MEETING

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 10TH SEPTEMBER, 2012

AT 10.00 AM

VENUE

LONDON BOROUGH OF ISLINGTON

TO: MEMBERS OF JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)

Chairman: Councillor Martin Klute (Chairman),
Vice Chairman: Councillor David Winskill (Vice-Chairman)

Councillors

Councillor Reg Rice	Alev Cazimoglu	Anne-Marie Pierce
Peter Brayshaw	Alison Cornelius	Graham Old
John Bryant	Alice Perry	

Substitute Members

Barry Rawlings

You are requested to attend the above meeting for which an agenda is attached.

Aysen Giritli – Head of Governance

Governance Services contact: Rob Mack, London Borough of Haringey 020 8489 2921
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Media Relations contact: Sue Cocker 020 8359 7039

CORPORATE GOVERNANCE DIRECTORATE

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Agenda and Report Pack – Late Report	1 - 18

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Head of Policy & Performance Eve Pelekanos

Haringey Council

AGENDA ITEM 1

Your ref:
Date: 04 September 2012
Our ref: SR/ POC
Direct dial: 0208 489 2921
Email: rob.mack@haringey.gov.uk

Dear Member

North Central London Joint Health Overview and Scrutiny Committee Meeting - Monday, 10th September, 2012 – Second Despatch

Please find enclosed the following item, which was not available at the time of the original despatch:

No	Item
5.	Barnet, Enfield and Haringey Clinical Strategy - Implementation To report on the implementation of the Barnet, Enfield and Haringey Clinical Strategy, with particular reference to the further development of primary care.

Please also find attached an additional item, which was not included on the original agenda:

12.	Transition Programme Progress Update - September 2012 To update the Committee on the next phase of transition from 1 October 2012 which will involve a shift from the current system to the new, with the new 'receiving' organisations leading in planning and preparing for 2013/14.

Yours sincerely

Robert Mack
Senior Policy Officer

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Agenda Item 5

NHS North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, ENFIELD, HARINGEY **WARDS:** ALL

REPORT TITLE: Barnet, Enfield and Haringey service developments and investment that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

REPORT OF: Siobhan Harrington , BEH Clinical Strategy Programme Director

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	10 September 2012

EXECUTIVE SUMMARY OF REPORT:

- The purpose of this report is to inform the JHOSC of the primary, community care and care closer to home service developments and investments that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.
- Key achievements to date are:
  - Increasing physical capacity in Primary Care for example Finchley Memorial Hospital
  - Extending opening hours of GP practices and pharmacies across all three boroughs
  - Moving care traditionally delivered in hospital to community settings
  - A developed Primary Care Strategy with a planned investment of £46.7million across the five boroughs in North Central London over the next three years
- Improvements to date and improvements planned are aimed at :
  - Improving access for local people
  - Improving the delivery and quality of care
  - Integrating care through providers working together around the needs of the patient
- £46.7million will be invested in North Central London primary care services in the five boroughs over the next three years detailed in the Primary Care Strategy document “Transforming the primary care landscape in North Central London”.
- The Primary Care Strategy is intended to underpin the borough implementation plans and is one of the enablers to the delivery of the BEH Clinical Strategy.
- Contact: Varuna Balmogim, BEH Programme Manager
  Varuna.Balmogim@nclondon.nhs.uk

RECOMMENDATIONS: The Committee is asked to note the content of this paper

DATE: 31 August 2012

BEH Clinical Strategy links to Primary and Community Services

Introduction

The purpose of this report is to inform the JHOSC of the primary and community care developments and investments that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

The report summarises the primary care strategy investment in Barnet, Enfield and Haringey as requested by the Joint Health Overview Scrutiny Committee meeting on the 9 July 2012, however it is important to note that investments and developments supporting the BEH Clinical Strategy include community service developments, the development of care closer to home and changes in ways of working.

