NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday 25th July, 10:00 a.m.
Committee Room 2 (First Floor), Camden Town Hall, Judd Street WC1H 9JE

Contact: Dominic O'Brien, Principal Scrutiny Officer

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Councillors: Rishikesh Chakraborty and Philip Cohen (Barnet Council), Larraine Revah **(Vice-Chair)** and Kemi Atolagbe (Camden Council), Chris James and Andy Milne (Enfield Council), Pippa Connor **(Chair)** and Matt White (Haringey Council), Tricia Clarke **(Vice-Chair)** and Jilani Chowdhury (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. ELECTION OF CHAIR

To elect the Chair of the Committee for the 2024/25 municipal year.

4. ELECTION OF VICE-CHAIRS

To elect two vice-Chairs of the Committee for the 2024/25 municipal year.

5. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 14 below).

6. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

7. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

8. TERMS OF REFERENCE (PAGES 1 - 2)

To note the terms of reference for the NCL JHOSC.

9. MINUTES (PAGES 3 - 34)

To approve the minutes of the North Central London Joint Health Overview and Scrutiny Committee meetings on 18th March 2024, 30th May 2024 & 31st May 2024.

10. START WELL UPDATE (PAGES 35 - 60)

To receive an update on the 'Start Well' programme following the recent public consultation on proposed changes to maternity, neonatal and children's services.

11. PRIMARY CARE ACCESS (PAGES 61 - 78)

To receive an update on access to primary care services in NCL.

12. DENTAL SERVICES (PAGES 79 - 92)

To receive an update on dental services in NCL.

13. WORK PROGRAMME (PAGES 93 - 100)

This paper provides an outline of the 2024-25 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

14. NEW ITEMS OF URGENT BUSINESS

15. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

- 9th September 2024 (10am)
- 11th November 2024 (10am)
- 3rd February 2025 (10am)
- 7th April 2025 (10am)

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Wednesday, 17 July 2024

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Agenda Item 8

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

Terms of Reference

1. To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

2. To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

3. To respond to any formal consultations on proposals for substantial developments or variations in health services affecting the area of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

4. The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

5. The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

6. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

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MINUTES OF MEETING OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Monday 18th March 2024, 10.00am-1:05pm

PRESENT:

Councillors: Pippa Connor (Chair), Tricia Clarke (Vice-Chair), Larraine Revah (Vice-Chair), Kemi Atolagbe, Rishikesh Chakraborty, Philip Cohen, Andy Milne and Matt White

51. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

52. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Jilani Chowdhury (Islington) and Cllr Chris James (Enfield).

53. URGENT BUSINESS

None.

54. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

55. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

56. MINUTES

Cllr Connor noted that a response had been received from NCL ICB to the recommendations made by the Committee following a deputation regarding the proposed sale of GP practices from Operose Health to HCRG Group. Cllr Revah noted that further questions could be asked about the background of the new

company that would be taking over the GP practices and Cllr Clarke expressed particular concerns about data gathering practices.

The minutes of the previous meeting of the North Central London Joint Health Overview and Scrutiny Committee were approved.

RESOLVED – That the minutes of the meeting held on 29th January 2024 be approved as an accurate record.

57. NCL COMMUNITY AND MENTAL HEALTH CORE OFFER

Cllr Connor opened this item and welcomed the NCL ICB colleagues and the local community groups that had joined the meeting.

Lauretta Kavanagh, Programme Director for Mental Health, Learning Disability and Autism at NCL ICB, introduced the report which provided an overview of the Core Offer programmes for Community and Mental Health services across North Central London (NCL) including improvements for residents made in the past year as well as the vision for delivery and challenges going forward.

Kay Isaac, Director of Operations at the Central London Community Healthcare NHS Trust, spoke about the investment into community services, the aim of which was to address health inequalities and reduce the 'postcode lottery' in terms of outcomes across the NCL area. The additional investment in 2023/24 included:

- **£2.5m for children and young people's services** – priority investment areas included streamlined assessment pathways for autism, Children's Looked After (CLA) service and CYP Special School Nursing.
- **£1.9m for adult services** – priority investment areas included work to reduce the length of hospital stays which had resulted in the average stay reducing from 34 days to 18 days. In addition, the time from referral to admission had reduced from 5 days to 3 days. Another priority area was faster responses for urgent care at home to help avoid the need for hospital admissions. Additional capacity had been provided for speech and language therapy.
- **£6.9m for virtual wards** – this investment had increased the number of virtual ward beds in NCL from 118 to 175, enabling more people to come out of hospital earlier and receive the same treatment at home.

Lauretta Kavanagh explained that 2023/24 was year 2 of the implementation of the core offer and that significant progress had been made with the additional investment made being generally against the tide of the wider financial pressures faced by the NHS. There was a lot of data to demonstrate increased access to services, increased workforce capacity and also work to level up the quality of services.

Jess Lievesley spoke about other major developments including the merger of the two Mental Health Trusts in NCL, which was expected to be completed by October 2024, the recent opening of a new inpatient facility at Highgate and the development of a single point of access for crisis mental health services.

A video presentation was played to the meeting about the transformation of community services and improved access to services in NCL. This video would be uploaded onto Youtube so that it could be accessed by a wider range of community groups and a booklet was also being produced for distribution. It was also suggested that the information could be promoted at the Mental Health Strategic Partnership in Barnet.

ICB officers responded to a range of questions and discussion points from Committee Members and community groups:

- On the issue of waiting time for autism diagnosis, Ruth Glover, Director of Open Door, commented that the process could often be complicated as young people with autism also had other conditions such as ADHD. She added that diagnosis was often important in gaining access to certain services and that Open Door had received some funding to provide support to young people pre, during and after diagnosis. Lauretta Kavanagh noted that there were some figures on waiting times on page 21 of the report in the agenda pack. She acknowledged that the pathways were too complex and that, from next year, there would be a programme of work to simplify them and to strengthen post-diagnostic support. The additional investment was particularly important due to the continued rising demand for autism services, among both children and adults. Cllr Connor noted that the Committee had previously highlighted waiting times for autism/ADHD diagnosis as an issue of concern at its meeting last year (Feb 2023) and suggested that, in addition to this, there should be closer communication between the NCL ICB and local organisations such as Open Door to ensure that the service offer met the needs of service users and that there was a joined up approach. **(ACTION)**
- Cllr Clarke noted that the waiting times for autism services were long in Islington although the cost per head was higher than other boroughs. She also expressed concerns about the impact of the long waiting times on early intervention. Lauretta Kavanagh explained that the spend in Islington was not as high when weighted according to need and that the aim of the current work was to equalise investment and outcomes across the NCL area.
- Cllr Revah expressed concern about young people potentially falling through the gaps of services and not being diagnosed until later in life. Jess Lievesley said that wait times for young people had come down significantly but had risen for adults as more people came forward later in life, but that the system was under pressure to cope with the additional demand from both cohorts.
- Cllr Revah asked what support was provided to people while they were waiting for an assessment for autism/ADHD. Lauretta Kavanagh said that there was a programme of work available for adults to have a support offer across NCL rooted in the voluntary sector. This was both for people on the waiting list for autism/ADHD and also post-diagnosis. Around £500k of investment was being made available for this programme in 2024/25.
- Anne Essex from Camden Carers highlighted the feeling that some carers experienced of a lack of compassion when in contact with services and an emphasis on what cannot be done rather than what support could be provided.

Jess Lievesley said that he was sorry to hear about this experience as this kind of support should be integral to how care was delivered. He added that there was high and rising demand for services on neurodevelopmental pathways, compounded by the need to provide ongoing support. The breadth of provision needed to be expanded, including to support people to move back into their lives and this meant a key role for the voluntary sector. Lauretta Kavanagh acknowledged the gaps in pathways and said that work was ongoing on how this could be improved next year, including by improving the availability of specialist mental health professionals across NCL. She added that, with the demand for autism/ADHD diagnosis so high, the challenge was to work with people earlier in the pathways and onto the right pathways so that resources were used wisely.

- Cllr Revah asked if any work was being done for carers who were worried about how a loved one with mental health conditions would be cared for after they themselves had passed away. Jess Lievesley said that he wasn't aware of any specific work in this area but acknowledged that this could be a worry for people and that cases such as this would be best managed not just by the NHS but in partnership with local authorities and voluntary organisations working with carers.
- Peter Lyons, representing mental health carers, highlighted the lack of supported accommodation in NCL people with severe mental health issues. Lauretta Kavanagh responded that, while this was not a primary responsibility of the NHS, the did work closely with local authority colleagues in this area. She said that further details about this could be provided by Richard Elphick at North London Councils about this integrated work. **(ACTION)**
- In relation to the ambition to equalise service performance, Cllr Milne requested assurances that this would bring everyone up to top performing level rather than lowering performance in any areas. Jess Lievesley clarified that the ambition was to level up and not level down but that there were some excellent pockets of practice in NCL as well as some pockets of deficit and so the aim was to balance this.
- Asked by Cllr Chakraborty about the bottlenecks that were preventing the rapid implementation of the solutions that were being discussed, Jess Lievesley said that these were many and varied. As an example, he explained that, in relation to the neurodevelopment pathway, there was currently no exit pathway from secondary care to be discharged to primary care so therefore a relatively well patient would continue to sit with secondary care providers which limited their ability to take on new patients.
- Cllr Clarke referred to a written statement provided by the Stuart Low Trust, a charity supporting adults at risk due to mental health issues and social isolation. However, they had not been invited to participate in the Islington Care Partnership and felt that more investment was needed in the model of integrated care to include the value offered by smaller local providers. Lauretta Kavanagh agreed to consider with colleague how these arrangements could be strengthened.

- Cllr White noted that, while neurodevelopment assessment waiting times for young people had improved, they were still long and asked whether further investment to reduce waiting times could result in savings by reducing treatment costs in the future. Jess Lievesley responded that assessments took around three hours so the capacity required to do this was high and so workforce was a factor as was balancing the overall needs of mental health services. He explained that the current goal was to work towards 28-day access and that the rates for this had increased from around 40% last year to over 70% now. Additional capacity had been brought in from the independent sector to help improve access times. Cllr Connor noted that the 28-day target applied only to assessments and not the time to get to the treatment stage. Lauretta Kavanagh responded that the whole pathway was being reviewed.
- Peter Lyons said that, although there were promises to do things quicker and better, he wanted more clarity on how outcomes would be measured. He referred to an example of being on the phone for four hours to access crisis support. Jess Lievesley acknowledged that the process was convoluted and that there was a need for a single route to access crisis services and said that this would be changing as part of the ongoing work, in addition to addressing the issue of differential service provision across NCL. Adele McCormark explained that the outcome measures had historically focused on the time to access an assessment but that this had changed to a focus on access to treatment. There was a national 4-week wait standard with a number of metrics that had to be satisfied for this to be met, including a completed assessment and for the first stage of the care plan to be in place. This dataset would be made available for Trusts across the country. Lauretta Kavanagh added that there was a need to keep refining the population health and integrated care strategy for NCL by advancing inequalities work and deepening the understanding of the needs of patients, including in parts of the community that were not being reached. Outcome measure tools were also specified in much of the mental health commissioning work to help understand the improvement of patients. Cllr Connor requested that information on the outcomes data and metrics should be provided to the Committee as part of the next report on mental health. **(ACTION)**
- Asked about crisis cafes aligning with crisis services, Adele McCormark said that this was about co-producing to align together and that the current work on access to crisis services included looking at variations between different boroughs and where people could be best supported outside of an inpatient admission. Jess Lievesley added that there was also an issue around better matching service capacity to known peaks in demand.
- Asked by Cllr Atolagbe about staffing levels of crisis services, Jess Lievesley explained that services were not fully staffed but, because these services were critical, bank or temporary staff were used when required. There was also an issue to address about the five boroughs working in different ways which impacted on the ability to deliver a consistent service across NCL.
- Yasin Ahmed, Chief Executive of the Nafsiyat Intercultural Therapy Centre, welcomed the approach of working with the voluntary sector and spoke about

the work of his organisation which provided intercultural services and therapy in up to 20 languages, but queried the current links with NHS talking therapies. Lauretta Kavanagh said that there were long waits in some areas for NHS talking therapies and that there was a conversation to be had in separating NHS talking therapies and other talking therapy services which may reach other parts of the local community. On a point from Yasin Ahmed about community link services which connected to housing or employment support, Adele McCormark said that primary care services were now looking to divert people to appropriate services such as this, as it was understood that mental health issues could often relate to specific challenges that a person was facing rather than requiring medication or psychiatric treatment.

- Sonja Scantlebury-Camara, from the Sewn Together community group, commented that there was no straightforward point of access when a group needed to get support for a service user in need of crisis services. While they had been provided with mental health first aid training by MIND, they were not qualified to deal with the sort of problems that required medical knowledge but it was very difficult to refer to services. She added that many service were still not racially appropriate with inadequate representation on language and culture. Jess Lievesley said that services were best accessed either through the 111 phone line or the crisis line. He agreed on the importance of cultural appropriateness and particularly on how services were not always able to access parts of communities that could be reticent to come forward with mental health concerns. This was often achieved better through voluntary sector organisations so there was an issue about how best to connect these organisations to the ICB. It was also important to intervene earlier as, for example, young black men had historically often come into contact with mental health services via the Police (under Section 136 of the Mental Health Act).
- Sonja Scantlebury-Camara spoke about a case of a young man who had died in a secure ward at St Ann's hospital where there had not been anyone on the ward who could deliver CPR and highlighted that there were other similar cases. She said that there was still not enough conversation about racial disparities in this debate and that there was insufficient representation across the workforce. Jess Lievesley acknowledged these points and said that mental health services had to work harder to reach into communities but added that it wasn't completely fair to say that they were not recruiting from those communities and that there was a broader representation of ethnicities in the workforce. The Chair and Chief Executive of the Mental Health Trusts were both from BAME backgrounds. This issue remained a high priority for the Board and change was happening but wouldn't happen overnight but the regular check and challenge on this was important. Lauretta Kavanagh committed to report back on progress on the Patient and Carer Race Equality Framework. **(ACTION)**
- Sonja Scantlebury-Camara raised concerns about people with mental health problems in the community in Haringey who had been in the system for a long time and were not being adequately supported or included in the new community model (including from being misdiagnosed a long time previously or not having access to services such as talking therapies). Jess Lievesley agreed to look further into these concerns. **(ACTION)**
- Sonja Scantlebury-Camara expressed concerns about the implementation of the Dialog+ system which she said some staff were not confident about using.

Adele McCormark said that there had been a national shift of focus onto outcomes, as discussed earlier, and that the DIALOG+ system enabled patients to communicate and record the outcomes that they wanted and for these to then be measured against. This was a massive cultural shift that would take time and it would be important to maintain dialogue with clinicians, patients and their families and to communicate better about the changes that had been made. It was suggested that this point about communications could be taken away as an action point. **(ACTION)** Jess Lievesley added that, while change often brought about complexity, at the heart of this process was a change in the power dynamic from outcomes being set by clinicians to outcomes being set by the patients themselves.

- Cllr Atolagbe noted that, according to page 17 of the agenda pack, *"18% of people on the NCL mental health services caseload are Black/Black British, however, Black/Black British people accounted for 27% of NCL mental health inpatient admissions in 2019/20"* and asked for more up to date figures on this to be made available. **(ACTION)**
- Asked by Cllr Atolagbe about the distress caused by the need for constant repetition of patient histories, Jess Lievesley agreed that patients were currently assessed too many times and that they needed to be able to tell their story once and then bring their care plan with them. Changes were being made on this but it would take some time for the transition to happen and the workforce to adjust.
- Farisa Nassiri, founder of the Yaran Women's Club spoke about the work of her organisation which was established in 2021 to support women suffering from mental health problems, typically from asylum seeker/refugee background and often with a traumatic past and PTSD issues. The referrals often came from GPs and social prescribers and other local services and the Club provided activities such as yoga, meditation, mindfulness and emotional health checks. A challenge for the Club was sustainability of funding and having an appropriate venue to provide services and, without this, the service would have to close. Lauretta Kavanagh committed to having a conversation about this service **(ACTION)** but added that NHS budgets were particularly stretched at present with rising levels of demand. Cllr Connor commented that this was an example of a voluntary organisation that was engaging with communities that mainstream mental health services were not always able to reach, and suggested that a cost-benefit analysis could help to establish the effectiveness of funding organisations such as this. Cllr Revah added that the ICB had emphasised the value of working with the voluntary sector and that organisations such as this were looking for recognition of the work that they do.
- Ruth Glover from Open Door raised concerns about funding and the need for longer-term contracts which had brought up as an issue in previous reviews but which she felt had still not been properly addressed. This led to significant challenges for the voluntary sector in maintaining their workforce. Cllr Connor said that the Committee had previously made a recommendation in favour of longer commissioned contracts which was vital for the stability of voluntary organisations and asked what progress was being made on this. Lauretta Kavanagh said that there was a move to what was known as '3 + 2 year contracts' but that she would need to consult with colleagues and provide an more detailed answer to the Committee in writing. **(ACTION)** Cllr Connor suggested that there should also be clarity on how this information should be

communicated more widely to the voluntary sector in NCL. Cllr Milne added that, in addition to the length of the contracts, the lateness of the decisions on contracts could also have an adverse impact on the voluntary sector.

- Cllr Connor requested clarification on how voluntary sector organisations could access commissioners at the ICB. Lauretta Kavanagh noted that the ICB was currently going through an organisational change due to a national requirement to reduce operational costs by 30% and this meant that there were staffing changes in the units for each of the five boroughs with some disruption to continuity, but that there would be specific individuals who could liaise with voluntary organisations. Cllr Connor commented that it was sometimes difficult for voluntary and community groups to know who best to contact at the ICB to develop links with statutory services and suggested that there should be a clear single point of access. She requested that the next report to the Committee on mental health would include details of the new ICB structure following the organisational change with particular reference to the main contacts that voluntary organisations in each Borough were able to liaise with. **(ACTION)** Sonja Scantlebury-Camara suggested that the promotion of employment and training opportunities within the health and care sector should be part the communications with local communities.
- Allegra Lynch, Chief Executive of Camden Carers, suggested that, alongside the other pathways, there should also be a specific pathway for unpaid carers which could be supported by the existing carers organisations in each of the five boroughs and help with issues such as support for hospital discharge. Jess Lievesley agreed with this and emphasised that work to support carers had to work as a partnership with carers and also with local authorities. There would need to be consideration over how the offer to carers should be framed. It was agreed that this conversation would be followed up outside of the meeting and Cllr Connor requested that the Committee be updated on this as part of the next report on this topic. **(ACTION)**
- An audience members commented that highly skilled professionals were needed at all stages of the mental health pathway in order to avoid missed diagnoses and delays. Jess Lievesley agreed that there could sometimes be complex presentations which professionals had to assess and also noted that there were currently differential approaches across the NCL boroughs which would be addressed through the measures described in the report.
- Cllr Connor noted that the transition process from children's services to adult services was an area that the Committee had previously monitored and requested further information about this as part of the next report on this topic. **(ACTION)**
- Cllr Connor noted that mental health support in schools had been mentioned in the report but that she was aware that this was not available in all schools in her borough (Haringey) so requested further details about the availability of this across NCL. Lauretta Kavanagh confirmed that no local authority areas anywhere in country had 100% coverage for this but that specific details of the coverage in NCL could be provided to the Committee. **(ACTION)**
- Asked by Cllr Connor how the Section 136 Hub and the 111 mental health line described in the report were accessed, Jess Lievesley explained that the Section 136 Hub was for Police only and assisted them in relation to their

powers under the Mental Health Act. He added that the 111 line for the public would be available from April and that the launch communications for this were being managed nationally. In response to concerns from Cllr Cohen that many people found it difficult to navigate the system when they had concerns about someone, Jess Lievesley said that the 111 line would be the first port of call but added that routes of access for interventions needed to be improved overall.

