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17 March 2022

To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Friday, 18th March, 2022

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

6. MINUTES (PAGES 1 - 8)

9. ICS FINANCE/GOVERNANCE (PAGES 9 - 12)

Yours sincerely

Dominic O'Brien,
Principal Scrutiny Officer

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MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 28TH JANUARY 2022

PRESENT:

Councillors: Pippa Connor (Chair) (Haringey), Clarke (Vice-Chair) (Islington), Cornelius (Barnet), Levy (Enfield), Cllr Revah (Camden) and Tomlinson (Camden)

13. FILMING AT MEETINGS

The Chair referred Members present to item 1 on the agenda in respect of filming at this meeting. Members noted the information contained therein.

14. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllrs Linda Freedman (Barnet) and Khaled Moyeed (Haringey).

15. URGENT BUSINESS

None.

16. DECLARATIONS OF INTEREST

Cllr Connor reported that she was a member of the Royal College of Nursing and that her sister worked as a GP in Tottenham. Cllr Cornelius reported that she was a Council appointed Trustee of the Eleanor Palmer Trust.

17. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Committee received a deputation from Brenda Allan and Alan Morton from NCL NHS Watch regarding the Estates Strategy. Ms Allan stated that the 2018 Strategy had outlined the financial imperatives that lay behind it, which were that there was not enough funding for services. Capital raised from asset sales had been used to address shortfalls in funding. There had been a lack of accountability in this process and estates had been eroded. In some cases, capital receipts had been transferred to revenue accounts.

There had been political and community opposition to the plans in the strategy. There had been no local authority on the estates decision making board. Better decisions were taken when more stakeholders were involved. Alternatives to asset disposals needed to be looked and decision making broadened out. It was important that the value of estates be retained by the NHS and not just used for one-off revenue expenditure. Details of asset disposals also needed to be put in the public domain. She felt that the Committee should agitate for alternatives to asset disposals to be

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considered fully by NHS partners so that it could be ensured that the NHS had the resources it needed for the future.

In answer to a question, Ms Allan stated that one option would be for the NHS to let properties for use as offices or housing so that it remained as a landowner. This would both release funds and retain value. She was aware that money was tight and that budgets had been capped but creativity was required in order to avoid longer term problems. In answer to another question, she stated that the Estates Board was the key decision making body. Membership of this needed to be broadened out and voting rights given to external participants.

The Committee thanked Ms Allan and Mr Morton for their contribution.

18. MINUTES

RESOLVED:

That the minutes of the meeting of 26 November be approved.

19. UPDATE ON THE ROYAL FREE AND NORTH MIDDLESEX HOSPITALS PARTNERSHIP

Caroline Clark, Group Chief Executive of the Royal Free, and Dr Nnenna Osuji, Chief Executive of the North Middlesex Hospital, reported on the strategic partnership arrangement that had been developed between the two NHS trusts.

Ms Clark stated that it was important that all providers in north London worked together. In particular, there needed to be equity between services in the north and south of the area covered by north central London. The aim of the partnership was to strengthen services and improve access. In addition, it would allow further consolidation of more specialised services. Chase Farm hospital had been rebuilt and was now a great facility for all in north central London. There were also plans expand provision on the site further.

She reported that it had been found that there were variations in community services in the area and the need to invest in them was greatest in the area around the North Middlesex hospital. Such investment was likely to assist with the performance of the hospital. The partnership arrangement could also help staff to work across the health system and area as well as bringing in more resources.

Dr Osuji stated that the two trusts had been working in partnership since 2017. The relationship had now been formalised though and this has made it easier to respond quickly to challenges. There was now a Partnership Board and a Memorandum of Understanding. The North Middlesex hospital served the vast majority of the population of Enfield and Haringey. There was a need to ensure that there was equity and parity in service provision and the closer arrangements would enable further consideration of inequality, including scrutiny of relevant data. Consideration was being given to bringing the population health committees from each trust together.

It was intended that the closer arrangements would increase the sum of the individual efforts of each NHS trust. It would also provide specific opportunities for development. The North Middlesex Hospital was a local hospital for local people and would always provide a range of core services, such as ITU, emergency care and maternity services. There were some more specialised services that the trust was less able to provide and the new arrangements would assist in making them more accessible.