Members are reminded that implementation of the BEH Clinical Strategy includes changes to emergency services, maternity, planned care and paediatrics across Barnet, Chase Farm and the North Middlesex University Hospitals. These acute service changes are due to be implemented by November 2013. This report will cover the following areas:

1. Background
2. Explanation of the planned primary care investment for 2012 to 2015
    a. How does the primary care investment listed in this report relate to local primary care strategies
    b. How the ratios were arrived at? (Assumptions used)
3. Report on the investment over a 5 year period: looking at the last 2 years, this year and the next two years
4. Conclusion

1. Background

1.1. The JHOSC received a presentation on the implementation of the BEH Clinical Strategy on the 28 May 2012 by Caroline Taylor, NHS North Central London Chief Executive Officer.

1.2. Henrietta Hughes, the acting Medical Director for NHS North Central London, attended the JHOSC in July and presented an update to the “Transforming the primary care landscape in North Central London”.

1.3. A whole system transformation is underway for Barnet, Enfield and Haringey to improve access and quality of care for local people.

1.4. This includes the implementing the BEH Clinical Strategy, Primary Care Strategy, Integrated Care Strategy, moving care closer to home agenda and improving urgent care services.

1.5. The BEH Clinical Strategy consultation took place in 2007, since then there have been a number of developments and projects to improve primary and community services across Barnet, Enfield and Haringey to support the delivery of the strategy.

1.6. The Primary Care Strategy supports the BEH Clinical Strategy. Both strategies complement each other and are key drivers to ensure that the local people get the

right care at the right time first time. The local Clinical Commissioning Groups (CCGs) and NHS North Central London are committed to ensuring that local people can see that changes mean real improvement in the services they receive.

1.7. The delivery of the Primary Care Strategy in Barnet, Enfield and Haringey is one of the many enablers for key plans for the transformation of health care locally

1.8. There has been investment in buildings to increase capacity in community settings in all three boroughs. In Barnet there has been the ongoing development of Edgware Community Hospital, Finchley Memorial Hospital, Vale Drive Primary Care Centre, Oak Lane and Edgwarebury Lane. In Enfield there has been the development of Forest Road and the Evergreen centre. In Haringey new capacity was developed in the Lordship Lane development and Hornsey Central.

1.9. Services that have historically been delivered in hospital settings are now being delivered in community settings such as dermatology, gynaecology, ophthalmology, diabetes and ear, nose and throat (ENT) services.

1.10. All three boroughs now have strategies to implement integrated care, where primary care providers, community care providers, social care and voluntary sector providers, as well as hospital providers, are working together to deliver joined up services in the community.

1.11. Whittington Health, the North Middlesex Hospital and Chase Farm Hospital have all developed urgent care centres, with plans in progress for a centre in Barnet Hospital. There are also a number of Walk in Centres.

1.12. There has been investment in end of life services in all three boroughs. This has supported care of people in the community and enabled advance care planning that supports people to plan and choose where they may die. This has resulted in additional investment in community palliative care services.

1.13. This paper focuses on examples of service developments and investments to primary and general community services. There have been further investments in both mental health and public health in the three boroughs which are not referenced in this paper.

2. Explanation of the primary care investment for 2012 to 2015

2.1. The successful implementation of the BEH Clinical Strategy requires investment across the whole healthcare economy in North Central London. This includes financial investment but also investment in changing ways of working in primary care, as well as at Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust.

2.2. Table 1 below shows the Primary Care spend as at 18 January 2012. The overall strategy is to make the best of existing resources as well as increasing investment in Primary care and Community Health services where appropriate.

Table 1.