- Asked by Cllr Atolagbe about the sharing of data, Jess Lievesley said that this was quite limited as the NHS could not share clinical records and could not access criminal records. He confirmed that Section 136 interventions would be recorded on the clinical records.
- Cllr Revah conveyed feedback from her local carers groups that some often found it hard to access information about the person that they were caring for. Jess Lievesley acknowledged that this could be challenging as individuals could sometimes withdraw consent, meaning that professionals could not share information, and that, in other circumstances, professionals may also 'err on the side of caution' and avoid sharing details unless they had explicit consent. The concept of the 'triangle of care' existed to try and bring this information together but this remained a challenge across the sector.

Cllr Connor thanked everyone for attending the meeting, highlighting the importance of working together, taking on board everyone's concerns and accessing expertise across the local community.

58. WORK PROGRAMME

This was the last meeting of the 2023/24 municipal year and a new work programme would be prepared for the first meeting of 2024/25 which would be in June/July 2024. There were already some standing items in the schedule but Members were invited to submit further suggestions for agenda items.

It was agreed that the Committee should continue the practice of dedicating at least one meeting per year to discussion with a wide range of community groups on a specific issue. This could potentially focus on mental health as in previous years or on a topic such as care for older people.

59. DATES OF FUTURE MEETINGS

Meeting dates for 2024/25 will be published shortly.

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Thursday 30th May 2024 - 2:00pm to 4:05pm

PRESENT:

Councillors: Pippa Connor (Chair), Tricia Clarke (Vice-Chair), Larraine Revah (Vice-Chair), Chris James, Andy Milne and Matt White

ALSO ATTENDING:

Cllr Richard Barnes (Barnet)

ATTENDING ONLINE:

Cllr Jilani Chowdhury

1. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllrs Atolagbe, Chakraborty and Cohen.

Cllr Richards Barnes from the London Borough of Barnet attended the meeting as a substitute for Cllr Cohen.

3. URGENT BUSINESS

The Committee noted the pre-election guidance which indicated that, during the current pre-election period, Councillors should exercise caution to avoid any potentially controversial statements/decisions that could be associated with a particular party.

4. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

6. SCRUTINY OF NHS QUALITY ACCOUNTS

Cllr Pippa Connor introduced the session noting that the two mental health Trusts represented at the meeting were expected to merge in October 2024. However, at present there were still two separate quality accounts reports for the Barnet, Enfield & Haringey Mental Health Trust and the Camden & Islington NHS Foundation Trust. The two Trusts were currently represented by one shared executive team as what was currently known as the North London Mental Health Partnership (NLMHP).

Amanda Pithouse (Chief Nursing Officer), Vincent Kircher (Chief Medical Officer), Andrew Wright (Chief of Staff) and Caroline Sweeney (Partnership Director of Nursing – Quality Governance) introduced the draft quality accounts of behalf of the NLMHP.

Amanda Pithouse set out the NLMHP strategy which had the stated Purpose of "Working with our communities to improve mental health" and a Vision of "Better Health. Better Lives. Better Communities." The four aims of the strategy were:

- Aim 1 – We will provide consistently high quality care, closer to home.
- Aim 2 – With our partners in North London and each Borough we will ensure equity of outcome for all.
- Aim 3 – We will offer great places to work, providing staff with a supportive environment to deliver outstanding care.
- Aim 4 – We will be more effective as an organisation by pioneering research, Quality Improvement and technology.

Some key developments over the past year had included:

- The publication of a new clinical strategy which had included service user, carer and partner input.
- The development of a new values and leadership framework which had involved over 600 staff and was aimed at supporting the merging of the workforces of the two Trusts.
- The publication of a new People and Organisational Development Strategy which aimed to make the organisation a great place to work and to attract and retain the best possible staff.
- The Partnership Board had signed up to a Sexual Safety Charter and Anti-Racism Statement and Action Plan.
- A new 78-bedded inpatient facility had opened at Highgate East.
- A new Mental Health Crisis Assessment Service had opened at Highgate West, providing 24/7 emergency mental health care across North London.
- New community mental health facilities had been opened at Lowther Road in Islington.

- A new section 136 pilot had been launched with the Metropolitan Police resulting in a 27% reduction of inappropriate detentions, a 38% reduction in people attending A&E and a 32% reduction in Police time spent attending mental health emergencies.
- A new mental health option had been added to the NHS 111 phone service with around 150-200 calls per week so far.
- The continuation of the Community Mental Health Transformation Programme which involved strengthening community services to keep more people out of hospital.

The NLMHP officers then responded to questions from the Committee about the Quality Accounts report for Barnet, Enfield & Haringey Mental Health Trust:

- Cllr Connor referred to an issue that had been raised at the previous year's scrutiny of the Quality Accounts about support for people with serious mental health issues after discharge. It had been noted at the time that a particular problem was the lack of supported housing for people in such circumstances and that this would require funding and further partnership working with local authorities. Vincent Kircher said that there had been no real progress since then in this area but that the problem was escalating with more people medically ready for discharge but without a place to go to. He added that this was a systems-wide problem but that it would be difficult to justify using NHS resources on housing. He added that there were regular multi-agency discharge events which provided a forum to discuss cases that were difficult to resolve. Andrew Wright noted that the shortage of suitable accommodation was a national issue. Amanda Pithouse commented that the Care Quality Commission (CQC) had recently outlined a systems approach to regulation with the intention of picking up system-wide issues that individual organisations could not address. However, this approach was currently paused due to the upcoming General Election.
- Cllr Revah highlighted long waiting times for mental health services and suggested that details of this should be included in future Quality Accounts reports. Vincent Kircher noted that this information was provided in the Board's integrated performance reports which were in the public domain. There was an ambition to reduce waiting times and there was now a 4-week wait standard from referral to treatment which was a challenging target to meet. He added that waiting times for children had been improving. Cllr Connor requested that a link to this information be provided to the Committee. **(ACTION)**
- Cllr Connor noted that the Committee had previously recommended that data should be provided on the monitoring of people being provided with support or signposting to other services following calls to the Crisis Helpline. Vincent Kircher confirmed that outcome data was recorded and that this could be provided to the Committee. **(ACTION)**
- Cllr Revah asked about follow-up work with housing organisations to support residents post-discharge as Councillors were aware of problems emerging through casework and often found it difficult to find the appropriate contact at the right service to obtain help for people in these circumstances. Vincent

Kircher referred to the community transformation work which involved neighbourhood teams working in an integrated way with primary care, local authorities and the voluntary sector which would provide those links. He noted that this work was still developing across North Central London (NCL) so there was still some way to go in some areas and that it would be beneficial for everyone to know who the core team was in their area with responsibility for these types of cases. This information was available online. (https://www.northlondonmentalhealth.nhs.uk/services)

- Cllr James referred to page 35 of the agenda pack which stated that 100% of service users felt that they did not receive enough support from their CAMHS team when moving from Children's Services to Adult Services compared to a national average of 54%. Vincent Kircher said that transition services were provided to help people in this change which could be difficult as the support provided by Adult Services was very different from CAMHS. Transitions had been specifically included as part of the clinical strategy, including by replicating services such as Mind the Gap in Camden elsewhere in NCL, but overall this was an area where improvements were required.
- Cllr Milne asked if there was a higher threshold required for Adult Services when compared to Children's Services because of a higher number of patients. Vincent Kircher said that, if anything, the opposite was the case because Children's Services were under so much pressure with high demand. However, there was also broader support provided through schools, including workers based in schools, to try and help those with less severe mental health needs through early intervention.
- Cllr Revah requested further details on how the proposed merger of the two Trusts would improve services and waiting lists. Amanda Pithouse explained that the two organisations had worked on this for some time, including through a strategic alliance some years ago before then becoming a partnership with one executive team which enabled the best elements and pockets of work from both Trusts to be scaled up. There was evidence that having engaged and happy staff improved outcomes for service users and the feedback from staff was that they wanted the opportunities to develop and work in different services. Having a single bed base across the five NCL boroughs would also help to keep patients closer to home. Andrew Wright added that having a stronger voice for mental health would be another benefit of the merger. He also noted that more detailed information would be provided to the JHOSC at a meeting in the autumn.
- Cllr Connor referred to page 10 of the agenda pack which referred to the importance of local community organisations and noted that a common concern raised by organisations such as this was the short-term nature of their contracts which impacted on their stability and financial planning. Vincent Kircher noted that a lot of the shorter contracts tended to be from local authorities and that the Trusts were in a position to offer longer contracts of up to three years which they felt was beneficial as it enabled the organisations to focus on service delivery. Cllr Milne commented that another common concern was that contract renewals were often not confirmed until very close to the end of the contract.

Andrew Wright said that both Trusts typically started the renewal process two-thirds of the way through a contract so this shouldn't be the case. Cllr Connor noted that these concerns may also need to be directed to the local authorities in NCL.

- Referring to the details of the CQC inspection on page 11 of the agenda pack, Cllr Connor noted that the Trust had been rated as 'Good' and that a robust improvement plan had been delivered to address the actions raised by the CQC. Asked if there were still any outstanding areas of concern, Amanda Pithouse said that the safety domain remained at 'Requires Improvement' for both Trusts and this related largely to staffing issues which was an ongoing challenge. Estates was also an issue and, although new state of the art buildings such as Highgate and Blossom Court had recently opened, there were other buildings in areas of Enfield and Barnet that were old and required more work. There was investment in estates across the Trust through the capital programme but often the actual fabric of the old buildings was a problem. Andrew Wright added that a new Estates Strategy was being developed and, as the decisions on how capital was allocated was now decided through the ICB, the case was being made for further improvements. Overall, the action plans from the CQC inspection had been delivered, but it was important to ensure that these were sustainable. This aim was supported by initiatives such as the Brilliant Basics programme as outlined on page 12 of the agenda pack.
- Asked by Cllr Connor about the progress against the CQUIN goals on page 30 of the agenda pack, Vincent Kircher provided further details:
    - CCH15b (Routine outcome monitoring in CYP and perinatal mental health services) – this was Amber due to performance against access targets. The locally agreed target was 7% which was being met but the higher national target of 10% was not being met. It was clarified that the 7% related to all births rather than mental health cases. Cllr Connor requested that data on the number of actual cases that this related to be provided to the Committee. **(ACTION)**
    - CCG15a (Routine outcome monitoring in community mental health services) – this was also Amber as the figures were improving but not where they would ideally be. Further work and action planning on this was ongoing.
- Cllr Clarke referred to the section on participation in clinical research on page 29 of the agenda pack and requested further details on the funding and the specific studies. Vincent Kircher explained that the two main sources of funding were the local Clinical Research Network (CRN) and Research Capability Funding (RCF). In Barnet, Enfield & Haringey around £27k of RCF was received but in Camden & Islington around £900k was received so if research could be spread across the NCL area in future then more could be achieved. He also clarified that the Short Names in the table referred to specific projects and that the PPIP2 project related to research on the withdrawal of anti-psychotic medication. There was a strong relationship with University College

London with joint appointments of clinical academics who were able to then bring research evidence into clinical practice to improve standards.

- Cllr Milne referred to the section on learning from deaths on page 35 of the agenda pack which stated that 263 service users had died in 2023/24 and requested further details on the 47 investigations carried out. Caroline Sweeney explained that mortality incidents were reviewed by a Panel and that all deaths had an initial review which would assess what further level of investigation was required. The 47 investigations referred to in the report were the cases where a full level of investigation was carried out, usually over a 60-day period. Vincent Kircher added that the cases requiring further investigation were often those that were unexpected, such as a suspected suicide for example. These figures did not indicate a particular trend in the figures in either direction.
- Cllr Connor requested further details on the section about Serious Incidents on page 35 of the agenda pack which stated that there had been 14 Serious Incidents in 2023/24 compared to 33 the previous year. Caroline Sweeney explained that the government had recently implemented the new Patient Safety Incident Response Framework which had changed the incident reviews and speeded up the learning process. This also meant that Serious Incidents were categorised in a different way, with some cases now dealt with through a different process. This accounted for the significant change in the figures.
- Asked by Cllr Connor about any other areas of particular risk, Vincent Kircher said that there was a risk register with various areas closely monitored and that the areas previously highlighted by the CQC report, such as estates, were high of the list of priorities.

Cllr Connor summarised some of the key issues raised during the meeting as communications over mental health casework in the community, including a direct point of contact for Councillors and others, addressing supported housing needs post-discharge and support during the transition from Children's services to Adult services. She also noted that there would be further discussions with the Committee on the upcoming merger between the two Trusts. Cllr Revah suggested that all questions from the scrutiny of the Quality Accounts the previous year should also be followed up with the answers circulated to the Committee. **(ACTION)**

The NLMHP officers then responded to questions from the Committee about the Quality Accounts report for Camden & Islington NHS Foundation Trust:

- Asked by Cllr Clarke about work on early intervention and talking therapies, Vincent Kircher said that early intervention and prevention was an overarching priority in the clinical strategy because this was essential to meet the rising demand on services. Early intervention applied to various different conditions and was part of the work of the integrated community teams. Talking therapies was aimed at mild to moderate common conditions such as depression and anxiety. These were successful interventions that treated a large number of

people. In response to a query from Cllr Clarke about the lower proportion of people completing talking therapies treatment moving to recovery, illustrated in the graph on page 86 of the agenda pack, Vincent Kircher said that the figure of 45% was within the normal range but had recently improved back up to the target figure of 50%.

- Cllr Clarke noted that only “suitable cases” were admitted for talking therapies treatment and asked how this and the length of treatment was determined. Vincent Kircher explained that the treatment length was pre-determined, starting with six sessions and then following a stepped approach, with up to six further sessions and then referral to secondary care services if required. He added that the eligibility criteria were based on whether the person had a treatable condition. Other issues such as alcohol/drug misuse or conditions such as psychosis required treatment from different services.
- Asked by Cllr Clarke about equal access to talking therapies, Vincent Kircher said that the Trust’s track record on access to services for people from BAME backgrounds was good when compared to national figures and there was also a diverse staff group.
- Asked by Cllr Clarke about the effectiveness of Electroconvulsive Therapy (ECT) services, Vincent Kircher said that this was a treatment for people who were very unwell and, while there was no specific data in the report on this, it may be possible to provide some data to the Committee. **(ACTION)**
- Asked by Cllr Revah for an update on services moving from St Pancras Hospital, Vincent Kircher said that there was a decant plan and that there were no longer any 24-hour units remaining as these had all moved to the Highgate site. Some other day services were still on site which would be moved over a period of time. He added that they were mindful of the destabilising effect for the teams, but the long-term aim was for an improved estate for the services.
- Cllr Revah commented that people caring for those with mental health problems often reported that services did not share information with them. Amanda Pithouse said that this was a historic problem which she agreed was frustrating as it was important to involve carers in decision making. Professionals were often in a difficult position when a service user did not want family members to be involved, for example because of difficult relationships or because of issues relating to their condition. Without this permission from the service user, the information could not be shared with carers. She added that a Carers Strategy from both Trusts was currently being developed which would include best practice and training in this area and carers would be involved in this process, but there was no easy solution to this problem.
- Cllr Connor asked whether specific conversations could be had with both the patient and the carers just before discharge took place to see what information could be shared and arrangements put in place. Vincent Kircher said that there was close contact with families and an ongoing conversation over a period of time as the Trust was acutely aware of the importance of involving families but noted that, in some cases, families were not involved or the patient did not give permission for information to be shared.

- Asked by Cllr Milne about recruitment and retention, Amanda Pithouse said that the situation with the recruitment of registered nurses had improved compared to previous years through new measures to attract staff. However, there were certain teams that it was more difficult to recruit to such as crisis teams. The Trust worked with Capital Nurse Programme, a regional programme run by NHS England which helped with recruitment and retention issues including international recruitment. Other initiatives included apprenticeships and the use of peer support workers. Vincent Kircher highlighted a care leaver recruitment programme and the recruitment of local people. He added that Camden & Islington had a good record of recruiting doctors with low reliance on locum doctors, though the situation was more difficult in Barnet, Enfield & Haringey so there was an active programme to recruit international medical graduates.
- Asked by Cllr Clarke about children's services provided out of the NCL area, Andrew Wright said that there was a long-term aspiration to ensure that the new organisation resulting from the merger would provide all of the mental health services for children and young people in NCL. At present, there were other providers which added complexity to the service provision, including in transitions.
- Asked by Cllr Connor if there were any outstanding areas of concern from recent CQC reports (other than the issues of staffing and estates which had been discussed), Amanda Pithouse highlighted that the acute wards pathway had improved according to the most recent inspection with the rating in the Effectiveness domain rising from 'Requires Improvement' to 'Good', with service users no longer being sent out of area.
- Cllr Connor referred to Aim 1 (Providing consistently high quality care, closer to home) of the Quality Priorities on page 79 of the agenda pack and described local cases that Councillors were aware of relating to people with serious mental health problems in the community, including those who appeared to be at risk of becoming violent. She explained that Councillors, GPs and members of the public did not typically know who to contact to provide assistance. Vincent Kircher said that all GP practices should know who their community consultants and teams were and that these details had been circulated to all team managers and were also on the website. He added that the crisis team had a four-hour response time and were not set up to respond to life-or-death emergencies. Building local relationships was important to this community approach so it was agreed that there was more to do on this.
- Referring to the section on Quality and Safety Reviews on page 82 of the agenda pack, Cllr Connor requested further details on the areas that required improvement. Caroline Sweeney said that there was an action plan for each service and that reports were made to the Quality & Safety Committee every two months to identify issues and trends. Specific issues included the challenge of the estate, the quality of food and patient issues such as patients not feeling that they know enough about their medication. Cllr Connor suggested that it would be useful to see an example of a team action plan in the Quality Accounts as it was not easy to understand just from the general description in the report.

- Referring to the section on Mental Health Community Service User Survey on page 90 of the agenda pack, Cllr Connor noted:
    - That the proportion of service users getting the help they needed when they last contacted the crisis team was 42% and that, while the national comparison was 43%, this appeared to be low. Vincent Kircher said that the Trust wanted this figure to be higher, but it was complicated as it was a measure of how people felt who were experiencing mental distress. Caroline Sweeney added that this data was based on high level feedback and that there was greater depth in the full management report. There was also benchmarking data across the London Trusts.
    - That 43% of service users did not have a Care Plan. Amanda Pithouse noted that this was based on a survey that went to community service users rather than inpatient services users and had only a 17% response rate. Vincent Kircher explained that the Care Plan was a specific document that not everyone had, but that the aim was for every service user to be included in the new Dialog+ care planning.

Cllr Connor thanked all those from the NLMHP for attending the meeting and noted the follow up actions that had been agreed.

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Friday, 31st May, 2024, 10.00 am - 1.00 pm

PRESENT:

Councillors: Pippa Connor (Chair), Tricia Clarke (Vice-Chair) and Matt White

ATTENDING ONLINE:

Councillors: Kemi Atolagbe, Rishikesh Chakraborty, Jilani Chowdhury and Andy Milne

7. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

8. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Cohen, Cllr James and Cllr Revah.

It was noted that four Councillors (Cllrs Atolagbe, Chakraborty, Chowdhury & Milne) had joined the meeting online. As only Councillors attending the meeting in-person could be considered towards the quorum requirements (which was a minimum requirement of four Members required, with one Member from at least four of the five boroughs), the meeting was technically not quorate. The meeting therefore continued as an informal briefing and it was noted that any formal decisions would need to be deferred to a future quorate meeting.