She reported that during the Omicron upsurge in Covid cases, additional beds had been put in place quickly on the Chase Farm site and Cape Town ward had been established. The new arrangements had enabled this to be undertaken quickly. There was a need to level up services in Enfield and Haringey and additional funds had been acquired to expand the community mentoring scheme. The Emergency Department at the North Middlesex dealt with challenging numbers of presentations but less than 10% of those attending needed to be admitted and most could be dealt with better in other settings. Work had taken place with primary care to provide access at the hospital and different models were currently being looked at for longer term provision.

In answer to a question on risks, Dr Osuji stated that it was essential that there was honesty and explicitness regarding challenges. It was not the first time that there had been a partnership with the Royal Free and it was important that there was clear messaging regarding its benefits. It was a partnership of equals with each partner contributing. Ms Clark stated that they wanted to be open and transparent. The objective was to ensure that there was a better offer for all patients.

In answer to another question, Dr Osuji stated that the new arrangements provided the opportunity to create different job opportunities, including progression, diversification and new posts. Both trusts were currently holding vacancies. There was a particular need for investment in community services.

Sarah Mansuralli, Executive Director for Strategic Commissioning at NCL Partners, reported that there had been a review of community services and this had revealed a large amount of inequity and this manifested itself in hospital performance. NCL Partners were looking to invest, particularly in the area around the North Middlesex Hospital, which was where there were the most significant gaps. This would be resourced by growth funding, delivering care in different ways and productivity gains.

In answer to a question, Ms Clarke stated that Chase Farm was being developed as the elective orthopaedic centre for the area, with the intention of it providing more low complex procedures. The increased levels of activity would improve quality and provide economies of scale. There were now 120,000 people awaiting treatment and there was a clear need for additional capacity to address it. In addition, there also needed to be the staffing resources required to reduce it.

Dr Osuji stated that transport was an important issue for the North Middlesex hospital and discussions were planned with Transport for London. In addition to making it easier to travel between sites, this could also help to address the green agenda. She would be happy to come back to the JHOSC to report further on this.

In answer to a question, Ms Clarke stated that the development of Chase Farm had been designed with the recognition that it may have to be expanded further in due

course. It would therefore be relatively easy to develop further the existing buildings on the site.

RESOLVED:

1. The trust report further to a future meeting of the JHOSC on the action that they were taking to address staff recruitment and retention and mitigate any areas of shortage; and

2. That health scrutiny overview and scrutiny committees in each borough be recommended to consider the role of their borough in the development of community services in their area.

20. ESTATES STRATEGY UPDATE

Nicola Theron, NCL Director of Estates, outlined progress with the Estates Strategy. The previous update to the Committee had been before the Covid pandemic. New governance structures had since been put in place. There was now an Estates Board which included Council representation, although it was not a decision making body. There were also local estates forums which included a range of representatives from individual boroughs, including Councils. These looked at how partners worked together, shared agendas and the securing of external funding. Representation from the Committee on these would be welcome.

More than 50% of primary care accommodation had been assessed as unfit for purpose. There was a driving need for investment and the realisation of assets. The process was also about reinvestment of capital. The aim was to ensure that all of primary care estates were fit for purpose but there was insufficient capital available currently. However, there had been some successful external bids for capital.

It was noted that it was important that there was system wide prioritisation covering the next three to ten years. There was not enough funding at the moment although some had been obtained though Section 106 agreements and the Community Infrastructure Levy (CiL). NCL were looking to work with partners on a local and national basis.

Ms Theron reported that there was a need to blend spending on estates and digital provision in a better way. There were some emerging examples of where this was taking place. There was also a need for increased capacity at borough level with consistency and improved access. Health inequalities also needed to be addressed as well as better coordination of governance arrangements.

The three year indication of capital allowances was useful as it facilitated planning. There was a £20 million reduction in capital though and consideration was being given to clinical led prioritisation. It was expected that the capital shortfall would reduce. There was a need for ambition to be maintained and external funding to be obtained.

It was noted that Estates Strategy was likely to be updated later in the year. It would need to ensure that Primary Care and Primary Network (PCN) priorities reflected local needs and optimises work with local authorities. There had been few recent estates disposals because of the pandemic.

In answer to a question regarding local estates forums, Ms Theron stated that they were similar in each borough. The Camden forum had met recently and the meeting had involved around 20 partners, including a number from the Council. They typically met quarterly but there were also informal monthly meetings. There were terms of reference for the forums. Representation from Councillors would be welcome, either on an ad hoc basis or more regularly.