HOW MUCH MONEY WILL North Central London/PCTS SPEND IN 2011/12?	£000's					
	Barnet	**Camden**	**Enfield**	**Haringey**	**Islington**	**NC London**
Total spending by PCT 2011/12 as at Month 6 projected to full year	**£579,500**	**£518,499**	**£482,704**	**£469,554**	**£481,540**	**£2,531,797**
HOW MUCH IS THAT PER HEAD "CRUDE POPULATION"?						
"Crude Population" numbers @ 1st July 2011	351,286	247,303	277,429	244,489	191,810	1,312,317
£s per head "Crude Population"	**£1,650**	**£2,097**	**£1,740**	**£1,921**	**£2,511**	**£1,929**
HOW MUCH IS THAT PER HEAD "REGISTERED PATIENTS"?						
"Registered patient" numbers @ 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per head "Registered Patients"	**£1,551**	**£2,066**	**£1,614**	**£1,725**	**£2,219**	**£1,792**
HOW MUCH IS THAT PER "UNIFIED WEIGHTED POPULATION"?						
"Unified Weighted Population" numbers 2011/12	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per head "Unified Weighted Population"	**£1,770**	**£2,023**	**£1,669**	**£1,703**	**£2,040**	**£1,828**
% difference between "Registered patients" and "Unified Weighted Population"	***-12.4%***	***2.1%***	***-3.3%***	***1.3%***	***8.8%***	***-2.0%***

a) DH funding can be viewed on a per capita basis in various ways. The weighted capitation formula produces a PCT 'Unified Weighted Population'. This is a hypothetical population that DH uses as a target to guide most of the PCT's allocation. It is based on a weighted combination of 19 socio-economic factors that are seen as convenient proxies for health needs.
b) The apparent massive funding differential using "Crude" or "Registered" populations is significantly reduced to the range of £1,669 per capita in Enfield to £2,040 in Islington. Using UWP means that the Barnet population theoretically reduces whilst Camden, Enfield, Haringey and Islington theoretically increase.
c) The difference between Registered Patients and UWP also highlights a funding challenge in Barnet.

2.3. NHS North Central London agreed the next steps in delivering better primary care services across Barnet, Camden, Enfield, Haringey and Islington at its March Joint Board meeting.

2.4. £46.7million will be invested in North Central London primary care services in the five boroughs over the next three years as detailed in the "Transforming the primary care landscape in North Central London". This Primary Care Strategy document is intended to underpin the borough implementation plans which specify the practical details. The combined strategy and implementation plans will determine how the NHS in North Central London will invest in primary care in each of the boroughs over the coming years. The result of this investment will be in the improvement in clinical, service quality and people being able to access services closer to home. This in turn will support a reduction in hospital usage and costs.

2.5. The £46.7 million comes from the return of "top sliced" 2% of our general allocation from NHS London. It is part of our preparation to reduce our historical over-reliance on hospital care, and provide more out of hospital care resulting in financial recovery and on-going financial balance. Table 2 details the investment across the five boroughs for the next three years.

Table 2. Primary Care investments for the current year and the next 2 years detailed in the Primary Care strategy for the 5 boroughs

	Barnet	Enfield	Haringey	Camden	Islington	NCL year total £000s
2012/13	£2,910	£2,797	£2,697	£1,798	£1,798	£12,000
2013/14	£4,835	£3,953	£3,665	£2,751	£2,751	£17,505
2014/15	£4,419	£3,945	£3,629	£2,630	£2,630	£17,253
Total	**£11,714**	**£10,695**	**£9,991**	**£7,179**	**£7,179**	**£46,757**

2.6. Our aim is to offer a high quality primary care team service, linked, when necessary, to more specialist services; all of which will enable people to live the best possible lifestyle in respect of their personal health and wellbeing.

2.7. The strategy recognises that transformational changes are needed to support the development and capacity of primary care and underpins the development of our five borough-based implementation plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. The strategy focuses on:

- Promoting health, wellbeing 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.

2.8. The borough teams have actively engaged with GPs and local stakeholders from February 2012 to May 2012 to develop the local Primary Care implementation plans. Each borough has a different starting point in their planning process to create the universal patient experience described in Section 4 of the strategy – “A patient’s perspective - This is how we want it to be” and has developed their own approach to implementation.

2.9. The borough implementation plans have identified the following clinical priorities for 2012/13:

- Access
- Frail elderly
- Long term conditions
- Continue early implementation of text message reminder capability, web based information systems and premises improvements.

2.10. The borough clinical priorities for 2013 to 2016 are being further developed and will be shared with the Borough Overview and Scrutiny Boards.