9. URGENT BUSINESS

The Committee noted the pre-election guidance which indicated that, during the current pre-election period, Councillors should exercise caution to avoid any potentially controversial statements/decisions that could be associated with a particular party.

10. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

11. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

12. SCRUTINY OF NHS QUALITY ACCOUNTS

Gillian Smith, Chief Medical Officer at the Royal Free London NHS Foundation Trust, introduced the draft quality accounts report for the Trust, noting that its main hospital sites were Barnet Hospital, Chase Farm Hospital and Royal Free Hospital with a range of services also delivered across other sites such as community hospitals and community-based clinics.

Gillian Smith explained that the theme of this year's quality account report was equality issues with the progress in these areas highlighted in the report, including through the quality priorities. It was also recognised that there was more to do on equality, diversity & inclusion and on addressing health inequalities.

Other developments included:

- The launch of a new Quality Strategy and the implementation of a new Patient Safety Incident Response Framework.
- There had been an increase in demand for services including urgent and emergency care and cancer diagnosis/treatment with further increases expected in the coming years. This challenge was reflected in the level of cancer performance against national targets and the Trust had moved into an enhanced support framework with NHS England to recover that position.
- In terms of elective care, there had been a huge impact from the industrial action which had impacted on the ability to reduce waiting lists, although a good position had been maintained against the longer waiting times.
- Good progress had been made against the quality priorities set out the previous year, including on patient involvement and the establishment of an involvement framework.

Gillian Smith then responded to questions from the Committee:

- Cllr Clarke asked about maternity services at the Royal Free Hospital in the context of the expected changes to services in North Central London (NCL) that had recently been consulted upon. Gillian Smith explained that the birth rate in NCL was falling and that, while the quality of services and patient feedback was good, it would not be possible to sustain services at the number of units currently in place in the longer term with the declining number of births.
- Cllr Connor referred to page 4 of the report, which stated that the CQC had carried out a focused inspection of maternity services at Edgware Community Hospital and had rated the service as 'Good' for the safe and well-led domains and requested further details on the ratings for the other domains. Gillian Smith

clarified that these were the only domains that had been inspected and that this had been the only CQC inspection of maternity services within the past year. The actions relating to previous CQC inspections had been covered in previous quality accounts reports and had now been closed.

- Asked by Cllr Connor about other CQC inspections relating to the Royal Free, Gillian Smith said that they were at an early stage of understanding what the inspection schedule would be under the new CQC framework, but that no announced inspections were anticipated at present. She confirmed that the most recent inspection of the whole Trust took place in 2018 and that the report was published in 2019 with an overall rating of 'Requires Improvement' with a variety of ratings across specific services. All of the actions from this inspection had been carried out with an ongoing process of self-assessment to identify where new issues or actions arose. Cllr Connor suggested that future quality accounts reports should include an explanation of the latest position with the Trust's CQC inspections, including the use of clear terminology. **(ACTION)**
- Cllr Clarke requested an update on the outcome of the Never Events framework referred to on page 28 of the report. Gillian Smith said that the output from the consultation had not yet been made available but that there had been a lot of learning from the implementation of the framework which had been in place for some years and that the approach to safety had moved on in some areas, as reflected in the new Patient Safety Incident Response Framework. She added that the Trust would be very interested and engaged with the outcomes from the consultation when this was made available.
- Referring to page 7 of the report on equality, diversity & inclusion, Cllr Connor requested further details on the 'Barnet Flow' programme. Gillian Smith explained that this programme focused on the processes for admission and discharge from hospital in order to keep the flow of patients going by ensuring that beds were available when required (including emergency admissions) and that patients were going home as early as possible when appropriate to do so. In terms of the equalities aspect of this, they were still at the stage of understanding the position before developing actions.
- Cllr Connor referred to the Maternity Equality, Diversity and Inclusion Working Group, described on page 7 of the report, and asked what changes had been achieved from this group. Gillian Smith said that actions had included specific antenatal classes for black women, translating some patient information into a wider range of languages and piloting some sessions with patients in language other than English. She added that the service, working with the Maternity and Neonatal Voices Partnership (MNVP), was doing a lot of listening work and reaching out across all areas of the community which would lead to further actions.
- Cllr White referred to Priority 1c (improving communications on waiting times and cancellations of appointments) and described the experiences of some residents with appointments being cancelled late and then having to try and rebook through a booking system that often did not have any available appointments for months and did not take clinical need into account. Gillian Smith acknowledged that there had been a large number of short notice cancellations in the previous year, including because of industrial action. She

added that the cancellations were done with clinical oversight with more urgent patients prioritised. The rebooking was also closely monitored but some patients were having to wait longer that the Trust would like and this was reflected in the current waiting times and waiting list. The Trust aimed to be as systematic as possible about the communications with patients and making sure that all available capacity was being used. Cllr White observed that the report appeared to be tracking the reduction in people who didn't attend their appointments but not how people's care was being negatively affected. Gillian Smith responded that this wasn't specifically the focus of this priority but that patients with very long waiting times were subject to clinical harm review. She also clarified that the process did not involve the patient going to the back of the queue if a rebooking was required. Cllr Connor suggested that a note to the Committee on how the process worked would be helpful. **(ACTION)**

- Cllr Atolagbe asked for further details on how the communications process worked after a cancellation. Gillian Smith reiterated that this was clinically led and prioritised and that the staff contacting patients were provided with the appropriate information and training to resolve the rebookings. Cllr Atolagbe commented that it was important to be mindful that non-urgent cases could become more urgent cases if not rebooked in time.
- Cllr Connor referred to Cancer Patients Missed Diagnosis under Priority 3c on page 27 of the report and asked if this was improving. Gillian Smith responded that the new Patient Safety Incident Response Framework provided some national parameters which defined the type of incidents and recommended that the organisation looks at previous incidents to ensure that themes are identified. Similar types of incidents then underwent the patient safety incident investigation under the new methodology. These considerations contributed to the list on page 27 which remained areas of focus.
- Asked by Cllr Connor about the implementation of 'Martha's Rule', Gillian Smith confirmed that the Royal Free was one of the Trusts participating in the first wave of pilot programme launched by NHS England and that Barnet Hospital and the Royal Free Hospital would be pilot sites. This would involve patients knowing how to access a second opinion and a more formalised process by which the clinical teams checked in with patients and a quality improvement approach to develop actions on delivering Martha's Rule.
- Cllr Connor referred to Priority 1b (fundamentals of care: nutrition) and noted that the Committee had previously expressed concerns about responsibility on the wards for ensuring that patients were assisted to eat properly. Gillian Smith said that this required a multi-professional approach including therapy input and medical assessment. Each hospital site had a group chaired by the Director of Nursing to oversee aspects of nutrition and hydration on the wards. This was an ongoing area of focus as reflected by quality priorities. Cllr Connor commented that future quality accounts should explain how problems in this area are flagged up and actioned, for example if a tray of food is left untouched by a patient.
- Asked by Cllr Clarke for further explanation on Never Events, the 'learning from deaths' section on page 58 and the 'patient safety incidents' section on page 66, Gillian Smith acknowledged that these were linked and required

comprehensive oversight. Never Events were a specific list of events that should always be prevented by processes in place. Learning from deaths was part of a national framework aimed at ensuring that deaths were scrutinised and that there was learning on care, safety and communication where appropriate. The Patient Safety Incident Response Framework covered any incident, however it was identified, the vast majority of which did not involve serious harm or death. Those that did involve serious harm or death were then investigated through the patient safety investigation process.

- Cllr Atolagbe requested further details on the proposed crisis hub for CAMHS assessment. Gillian Smith explained that this was a rapid assessment process aimed at preventing patients from needing to come to the Emergency Department out of hours by providing a more direct route into the professional support that they required.
- Referring to the waiting list statistics on page 70 of the report, Cllr Connor asked how this was being addressed, noting that there were 102,000 patients on the waiting list, up from 92,000 at the start of the year and that 5,000 of these patients had waited for more than a year. Gillian Smith explained that additional capacity had been added, including on weekends, to deliver increased activity. All options were continuing to be assessed with a clinical focus on treating the most urgent patients first. She added that the main setback in this area in the past year had been the impact of the industrial action.

Cllr Connor thanked Gillian Smith for attending the meeting and also acknowledged the positive developments in the report which the Committee had not had time to cover.

Whittington Health NHS Trust

Sarah Wilding, Chief Nursing Director, and Anne O'Connor, Associate Director of Quality Governance at the Whittington Health NHS Trust took questions from the Committee on the draft quality accounts report for the Trust:

- Cllr Connor noted that the previous year's quality accounts report had included details of a proposed CQUIN for 2023/24 on Compliance with Timed Diagnostic Pathways for Cancer Services and asked about progress in this area since then. Sarah Wilding said that there had been a huge focus on diagnostics and the partnership with UCLH to make sure that patients were diagnosed and treated as quickly as possible and this was predominantly an area of improvement.
- Cllr Clarke raised concerns about the standards of the estate at parts of the Whittington Hospital, noting faulty lifts as an example. Sarah Wilding acknowledged that some of the environment and maintenance was not at the standard they would like and so there had been a focus on some of these priority areas over the past 6-9 months, including lift maintenance. However, there was a challenge with capital spend in NCL. Cllr Clarke asked for further details to be provided about the lift maintenance at the Whittington. **(ACTION)**

- Asked by Cllr Clarke about the rate of ‘C.diff’ (clostridioides difficile infection), Sarah Wilding noted that there had been 23 cases in 2023/24 against a trajectory of 13. The response to this had included a huge drive on hand hygiene and antibiotics compliance as well an environmental focus on cleanliness. She also noted that, across the 23 cases, only one area of exact transmission between patients had been identified.
- Cllr Connor queried the use of the term “damage to organisational reputation” in a paragraph on page 108 of the agenda pack which related to the potential risks associated with failing to provide outstanding care because openness was an important factor in dealing with any issues of concern. Sarah Wilding said that this was not the intention of the terminology used but that this was a helpful reflection which she would feed back to colleagues. She also felt that the Whittington was known for being open and transparent and also had a strong relationship with the CQC.
- Cllr Connor referred to the target on page 116 of the agenda pack to reduce waiting times for first appointments across CAMHS, OT (occupational therapist) and SLT (speech and language therapy) by at least 20% by the end of March 2025 and asked how realistically this could be achieved. Sarah Wilding acknowledged that this could be seen a ‘stretch target’ but said that it was ambitious because CAMHS was an area of focus for the Whittington and that there was a drive for improvement in waiting times for children’s autism, ADHD assessments and access to speech and language therapists.
- Cllr Connor referred to the action on page 118 of the agenda pack to further develop the intranet page for people with autism and learning difficulties and asked about service user input to the format. Sarah Wilding said that there was an active learning difficulties patient group and so the content and accessibility work had been developed in partnership with this group. There was strong partnership working in this area and an ambition to develop this further with adults with autism.
- With regards to neonatal services, Cllr Clarke welcomed the progress on delayed cord clamping and the acquisition of the Concord Birth Trolley. Sarah Wilding noted that delayed cord clamping was looked at as part of the quality improvements last year and this was why it had been brought forward as outlined in the report. In response to a point from Cllr Atolagbe about the requirements for improvement at the neonatal unit, as set out on page 124 of the agenda pack, Sarah Wilding acknowledged that delayed cord clamping had been a negative outlier at the Whittington so there had been a drive for improvement.
- Referring to the section on the Perinatal Mortality Review Tool (PMRT) on page 164 of the agenda pack, Cllr Connor noted that 12 cases met the eligibility criteria for PMRT review and asked for further details on the learning from this. It was agreed that further details would be provided in writing. **(ACTION)**
- Asked by Cllr Clarke about the progress on the Start Well consultation, Sarah Wilding said that the ICB would be reviewing the results from this but the decision on next steps was not expected until next year.
- Cllr White referred to the staff survey described on page 145 of the agenda pack and highlighted the importance of staff morale in delivering good quality

care. He questioned whether comparing figures to other Trusts was the right way to assess this and asked whether there were any targets in place. Sarah Wilding explained that the staff survey was looked at by the CQC in a comparative way which is why the data was set out in this manner. Comparisons were also made to the data from previous years to understand which areas were improving and declining. Actions resulting from the survey included a drive to ensure that staff had the right equipment they needed.

- Cllr Connor referred to Q20a of the staff survey on feeling secure to raise concerns about unsafe clinical practice, to which 70% had answered yes. She asked what more was being done to raise this figure. Sarah Wilding said that actions included publicising to staff the multiple ways of reporting unsafe practice, formally or informally, and this had been done successfully in maternity services. She added that a low proportion of staff reporting concerns did so anonymously which was a positive sign about the culture of accountability and also noted that the Board was very visible. Anne O'Connor commented that there was oversight of any trends that emerged through the reports received.
- Cllr Connor noted that, according to the section on the Freedom to Speak Up Guardian on page 167 of the agenda pack, there had been an increase in concerns raised by administrative and clinical staff. Sarah Wilding observed that there had been various rounds of staff engagement which may have increased the confidence of staff to report issues. There had also been some gaps in some of the administrative teams about six months previously which had caused pressures that may have resulted in more concerns being raised.
- Asked by Cllr Atolagbe about actions to improve the indicators on staff morale and well-being set out on page 149 of the agenda pack, Sarah Wilding said that valuing staff was essential and there had recently been various staff awards to recognise contributions to quality care. A new Head of Well-being had recently been appointed who was leading on some new initiatives in this area and there were also more resources to support staff when circumstances were challenging. The Chief People officer now worked between the Whittington and the UCLH which provided opportunities to share best practice.
- Cllr Atolagbe asked for an update on the closure of Simmons House, as described on page 133 of the agenda pack. Sarah Wilding said that Simmons House had been temporarily closed with the staff redeployed to support children and young people elsewhere in the system and that work was ongoing with the provider collaborative to establish interim arrangements. She also confirmed that there was not yet an agreed date for the reopening of Simmons House.
- Asked by Cllr Atolagbe about the 'Requires Improvement' CQC ratings in certain areas, Sarah Wilding noted that the inspection had taken place in 2019 and there had been no further CQC visits in these areas since. However, quality visits were carried out and she also chaired a committee that looked at learning and improving across the organisation.
- Cllr Connor requested further details on compliance with the Data Security and Protection (DSP) toolkit referred to on page 135 of the agenda pack. Sarah

Wilding explained that there had been a drive to improve mandatory training in relation to this which was monitored through performance meetings.

- Cllr Connor referred to page 173 of the agenda pack which explained that the target for the Urgent Response and Recovery Care Group to ensure that patients were seen within certain times had been only partially met. Sarah Wilding confirmed that there had been a drive to treat more patients through virtual wards but that there had been some challenges with staffing in those areas so there was ongoing work to improve recruitment. This was all monitored through performance meetings. Cllr Connor asked whether the virtual ward capacity would be reduced because of the lack of staffing. Sarah Wilding explained that virtual ward capacity was reviewed at daily meetings each morning in terms of capacity, staffing and safety with patients then triaged accordingly.

Cllr Connor thanked Sarah Wilding and Anne O'Connor for attending the meeting and noted the follow up actions that had been agreed.

North Middlesex University Hospital NHS Trust

Lenny Byrne, Chief Nurse, and Vicky Jones, Medical Director for the North Middlesex University Hospital NHS Trust, introduced the draft quality accounts report for the Trust highlighting:

- the recent work on patient experience and patient voice;
- the response to the CQC review of maternity services in May 2023;
- the work on the patient safety incident response framework, including a focus on deteriorating patients;
- the implementation of 'Martha's Rule' which had included some funding as part of a national programme;
- procedural safety work in theatres which had contributed to there being no Never Events in the past year;
- a paediatric diabetes audit which had positive results on the screening and support for managing sugar levels in young people and patients in the most disadvantaged groups.

Lenny Byrne and Vicky Jones then responded to questions from the Committee:

- Cllr Connor requested further details on the recent CQC inspection which had rated the Trust overall as "Requires Improvement" and had rated maternity services as "Inadequate". Lenny Byrne said that the main inspection had highlighted a number of key issues including:
    - The management of grievance cases. An improvement plan had been introduced with HR processes to ensure that reviews were undertaken in a more timely manner.

  - Responsiveness to patient complaints and closing them in a timely manner. A Trust-wide plan had been established on the timely management and best resolution of complaints.
  - Closing down serious incidents. Further information about the management of serious incidents and how learning was shared across the organisation had been included in the report.
  - Leadership and development opportunities for a wider group of staff. The number and type of leadership courses had been extended.
  - The CQC raised concerns about the potential merger with the Royal Free and the impact on the capacity of the executive team. There was a plan to manage the capacity constraints with some additional consultancy to support the executive team.
- With regard to the CQC review of maternity services, Lenny Byrne explained that the review had identified 26 compulsory or 'must do' actions, including on safety issues and the management of the triage service. There was therefore not a single fix and so incremental improvements and continuous monitoring and oversight would be required. The final report had been published in December 2023 and some actions had already been put in place prior to this based on provisional feedback from the CQC. Specific issues included:
  - It was considered that the Trust did not have a best practice standardised national tool for the monitoring, management and oversight of patients. There were also issues around staffing, equipment and the culture of the department.
  - A key priority was patient safety and, on triage, the 'BSOTS' system was now being used which was a standardised national best practice system.
  - Due to the CQC rating, the service had been automatically stepped onto a national support programme, which included a midwifery expert being on site three days per week providing additional support, oversight and scrutiny.
  - On staffing, there had been a vacancy rate at the time of the inspection which was now in the process of being filled with 27 new midwives recently recruited. The Trust was also waiting for a national standardised skill mix review of maternity services which was an assessment tool that would specify the staff required to safety manage the population.
  - On culture, a programme of listening events and culture improvement measures had been put in place across maternity services.
- Cllr Atolagbe observed that there did not appear to be feedback from staff in the report. Lenny Byrne responded that, although this had not been included in the report, there had been significant contact with the teams in maternity and monthly executive listening events. There were also executive visits to different parts of the organisation every morning between 9am and 10am. Further information on staff feedback could be included in the final version of the report. Cllr Connor commented that it would be useful to see that evidence and data in the report to be able to demonstrate that things were changing in a positive direction. **(ACTION)** Vicky Jones added that the NHS staff survey had been reviewed since the CQC visit and that each department was developing action plans in response to this. In particular, the maternity team had picked up an

issue of making sure that communications reached everybody and so this needed to be done through various formal and informal channels.