The Committee requested further information regarding terms of reference, how local concerns were fed into the forums, their relationship with the NCL Estates Board. Details of membership and access to minutes were also requested.

In answer to another question, Ms Theron stated that she was happy to provide an update on property disposals for a future meeting. Some of the receipts had been reinvested in IT and supporting the workforce. Where divestment took place, the intention was for it to be done in order to re-invest. It was part of the process of developing the best possible care for local people.

The Chair stated that an update on disposal of assets would be welcome, including details of which estates had been sold and how the capital realised had been used. Assets could only be sold once and it was therefore important that the process was sustainable.

The Committee noted that there was a £40 million gap in funding for primary care. Ms Theron stated that more work was needed on how this gap would be reduced. NHS Property Services had less money at their disposal and strong cases therefore needed to be developed to secure funding. There was a five year plan and it was important to fund growth and the equalities agenda. Plans needed to be deliverable and each priority secured. It was important to ensure that the revenue implications of investments were affordable and space needed to be used as efficiently as possible. In addition, they were always looking to replace a capital scheme with an affordable revenue solution.

The Chair requested further information on how revenue fitted in with capital as well as to gain an understanding regarding capital receipts, including who they were retained by. It was important to avoid the selling off of estates to mitigate revenue pressures. In addition, further detail was requested on alternatives to disposals and what would be the impact of the £40 million funding gap not being breached.

RESOLVED:

That a further update be provided to the Committee on the Estates Strategy including:
- Governance including terms of reference, membership and minutes of estates bodies plus how local concerns are fed into local estates forums and their relationship with the NCL Estates Board;
- Detail on disposal of assets, including which properties have been sold and how the capital realised had been used;
- Alternatives to asset disposals; and
- What would be the impact of the £40 million funding gap not being breached;

21. DENTAL SERVICES UPDATE

Kelly Nizzer, Andrew Biggadike and Rakhee Patel from NHS England reported on NHS dental services in north central London.

Ms Nizzer reported that dental practices had been asked to close at the start of the Covid pandemic due to safety concerns for patients and staff. They had remained closed for 12 weeks, which had caused a large backlog. During this period, only patients in urgent need had been seen. Urgent care hubs had been established and these had been treating between 1500 and 1750 patients per day. These were still operating, although the numbers of them had been reduced. Primary care dental services were being gradually re-established, with full capacity being reached in the current quarter. The backlog in each borough varied and was dependent on the size of the NHS contract.

£50 million of short term funding had been allocated by the government to address backlog. The funding was only for eight weeks and could not be carried over. It did not provide for the full range of treatments and was only intended to stabilise patients. There was a London wide access issue for dental care and this had been the case before the pandemic. Services were doing that they could to deal with it. There were still 35 urgent care hubs and these were operational from 8:00 a.m. till 1:00 a.m. and were treating 600 patients per day. This was not happening anywhere else in the country. However, they could only see people who were in pain. The eight weeks of additional funding was welcome but would not fully address the backlog.

Mr Biggadike reported on waiting times for secondary and acute care. There were no patients waiting for more than 104 weeks at the Royal Free but there a small number waiting for between 52 and 89 weeks. At UCL, there was only one patient that had been waiting over 104 weeks and the majority were under 52 weeks. The backlog was affected by clinical priority as those waiting for dental procedures were often not considered high enough. Some additional funding had been obtained to provide additional general anaesthetic procedure rooms at Barts though. North east London and Barts had the longest waiting list. Community Dental Services were recovering well but still under pressure. In respect of looked after children, there was a pilot project in place for high street dentists to treat them. Oral health promotion was reliant on being commissioned by local authorities and some were better than others in doing this.

Ms Patel reported that there was variation in the levels of dental health amongst children in north central London. 27% of five year olds had been found to be suffering from some sort of decay. Levels in Haringey and Enfield were well above the average. Mr Biggadike stated that London wide fluoridation would address this but it was very unlikely to happen. Some schools had supervised brushing as part of oral health promotion. Some oral health promotion work was also done with special schools. It would be beneficial for more work to be done but there was a lack of funding. It was dependent on local authorities for funding and being made a priority. It was noted that provision varied between boroughs. Some provision was universal and some was targeted, with targeted services being the direction of travel. Four of the boroughs commissioned services from Whittington Health whilst Barnet had commissioned a private company and only provided for children and not care home or for people with a

learning disability. Levels of dental decay were highest amongst deprived communities.

