisational boundaries should not be a barrier

LondonHealth PROGRAMMES

NHS London

The model of care

- Improve early diagnosis by addressing public awareness, GP access to diagnostics, screening uptake rates and health inequalities
- Extended local provision of common cancer services, such as chemotherapy, non-complex surgery and acute oncology. Further consolidation of surgical services for rarer cancers into specialist centres
- Providers working together in a small number of integrated systems delivering standardised pathways

Early diagnosis

- Working group consisting of GPs, public health consultants, diagnostic experts and patient representatives
- Aim is to identify the most effective evidence based interventions to improve early diagnosis
- The shadow London Health Improvement Board has selected prevention and early diagnosis as a priority – reporting in October
- Health and Wellbeing boards will support this process locally, recognising local population issues and promoting positive messages

LondonHealth PROGRAMMES

NHS London

Integrated cancer systems

- Groups of hospitals working together to ensure that patients experience seamless cancer care
- Integrated cancer system specification developed in partnership with cancer community
- Two proposed systems submitted system and service plans on 30th June
- 'The Crescent' and London Cancer
- Assurance process completed involving GPs, nurses, Macmillan, external clinical experts and commissioners
- Recommendations to commissioners in September

LondonHealth PROGRAMMES

NHS London

Next steps

- Continue to support integrated systems in their service planning
- Share possible local implications with Health Overview and Scrutiny Committees in late autumn

- Further information

http://www.londonhp.nhs.uk/services/cancer/

- Further queries

cancer@londonhp.nhs.uk

LondonHealth PROGRAMMES

NHS

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

31 October 2011

Future Work Plan

1. Introduction

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

14 November (Haringey)

1.2 This will be a special meeting to consider the issue of the Barnet, Enfield and Haringey Clinical Strategy.

5 December (Barnet)

1.3 Items for this meeting are currently as follows:

1. Transforming Child and Adolescent Mental Health Services (CAMHS) - In-patient Services for young people living in Barnet, Enfield & Haringey

2. QIPP Performance

3. Urgent Care

4. Vascular surgery

5. Future work plan

Future Meetings:

1.4 Further meetings of the Committee will take place as follows:

- *Monday 16 January – Camden*
- *Monday 27 February - Islington*

1.5 Agenda items for these meetings will be agreed in due course.

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