- Cllr Clarke welcomed that there had been zero Never Events at NMUH in the past year but noted that, according to page 45 of the report, 25 deaths (just under 2%) were judged to have been likely to have been caused by problems in the care provided to the patient and there also appeared to be a high number of stillbirths. Vicky Jones explained that there was a very low threshold for scrutinising deaths and therefore about 25% of deaths were scrutinised. The NMUH also had a higher proportion of deaths that occurred in the hospital, as opposed to the patient home or hospice care, which further increased these figures. This data was used to drive improvements around deaths and there had been a focus this year on detecting and managing deterioration. Vicky Jones also emphasised the importance of preventing stillbirths and explained that it was difficult to judge crude numbers. It was better to use an adjusted ratio which took into account deprivation and birth numbers and, on that basis, NMUH was in line with their peers. However, there was a strong focus on the improvement plan which included risk assessments at every part of a patient's journey through maternity care.
- Cllr Connor queried why, according to page 46 & 47 of the report, there had been 12 patient safety incidents resulting in severe harm or death in the reporting period for September 2019 but 126 incidents in May 2024. It was agreed that these figures would be checked and an explanation provided in writing to the Committee. **(ACTION)**
- Cllr Connor requested further details on improvements to the support provided to patients in maternity care. Vicky Jones cited the example of triage when a patient had been in touch to explain worrying symptoms, had been advised to come in for assessment and then not done so, but there were now processes to follow up with that person. Improvements had also been made to interpretation services.
- Cllr Clarke referred to the work on deferred cord clamping at the Whittington which the Committee had heard about in the previous session and asked if the hospital Trusts were working together on this. Vicky Jones confirmed that this had been a real area of focus over the past two years as the NMUH previously had a low rate of deferred cord clamping. 100% of babies were now considered for delayed cord clamping and, as this was not clinically appropriate for all babies, delayed cord clamping was carried out in over 70% of cases.
- Referring to page 25 of the report about patient experience, Cllr Connor asked what was being done to ensure patient nutrition and hydration on the wards in cases where patients were not eating the meals provided. Lenny Byrne said that he had recently reviewed the fundamentals of care including protected mealtimes. This involved reducing the activity on the ward at breakfast and lunch times to allow patients to have their meals in peace and quiet and also to allow the nursing staff to focus on drug rounds and the provision of the meals. There was ongoing work to ensure that protected mealtimes were consistent across the hospital. There was also a 'red tray' system in place which identified patients who required additional support with nutritional needs. The evidence from the nutritional steering group was that this was working well. A hot meal

service had also been added to the Emergency Department for patients who required this. Asked by Cllr Connor about the data on patient nutrition and hydration, Lenny Byrne acknowledged that there could be further detail provided in the final report about the actions that were being taken in this area. **(ACTION)**

- Cllr Connor asked about conditional discharge patients including information about who there should contact for support in order to reduce the risk of readmissions. Lenny Byrne reported that there had been work on information packs for patients upon discharge from various services including contact information and follow up instructions. There was also an ongoing review of clinical nurse specialists which would include ensuring that clear discharge planning was part of their remit.
- Cllr Atolagbe referred to the 'North Mid Loves Our Patients' initiative on page 29 of the report and suggested that further data should be made available on this. **(ACTION)**
- Referring to CT head and spine scanning on pages 32 & 33 of the report, Cllr Connor noted that these had declined in the past year due to the volume of patients and inability to fully assess trauma patients in the space within the Emergency Department. Vicky Jones explained that one change was that older patients having a CT head scan also now had a CT spine scan at the same time as they had a higher risk of spine injury so this was a positive change. In addition, there was an external provider for the night time reporting of CT scans and there had been work on the agreement to ensure that they were feeding back those reports in a timely way. There had been positive progress on reporting times.
- Asked by Cllr Connor about the CQUIN funding, Vicky Jones confirmed that the national funding programme had ended and so there were no payments that came with achieving these targets in the future. The national recommendation was to continue to work on the areas most relevant to the organisation and so NMUH would be working on the ones that fit with the organisation's safety priorities.
- Cllr Connor observed that the reassurances given on the various questions asked had been clear from the answers provided but had not necessarily been made clear in the draft report itself. Lenny Byrne said that this was helpful feedback which would be considered in the development of the final report. He added that there had been an internal conversation about the right amount of information to provide in the report as there was a large amount of data accumulated on improvement work which could not all be included. He also noted that any additional information required by the Committee on maternity services or any other aspect of NMUH services could be provided.
- Asked by Cllr Connor to highlight one issue that could improve services for residents, Vicky Jones said that her priority would addressing the small pockets of poor culture that had been identified. This did not reflect the vast majority of NMUH staff, but it was important to ensure that local residents could feel confident that they would always be treated with kindness, respect and by staff who have the appropriate training to deliver the best care. Lenny Byrne said

that he had two areas which were improving maternity services and setting up the Patient Partnership Council to help enable a patient voice representative of the diverse populations served by the Trust.

Cllr Connor thanked Vicky Jones and Lenny Byrne for attending the meeting and noted the follow up actions that had been agreed.

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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NHS

NCL Start Well programme

NCL Joint Health Overview and Scrutiny Committee update

July 2024

Background and purpose of this update

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Background

- A public consultation was conducted between 11 December 2023 and 17 March 2024 which focussed on proposed changes to maternity, neonatal and children's surgery
- The consultation aimed to reach a wide range of residents, patients, staff and stakeholders gathering feedback on the proposed changes to services
- During the 14-week consultation a large amount of feedback was gathered on the proposals. Before agreeing how to proceed, the feedback gathered will need to be considered
- We are working with an independent organisation (ORS) to analyse the feedback received and in due course will publish their full evaluation report. Before this is available, ORS have produced an interim report which outlines at a high level the emerging findings from the consultation

Purpose of the update

Now that we have the emerging findings report, we are using this to inform our approach to next steps and the key areas of additional work that are needed to consider the feedback received during the consultation.

The purpose of this paper is to give an update to JHOSC on the programme and to request the JHOSC's formal feedback on both the proposals and the consultation. **We are seeking the JHOSC's feedback by 16th August.**

To support this, today's update includes:

- A reminder of the proposals included in the consultation
- The activity to promote, and the reach achieved, through the public consultation
- The emerging high level feedback themes
- The proposed next steps and additional work which are being put to the ICB Board for approval at their meeting on 23 July 2024

Purpose of today's update to the JHOSC

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Today we are giving an update to the JHOSC on the Start Well programme. At the end of the update JHOSC members are asked to:

- **Note** the programme update including significant efforts that were made to engage with staff, stakeholders, patients, the public and local authorities during the with the public during the 14-week consultation period
- **Agree** to providing feedback on the consultation proposals by 16th August 2024
- **Note** the next steps proposed to the ICB Board
- **Note** the proposed timeline relating to a decision making meeting

In addition to this paper, three papers have been published to support this update. They are:

- Start Well programme: consultation methodology, activity and reach report
- Start Well programme: consultation key findings – interim report from ORS
- Start Well Programme: proposed next steps

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Background and proposals consulted on

The Start Well programme will support us to reduce inequalities and improve population health outcomes

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The Start Well programme is one of a number of programmes that the ICS is progressing in line with its overarching strategy to improvement access, experience and outcomes for North Central London residents. Other programmes underway designed to improve population health outcomes include delivering a core offer for community services and mental health services as well as the implementation of a Long Term Conditions Locally Commissioned Service in Primary Care.

The Start Well programme was initiated to ensure services are set up to meet population needs and improve outcomes. The drivers for starting the work demonstrate that the programme is key to delivering against our duties around population health improvement and tackling inequalities

- **Improving care at the start of life has the potential to have far reaching impacts on overall population health and life outcomes**
- **There is longstanding inequity in service provision across maternity, neonatal and paediatric services – with not everyone having access to the same care as others**
- **The quality of services could be improved, and some service users face differential outcomes and experience**
- **Our workforce is constrained and, in some instances, our people are working in environments that are not set up for them to provide the best possible patient care**
- **Ensuring we are in a position to respond to national reviews and best practice guidance such as the Three Year Delivery Plan for Maternity and Neonatal Care**

Start Well is a collaborative programme involving a wide range of patients, carers, community representatives, clinical leaders and ICS partners

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Start of review
November 21

Agreement across all organisations to commence the programme following Trust Board engagement.

Case for change development
November 21 – May 22

The clinical case for change was co-developed through significant clinical engagement, including: 60 interviews, 12 reference group meetings, 2 large clinical workshops and 5 surgical deep dive sessions

Case for change engagement
July – September 22

Engagement with patients and the public on the case for change, including:

- 207 in depth discussions
- 389 questionnaire responses
- 16 stakeholder meetings
- 2 youth summits

Over **75% of respondents agreed or strongly agreed with opportunities identified**

New care models
July – September 21

Future facing best practice care models were developed. This involved **over 100 clinicians** through workshops and task and finish groups

Options appraisal
November 22 – May 23

Evaluation of options was undertaken through **10** clinical reference group meetings, **8** finance group meetings and **3** patient and public engagement group meetings

Options appraisal workshop
May 23

Programme board workshop where options were narrowed involving local authority partners, Trust reps as well as NEL, NWL and Herts.

Pre-consultation business case development
May 23 – September 23

Drafting of pre-consultation cases that outline proposals and new clinical model to be implemented

IIA engagement
May – June 23

Engagement with **over 120 service users** about their experiences of maternity and neonatal care to build up an understanding of the impact of implementing changes

Finance assurance
August 23 – September 23

Assurance of capital assumptions for each option through 1:1 assurance meetings with CFOs

Further assurance of wider finance case through CFO group, and sign off in September

Clinical senate review
July 23

A panel of over 30 senate panel members reviewed and feedback on proposals. Lead clinicians from NCL represented the programme

NHSE Assurance
November 23

Assurance of proposals by NHSE, a requirement in advance of commencing a consultation. Trust Board sign up to proposals is needed for this

ICB Board
December 5th 23

Giving approval to commence consultation on proposals

Public consultation
December 23 – March 24

Seeking feedback on proposals which will inform subsequent decision making

The programme, which began in November 2021, has benefited from extensive clinical and service user input.

Recap: there were three separate proposals included in the public consultation

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Maternity and neonates

The number of maternity and neonatal units in NCL:

Proposal one: The proposals include implementing a care model that ensures all NCL sites offer the same minimum level of neonatal care. To enable this, it was proposed to consolidate maternity and neonatal care across four sites compared to the current five. The two options that were consulted on were:

- **Option A** (our preferred option) proposed closing services at Royal Free Hospital
- **Option B** proposed closing services at Whittington Health
- **Both options** proposed retaining services at Barnet, North Mid and UCLH, and significantly investing in services

Proposal two: The birthing suites at Edgware Birth Centre

- Proposal to close the birthing suites at the standalone birth centre at the Edgware Community Hospital site
- The proposal included retaining the antenatal and post natal services that are provided at the site

Children's surgery

Proposal three: Proposal to **consolidate surgery for young children (under the age of 5) and low volume specialties at two 'centres of expertise':**

- **Centre of expertise for emergency and planned inpatient** care proposed to be at **GOSH** – this proposed the creation of a surgical assessment centre for improved emergency access
- **Centre of expertise for planned day case** surgery proposed to be at **UCLH**
- These sites were chosen due to their existing availability of specialist surgeons and anaesthetists to deliver this work

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Consultation promotion and reach

Consultation aims and purpose

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As set out to the JHOSC at their meeting on 30th November 2023, the programme set out to **deliver a 14-week public consultation** in line with best practice that complies with legal requirements and duties. We aimed to:

- Provide clear and accessible information about proposals and how they have been developed
- Allow time and opportunities for feedback from staff, residents, and stakeholders
- Ensure diverse voices are heard
- Seek alternative proposals or new evidence
- Understand the pros, cons and unintended consequences of the proposals
- Explore mitigations for any disadvantages
- Find out what matters most to patients and how this might affect implementation
- Ensure feedback was recorded and could be analysed to support thoughtful decision-making

We achieved this through:

- Developing a range of materials that explained the consultation proposals in an accessible way
- Ensuring feedback could be shared several ways: questionnaire, telephone, written response, at a focus group and through attending a public drop-in session
- Focussing resources and working with the voluntary sector to reach population groups identified as potentially more impacted through our impact assessments
- Widely promoting the opportunity to take part in the consultation through social media and other promotional opportunities
- Engaging with staff working across services and in the wider NHS
- Identifying local political and other stakeholders to seek their feedback on the proposals

What we are aiming to understand through consultation feedback

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A questionnaire was developed which was designed to gather feedback on the proposals. The questionnaire had separate questions covering each of the three aspects of the proposals and these questions were then used as a framework for focus groups and meetings that were undertaken to gather feedback. At a high level, these questions covered:

- The **characteristics / demographics** of the person or organisation responding (e.g. gender, age, place of residence, capacity in which they were responding)
- Whether the **challenges described were recognised**, and the extent to which there was agreement that changes are needed
- The **level of support for the proposal described**, and which of the options for maternity and neonatal services was preferred
- Any **alternative solutions** that could address the identified challenges
- Any **equalities impacts** of the proposed changes

There were also a number of other feedback mechanisms made available, including written submission, attendance at meetings / focus groups and drop-in feedback sessions which aimed to capture the same information as the questionnaire.

These questions allowed levels of support for the three proposals to be assessed, and how this varied by type of stakeholder or place of residence, as well as providing an opportunity for stakeholders to suggest alternatives, describe impacts and raise any other concerns.

Cumulatively, feedback from these questions will ensure decision-makers are properly informed of the diversity of views from different stakeholders, in conjunction with a range of other available evidence, as they move towards making final decisions.

We appointed an independent organisation to evaluate and write up the feedback gathered. Given the volume of feedback received, at this stage, we have an interim report which gives the high-level themes from the feedback. In due course, we will publish a full evaluation report which goes into much more detail about the feedback received and the ICB will later describe its responses to this feedback.

During the consultation we widely promoted the opportunity to participate whilst seeking in depth feedback from potentially impacted groups

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Promotional activities

Social media promotion leading to over **720,000** impressions and over **3,670 clicks** through to the consultation website

Video content totalling **1,310 views**

Print adverts placed in **13 local papers** or circulars

Over **40 items of news coverage** in local and national press

Nearly **7,000 letters sent** to households in target geographies

Meetings and feedback opportunities

Programme team attendance at **199** different meetings or events, reaching just under **3,400 people**, of which:

32 were in depth staff feedback sessions with **over 470 participants**

26 were promotional drop ins at local hospital sites reaching nearly **600 people**

46 were sessions targeted at communities who have protected characteristics or face health inequalities reaching **503 people**

Example communities reached:
Orthodox Jewish community, Black and Asian women's groups, families with learning disabilities, women over the age of 35, women with experience of maternal medicine services, women living in areas of deprivation, people with experience of mental health problems, women and people with poor English proficiency

34 were in target geographies as identified by the interim integrated impact assessments reaching **582 residents**

8 were local GP meetings reaching **279 GP staff** across NCL as well as Brent and Harrow

9 were targeted close the Edgware Birth Centre, reaching **81 staff and residents**

Engagement was separately commissioned with hard to reach groups such those experiencing homelessness **reaching 42 people**

Separately commissioned focus groups and interviews with people living in target geographies **reaching nearly 30 residents**

These activities led to significant amount of feedback on the proposals which is being independently analysed

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Engagement with the consultation and feedback

9,000

Nearly **9,000 website** views, of which **6,335 were individual users**

- **3,112 questionnaire responses, of which:**
  - **2,031** came from members of the public
  - **1,060** came from NHS staff
  - **21** came from organisations

We are working with an independent organisation (Opinion Research Services) to write up the feedback from the consultation, and we will be publishing their full evaluation report in due course.

Given the breadth and depth of engagement that was undertaken throughout the consultation, there is a significant amount of feedback to be analysed. The final feedback report will be considered by decision makers before a decision is taken relating to service changes and incorporated into the decision making business case and an updated Integrated Impact Assessment.

79 written submissions and emails of which:

- **32** came from members of the public
- **47** came from NHS staff, stakeholder organisations and officials

Local Authority input into the consultation

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Through the consultation period, we also sought feedback from Local Authorities through attending the following meetings:

- *Barnet Health Overview and Scrutiny Committee*
- *Brent Health Overview and Scrutiny Committee*
- *Camden Health Overview and Scrutiny Committee*
- *Haringey Health Overview and Scrutiny Committee*
- *Islington Health Overview and Scrutiny Committee*
- *Harrow Health and Wellbeing Board*
- *Enfield Health and Wellbeing Board was scheduled but the meeting in was subsequently stood down (and papers were circulated)*

An update about the programme was also included in the inner NEL and outer NEL JHOSC papers during the consultation period (but meeting attendance was not requested)

Written or questionnaire responses were provided by:

- *Barnet Council (Barnet Adults & Health Overview and Scrutiny Sub-Committee)*
- *Brent Council (Cabinet Member for Public Health and Adult Social Care and Health and Wellbeing Board Chair)*
- *Camden Council*
- *Haringey Council*

In addition to the above, other political parties, elected members, assembly members also submitted written responses.

The consultation was part of our ongoing commitment to engaging with the public, staff and stakeholders

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Case for change development
- Review of existing patient experience insights data from 11 different sources
- Establishment of a youth mentoring scheme and youth summits
- Targeted engagement with a small number of patient groups

Winter 2022

Case for change engagement
- A 10-week engagement programme
- 43 engagement events
- 207 in-depth conversations
- 389 questionnaires completed

Care model development
- Establishment of the Patient and Public Engagement Group (PPEG) to review and input into care models
- Feedback from case for change engagement informed their development
- Two youth summits involving 35 young people

Summer 2022

Options appraisal
- PPEG responsible for development and initial evaluation of access criteria
- PPEG Chair a member of the programme board and participated in the programme board workshop for the options appraisal

Interim IIA Engagement
- 11-week targeted engagement period focussing on those with protected characteristics and at risk of poorer outcomes
- 38 sessions held, reaching 124 patients

Spring / summer 2023

Public Consultation
- Widely promoted high volume engagement with all staff, stakeholders and residents
- Ongoing local authority consultation
- In-depth conversations with targeted groups
- A formal part of our statutory duties around substantial service change and ongoing involvement of people and communities

Winter 2023/2024

Planned Further IIA engagement (TBC)
- Further engagement will be planned with potentially impacted groups focussing on mitigations for any disbenefits

Autumn 2024

Meeting legal duties relating to engaging and involving the public and under the Equality Act / PSED

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The programme has successfully delivered a wide-ranging consultation. The **comprehensive feedback** gathered will play a **crucial role in shaping the final decisions on the proposed changes**, ensuring that the services provided are safe, timely, and of outstanding quality for all local residents.

Meeting legal duties

NHS Act 2006

Through the breadth and depth of engagement undertaken both during consultation and prior to it, including by way of formal public consultation, we have demonstrated our ongoing commitment to involve the public and staff and local authorities in our development of proposals.

The Equality Act and Public Sector Equality Duty

Our interim IIAs formed an important part of ensuring we meet our legal duties under the Equality Act 2010, including the public sector equality duty at the pre-consultation stage:

- They identified target populations who may be more impacted by proposals, with a focus on those with protected characteristics.
- Based on this, we identified groups that we particularly wanted to hear from during the consultation.
- The methodology, activity and reach report describes that we were successful in hearing from the full range of these groups.
- Their feedback will be reflected in an updated impact assessment and will further inform our approach, in compliance with our legal duties under the Equality Act

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Interim feedback themes

Maternity and neonatal services: ORS interim report feedback themes (1/2)

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Agreement with challenges

- Across all engagement activities, a **substantial majority agreed that changes are needed to address current challenges facing services**, with **67% of questionnaire respondents either strongly agreeing or tending to agree**
- There was **overall agreement with the proposal that all neonatal units in NCL should offer the same minimum level of neonatal care** (i.e. at least level 2):
  - **Nearly three quarters of questionnaire respondents (72%) either strongly agreed or tended to agree with this proposal**
  - Slightly lower agreement among those living near Royal Free Hospital (63%), service users/parents/carers, and local residents compared to NHS staff

Less support for consolidation of services

There was **less support for consolidating maternity and neonatal services** from five to four sites:

- Under half of NHS staff members agreed
- Higher agreement among neonatal staff, lower among maternity staff
- Around a quarter of service users/parents/carers agreed; over three fifths disagreed
- Higher disagreement (69%) among those near Royal Free Hospital, though widespread elsewhere

Concerns raised around:

- Consolidation could increase service pressures, disruption of effective working relationships, and issues with capacity, staffing, and quality of care
- Travel concerns: longer travel times, unreliable public transport, congestion, and increased travel costs.