In respect of the oral needs assessment, Ms Patel stated that there was a need to do this across London. All relevant data needed to be looked at, needs assessed and gaps identified. It was important to ensure that practices were located in the right places when re-procurement took place.

Councillor Cornelius requested further information regarding oral health promotion in Barnet. Mr Biggadike stated that Barnet had not procured its services from a community provider but was instead using an external provider. Historically, it had only provided such services to children and young people. He agreed to provide further details of the current situation to Councillor Cornelius.

In answer to a question regarding access funding, Ms Nizzer reported that funding could not be accrued and would not be sufficient to clear the backlog. She was not anticipating any underspend though. Continued funding had been provided for the urgent care hubs in London though. It was noted that there would be ongoing challenges in Community Dental Services and secondary care as well.

The Committee expressed concern at the size of the backlog and at the long waiting times for secondary care. It expressed its support for efforts to secure additional funding and improve access. It was agreed that information would be sought from each Director of Public Health in north central London regarding funding for Oral Health Promotion and how this was allocated.

RESOLVED:

That information be sought from the Director of Public Health in each borough regarding funding for Oral Health Promotion and how this was allocated.

22. WORK PROGRAMME

It was agreed that the next meeting of the Committee would consider the following items:

- Mental Health and Community Services Review; and
- ICS Finance.

In respect of the proposed LUTs item, Ms Mansuralli reported that that the service was now operating according to clinical guidelines and there was no further reviews planned. Only adults were being treated by the service whilst children were being treated by Great Ormond Street and other NHS tertiary providers. It was agreed that she would provide a short update in writing to confirm this.

In respect of the Mental Health and Community Services review item, it was agreed that the two issues would be separated out. Although there were common areas between them, there were also key differences.

It was agreed that the Fertility Review and Digital/Health Inequalities be added to the list of items for future meetings. In addition, the proposed item of workforce should be

expanded to include details of initiatives at between the Royal Free and the North Middlesex Hospital.

CHAIR: Councillor Pippa Connor

Signed by Chair ………………………………..

Date …………………………………

NCL ICS – response to questions from Cllr Connor, chair of NCL JHOSC 17.03.2022

The questions received are in bold, with responses after each.

The outline responsibilities of the ICB are on slide 9 in the main pack, along with the membership of the emerging forums supporting the development on slides 11-13. The key financial principles are on slide 17 and these are guiding the development of a finance strategy of the ICS.

It is important to note, final financial guidance for 2022/23 is not yet published and allocations are draft – and subject to further changes. The CCG remains the statutory body planning for 2022/23 as the date

- **The current financial situation for each of the main Hospitals trusts within NCL CCG**

The planning process for 2022/23 is currently underway so it is not possible to share figures for the upcoming financial year yet.

A summary of the 2021/22 figures are being prepared and will be shared with the committee.

N.B. All NHS trusts will continue to make their annual accounts publicly available on their websites:

- https://www.royalfree.nhs.uk/about-us/corporate-information-and-accountability/annual-reports/
- https://www.whittington.nhs.uk/default.asp?c=1030
- https://www.northmid.nhs.uk/corporate-documents/
- https://www.uclh.nhs.uk/about-us/what-we-do/our-performance/annual-report-annual-plan-and-quality-account

- **An explanation on how any debt or financial surplus will be managed across all Trusts.**

NHS Trusts will be required to manage their financial plans in line with the current financial regulations. Organisations have agreed financial principles to help ensure that there is alignment between organisation and system financial sustainability. The NCL financial principles are on slide 17 and these are guiding the development of a finance strategy of the ICS.

- **Who has responsibility for individual financial overspend once the NCL ICS board is officially formed?**

NHS Trust boards will continue to be responsible for the financial position of their own individual organisations.

The ICB will be responsible for the annual allocation process, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). The ICB will be regulated by NHS England in a similar way to the CCG is now.

- **How will each Trusts AGM report their finances both to their own board and the NCL ICS board. Which board will have final decision making in terms of any new proposals with a substantial financial tag.**

NHS Trusts will continue to report their finances to their boards and publish annual accounts, and will be responsible for making decisions within the agreed financial architecture and funding envelopes. The ICB will work closely with providers to determine where new investments are made.

Trusts will continue to approve spend relating to their own organisations.