3. Report on the investment over a 5 year period: Looking at the last 2 years, this year and the next two years (2010 to 2015)

This report details key examples of primary care, community services and care closer to home developments and investments for Barnet , Enfield and Haringey. Reference is made to developments since the BEH Clinical Strategy Consultation in 2007.

3.1. Barnet Developments and Investments

3.1.1. Past Developments and Investments

- The development of Oak Lane, Edgwarebury Lane, Lane End Medical Practice and Vale Drive were key to improving access to community services and intermediate care and improving primary care premises. A total of £250,000 was invested in these premises from 2007
- Developed the GP lead Health Centre in Cricklewood
- There is an annual investment of £25,000 each year in GPs with special interests.
- Implemented a referral management system for all GP and dental referrals to make sure patients get to the right service first – £500,000 invested annually.
- Investment of £3,155,440 since July 2008 in improving access to primary care with now 88% of GP practices providing extended opening hours.
- Expansion of Information Communication Technology (ICT) and enablement services.
- An investment in a rapid response service as part of the intermediate care and in enablement developments to prevent 30 readmissions. (Rapid Response £416,000, Enablement £195,000; January 2012)
- Commissioning of an integrated community Chronic obstructive pulmonary disease (COPD) service providing community clinical with specialist support, admission avoidance, case management, pulmonary rehabilitation and home oxygen assessment and review. (£560,000 ; June 2011)
- A single telephone number was introduced so that acute providers could access intermediate care assessment and services from one point of access.
- Invested £450,000 over the last two years in additional Health Visitors
- Invested £150,000 in home enteral feeding service for adults
- In November 2011 a nurse navigation scheme opened at Barnet A&E to redirect people with primary care problems to GPs and pharmacies
- More services provided in the community resulting in fewer patients having to be seen in hospital (Musculoskeletal, COPD, diagnostics, urology, gynaecology, ENT, minor oral surgery, community anticoagulation, ophthalmology, cardiology and dermatology)
- Developed integrated health and social care teams for rapid response frail elderly as part of system wide redesign of frail elderly services
- Further development of an integrated approach with children's services particularly speech and language therapy and CAMHs Tier 3
- Initiated redesign of dementia and stroke integrated community pathways
- A rapid response palliative care service for people in their own home £119,000 in 2011/12 and £250,000 in 2012/13

- Significant developments at Edgware Community Hospital including a new renal unit developed to allow community based dialysis and outpatient clinics. Opened in October 2011
- Implemented enhanced GP support to care homes as pilot
- Two fully functioning walk-in centres at Edgware and Finchley

3.1.2. Barnet Primary Care Implementation Plan (Current and next 3 years)

- Barnet Primary Care Implementation plan identifies that £11.7m will be invested in primary and community services over the next 3 years; of this £2.9m has been allocated for 2012/13.
- The Finchley Memorial Hospital and Edgware Community Hospital are key developments in Barnet that will assist in the development of primary and community care capacity.
- The new Finchley Memorial Hospital will provide consulting and treatment rooms, therapy suites, x-ray facilities, and pharmacy and inpatient beds. These have been designed to provide flexibility in use. The hospital will serve a higher proportion of older adults and facilitate the re-design and delivery of community-based pathways which will focus on:
  - Management of long term conditions to help people stay healthy and maintain their independence;
  - Rehabilitation of people who require additional support to recover from an acute health event;
  - Assessment, diagnosis, and treatment of people with a common need that can be safely and quickly managed without the use of highly specialised diagnostic and therapeutic interventions: e.g. dermatological and musculoskeletal problems;
  - An infusion suite where people will have infusions that historically have meant time in hospital;
  - Primary and urgent care.

- Edgware Community Hospital will be utilised to complement provision at Finchley Memorial Hospital with, for example, expanded provision of day surgery, and integrated long term conditions clinics. Services will not necessarily be duplicated across both sites, allowing a greater range of services to be provided in total.