Support for option A or option B

- Those near Royal Free Hospital favoured continuing services there (Option B)
- Those near all other hospitals supported Option A (keeping provision at Whittington Hospital)

Note: this is a summary of the interim findings report which has been produced by an independent organisation who were commissioned to analyse and report on the consultation feedback. They will be producing a full report in due course, which will be published and reviewed by decision makers.

Maternity and neonatal services: ORS interim report feedback themes (2/2)

North Central London Health and Care
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Support for retaining services at Whittington Hospital (Option A)

- Option A seen as the least disruptive option due to the quality and nature of services already provided; the established multi-disciplinary team/effective use of Allied Health Professionals; that Whittington Health already has an LNU (level 2) and managing more births than Royal Free Hospital (including concern as to feasibility of uplifting Royal Free Hospital to a level 2 unit)
- The importance of co-location with other teams/services e.g., paediatrics, haemoglobinopathy, sickle cell, Female Genital Mutilation (FGM) team
- Strong existing links with community resources and UCLH, including maternity pathways, which would be lost under Option B
- Serves a wide area with deprived communities, with poorer birth outcomes, and younger populations (e.g., North Islington, Haringey)

Support for retaining services at Royal Free Hospital (Option B)

- Strong feedback (particularly from staff at the Royal Free) relating to services currently provided at the site relating to maternal medicine pathways and the importance of specialties that are already on-site to support high-risk pregnancies/births and manage perinatal emergencies (including haematology, renal services, HIV unit, foetal medicine, interventional radiology, surgical expertise, transplantation and rare diseases)
- There is joined-up working between Royal Free Hospital and Barnet Hospital, with consistent policies between the two
- Royal Free Hospital was occasionally said to have better quality buildings than Whittington Hospital
- It is the hospital of choice and caters for the specific needs of the local Orthodox Jewish communities

Note: this is a summary of the interim findings report which has been produced by an independent organisation who were commissioned to analyse and report on the consultation feedback. They will be producing a full report in due course, which will be published and reviewed by decision makers.

Edgware Birth Centre: ORS interim report feedback themes

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Recognition of the challenges and agreement with the proposal

Across all engagement activities, there was **broad recognition of the current challenges facing services and the need to make changes:**

- Most questionnaire respondents agreed that changes should be made to respond to the current challenges, although over a quarter (27%) of those living *closest to Edgware Community Hospital* disagreed

Overall, about three fifths (59%) of respondents agreed with the proposal to close the birthing suites, with many tending to cite the **low number of births** as the basis for supporting this proposal. However there was higher disagreement among respondents living closest to the site.

Disagreement with the proposal and concerns raised

Among those that **disagreed or raised concerns with the proposal**, it was highlighted/suggested that:

- EBC provides good-quality care, with some disputing the data that implies a lack of demand for the service
- It will reduce patient choice (including for lower socio-economic populations, and those from Harrow and Brent), and that there is evidence to suggest that standalone midwife-led birth units are the safest option for low-risk births
- Any closure should be accompanied by enhancements to midwife-led birthing provision elsewhere (and as close to home as possible)
- The number of births might rise if the service was better publicised, or if a decision was taken to close maternity and neonatal services at the Royal Free Hospital

Note: this is a summary of the interim findings report which has been produced by an independent organisation who were commissioned to analyse and report on the consultation feedback. They will be producing a full report in due course, which will be published and reviewed by decision makers.

Children's surgery: ORS interim report feedback themes (1/2)

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Recognition of the challenges and agreement with the proposal

- Most participants **agreed that changes should be made to improve children's surgical services**
- There was majority agreement from residents and patients that **the proposal to create two new 'centres of expertise' would benefit babies and young children**, and that, if created, the **planned inpatient and emergency surgery centre should be at Great Ormond Street Hospital for Children (GOSH)**, and the **day case centre should be at UCLH**
- This was acknowledged in the context of potentially increased travel times, given an understanding of the specialist skills that are needed to care for very young children needing surgery

Concerns raised by GOSH Executive Team

GOSH Executive Team feedback highlighted that:

That the consultation provided valuable, detailed feedback from the staff, leading them to conclude that the proposal requires further design. As an organisation they are committed to addressing the challenges related to emergency surgical pathways. However, due to the potential unintended consequences of the current proposal and the suggestion that the Centre of Expertise for emergency surgery would be ideally placed to be delivered at a site with an adjacent paediatric emergency department, they propose that further work with partners, and including the North Thames Paediatric Network, may result in developing a more effective alternative solution.

Note: this is a summary of the interim findings report which has been produced by an independent organisation who were commissioned to analyse and report on the consultation feedback. They will be producing a full report in due course, which will be published and reviewed by decision makers.

Children's surgery: ORS interim report feedback themes (2/2)

North Central London Health and Care
Integrated Care System

Potential alternative solutions proposed through a range of responses to the consultation

- Whether UCLH should instead be the centre of expertise for emergency surgery due to its existing expertise in paediatric anaesthesia and paediatric emergency department
- Could there be a model where outreach from GOSH is provided at one of the other NCL secondary care sites
- Children's day surgery could be provided at the site which may no longer provide maternity care
- Two large paediatric hubs should be created in NCL and North West London, that are spokes of GOSH/UCLH, to reduce travel and improve long-term sustainability
- Pathways should be considered across North Thames to make the most of the specialist workforce that exists across the capital

These suggestions would need to be assessed against the agreed options appraisal criteria to determine their feasibility.

Note: this is a summary of the interim findings report which has been produced by an independent organisation who were commissioned to analyse and report on the consultation feedback. They will be producing a full report in due course, which will be published and reviewed by decision makers.

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Proposed next steps

As anticipated, the interim feedback report highlights important additional areas of work that are needed before agreeing how to proceed

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The interim feedback will inform the approach to next steps and several areas of work have been identified which ensure that the consultation feedback is taken into account.

Maternity and neonates

- Further work to refine the care model in relation to:
  - Maternal medicine pathways
  - Interventional radiology pathways
  - Antenatal and postnatal pathways
- Reviewing the patient flow modelling to ensure the assumptions are sufficiently robust and include the most recent data that is available
- Further exploring the impact on gynaecology services for the site that is proposed to no longer support intrapartum care
- Impact of any changes on out-of-hospital maternity care and community pathways
- An updated integrated impact assessment

Edgware Birth Centre

- Understand the latest data about the birth numbers at the unit
- Work to describe further the midwifery-led offer at collocated birth centres should a decision be made to close the birthing suites
- Outlining how the space at the Birth Centre could be used to support maternity care for the local community should a decision be made to close the birthing suites
- An updated integrated impact assessment describing the potential impact of the proposal and identifying any additional mitigations that may be needed

Children's surgery

- Start the work that would be needed to write a decision making case around the day case element of the proposal. This would need to include an understanding of any potential interdependencies between the day case and emergency and planned inpatient aspects of the model.
- Subsequent to this we would consider the next steps in relation to the emergency and planned inpatient activity, taking into account the range of feedback received and alternative options proposed

The programme Board will continue to oversee this work, reporting into the ICB Board

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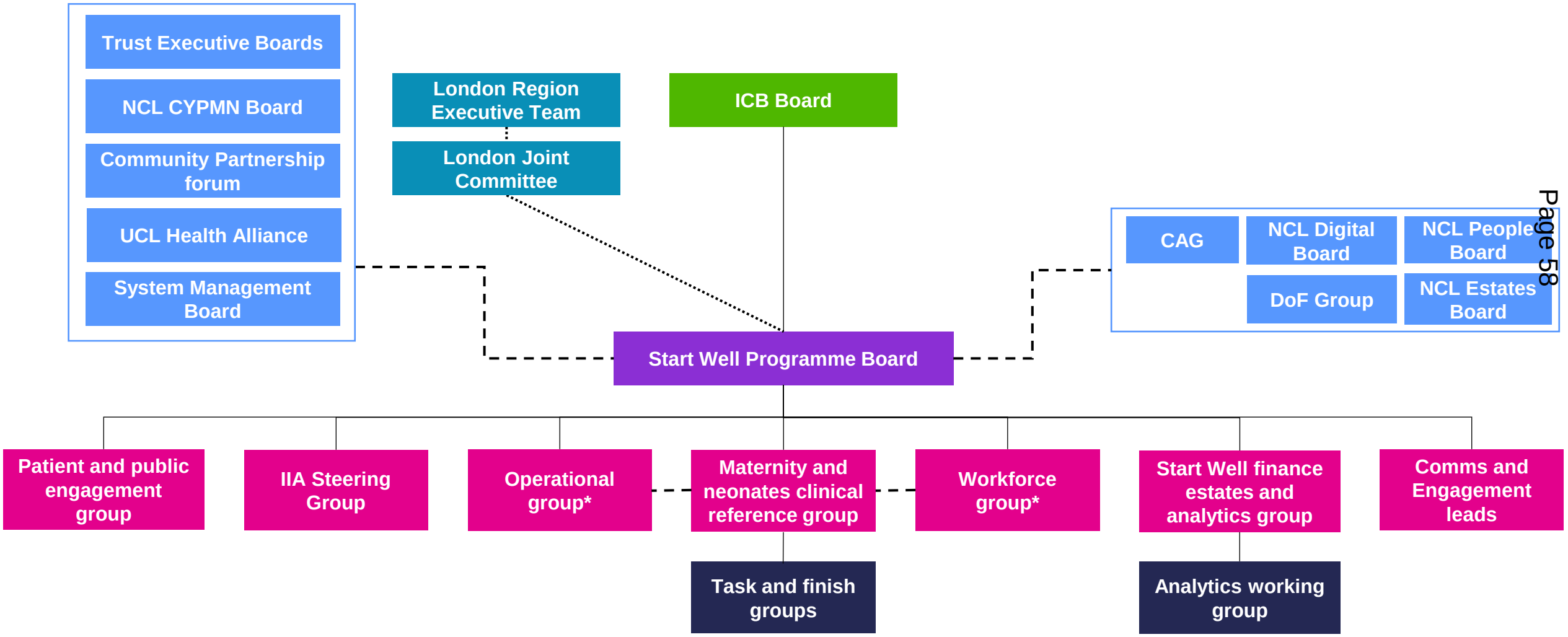
..... Provide input/sign off as required

- - - - Key stakeholder reporting

——— Direct reporting line



*Proposed to be set up in the Autumn

The additional work undertaken will inform a decision making business case to be considered by commissioners

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Agree preferred option following feedback from consultation and update integrated impact assessment	• Review feedback from the consultation and finalise the clinical model • Review and update anticipated benefits and update financial modelling • Update options appraisal (if required) and agree preferred option • Update integrated impact assessment
Detailed implementation planning for preferred options	• Timeline with milestones and interdependencies and a plan for maintaining quality during the transition and following implementation • Programme management structure and resources for implementation, prioritised risk register with mitigations and identified risk owners • Plans for how benefits will be monitored and realised and for how patients and the public will be engaged and communicated with during implementation
Draft decision making business case (DMBC)	• Write DMBC – including response to consultation feedback – e.g., 'you said, we did' and response to the consultation
Governance and decision making	• ICB Board and NHSE London Region Specialised Commissioning are decision makers • Decision making will be in public and the date of this will be published well in advance

Proposed next steps and timeline for decision making

North Central London Health and Care
Integrated Care System

- We are seeking ICB Board approval for the next steps outlined in this paper at their public meeting on 23rd July
- Governance groups will be re-established to commence the additional work required
- We are aiming to have completed a decision-making business case towards the end of 2024 / early 2025 for consideration by decision makers (the ICB Board and NHSE London Region specialised commissioning). This will incorporate both feedback from the final consultation report and the formal JHOSC feedback which we are requesting by 16th August
- We will notify the JHOSC when we have confirmed the date of a decision making meeting

North Central London
Integrated Care Board

GP access in North Central London

July 2024

Executive summary

There are more appointments being provided than ever before. Despite this, patient satisfaction with access to General Practice has declined:

- Patient satisfaction with General Practice, as measured through the national GP Patient Survey, complaints and stakeholder feedback, has declined in recent years. This is a National trend.
- Within NCL there is significant variation between practices, with some exemplar providers who have been able to maintain a consistently good patient experience.

The National Delivery Plan for Recovering Primary Care Access was published in May 2023:

- This is focused on recovery of patient experience of and satisfaction with access.
- The two-year programme sees ICBs support practices to transition to the '*modern general practice*' operating model. This involves operational and technical changes to the way practices work and improvements to the interface with patients.
- It aims to tackle the '8am rush' for appointments and ensure all patient requests are reviewed, triaged and a responded to on the day

We are 1 year in to implementing this locally:

- Interventions have been designed to support practices to manage demand and improve patient satisfaction.
- The ICB is tailoring the programme to meet local need and will support this with a communications campaign for local patients
- Reducing Practice workload is key as demand outstrips capacity – so improvements to the primary/secondary care interface and optimal use of other areas of primary care (in particular community pharmacy) are local priorities.

General practice delivers 95% of all NHS patient contacts in NCL. The number of appointments offered by General Practice in NCL continues to grow. In 23/24 our Practices delivered:

- Approximately 680,000 appointments per month.
- Approximately 100,000 Online Consultations per month
- Approximately 30,000 out-of-hours appointments per month (evenings, weekends and bank holidays).
- Enhanced services - including vaccinations - not counted above.

Appointment demand outstrips list size growth:

- Practice list sizes have grown by about 15% over the last 5 years
- Appointment numbers are up 15-30% at most practices (2023/24 compared to 2019/20):
- New ways of working, new roles, use of technology are all there to help manage workload, support productivity and manage this demand.

- In 23/24 an average 64% of all appointments were face to face. They have remained at this level for 12 months. This represents roughly the same number of face to face appointments as delivered pre-pandemic.
- 52% of NCL appointments (as at April 2024) are provided same day. This is higher than many peers in other ICS.
- NCL practices are consistently exceeding the national standard of 90% of appointments taking place within 2 weeks of booking.
- Same-day 'episodic' care needs to be balanced against capacity for planned and proactive care. We are therefore focused on embedding the new NCL Long Term Conditions locally commissioned service.
- Further growth in capacity is unlikely to be sustainable without comparable growth in workforce, funding and estates.

Workforce is critical:

- NCL has gone from having one of the highest GP leaver rates in the country to one of the lowest. We now stand at the top of the table, having seen the largest reduction in GP leaver rates over the past 12 months (since the figures began, Dec 21-Dec 22) and one of the lowest leaver rates in the country.
- In 23/24 600 staff joined NCL under the Additional Roles Reimbursement Scheme (ARRS). The combined Practice and PCN workforce has grown by over 6% under this scheme.
- The Long Term Workforce Plan will need to support any further growth in workforce.

Estates is critical:

- NCL ICB has invested £13m in primary and community estate in the last two years.
- We have prioritised development of primary care estate in deprived areas.
- We have established 6 new health centres over the last three years and begun work on 2 more expected to complete in 2024/25.
- As a system we have committed 5% of the NCL ICS Capital envelope to Primary Care – one of the only places in the country to do so.
- We are also creating clinical capacity with conversion of records rooms, approval of additional rooms where free in health buildings and use of void space for integrated working.

Digital is critical:

- All GP Practices now have a Cloud Based Telephony (CBT) System - this improves patient experience through features like call routing and allowing patients to request callbacks rather than wait on hold.
- Data from these systems helps Practices review call volumes and patient waiting times, which they can use to make changes to their ways of working and staffing rotas to align capacity to demand.
- 136 Practices have received new Wi-Fi connections.
- We are also implementing technology that support primary care staff to work flexibly and deliver in their Primary Care Networks.

We are already hearing success stories:

- NCL PCNs are reviewing patient feedback (collected from multiple sources) together and taking collective action on common themes.

- Several have already been able to demonstrate sustained improvements in patient satisfaction scores.
- With telephone data some practices are working together to support each other during busy periods.
- Practices have increased the range of self-booking options available via the NHS app
- Practices are investing in care navigation training for reception teams.

1 Introduction

The national Delivery Plan for Recovering Primary Care Access was published in May 2023. In November 2023 the ICB Board received the NCL plan, reflecting national requirements and local priorities. In response to board feedback we have strengthened our planned approach to communication and engagement with patients and the public, enhanced work on digital inclusion and further developed our approach to benefits realisation and evaluation of impact. The national and NCL plans are designed to support Practice transition to the *Modern General Practice* operating model (appendix 1).

This report summarises progress since November (as of March 2024) and our approach to delivery and evaluation of impact. In February 2024 a more detailed report was received by the NCL ICB Primary Care Committee (PCC). This covered all national assurance requirements and is publicly available. Delivery is on track across all areas of the plan, with slower progress around self-referral pathways and the Primary-Secondary Care Interface, but this is the case nationally.

This summary paper was presented to NCL ICB Board in March 2024 to support Board review of progress against plan. It is shared here with the JHOSC as it describes steps the ICB has taken to maximise impact and positions this work in the wider context of challenges and areas of focus for General Practice.

2 Background and context

2.1 Scale of contribution of General Practice

General practice is delivering ~95% of all patient contacts in NCL. In 2023/24 NCL GP practices delivered, collectively, on average 680,000 appointments / month, and the most recent data (April 2024) shows they also triage ~100,000 online consultations a month. This data does n[1]ot include the ~30,000 out-of-hours appointments / month provided across NCL in evenings, at weekends and bank holidays. In total this represents >800,000 documented patient contacts with General Practice a month.

Practice list sizes have grown by ~15% over the last 5 years but appointment volumes are up 15-30% compared to pre-pandemic volumes (2023/24 compared to 2019/20). This is the result of increased productivity as appointment demand continues to outstrip list growth. In 2023/24, levels of face to face GP appointments recovered to an average 64% of all appointments and have remained at this level for 12 months. NCL practices provide a higher than average volume of same day appointments (52% April 2024) compared to peers in other ICS', and consistently exceed the national standard of 90% appointments taking place within 2 weeks of booking.

General practice is delivering ~95% of all patient contacts in NCL. In 2023/24 NCL GP practices delivered in average 680,000 appointments / month, and the most recent data (April 2024) shows they

[1] Through practices working together in Primary Care Networks to deliver *enhanced access services* and through borough-based GP hubs commissioned by NCL ICB

also triage ~100,000 online consultations a month[2]. This data does not include the ~30,000 out-of-hours appointments provided a month across NCL at evenings, weekends and bank holidays. In total this represents >800,000 documented patient contacts with General Practice a month.

Practice list sizes have grown by ~15% over last 5 years but appointment volumes are up 15-30% compared to pre-pandemic volumes (2023/24 compared to 2019/20)[3]. This is the result of increased productivity as appointment demand continues to outstrip list growth. In 2023/24, levels of face to face GP appointments recovered to an average 64% of all appointments and have remained at this level for 12 months. NCL practices provide a higher than average volume of same day appointments (52% April 2024) compared to peers in other ICS', and consistently exceed the national standard of 90% appointments taking place within 2 weeks of booking.

Demand for appointments has outpaced growth in practice list sizes. There is variation at practice level but all sites are under considerable pressure and the extraordinary workload is impacting patient experience, staff retention and wellbeing. The activity picture is incongruent with declining levels of patient satisfaction with access.

Major transformation of the practice operating model has taken place over the last 3 years – new staffing models, new access routes and rapid digitisation with new technology for access, consulting and communication. The access recovery plan assumes practice systems and processes, people's understanding of them, and the overall efficacy of the practice operating model can be improved and in doing so, patient satisfaction with access will improve. We know that patient satisfaction with General Practice, as measured through the national GP Patient Survey, complaints and stakeholder feedback, has declined in recent years. This is a national trend, but within NCL we have significant variation between practices, with some exemplar providers who have been able to maintain a consistently good patient experience. Patient outcomes overall remain high.