- **Details of any extra money that the government will be giving to newly established ICS's and whether these are one off or ongoing**

There hasn't been any additional funding given to ICSs specifically. There will be been additional investment to support the elective recovery in 2022/23, as part of the national response to the Covid-19 pandemic. This is linked to the activity that trusts complete. The final guidance on how the detail will work is still awaited.

- **How the NCL ICS will be structured in terms of financial governance, who will be on the main board?**

The Integrated Care Board will take on the current statutory responsibilities of the CCG. On this board there will be:

- Chair
- Two Independent Non-Executive Members
- Two Partner Members- NHS Trusts and Foundation Trusts
- Two Partner Members- Providers of Primary Medical Services
- One Partner Member- Local Authorities
- One Partner Member- UCL Provider Alliance
- Chief Executive
- Chief Financial Officer
- Chief Nurse
- Chief Medical Officer.

The detail of the proposed governance is on slide 10. This is still subject to change, subject to the legislative process.

- **How will the NCL ICS be scrutinised in terms of financial spend? Where will minutes be published from the finance board?**

The ICB will be regulated by NHS England in a similar way to the CCG is now. The ICB will hold meetings in public and publish papers on its website. We expect local scrutiny arrangements to continue through HOSCs and NCL's JHOSC.

- **What role will the government play in any financial oversight?**

The ICB will be regulated by NHS England in a similar way to the CCG is now. NHS England in turn has a relationship with The Department of Health and Social Care.

- **How will the NCL ICS finance board interact with the 5 local boroughs?**

The ICB will have statutory responsibility for the NHS budget and spend as the CCG currently does now.

There will be continued work with partners to develop how this works at place or borough level, but there will be no changes to financial arrangements on the 1 July in the creation of the ICB as a statutory body.

- **How will any council representative on any board be supported in both understanding and challenging any future initiatives?**

The Local Authority partner member will have officer support to work as part of a unitary board.

- **How will the public have any awareness of decisions taken at board level?**

ICB will hold meetings in public and publish papers on its website, as the CCG does currently. There will also be continued engagement through current borough engagement forums and mechanisms.

We are also continuing to develop a strategic engagement forum, with members of healthwatch, Voluntary sector groups and lay members. This is described on slide 11.

We are also learning and building on work like the orthopaedic review to build up improved engagement and involvement processes.

Last week we advertised two important roles in our new NCL ICB Executive Management structure – for Independent Non-Executive Members. These roles bring independent oversight and constructive challenge to the priorities, plans and performance of the ICB and decision making. They are similar to the Lay members of the current CCG Governing Body.

- **Who will chair any future NCL ICS finance board?**

For the ICB, this will depend on the final constitution, in addition to the Chief Financial Officer (yet to be appointed) a finance committee will need to have non-exec/lay members and may include the chair.

- **Who will oversee any joint NCL ICS and Council funded projects?**

This will depend on the project. There are already joint arrangements called section 75 agreements for jointly managed budgets. These have joint NHS and Local Authority officer leads.

- **If the NCL ICS overspend or are in debt at the end of the financial year what powers do any external authority such as NHSE or the Secretary of State for Health and Social Care**

The ICB will have statutory responsibility for the NHS budget and spend as the CCG does now.

The ICB will be regulated by NHS England in a similar way to the CCG is now. NHS England in turn has a relationship with The Department of Health and Social Care.

- **What is the role of the Health and Wellbeing boards in relation for any initiatives undertaken by the NCL ICS in terms of the financial commitment and oversight of outcomes?**

The Health and Care Bill does not change the roles or remits of the Health and Wellbeing boards, they remain statutory committees of the Local Authority.

- **How will the JHOSC be aware of any new proposals with a significant financial impact or significant impact on local services for residents so they can scrutinise any decisions?**

The ICB will continue to work closely with the JHOSC, and local HOSCs, as the CCG does now.

- **Currently, are all trusts within the NCL CCG's financially stable? Are any trusts in deficit and if so will taking this deficit into a new single NCL ICS finance board incur any financial penalties from the government?**

As per the finance information shared above, there are some financial challenges across North Central London. The ICB will be regulated by NHS England, not the government.

- **What plans do each of the trusts have in place to keep their books balanced? Will this include the sale of Estates?**

As part of the move to the ICB, a financial strategy is being developed. We are happy to share this once more developed. This will align with the NCL estates strategy to ensure that we have a fit-for-purpose estate to meet the needs of local people and the health and care system