3.2. Enfield Developments and Investments

3.2.1. Past Developments and Investments

- 85% of GP practices in Enfield have signed up to offer extended hours (up to 20:00). This is part of the additional £1.9m spent on primary care since 2007/08. Out of Hours GP services are provided by BarnDoc from 6:30pm to 8:00am every night, and all weekends and bank holidays
- Two new developments and improvements in practices in Evergreen and Forest Primary Care Centres. Five single handed practices have come together as one in Evergreen with investment of £588,000

- Development of a hub and spoke model, for integrated community-based dermatology service with an investment of £ 527,000 was opened in July 2012
- The development of increased diagnostics in the community over the last 5 years with ultrasound scans, Dexa scans, MRI and echo tests available in the community. This has resulted in £1 million investment since April 2007
- Investment of £68,000 in a Community Parkinson's Disease Specialist Nurse in April 2011
- Investment in a fracture liaison and falls prevention service, £173,684 in 2012/13 and £247,728 in 2013/14 of this £150,000 is from social care funding
- The development of a consultant led integrated care multi disciplinary team (MDT) to support admissions avoidance and readmissions from care homes with a high rate of acute admissions was established in the North of Enfield and will now be rolled out to the South of Enfield. A total investment of £708,000 annually over the next 4 years.
- Single point of contact phone number which will be delivered through NHS111 from April 2013 with an investment of £400,000
- Twenty community hospital beds in Magnolia ward plus investment of an additional eight beds in 2011.
- Development of self management strategy with appointment of seven community nurses to support patients' self management and consisting of an investment of £398,000
- New services being provided in the community which have been provided in hospital settings previously, e.g. ophthalmology at Chalfont Road and a sexual health outreach service for under-18s, with an investment of £1.1million since 2007
- The development and commissioning of London Ambulance Service emergency care practitioners working in the community and preventing hospital admission where appropriate as well as delivering emergency care closer to home.
- Rapid response team and extension of hours available
- Rehabilitation beds and centre – completed in Chase Farm with a £2.7million investment

3.2.2. Enfield Primary Care Implementation Plan (Current and next 3 years)

- Enfield Primary Care Implementation plan identifies that £10.6m will be invested in primary and community services over the next 3 years; of this £2.7m has been allocated for 2012/13. This investment will assist in improving access to and the quality of primary care in Enfield.
- At the core of the Implementation Plan is the ambition to develop GP-led integrated Primary Care Networks. There will be four networks in Enfield.
- A significant investment in information technology allowing patients to be reminded about appointments by text, giving out timely information on services and managing conditions through improved data sharing will enable practices to achieve better outcomes for patients.
- During Year 1 (of a 3-year plan), the integrated Primary Care Networks will enable an improvement in access to primary care. Years 2 and 3 will see the development of new services or expansion of pilot schemes

- Estates development to improve patients access in two Edmonton practices and Ordanance Road are planned with a potential further two sites to be developed.
- The Enfield implementation plan was presented to the Enfield Health and Wellbeing board on 11 June 2012 and is now available on the internet.

3.3. Haringey Developments and Investments

3.3.1. Past Developments and Investments

- Developments to four large neighbourhood health centres, all providing primary care through GP practices, Community services via Whittington Health and care closer to home.
- Lordship Lane – capital investment of £300,000. The development of clinics for people with long term conditions and increased provision of diagnostics such as ultrasound scanning.
- GPs with special interest developed in musculoskeletal services, dermatology and ENT
- 84% of GP practices in Haringey have signed up to offer extended hours (up to 20:00).
- Laurels Healthy Living Centre – Investment of £400,000 in April 2011
- Tynemouth Road – community midwifery team and women's services
- Community anti-coagulation service
- Community pharmacy network providing emergency hormonal contraception (EHC) and Chlamydia screen and treat services.
- North East Haringey Collaborative of GP practices piloting integrated care approach including running case conferences for complex patients 65 years or older
- Hornsey Central – Investment of £300,000 in March 2011with the introduction of additional clinics supported by diagnostics such as ultrasound scans. Community services now being delivered for gynaecology including hysteroscopies in the community; diabetes; dermatology and ophthalmology. Community physiotherapy centre developed with gym. New pharmacy service with extended hours of opening 7 days per week.
- Assessment and Urgent Care Centre provided at Whittington Hospital and NMUH, including a GP led front-end
- Investment in rapid response services and enablement to prevent people being admitted to hospital
- Ambulatory care service now delivered at the Whittington hospital