Access to General Practice is a major priority nationally and locally and continues to be a focus in political debate. Appointment numbers do not convey the full scale of work undertaken on behalf of patients by General Practice. Changes to Acute services in particular – changes to their operating model, backlog from the pandemic and the impact of frequent industrial action – impact General Practice. Appendix 2 has been prepared by General Practice providers to show the scale and type of 'behind the scenes' work undertaken in general practice on top of appointment activity.

2.2 Patient satisfaction with General Practice

Practices are providing more appointments than ever before, but there is an overall drop in satisfaction with access and significant variation in national and local GP Patient survey results. A negative perception of general practice is also prominent in national media coverage, and practice staff have seen an increase in verbal and physical abuse.

In response to the pandemic, and to help practices handle increasing demand, new routes into General Practice and new tools for triage and consultation have been introduced at pace over the last four years. Digital tools play a dominant role in access (online bookings, online consultations e.g. e-consult, NHS app usage) and patient list management (supporting risk stratification for proactive care, call / recall etc). However, there is variation between Practices in the way changes have been implemented and the

[2] National GP Appointment Data, National Online Consultation Data
[3] Raw list size January 2023, National GP Appointment Data 2019-2023

extent to which different tools are used or used effectively. Some tools are not yet intuitive for practices or patients and considerable development work is needed by those who own the products.

Work to communicate changes to patients and to support them to use digital channels has sometimes lagged behind their introduction or been sufficiently broad and deep to effect understanding. Digital exclusion and language barriers also remain a risk.

2.3 Policy context

Delivery of the Primary Care Access Recovery Plan is taking place in the context of a heightened national focus on General Practice more broadly:

- The Fuller stocktake Next steps for Integrating Primary Care articulated well *why* General Practice needs to change and at a high level *what* needs to change, with the proposed introduction of Integrated Neighbourhood teams, a streamlining of access and segmentation of episodic demand and proactive, personalised care, development of end to end urgent care pathways, and a focus on prevention. Work continues on *how* these changes should be achieved;
- The Hewitt Review made recommendations for a new framework for GP primary care contracts, an outcomes focus, a new approach to incentive schemes; support to primary care at scale;
- NHS England are consulting on the future of national incentive schemes – the Quality and Outcomes Framework and the Investment and Impact Fund;
- The current national GP contract ends in March 2024, with a one-year contract in negotiation for 2024/25, and significant change expected from 2025/25;
- The Academy of Medical Royal Colleges reviewed action needed at the interface between primary and secondary care – recommendations from this have been incorporated into the Primary Care Access Recovery Plan; and
- We know that challenges related to workforce, primary and secondary care interface, primary care estate, patient safety, access and proactive care are part of current discussions at many levels.

In London:

- a Londonwide Strategy for Health is in development, with a goal related to patient access to care;
- Deliberative Engagement with patients and the public about the future of primary care has been jointly commissioned by London ICBs with NHSE (London) – this is focusing on choices, implications and 'trade-offs' to be considered in future developments (see section 5)
- Londonwide LMCs has published a report focused on retention in London General Practice, with Key Lines of Enquiry for ICBs to consider in supporting retention.

In NCL the ICB is leading the development of local Ambitions for General Practice, through extended local dialogue. These ambitions will underpin our decisions and actions and articulate shared aims to frontline teams and patients. Whilst focused on General Practice they will be set in the context of integrated working and population health, and consider interfaces with other sectors and partnership working, in particular at Neighbourhood level.

3 Our response to access recovery: programme overview

The National Access Recovery Plan has four key aims and fourteen areas for action. These are outlined in Figure 1 below. The detail of NCL progress against each area was recorded in the full PCC report. There is a national practice and PCN support offer and an expectation that ICBs provide and arrange for local hands-on change support.

It is expected that the overall impact of the programme will be *improved patient experience of accessing general practice* – as measured through the national GP Patient Survey. A related aim is reducing pressure on General Practice by increasing capacity elsewhere in the system (community pharmacy) or reducing administrative workload (self-referral into community services, reduction of bureaucracy at the interface). Effective access – for urgent, planned and proactive care – is essential to population health improvement and this programme of work has been shaped to support progress against three key NCL population health outcomes:

- The care navigation and triage elements of modern general practice allow practices to better direct people to the *local services that can best meet their needs*;
- Digital General Practice access routes allow people to take *greater control of their healthcare and keep themselves well*;
- Strengthening the interface and between General Practice and Community Pharmacy creates opportunities for collaboration on *preventative care* such as vaccinations, and development of better *integrated care for patients with complex needs*.

Since the last report we have mobilised the practice change support offer, shaped and commissioned a communications and engagement programme, seen significant shifts in key KPIs related to digitisation and the practice operating model and undertaken a significant amount of work with local Community Pharmacies to mobilise Pharmacy First (which enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways). The detail and impact to date is described in section 4.

We will continue to develop the link between the programme and NCL outcomes framework to demonstrate these impacts more clearly. We have described briefly in this report (see section 4.3 and full detail in the PCC paper) how we expect to track impact of the programme using structure, process and outcome measures.

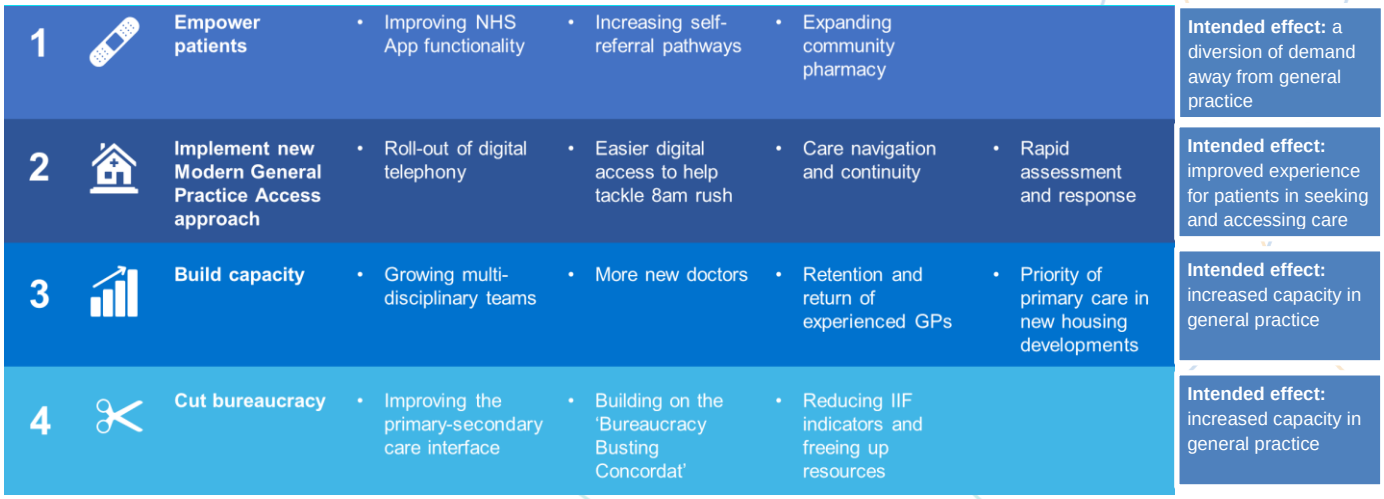

Figure 1 – key aims, actions and intended effect

4 Programme delivery (As March 2024)

4.1 Progress since November 2023

We are on track with programme delivery against each major area above and have made significant progress since November. Highlights are:

1. Empowering patients – supporting a diversion of demand away from general practice when appropriate	• 95% of NCL practices are now correctly configured to enable online records access for patients • 80% of NCL practices are now offering prospective online access as default in the NHS app (a 58% increase from November 2023). • 54% of NCL patients are registered with the NHS app with 36% of patients logging in to the app in January 2024 (significantly up from previous months). Viewing records is the most popular feature, followed by ordering repeat prescriptions, viewing test results and managing appointments. • We are on track to meet targets for increasing self-referral activity into Community services, allowing patients to self-direct across a range of pathways. • 96% of Community Pharmacies in NCL have signed up to deliver *Pharmacy First* services.
2. Implementing new Modern General Practice Access approach – improving the experience for patients in seeking and accessing care	• 92% of practices are using digital telephony. 100% of practices have signed agreements for digital telephony systems, supporting transition to these systems by the national deadline of March 2024. • 100% of practices have digital access and online consultations enabled. • We released our full 23/24 practice transition and transformation funding by March 2024. This has supported 36% of practices to plan transition to the modern General Practice operating model to date. All practices will be covered during the programme. • Using data and insight we identified 65 practices for a structured diagnostic conversation with a clinical facilitator. We completed 40 by March 2023, informing understanding of practice support needs. • We have commissioned a local GP Federation to provide leadership, expertise and hands-on change support to practices from March 2024 (see section 4.2).

3. Building capacity – growing and strengthening the multi-disciplinary general practice team	• Work with practices includes:
	  • support for recruitment, induction and supervision of ARRS staff. We have seen data that suggests we are now the ICB with the highest GP retention rate in the country.
	  • delivery of GP retention initiatives via the Training Hub (mentoring, fellowships, coaching and leadership development)
	  • appointment of joint PCN and Training Hub workforce and education leads
	  • development of multi-professional education
	  • introduction of a flexible staffing pool (to develop an NCL pool of locums)
	  • initiatives to support primary care staff wellbeing.
	• We are funding a deep dive into the supervision of ARRS staff and designing training for ARRS Supervisors to support high quality supervision and the retention of the ARRS workforce.

4. Cutting bureaucracy – freeing up capacity in general practice	• The NCL Clinical Advisory Group has approved a *Consensus Document* detailing how primary and secondary care will work together to reduce bureaucracy at the interface of these two key sectors.

	• Relationships are good in NCL supported by local interface groups around each Trust. • We are reviewing the work programme and thinking about how we support buy in to operational changes from primary and acute providers, focused on 'win-wins' and evidence of the positive impact streamlining this interface could have for staff and patients.

4.2 Optimising impact

The transformation effort under this programme – from practices / providers and the ICB - is significant, and we want to optimise the impact of the programme. As an ICB we are going beyond the nationally prescribed change support offer for practices.

We have scoped individual practice support needs through practice engagement and desktop review of data held by ICB teams. 'MDT' meetings brought together leads from Primary Care, GP IT, Digital, Workforce and Estates to share insight and develop bespoke practice support offers to optimise impact. Through this process we identified our own priorities:

- Telephone access processes
- Practice website quality
- Demand and capacity management
- Engagement and communication with patients
- Digital maturity amongst practice teams
- Supporting practice managers and reception teams

We have appointed a lead provider and the offer will include subject matter experts working in practices to effect change. Technical support will come from ICB GP IT and Digital First teams, who will support practices to implement the "must-do" requirements of the access recovery plan. GP IT are working with digital telephony suppliers to offer training and support to leverage the full benefits of the telephony systems. We have shaped a Digital Change Facilitator role and commissioned this additional capacity to provide hands-on support at practice level. Dedicated resource packs are in development to ensure practices have high-quality information and guidance. The team will take an agile approach and continuously adapt in response to practice and facilitator feedback, aligning support where required from external suppliers.

Acknowledging the risk that increased digitisation will exclude people who do not have access to – or are not confident using – technology, we have focused on over the last few months on digital exclusion / inclusion. We are funding pilot projects in each borough. These will connect practice teams to voluntary sector organisations with expertise in digital inclusion. Leads will work in General Practice settings to help patients engage with tools like online consultations and the NHS app. We will use the learning from pilots to develop a longer-term digital inclusion plan for General Practice based around interventions with proven impact.

The success of the programme rests on our ability to help practice teams create the space to engage, shape and embed change at practice level. Given the number of asks on practices, and the multiple elements under this programme alone, we have worked with the GP Alliance and Federation providers to shape a Joint Oversight Group. Convened by the lead provider of the change support, this will coordinate all offers of support and ensure a coherent package and logical sequence of interventions for each practice.

4.3 Measuring impact

We want to ensure the programme delivers meaningful and demonstrable change for patients. Building on Board feedback from November, we have developed an impact monitoring approach - tracking several indicators that would as a whole represent improved patient experience. We will use a three-stage approach measuring structural, process and outcome measures for each area of the programme. The framework is shown in appendix 3 with a detailed description in the PCC report.

The primary outcome measure for the programme is improved *patient experience of access* as measured through the national GP Patient Survey. We are looking for and working towards:

- an overall increase in NCL average scores
- a reduction in the variation between the highest and lowest scoring practices
- a reduction in the number of NCL practices who appear in the lowest 20% of practices nationally for each of the questions.

As the survey reports annually, with data collection in Winter and publication of results in July, it is unlikely that we will see the full impact of the work until summer 2025. We will work in the meantime with qualitative feedback from patients and other stakeholders and monitor complaints trends, online reviews. Local surveys are undertaken with patients where there may be formal concerns about a practice and/or it is subject to a formal Performance Review. This is taken via PCC.

In some cases, increased digitisation has correlated with a reduction in patient satisfaction with making an appointment as measured by the GP Patient survey. Our change support offer includes work with practices where this may have happened, but we note the potential for survey results to decline before they get better. We will benchmark against National data to isolate local issues and use local case studies and the GP Friends & Family Test (once firmly established) as interim measures of satisfaction.

An important aim of the wider programme of work is reducing pressure on General Practice by increasing capacity elsewhere in the system (community pharmacy) or reducing administrative workload (self-referral into community services, reduction of bureaucracy at the interface). Outcome measures require further development but will focus on reduction in pressure on practice staff and patient satisfaction with alternative pathways.

4.4 Programme challenges and risks

At programme level the overall risk profile has reduced since November 2023 and several risks will be closed as we near the end of the first year of the programme. The most significant programme risks are:

- that we deliver the plan but do not significantly impact key outcomes like patient satisfaction and staff morale. This is mitigated in part by our approach to optimising impact, but also relates to general practice challenges that we are seeking to progress beyond the scope of this programme – see section 5.
- that variation persists at practice and PCN level. Locally we have developed an approach to mitigate this risk - using data to baseline, target change capacity and track impact in a formative and summative way.
- practice engagement with the plan. We have reduced the risk-rating since November due to positive responses to date, but practice funding and capacity for change is limited at a time when practices are also focusing on implementation of the long-term conditions locally commissioned service (LTC LCS). We have identified specific risks around engagement with the NHS App and the Support Level Framework which we will continue to monitor.

- varying levels of engagement from acute trusts with implementing the recommendations in the plan about improving the primary / secondary care interface and reducing the administrative burden on practices, which will in turn free practice staff up to focus on other areas of delivery.

We are identifying critical success factors not prominent in the National plan. Digital inclusion is key - closing the gap between the presence of technology and digital channels and patient use and satisfaction with them. The lack of recurrent funding and capacity to support sustained work on digital inclusion has been highlighted as a risk by National and NCL Equality Impact Assessments. The ICB Primary Care, Communities and Digital teams are developing plans to address this, within scope of ICB remit and influence.

5 Wider considerations

Whilst the Access Recovery Plan is a significant programme of work for NCL ICB, it is somewhat narrowly focused on patient experience of access to general practice. As an ICB we are aware of, and actively seeking to address a much broader set of challenges for general practice. The NCL ICB Ambitions are key to this. We are also influencing at London and National level to shape the future of primary care. Considerations for the Board include:

Continued increases in demand for primary care

We anticipate demand for general practice services will continue to outstrip capacity and resources. The 2024/25 GP Contract was released at the end of February, positioned as a 'stepping stone' to a longer term deal, however national messaging emphasises financial challenges. ICBs and ICS need to consider discretionary investment locally, with some national evidence suggesting the relative proportion of investment into general practice has reduced over the last few years.

New pathways (self-referral to community services, and use of community pharmacy) will have a small benefit if they can contain the activity (avoiding multiple contacts for the same presentations), however the capacity will not make a significant dent. We hope to access better data on demand (met and unmet) from telephony systems. We believe action is needed around staying well, self-care and self-management and standardised triage to analyse need and navigate patients. Technology and AI offer opportunities in this space. This will require significant work to build public understanding of new models as they emerge.

Trends in patient expectation

Rapidly changing patient expectations might impact work to improve patient satisfaction. The five London ICBs, together with NHSE (London), have commissioned a London-wide programme of deliberative engagement to support deeper conversation and choices around the future of primary care in London. Topics for deliberative engagement include the role of digitalisation, how patients may be better navigated to meet need, and multi-agency ways of working. There will also be a focus on the knotty question of standardisation of service vs local flexibility across London. We will also consider 'trade-offs' that accompany change, for example having need met more swiftly, may mean that patients are not able to see their clinician of choice.

Balancing on-the-day demand with capacity for proactive and preventative care

We have noted a significant increase in appointment numbers since before the pandemic; however we need to acknowledge that with a finite workforce this may be at the expense of capacity for prevention and proactive care. In North Central London we have recently commissioned a model for proactive management of care for patients with long term conditions. We have worked closely with General Practice and partners to design this, thinking about how we deploy population health management tools

to increase the efficacy of the interventions, the role of the GP and wider practice team and how general practice and partners such as the VCS and Trusts might integrate their approaches. If we continue to prioritise this – and there is no significant investment into general practice or growth in workforce – we would expect appointment numbers to remain relatively static and would not expect the rapid growth we have seen over recent years. We will need to monitor patient satisfaction and outcomes for key population groups closely to ensure we get the balance right.

Improving general practice premises

The ICB is responsible for strategic estates planning and support to develop the General Practice estate. This covers approximately 200 buildings in NCL. We must work with providers to ensure there is sufficient space to deliver commissioned models of care, secure a fit for purpose estate that meets standards, secure value for public money and support redevelopment. Revenue costs for the General Practice estate are managed via PCC.

Just under half the NCL general practice estate was built before 1948. There are declining numbers of 'owner occupied' premises (GP Partners as landlords) and as Partners retire and release premises we see an increase in Leasehold which increases cost to the NHS and impacts the General Practice business model. The current General Practice estate is not sufficient – nationally or locally - to support and sustain the *Modern General Practice* model. National changes are also needed to reflect in estates guidelines the significant growth in the workforce, the PCN model and integrated working and changes to the practice operating model.

The ICB is reviewing estates needs – triangulating contract, estates, finance and other information to understand current and future patterns in the estate. We are taking proactive action on capital allocations for the general practice estate, securing 5% of the Capital envelope per annum (one of the only ICBs in the country to do so). We are also digitising patient records and converting record rooms to clinical to optimise space. We are influencing at a National level with local lessons shared to inform the anticipated national Infrastructure Strategy.

Securing recurrent investment for digital developments

We are seeing an acceleration in the development of new digital tools and approaches that may support the sustainability of general practice. However with this comes both development costs and the recurrent costs of licences and kit. Currently this tends to be supported with non-recurrent funding which enables pilots of new approaches, however to be able to embrace, test, evaluate, roll-out and sustain the use of new digital tools, we will require recurrent investment. This forms part of the ICS Capital envelope and we need to achieve a balance between estate and digital investment.

Maintaining and strengthening the multi-disciplinary team

The introduction of a wider multi-disciplinary team in general practice is changing the nature of work for senior GPs, who now spend a larger proportion of their time supervising the wider team. In developing our Ambitions for General Practice, we will consider how the growth of the MDT is changing the nature of practice leadership and supervision models, and how we can support practices to make this shift safely and consistently. There is also some risk to retention of staff recruited under the additional roles reimbursement scheme (ARRS) as national investment is set to level out in 2024/25 after five years of growth.