3.3.2. Haringey Primary Care Implementation Plan (Current and next 3 years)

- Haringey Primary Care Implementation plan identifies that £9.9m will be invested in primary and community services over the next 3 years; of this £2.6m has been allocated for 2012/13. This investment will assist in rebalancing the health system to

ensure more investment in the primary and community settings allowing greater care closer to home.

- The development of networks is vital for the delivery of the integrated care and urgent care strategies. Haringey have four collaboratives which will continue as the infrastructure for their local networks.

4. Conclusion

4.1 This paper has informed the JHOSC of examples of primary and community care investments and developments that have happened and are planned to happen that will be part of the wider health system changes that complement the acute service changes happening in the BEH Clinical Strategy.

4.2. High quality safe sustainable health services for local people in Barnet, Enfield and Haringey is the overarching aim of the BEH Clinical Strategy, the NCL Primary Care strategy and the ongoing development of health services. Alongside investment local health services continue to require culture change in the way care is delivered to meet the needs of local people.

4.3 Communicating these changes and engaging local communities and people in these changes will remain a priority over the coming months.

NHS North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Transition Programme Progress Update – September 2012	
REPORT OF: Alison Pointu Director of Quality and Safety and Executive Lead for Transition NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 10 September 2012

EXECUTIVE SUMMARY OF REPORT:

Members of the Joint Health Overview and Scrutiny Committee have received regular Transition Programme updates throughout the Transition period.

We are now entering the next phase of Transition from 1 October 2012, where we will see a shift from the current system to the new, with the new 'receiving' organisations leading in planning and preparing for 2013/14. They will also take on much of the delivery agenda for 2012/13 and the PCT cluster will hold the new system to account for the operational delivery of 2012/13 priorities.

The purpose of this report is to provide an overview of recent developments in the system and describe the implications for NHS North Central London and the new 'receiving' organisations that will replace it.

Amy Bray
Transition Programme Manager
NHS North Central London

RECOMMENDATIONS:

The Committee is asked to comment on the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future.

The Committee is also asked to note the latest development status of the NHS Commissioning Board Authority, Public Health transition, Clinical Commissioning Groups and North Central and East London Commissioning Support Unit.

Attachments include: No attachments.

Alison Pointu

Director of Quality and Safety and Executive Lead for Transition
DATE: 30 August 2012

TRANSITION PROGRAMME PROGRESS UPDATE – SEPTEMBER 2012

Introduction

From 1 October 2012 there will be a shift from the current system to the new, with the new organisations leading in planning and preparing for 2013/14. They will also take on much of the delivery agenda for 2012/13 and the PCT cluster will hold the new system to account for the operational delivery of 2012/13 priorities.

This approach is intended to minimise the risk of a 'big bang' transition of functions and staff on 1 April 2013 and provide resilience for delivery, as well as providing receiving organisations with the opportunity to build teams in parallel with taking on responsibility for functions, with support from 'sending' organisations.

During the transition period there will remain a core cluster team supporting statutory PCT functions and governance arrangements until 31 March 2013.

As we prepare for handover of functions from existing 'sending' organisations to new 'receiving' organisations, it is critical that clear, consistent handover plans are in place to enable the smooth migration of functions. The core Cluster Transition Team is working with each Directorate across the organisation to ensure functions are packaged appropriately for handover to the relevant receiver(s).

The Transition Programme and its composite Legacy, Handover and Closedown Programme and enabler workstreams will be on-going throughout the transition period (to April 2013). Progress will be reported to the North Central London Senior Leadership Team weekly and overall Cluster migration status will be reported monthly to the pan-London System Transition Group (STG). Strong links will be maintained with the STG to ensure the Cluster is sighted on and prepared for developments in transition as they occur.

NHS Commissioning Board Authority (NHS CBA)

From 1 October 2012, the NHS Commissioning Board will become a Non-Departmental Public Body, assuming its full statutory functions and acting as a host to other new receiving organisation that continue to emerge including the Commissioning Support Units (formerly Commissioning Support Services) and Clinical Commissioning Groups.

With the appointment of Anne Rainsberry as Regional Director of the NHS Commissioning Board London (NHS CBL), work is underway on its design so that it can begin operating from October and take on its full range of responsibilities from April 2013.

Appointments have now been made to the senior leadership team at the NHS Commissioning Board Authority (NHS CBA). Each Director now in post is working closely with their emerging teams to ensure the Board Authority is ready for its launch in October.

At the time of writing, finalised structures for the Board were due to be released by the end of August 2012 following a period of engagement, review and refinements to reflect feedback. Cluster representatives were involved in Design Groups to shape these structures, specifically in the areas of Primary Care and Direct Commissioning.

From 1 October, the NHS Commissioning Board London will report to the accountable officers within Sending organisations (i.e. PCT Cluster Chief Executives) for the in-year delivery of specific functions. The NHS CBA will also be responsible for planning for 2012-13-14.

Public Health

It is understood that the majority of Public Health functions will transfer from the Cluster to Local Authorities, Public Health England (PHE) and the NHS Commissioning Board in April 2013. It is likely that specific functions such as screening and immunisation will transfer at an earlier stage.

Nationally, a joint operating model between Public Health England and the NHS Commissioning Board is currently being developed as part of the design process for the commissioning of screening and immunisation. Outstanding issues are currently being worked through with national colleagues, including differences in views about the role of Public Health and variances in the NHS Commissioning Board Local Area Team or Public Health England structure as elsewhere.

Transition plans have been developed by each of the local Public Health teams across North Central London, and used to develop an understanding of key local issues and input emerging intelligence on national timescales. Implementation of these plans will depend on the resolution of any issues during the transition period, and to a degree on the readiness of Local Authorities and Public Health England to receive public health functions in advance of April 2013.

Local planning is also dependent upon the timely receipt of national guidance – specifically in relation to the legal basis for people transition (TUPE or Transfer Orders), Shift phase guidance for the novation of contracts, and the financial allocations for Public Health.

Local teams are being encouraged to prepare contingency plans in the event that the guidance produced is not sufficiently prescriptive, and we are working closely with NHS London to keep abreast of any developments.

NCL has an established dialogue with NHS London through weekly London Public Health transition meetings which provide an opportunity to escalate issues that require a regional and/or national solution and also to share best practice across London.

Each local team is close to completing a register of all Public Health contracts which they currently commission. This has been supported by work within the cluster contracts and finance teams to provide a breakdown of the Public Health service lines of the block contracts.

Work is on-going with the NCL Cluster HR team to ensure local Public Health teams are receiving the necessary support and clarity they require on emerging people transition issues. There are regular briefings with local teams, and where necessary, any issues arising have been escalated.

Finance and HR are working together to establish the ‘overhead allocations’ – which maps the future destination of NCL cluster staff who have a Public Health element to their work but may not necessarily face the Local Authorities. It is essential that we have a clear understanding of which functions are currently provided, where the funding will flow, where the role of the individual will be mapped to, and the future destination of the individual themselves in order to ensure that local councils are clear on which services they may need to acquire in the future through arrangements with organisations such as the CSU, PHE, CCG and NHSCB.

Where Public Health functions are merging (in Barnet and Harrow and in Camden and Islington) joint Transition Group arrangements are now in place for the duration of the transition period. The swift appointment of a single Director of Public Health in each of these areas is critical to driving the local transition forward.

Commissioning Support Units (CSUs)

Following confirmation that all 23 NHS Commissioning Support Units will progress to be hosted by the NHS Commissioning Board from 1 October 2012, the NHS Commissioning Board Authority is now using the term 'commissioning support unit' (CSU), rather than the previously used term 'commissioning support service' (CSS) so it can begin to distinguish these NHS organisations from others in the wider commissioning support services market.