Supporting change and a quality improvement approach

Through our System Access Improvement Plan we are exceeding national requirements for change support to practices, because we understand the level and pace of change required. This offers a prototype approach to change support which could be built upon to embed a consistent model, similar to

the Clinical Effectiveness Group approach used in other ICBs. We are keen to explore this as part of our ambitions and approach to financial planning for general practice in NCL.

6 Communications and engagement

In November the Board noted the importance of communication and engagement to support patients to effectively self-manage, access support when it is needed and understand the challenges and choices faced by general practice teams. The previous section makes clear the scale of change that may be experienced, beyond the delivery of the System Access Improvement Plan. This in turn underlines the need for sustained communications, engagement and dialogue with patients, the public, and stakeholders locally, aligned to the outputs of the Londonwide deliberative engagement and our general practice ambitions.

The national access recovery campaign launched in January 2024. Building on previous campaigns, activity focuses on three key themes - digital access, the wider practice team and wider care available. There are also national communications on the launch of Pharmacy First to supplement our local approach to increasing patient awareness of new access routes into services.

National materials linked to the recovery plan are relatively high level so we are supplementing this with a full communications plan locally. We will message via partner and stakeholder channels, traditional local media and digital platforms such as newsletters, websites and social media. Working closely with our local voluntary and community sector groups we will use trusted voices to help share our message. We will also draw on ICB clinicians and primary care staff to enhance the impact of the campaign. Materials to be developed include profile pieces, template materials that partners and stakeholders can adapt, video content and images.

We have developed a practice-facing Directory of Services web page available via the NCL GP Website to support practice staff with care navigation.

7 Next steps

North Central London has developed its programme of work, has clear plans and is making progress against national deadlines. It is a whole-ICB approach with critical support from across our Directorates.

This will need to be maintained as a priority during transition of our own structures and operating model. We are enhancing the work as necessary and considering all key success factors.

Beyond this work we are seeking to develop, through local dialogue, our *Ambitions* for general practice in NCL which will seek to address the wider considerations outlined in this paper.

Appendix 1 – The patient journey under the modern General Practice operating model

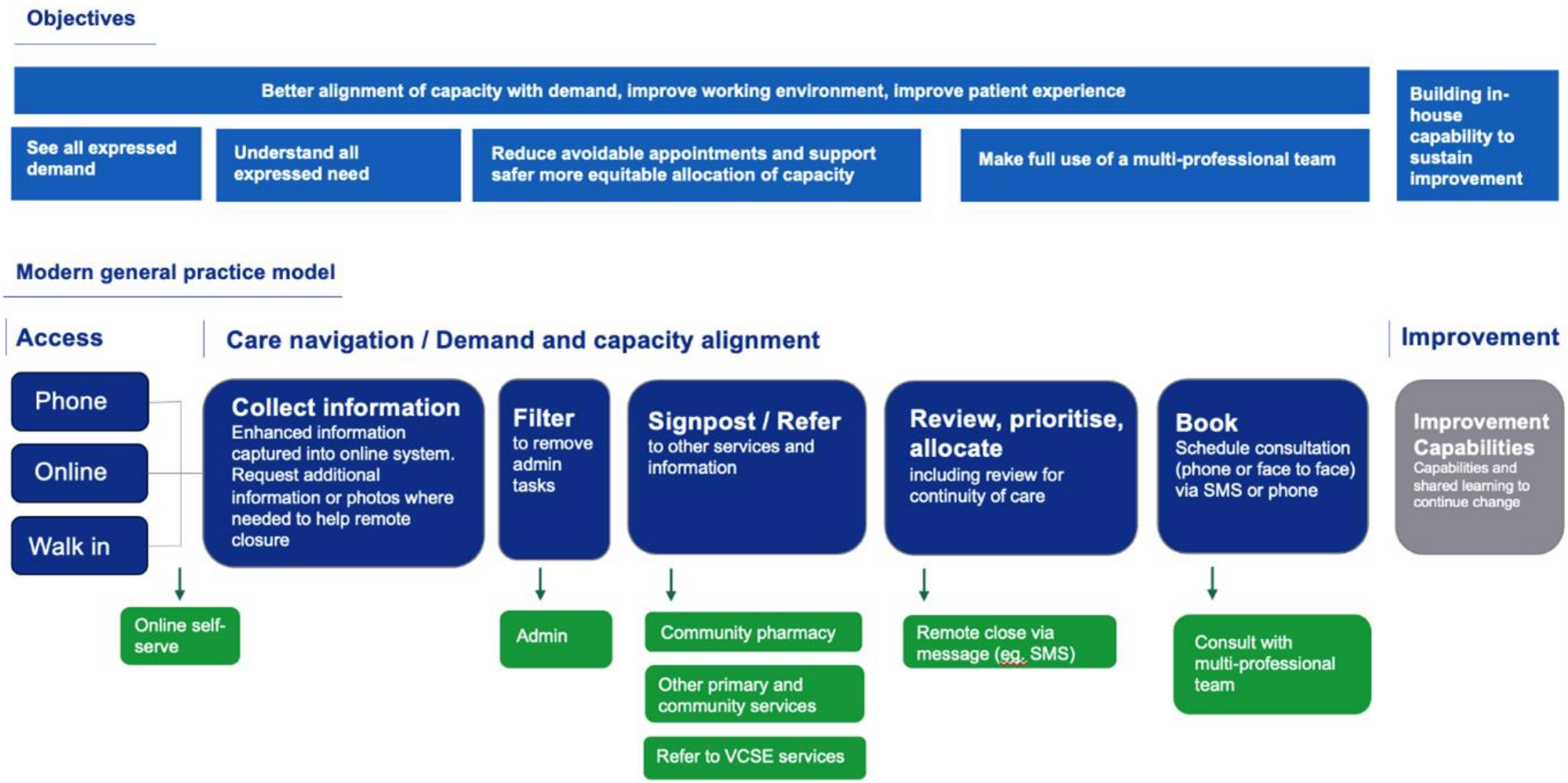

Figure 2 – visualisation of the modern General Practice operating model

North Central London
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Appendix 2 – the work of a GP and their team (source: Londonwide LMCs)

Appendix 3 – Measuring impact

		2023/24				2024/25				2024/25	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Practice-level change	**Patient experience of GP access**		**2023 GP survey** (baseline)				**2024 GP survey** (interim)				**2025 GP survey** (final)
		Ongoing qualitative feedback from patients and other stakeholders									
	PCN capacity and access improvement	**Structure:** PCNs write improvement plans	**Process:** PCNs track progress against the deliverables in their improvement plans			**Outcome:** PCNs demonstrate improved patient outcomes					
	Transition to modern General Practice		**Structure:** Practice survey measures readiness for change			**Process:** practice uptake and use of transition funding is monitored against NCL schedule and practice plans					
							Outcome: impact of practice use of their transition funding to move to modern general practice				
	Hands-on change support			**Structure:** MDT meetings agree support needs		**Structure:** SLF conversations develop understanding of need					
							Process: practice uptake of hands-on change offers				
									Outcome: impact of hands-on change offer		
Digital& IT	**Digital and IT change**		**Structure:** implementation and switch-on of key digital tools / features								
						Process: reducing variation in levels of digital activity					
			Structure: telephony upgrades in place								
				Process: reducing variation in telephony activity							
								Outcome: impact of digital and IT change on patients			
Wider programme	**Pharmacy First**			**Structure:** pharmacy sign-up to deliver the service							
							Process: Pharmacy First activity				
	Self-referral		**Structure:** provider uptake of self-referral pathways								
						Process: Patient self-referral activity					

	Interface		**Structure:** Interface infrastructure baseline	**Process:** Ongoing interface measures to demonstrate achievement of 4 priorities (details TBC)	

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Dental Services Update for North Central London

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July 2024

1.0 Executive Summary

In April 2023 Dental, Optometry and Community Pharmacy Services (collectively referred to as DOP Services) were delegated from NHS England (NHSE) to Integrated Care Boards (ICBs). This included the transfer of budgets (~£162m for North Central London (NCL)) for the three service areas including responsibilities for contract management, service development and transformation.

The delegation of the DOP Services was accompanied by the transition of the former team who supported all routine DOP activities (invoicing, monitoring, contract management etc) from NHSE to the ICBs. It was agreed that North East London ICB (NEL ICB) would host these services on behalf of all London ICBs and a Memorandum of Understanding (MOU) was agreed between the ICBs to outline the relationship with the team (called the DOP Hub). In addition, a governance structure was established to collaboratively oversee the services at a London level that involves all London ICBs working together on shared issues.

The responsibility for delegated Dental Services sits within the Strategy & Population Health Directorate of the NCL ICB. Dentistry, encompassing Primary Dental Services, Community Dental Services and Secondary (hospital based) Dental Services, represents 71% of the total budget for DOP Services with a total spend for 23/24 of £114.5m across all areas increasing to £116.9m in 24/25.

Following delegation of Dental Services the NCL ICB has embarked on a wide ranging transformation programme utilising both existing underspends and core ICB funding and including a £600k commitment of recurrent funding focused on ensuring we have a consistent offer to rough sleepers, providing support for those experiencing homelessness (including asylum seekers), providing support to those in residential care who would not have otherwise be able to access care and also focused on reducing waiting times for children and young people (CYP) who need more specialist care.

The NCL ICB has also expanded access to Primary Dental Services increasing activity from 67% of plan to 87% of plan in the first year of delegation (from Apr 23 to Mar 24) and we are now seeing it running at nearly 95% of plan. This increase in activity is in excess of the aspirations of the National Dental Recovery Plan announced under the previous government and reflects changes we have agreed to extend activity across a wide range of Primary Dental Practices, supporting practices to develop new skills and therefore expand the capability to deal with more complex issues and working with our Local Dental Committees, the Dental Confederation and the British Dental Association to both expand existing capacity and reduce the number of practices handing back their contracts.

The NCL ICB has also continued our support for patients in acute pain being able to access urgent appointments, nearly always on the same day, via a call to 111 and our support for Looked After Children having access to specialist support. We have started investing into the shared agenda with Local Authorities around Oral Health Promotion and have formed a pan NCL working group with Public Health and NHS England (NHSE) Colleagues to increase the effectiveness of our collective investments in this important preventative work.

In achieving the transformation in access and activity we have seen we recognise the importance of our Community Dental Services (CDS) which, for NCL, is provided via the Whittington Hospital NHS Trust (WH). All referrals to more specialist care are triaged by the CDS and through this approach the vast majority (~92%) of all referrals to hospital are managed in a community rather than hospital-based setting. This has an important impact on waiting times and waiting list sizes for intensive hospital based treatments. The CDS also leads on our work with those experiencing homelessness including rough sleepers and our work supporting LAC, people in Residential Care and the development of skills within the wider Primary Dental Community. Referrals into the NCL CDS are 40% above that of pre-pandemic levels yet Referral to Treatment (RTT) times remain one of the best in the country at 80% against the target of 92% even with the increased referral rates. The NCL CDS is also at the forefront of improving outcomes for CYP with Special Educational Needs including reshaping the screening programme currently undertaken into a programme of Supervised Tooth Brushing (STB) which will improve outcomes. The aim is to have all Special Educational Schools undertaking STB before the end of 24/25.

Whilst noting the significant achievements that have occurred since delegation in April 2023 and in particular the work we have done to expand Primary Dental Capacity we do need to note the constraints the ICB is working within which relate to the inability to change the nationally set contractual terms and the fact that responsibility for workforce development and practices remain a national issue that cannot be influenced more locally. The constraints also include the fact that dentistry, unlike General Practice, provides no right of registration for patients and the limitations of the payment system, based as it is on the use of UDAs (Units of Dental Activity) further impacts what the ICB can and cannot influence.

Our focus for the future includes improving the oral health of those with Long Term Conditions such as Diabetes as well as identifying Cardio-Vascular Disease (CVD) in those who present with Oral Health issues (and also in those who present with Ophthalmic related issues to Community Optometrists) for which the NCL ICB has been awarded funding for two pilots to undertake pathfinding work to determine whether we can help provide earlier identification and interventions and therefore improved health outcomes. We are also seeking to see whether we can expand the support for patients in Residential Care to those in other care settings and are currently working up the plans and costs of doing this in a phased way. Finally, we are also working with the London Paediatric Managed Clinical Network, our Urgent Dental Care Providers and the Community Dental Service to develop a new paediatric trauma pathway which will lead to improved outcomes (in terms of retained teeth) for CYP

This report provides a summary of progress the NCL ICB has made in dental services following delegation and is presented for comment to the JHOSC.

2.0 Overview of DOP Services in NCL

Dental, Optometry and Community Pharmacy Services (collectively referred to as DOP Services) were delegated from NHS England (NHSE) to ICBs in April 2023 along with a budget (for North Central London (NCL)) of ~£161m across the three areas. Of this, Dental Services (encompassing Primary, Community and Secondary or Hospital Based services) accounts for £114.5m (71%) of the total across 170+ contracts as summarised below.

Overview of Dental Services in NCL	Provider/No. of Providers	NCL ICB 23/24 DOP Budget	NCL ICB 24/25 DOP Budget
Acute Dental Services	UCLH/ RFH/ Out of Sector	£35.4m	£35.7m
Community Dental Services (CDS)	Whittington Health	£4.5m	£5.3m
General Dental Services & Orthodontics	~170	£74.6m	£75.9m
	Total NCL Dental Spend	£114.5m	£116.9m

The table above gives a snapshot of the contracts at a point in time given that new contracts are constantly being added/amended and some are handed back. The values fluctuate as well based on activity seen, with some funding being returned to the ICB for reallocation where not spent, as well as the fluctuations due to changes initiated in year, some of which are alluded to below. Therefore, the table above should be seen as providing an indication of the spend and contracts as at the time of writing this report.

The delegation of DOP Services was accompanied by the delegation of the DOP Staffing Hub, consisting of the team who previously supported DOP Services within NHSE London Region but are now hosted by North East London (NEL) ICB on behalf of all London ICBs. This team provides the administrative and management functions to manage the routine aspects of the ~5,000 contracts across London (spread across Dental, Optometry and Pharmacy contracts) including dealing with budgets, contracts, invoices, claims, challenges, terminations and all other routine management actions.

The DOP Hub, whilst managed day to day by the NEL ICB for London, is overseen by a DOP Governance Group involving all London ICBs. This group is provided with information on activity, spend and progress for each of the three services.

Transformation of services lays within the remit of each ICB who, across London, use the DOP Hub Team to support the implementation of improvement initiatives. For the NCLICB, Dental Services are managed within the ICB's Strategy & Population Health directorate who have initiated a wide ranging programme of transformation and agreed an initial increase in spend on Dental Services of a recurrent £680k, the details of which will be provided within the body of the report along with our plans for future areas of focused improvement.

3.0 Strategic Dental Challenges

Before we move to the review of what the NCL ICB has undertaken to improve access and outcomes in Dental Services we need to be aware of the strategic challenges faced in the work that has been undertaken and these are summarised below:

- The ICB has limited ability to influence the structure and payments associated with the GDC (General Dental Contract). Dentists are paid based on UDAs (Units of Dental Activity) and dentists sign up to providing a certain number of UDAs per year but many do not achieve the contracted amounts. The NCL ICB has worked hard with the DOP Hub to ensure that as much of this underspend is returned back into Dentistry to target inequalities and increase access. This will be explored in more detail later in this report.

- A key point to note is that unlike Primary Care General Practitioners (GPs), patients have no right of registration with a practice and whilst this means they can access treatment from any NHS Dentist, should there be capacity for them to be seen, it does mean that many patients cannot get access to NHS funded treatment. Not all NHS treatment is free in all cases and adult patients need to contribute toward their treatments based on a scale of charges.

- In terms of workforce, which remains an issue for the NHSE National team rather than a matter that can be tackled directly by the ICB, there continues to be a movement of clinicians (dentists and dental nurses) away from providing NHS care into providing private care. The access to workforce has been affected by industrial action as well.

- The impact of the pandemic is still be felt in dentistry with a general increase in patient acuity, particularly amongst children and young people. This reduces access for the wider population as individual patients need longer treatment to restore them to good oral health. This also reduces the payments received by dentists as they have to do more work per UDA.

- Secondary care dental support continues to be affected by lack of anaesthetists and access to beds, especially when there are higher priority patients to be supported. Access has also been affected materially by the recent industrial action, adding to waiting lists.

- Media coverage of dentistry is relatively high with the diagnosis of oral cancers the most recent topic. As any patient in acute pain living within London can access an urgent appointment via the 111 Service (a service not available anywhere else in the country) and with increased primary care access in London compared to elsewhere in the country and relatively short waiting times in secondary care the challenges in London are less pronounced than elsewhere.

In addition to, and partly in response to, the challenges above the previous government published a Dental Recovery plan on the 7th February 2024 entitled: Faster, simpler and fairer: our plan to recover and reform NHS dentistry. The key commitments in this plan are stated as:

- In 2024, significantly expand access so that everyone who needs to see a dentist will be able to. This will begin with measures to ensure those who have been unable to access care in the past 2 years will be able to do so – by offering a significant incentive to dentists to deliver this valuable NHS care. Introduction of mobile dental vans to take dentists and surgeries to isolated under-served communities.

- Launch 'Smile for Life' – a major new focus on prevention and good oral health in young children, to be delivered via nurseries and other settings providing Start for Life services and promoted by Family Hubs. The introduction of dental outreach to primary schools in under-served areas in addition to taking forward a consultation on expanding fluoridation of water to the north-east of England – a highly effective public health measure.

- Ramp up the level of dental provision in the medium and longer term by supporting and developing the whole dental workforce, increasing workforce capacity as committed to in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

The significant NHS aspects of the plan in respect of dental commissioning are:

- Increase in the minimum UDA value to £28.00; in NCL this affects 11 practices in total, increasing annual recurrent spend by £79k.

- Introduction of a new patient tariff for 2024/25. This will pay an additional amount between £15 and £50 for a new patient registration in addition to the funding the practice would already receive. This was implemented from 1st March 2024 and is time limited to end of financial year 2024/2025 and currently we are unable to predict the impact on registrations but expect this to be material.

- Outside of London, the plan also requires the roll out of dental vans in certain underserved ICBs. This is focused on isolated rural and coastal communities and therefore not applicable to London.

- Introduction of a 'golden hello' scheme (£20k per dentists, split over 3 years, available for posts agreed by regions / ICBs to be priorities for access) to encourage dentists to move into under-served areas and supporting those practices with the lowest rates of payment for their work. Given the relatively comprehensive access to dental support in London compared to the rest of the country it is not yet clear whether this incentive will be applied to London.

The plan also commits to bringing forward proposals for reform, however there is no specific detail around this, as they are subject to further work and will may require consultation. Whether the new government retain the Dental Recovery Plan as stated or revise it is yet to be determined.

4.0 Overview of Community & Dental Services within NCL

This section provides an outline of the additional services delivered across NCL that augment the services provided by Primary Dental Practitioners starting with the Community Dental Services.

Community Dental Services (CDS)

CDS serves following patient groups, paediatric, special care, elderly and homeless and provides oral health promotion (OHP) on behalf of the local authorirties that commission it. For NCL the CDS is delivered by Whittington Health NHS Trust. The contracts have had a significant impact on the number of patients who need to progress to more intense treatment in secondary care and has positively impacted a wide range of areas such as increasing the skills of primary dental practitoners and providing enhanced support to those experiencing homelessness and others. The initial contract issued by NHSE are due to come to an end and a plan is being pulled together to commence a direct award process using the Provider Selection Regime to issue new contracts for up to 10 years for these essential services across London.