From 1 October 2012 the North Central and East London Commissioning Support Unit (NCEL CSU) will be hosted by the NHS Commissioning Board, as it becomes responsible for delivering agreed functions on behalf of 12 Clinical Commissioning Groups. The NHS CBA is currently developing these hosting arrangements through a series of working groups focusing on key areas such as HR, informatics, intellectual property and estates.

The outcome of the business review and assurance process for the majority of commissioning support services to be provided at scale has been agreed. The Board Authority has named the CSUs that will offer business intelligence, clinical healthcare procurement and business support services.

The outcome of the 'Checkpoint 3' business review process will be a provisional licence to operate. These outcomes for each CSU have now been discussed with Managing Directors. The Full Business Plan for the NCEL CSU was prepared and shared as part of the Checkpoint 3 timeframes in August 2012. Future checkpoints are expected in December 2012 and in Spring 2013. Site visits of each CSU will be undertaken by the NHS CB and NHS London as well as independent business experts in October. Each CSU submitted proposals for its future name and brand identity as part of the Full Business Plan which, subject to agreement, will form an integral element of the license to operate arrangements.

Draft guidance on HR and recruitment has been shared with CSUs. The governing body of a CSU cannot be a 'Board' or have Non-Executive Directors. Appointments have now been made to all Director-level posts within the NCEL CSU, and job matching is underway to ensure staff are appointed to all tiers of the organisation.

Clinical Commissioning Groups (CCGs)

From 1 April 2013, England must have complete coverage by established Clinical Commissioning Groups (CCGs) to ensure the whole population is appropriately served. In order for CCGs to take on the full range of their statutory duties they must be authorised to do so by the NHS Commissioning Board (NHSCB). First applications by CCGs to the NHS Commissioning Board Authority to become authorised were submitted on 2 July; site visits undertaken in September; and decisions made in October. Final decisions on authorisation are expected in January 2012.

Islington CCG successfully submitted its authorisation application in wave one in July. A subsequent mock site visit by the NHS Commissioning Board proved to be a valuable learning experience, and the feedback from NHS London is now being used to help prepare the CCG's governing body for the site visit with the NHS CBA on 18 September.

Preparations are underway by Haringey, Camden and Barnet CCGs ahead of their application submissions in wave three.

Each of the five emerging CCGs in North Central London is in the process of recruiting and appointing the members of their governing bodies and leadership teams.

To reflect the changing nature of the system from October, new contractual arrangements are being developed between the CSU and CCGs in the form of Service Level Agreements. A 'Learning by doing' event has been scheduled for early October to enable a simulation of how CCGs, the NHS Commissioning Board and CSU will operate within the new health system to commission effectively from providers. The event will test the architecture of the organisations, as well as identifying what enablers and blockers are likely to support and challenge commissioning.

Meetings have taken place across the Cluster team to discuss collaborative working and the support CCGs may require in helping to decide which collaborative working options they would like to take forward in the future. As part of this discussion, risk-sharing proposals have been developed, seeking to encourage CCGs to prepare for the future by adopting an agreed approach to risk sharing during the shadow-operating period.

Enfield CCG continues to work on their application for the delegation of all remaining eligible budgets. An informal review is taking place with some members of the Cluster team on 29 August, and a second review will be scheduled prior to the NCL Director Panel review on 26 September. The final sign off of Enfield CCG's application for delegated responsibility is scheduled with the sub-group of the joint boards on 3 October, prior to the submission of their wave 4 application for authorisation on 1 November.

In addition, the new working arrangements for the Clinical Commissioning Council have now been agreed. New terms of reference were agreed at the Council meeting in July, transforming the Council into a collaborative organisation for the 32 London CCGs. The working arrangements for the Council have been developed in a series of meetings with designate Chief Officers/Chief Clinical Officers. Howard Freeman has been appointed as chair for two years.

If residents of your boroughs have any questions about Transition at NHS North Central London or would like to receive further information or information in another format, please contact: Amy Bray, Transition Programme Manager, Amy.Bray@nclondon.nhs.uk

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