Key facts associated with the CDSs across London with specific references to what NCL are doing to address these issues are summarised below:

- All referrals for more specialist care are triaged via the CDS and result in only 8% of all referrals being sent on for treatment in Acute Care.
- The overall number of referrals to specialist care are increasing predominantly in paediatrics and within NCL we have invested in increasing capacity in our CDS along with the increase in paediatrics general anaesthetic, inhalation and intravenous sedation capacity within the CDS Sector we are seeing waiting lists stabilise and show signs of reducing for the first time since the start of the pandemic
- CDSs are seeing an increase in paediatric oral decay due to poor diet. Supervised brushing activities in schools are currently at full capacity and NCL are seeking ways to expand this further through the Oral Health Promotion Working Group that we have formed with Local Authority partners and the investment we have made in Oral Health Promotion (OHP) as part of our Dental Transformation Programme referred to later in this document.
- Demand for dental care amongst elderly people is also increasing driven by deteriorationg oral helath in the population though lack of nursing staff and therefore brushing of residents' teeth. This is being tackled within NCL through increased investment to provide a consistent offer to those in care settings (focusing initially on those in residential care settings) to address this need.
- We have implemented a consistent offer for roughtsleepers and expanded support to those experiencing homelessness (including asylum seekers) to improve oral health due to increasing numbers and spread of rough sleepers across NCL.

Secondary Care Dental Services

Since the introduction of the Community Dental Services (CDS) across London, there has been a significant change in the case mix of patients requiring treatment within a secondary care setting. This has seen an increase in the percentage of the total activity of neuro-diverse patients who generally require longer treatment times, which limits overall capacity.

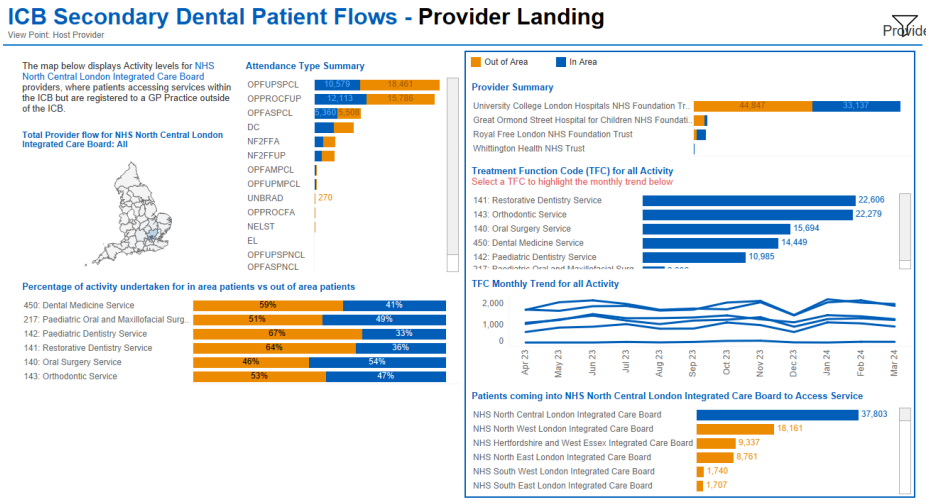
Work to understand this trend is likely to lead to the production of a detailed research paper and potentially changes to how this patient cohort is supported in community and primary care to reduce the number needing to be seen in a secondary care setting.

Within NCL we have two Secondary Dental Treatment Centres provided by University College London Hospitals (UCLH) and the Royal Free (RFL). Some activity for complex paediatrics is also delivered at Great Ormond Street Hospital (GOSH) but this remains directly commissioned by NHSE and is in part overseen by clinicians from UCLH.

The services delivered across our two secondary care providers (UCLH and RFL) includes:

- Oral Surgery (including Paediatrics)
- Restorative Surgery
- Orthodontics
- Dental Medicine
- Maxillofacial (including paediatric services)

A summary of secondary care activity undertaken within NCL for 23/24 is shown below:



The table above provides a snapshot of activity undertaken within NCL providers and shows the following:

- During 2023/24 there were 33,137 NCL patient attendances at UCLH, 3,446 NCL patient attendances at Royal Free (there is an issue with Royal Free data and this figure is slightly innacurate) and 860 NCL patient attendances at GOSH (activity commissioned by Specialised Commissioning)
- Against the 33,137 NCL patients who attended our providers, they also had a total of 44,847 attendances for patients from outside NCL ICB including:
    - 18,161 NWL patients
    - 9,337 Hertfordshire and West Essex patients
    - 8,761 NEL patients

In addition to the above, there were 14,150 episodes of care for NCL Patients that were delivered outside of the NCL area.

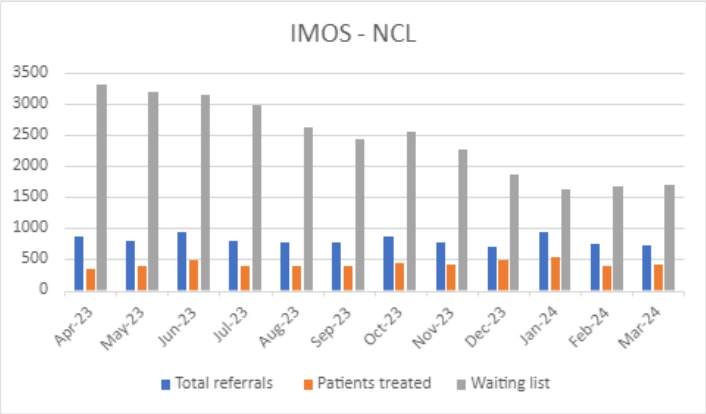
Intermediate Minor Oral Surgery Services and Level 2 Complexity Endodontics

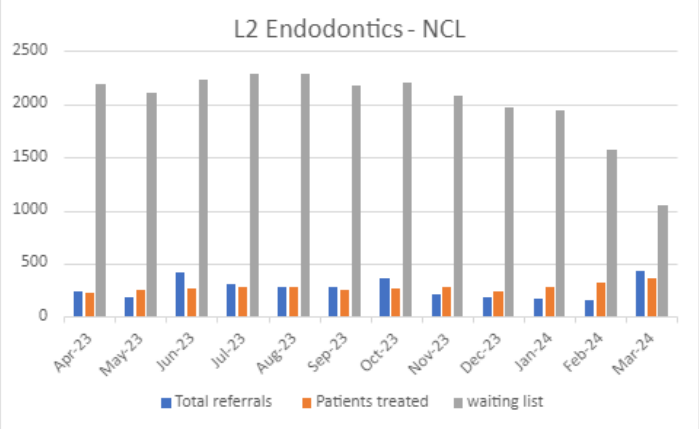
Most of our complex oral surgery is undertaken in hospitals but sometimes the treatment required is too complex to be undertaken in a Geneal Dental Practice or the Community Dental Service but not sufficiently complex to be undertaken in a hospital. In these instances, treatment may be undertaken by an Intermediate Minor Oral Surgery (IMOS) service. IMOS services treat patients aged 13 years and over, typically on referral from their regular dentist. Once the treatment has been delivered, patients are discharged to their regular dentist for ongoing care.

The Level 2 Complexity Endodontic service (root canal treatment), is also for treatment too complex for standard dentistry but not complex enough to require referral to a hospital. The endodontic treatment is delivered by an accrediated specialist and the patient is discharged to the referring dentist for the definative restoration, usually a crown.

These services are seeing an increase in demand but waiting lists are being slowly reduced. To increase the workforce for these services, we are working with Managed Clinical Networks, Local Accreditation Panels and the Office of the Chief Dental Officer to implement an accreditation process “with conditions”. This means an applicant who is not quite suitable for full accreditation would be supervised when in practice until they are deemed competant to work in isolation, this is an innovative pathway being created by London to address waiting times and increase clinical skills.

Both services have decreasing waiting lists as evidenced in the graphs below. Waiting lists are required so appointments can be palnned effectively to maximise clinical efficiency.





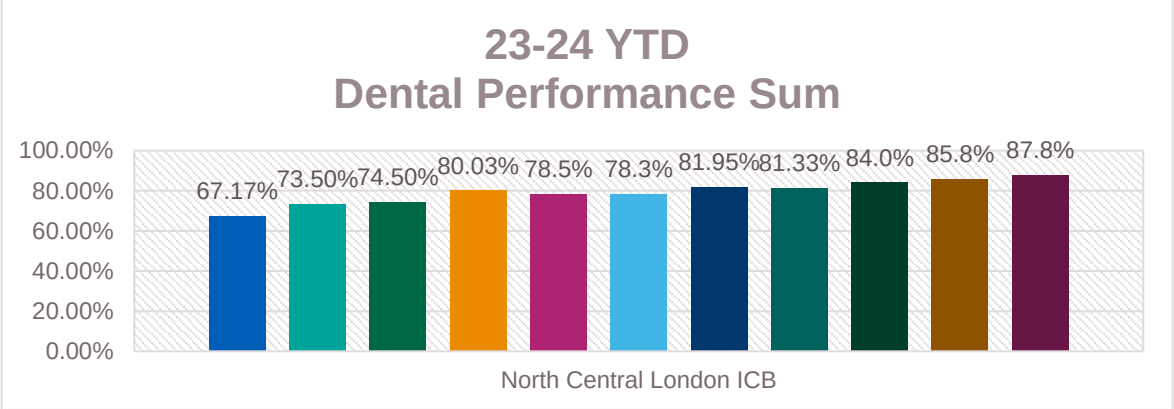
5.0 NCL ICB Strategic Response

In response to the strategic challenges around Dental Services, the NCL ICB has initiated a number of programmes of work to stabilise services, improve access and activity and improve outcomes as detailed below:

Primary Dental Services Access & Activity

The NCL ICB has been particularly concerned about improving access and activity in Primary Dental Services which was only running at 67% of the budgeted activity at the point of delegation. Through working with the Local Dental Committees (LDCs), the Dental Confederation and a wide range of Dental Practices and through targeted changes to dental activity levels in contracts where there was a willingness to do so we have seen activity increase to ~87% of plan by the end of the first year of delegation and a further increase to 95% as at the end of Q1 24/25. Whilst there are still aspects to deliver of the National Dental Recovery Plan referred to earlier, the activity levels are above the aspirations of the recovery plan and have been achieved significantly in advance of the two year timeline.

NCL ICB	GDS/PDS Dental Contract UDA Delivery 2023/24 (% of Plan)										
	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
% of Plan Delivered	67.2	73.5	74.4	80.0	78.5	78.3	82.0	81.3	84.0	85.8	87.8



The increase in activity has been achieved through a variety of means including some related to our transformation programme but the largest single impact has been the £1m investment that the NCL ICB has agreed to make from the dental budget underspend in a total of 42 practices to increase the number of Units of Dental Activity (UDAs) which has delivered an additional 31,500 as detailed in the table below:

Borough	No of Practices	UDAs Awarded	Value of UDAs
Barnet	11	8,000	**£264,000.00**
Camden	6	5,000	**£165,000.00**
Enfield	8	6,000	**£198,000.00**
Haringey	9	6,500	**£214,500.00**
Islington	8	6,000	**£198,000.00**
TOTAL	**42**	**31,500**	**£1,039,500.00**

Dental Transformation Programme

We have also formed a Dental Transformation Programme and committed £600k recurrently into this which is focused on the areas below, some of which has been referred to earlier in the document:

- Reducing waiting times for Children & Young People (CYP) needing specialist care.
- Ensuring a consistent offer across NCL for Rough Sleepers.
- Providing access to specialist care for those experiencing homelessness including asylum seekers.
- Providing access to specialist care for those in Residential Care Homes.
- Targeted work with schools in deprived areas to reduce the use of sugary drinks with the aim of improving oral health.
- A collaborative programme of work with Local Authorities around our shared commitments to improving Oral Health Promotion.

The detail of the recurrent investment that the NCL ICB has made is shown below:

Additional Investment Plans for 24/25	2024/25 (full year)
Increasing Theatre Capacity for the WH CDS	£323,762
Residential Care Homes Support	£17,683
Homelessness Capacity Support & Rough Sleepers Programme	£29,165
Investment in Oral Health Promotion (OHP)	£99,600
CDS Provision of Weekend Clinics	£107,523
Giving Up Loving Pop (GULP) Pilot Programme	£22,195
TOTAL	**£599,928**

This work has already started to show results and we expect to be able to provide a full update on the impacts from Q1 25/26 onwards.

Supporting On-Going Commitments

In addition to our work to expand capacity in Primary Dental Services and our Dental Transformation Programme, the NCL ICB has reaffirmed our commitment to a number of high impact initiatives including:

- Providing urgent access, often same day, to all patients in acute dental pain via the 111 Service.
- Continuing our support for Looked After Children (LAC) to access specialist care.
- Supporting the expansion of Child Friendly Dental Practices enabling them to support more children who suffer from anxiety in relation to dental treatment.

CVD Pilots

The NCL Integrated Care System (ICS) has been selected to be pilot sector to two pathfinders to help identify patients with Cardio-Vascular Disease (CVD) who present with either Oral Health or Optometry related health issues as these can be early indicators of a range of long term health issues which, if caught earlier and managed proactively, can significantly improve outcomes for patients.

6.0 Looking Forward/Next Steps

Whilst there has been significant progress in improving access and outcomes for dental services, and remembering we are working within a series of constraints related to areas such as the contract and payment form and workforce, we are already considering a range of developmental areas that will build on our existing transformation work and increase the impact we are having on patient health outcomes. These developmental areas include:

Supporting Patients with Long Term Conditions

The work on the CVD Pilots referred to in the previous section is related to work we wish to commence around improving the oral health of patients with Long Term Conditions (LTCs), in the first instance focusing on those with Diabetes. LTCs can have a severe negative impact on oral health which in turn impacts on a wide range of outcomes including contributing to social isolation and an inability to work.

Expanding Access in Care Settings

We are going to use the initial work we are undertaking to improve outcomes for people in Residential Care settings to consider whether the extent of the benefit of expanding this to include people in other care settings. We are currently monitoring the impact of our current work and working up costings with our partners across health and social care.

Improving Outcomes in Paediatric Trauma

The London Paediatric Managed Clinical Network, in collaboration with Urgent Dental Care (UDC) providers and CDS, is developing a paediatric dental trauma pathway to provide the most effective treatment outcomes possible. The proposal would include trauma training for all UDC dentists, a trust rota to provide consultant advice and guidance for dentists treating trauma, a fast track into CDS or secondary care for further treatment and specific practices to which patients can be discharged for the continuation of treatment (this aspect is particularly vital to those patients who do not have a regular dentist). The successful implementation of this pathway would increase the number of teeth retained after trauma, shorten waiting times and reduce the significant stress experienced by patients and parents.

Improving Outcomes in Special Education Settings

The NCL ICB are working with CDS providers to revise the offer to children is Special Education Settings (SES). Currently SES pupils are offered screening in much of London, however, this has limited impact as it does not involve any treatment and the parents or carers who give permission for the screening are often already users of CDS. It has been agreed by partners involved in supporting SES that there will be a move away from screening and the resource will be used on increasing the offer of supervised tooth brushing (STB) where schools wish to participate. The goal for London is STB in all SES for all ages, there will also be a drive to promote the CDS with families not currently engaged.

7.0 Closing Remarks

As can be seen from the above the NCL ICB have taken proactive steps to improve outcomes and access and improve oral health in adults and children across a wide range of settings. Our work has targeted inequalities such as care for those in care settings and those experiencing homelessness. We have continued our support for Community Dental Services, access to Urgent appointments for those in acute care and we have been proactive in delivering our commitments under the National Dental Recovery Plan. This has resulted in an increase in activity from 67% to 95% of plan with a corresponding increase in capacity in Primary Dental Services as well as a range of other benefits such as a consistent offer to Rough Sleepers across NCL.

The delivery of these achievements have been made whilst working within the constraints we face and as can be seen we have plans to extend the impact and scope of our work in dental services further. We are as yet unsighted on the changes that may arise from the new government in this area but that does not diminish our commitment to working collaboratively with our partners across health and social care to improve outcomes for our population.

This paper is presented to JHOSC for comment and feedback.

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2024-2025	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 25th July 2024

SUMMARY OF REPORT

This paper reports on the 2024/25 work programme of the North Central London Joint Health Overview & Scrutiny Committee and also requests confirmation of the reports for the next meeting.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the current work programme for 2024-25;

b) Propose possible future agenda items for the 2024-25 work programme.

1. Purpose of Report

1.1 This item outlines the areas that the Committee has chosen to focus on so far for 2024-25.

1.2 The next meeting of the JHOSC is scheduled to take place on 9th September 2024. The Committee is requested to consider possible items for inclusion in the 2024-25 work programme.

1.3 Full details of the JHOSC's work programme for 2024/25 are listed in **Appendix A**, including scheduled items and also as yet unscheduled items on which the Committee has previously indicated that it wishes to receive further updates.

2. Terms of Reference

2.1 In considering suitable topics for the JHOSC, the Committee should have regard to its Terms of Reference:

- "To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people."

3. Appendices

Appendix A –2024/25 NCL JHOSC Work Programme

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Appendix A – 2024/25 NCL JHOSC work programme

25 July 2024

Item	Purpose
Start Well	For the Committee to receive an update on the 'Start Well' programme following the recent public consultation on proposed changes to maternity, neonatal and children's services. The most recent previous update was considered by the Committee in November 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77973
Primary Care Access	For the Committee to receive an update on access to primary care services in NCL.
Dental Services	For the Committee to receive an update on dental services in NCL.

9 September 2024

Item	Purpose
Finance Update	For the Committee to receive a detailed finance update to include latest figures from each Hospital Trust in NCL and the overall strategic direction of travel. This follows on from the previous discussion at the meeting held in September 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77009
Estates Strategy Update	For the Committee to receive an update on the NCL Estates Strategy. This follows on from the previous discussion at the meeting held in November 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77972
Proposed merger of Royal Free London NHS Foundation Trust and	For the Committee to be briefed by the CEOs of both Trusts on the business case for the proposed merger

North Middlesex University Hospital Trust	

11 November 2024

Item	Purpose
Workforce Update	An update on workforce issues in NCL. A staff representative to be invited to speak at the meeting. The most recent previous update was considered by the Committee in January 2024: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=78558
Winter Planning Update	To provide an overview of the planning for winter resilience in NCL for 2024/25. To include: - how the 'single point of access' intervention would work in practice. - whether data the modelling for Winter 2023/24 reflected the data from what actually happened.
North London Mental Health Partnership update	

3 February 2025

Item	Purpose
St Pancras Hospital	To receive an update on the St Pancras Transformation Programme.
UCLH/Whittington collaboration	

7 April 2025

Item	Purpose
Community-based meeting	

Possible items for inclusion in future meetings

- Health inequalities fund – previous update to the Committee was in March 2023. It was specified that the next update report should include details of the outcomes of the Middlesex University evaluation and a greater understanding of how the health inequalities work was being embedded in local authorities.
- Healthcare data and analytics/privacy issues.
- Smoking cessation & vaping.
- Update on funding for NHS dentistry for both adults and children.
- Strategic role of GP Federations.
- Vaccination initiatives tailored to specific local needs in each NCL Borough including outreach work with community pharmacies.
- Ambulance waiting times and pressures across the system including A&E Departments.
- Primary care commissioning and the monitoring of private corporations operating in this area.
- The efficacy of online GP consultations, how the disconnect between the public and the medical profession could be addressed, how the public could be reassured that outcomes would be equally as high as face-to-face consultations and how capacity can be improved in this way.

2024/25 Meeting Dates and Venues

- 25 July 2024 - Camden
- 9 September 2024 - Islington
- 11 November 2024 - Haringey
- 3 February 2025 – Enfield
- 7 April 2025 – TBC

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