MINUTES OF THE MEETING North Central London Joint Health Overview and Scrutiny Committee HELD ON Monday, 9th September, 2024, 10.00 am - 1.30 pm

PRESENT:

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

ATTENDED ONLINE: Cllr Jilani Chowdhury.

27. 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'.

28. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Chakraborty and Cllr Atolagbe.

Apologies for lateness were received from Cllr Clarke and Cllr Revah.

Apologies for absence were received from Richard Dale, Executive Director of Performance and Transformation (NCL ICB).

29. URGENT BUSINESS

None.

30. DECLARATIONS OF INTEREST

Cllr Connor gave information that she used to work at the North Middlesex University Hospital (NMUH). She is also a member of the Royal College of Nursing, and her sister works as a GP in Tottenham. Cllr White gave information that he was an outpatient of NMUH Diabetes Department.

31. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Scrutiny Officer stated that none had been received within the statutory period.

32. MINUTES

The Committee was still waiting for responses to some actions from the last meeting. The Chair ran through follow up questions for the Scrutiny Officer stemming from the NCL Mental Health Community Core Offer Implementation Update report.

- Item 3 and how quickly contracts were being given in the Voluntary and Community Sector. **ACTION**
- More details were requested on Item 5 regarding the lack of appropriate community support for those who were clinically ready for discharge but remain in a hospital bed. Information was also requested on how the Mental Health Trust was working with councils and other organisations to resolve this. **ACTION**
- Cllr Connor then requested further information as to which schools were part of the Mental Health Trust's Trailblazers programme. **ACTION**

Cllr Cohen told the Committee that the Barnet Primary Care Access Consultation had concluded. The full report on the results will go to Barnet's Cabinet in September. Cllr Cohen will let the Committee know once approved. **ACTION**

The Chair updated the Committee as to the Terms and Conditions work conducted. She then suggested that the action tracker should be part of the meeting pack – and time allocated to run through it after the 'Minutes' agenda item. **ACTION**

It must be noted that the number of apologies given by Members meant that the Committee was not quorate. To be quorate there are two criteria:

a) For at least four Committee Members to be present. This condition was met.

b) For Members from at least four of the five NCL boroughs to be present. This condition was not met.

In the circumstances, the meeting continued as a briefing for the Members present. This meant that discussions on the agenda items could continue but any formal decisions made before 10:45am could not be ratified. Minutes were NOTED BUT NOT APPROVED by the Committee. Minutes to be approved at next meeting – **ACTION.**

33. NMUH/ROYAL FREE MERGER

North Middlesex University Hospital (NMUH) and Royal Free London Group (RFLG):

Dr Nnenna Osuji - Chief Executive of NMUH.
Peter Landstrom - Chief Executive of RFGL.

The CEO of the Royal Free Trust Mr Landstrom introduced the topic. This was an update further to a Committee briefing in February. He stated that a decision was made to further explore the merger. The full business case was finalised. He

explained that the business case was now with NHS England where appropriate testing and scrutinization will occur. After this, a recommendation for approval/refusal will be made to the Secretary of State. He emphasised that the merger was not for financial benefit but for the removal of barriers that prevented service delivery going further and faster for staff and patients. He stated that the Royal Free London Group (RFLG) covers several services and locations, however local leadership and identity remains strong. He wanted to reassure the Committee that the merger was designed to keep services local for residents.

Dr Osuji explained that the merger would provide benefits to both organisations, in terms of surgery, elective hubs, clearing the backlog from COVID as well as presenting advantages in terms of Research and Development. She used the example of Colo-rectal surgery. A larger number of Colo-rectal surgeries brought complex cases together. The merger meant that clinical practice could be standardised with training and innovative practices could also be used such as robotic surgery.

She emphasised that there were still internal conversations with staff and stakeholder engagement that was still ongoing. Work was continuing on the dedicated Terms and Conditions. Dr Osuji then invited feedback and questions from the committee.

Cllr Connor expressed apprehension that the NMUH would no longer be a ‘sovereign’ hospital but a ‘fourth health unit’ in the RFLG as per the terminology in the report. She speculated that this may influence staff morale and how patients saw the hospital. She felt that the terminology should reflect integration. She also wanted to know with what confidence it could be said that in a few years' time there would not still be a problem with getting the right treatment to a particular cohort of patients. She wanted assurance that the NMUH would still be a local hospital for local people.

Dr Osuji assured the Committee that the hospital would remain uniquely NMUH. She emphasised that the outcome of the merger would be the same – to have access to excellent care no matter where residents live and for the Group to have strong community links where they operate. Furthermore, she explained that they had looked at ‘warranted and unwarranted variation’ in statistics related to population and care. In response they had looked at representation in the corporate structure. The CEOs of all local health units would be represented at Board. They are considering expanding further local representation at Board, however non- execs and local units are still represented in sub committees and working groups. The role of ‘critical friends’ to her were also vital in getting things right.

Mr Landstrom emphasised that the RFLG is specialist but also very aware that it is made up from local hospitals and services and local priorities must remain.

Cllr Connor also raised that any future paper from the Panel should have a little more depth. She stated that she had confidence that the patients of NMUH would be represented well after talking further with the panel - however it would be beneficial to the Committee to see this in the report. She added that the Committee would like to

know more about the lines of accountability and how subcommittees are going to feed into the Board. Also, more about how North Mid Governors and Staff reps can feed into the process of governance. **ACTION**

Cllr Milne then questioned the panel's wording in the agenda pack presentation that '*currently, the merger does not anticipate significant change.'* Mr Landstrom admitted that the service could change but that this was dependant on future issues not yet identified. He emphasised that engagement was key in this and if changes were to occur then the organisation would engage and consult properly with staff and patients alike. Dr Osuji also affirmed that she was not anticipating any changes but that if they did occur these would go through due process.

Cllr Milne then asked about the aim of the Group to become a World Class Cancer Centre. He asked how far NMH was from this currently, and what plans there were to share best practice with other hospitals such as the Royal Marsden. Mr Landstrom responded that, he believed the Group had all the ingredients to make this aim achievable, however there was still a long way to go. With the merger the RFLG would become the second largest Trust in the country. He highlighted that in North London cancer prognosis was good, however sometimes services were not seeing patients quickly enough. But he stated that diagnosis was improving. There were some further challenges in planning for growing demand in cancer care. He believed that working together with other hospitals was key and mentioned the Barnet Oncology Department as an example.

Cllr Milne then expressed surprise that the Electronic Patient Records (EPR) were not already amalgamated and national. He stated that he could see all his patient records on the NHS app and asked how this was the case if all patient records were not amalgamated.

Mr Landstrom responded that there is no national system even within hospitals, primary care, and secondary care. The records themselves are on different databases and are sometimes paper based. Integration of data has not been achieved. For Mr Landstrom it was critical for the Group to join up specialist input. Dr Osuji added that the systems are not the same and have different access permissions and ways in which databases talk to each other. However, the ultimate aim will be to ensure patient records are in patient hands. She stated that it also presented the group with lots of opportunities when it came to Research and Development. She used the example of the analysis of all those on the Cancer pathway – an integrated system would help clinicians find out whether they are diagnosing patients within 62 days. However, she stated that there will always be patients who come through the front doors of the hospital that are only caught in the late stages of cancer.

Cllr White then enquired about the risks associated with automatically integrating record systems into a new overall record. He emphasised the risk and asked the panel whether they had systems in place to mitigate this. Dr Osuji responded that they wanted to safeguard the sanctity of the EPR. There were various IT Project

Management procedures that were being followed, such as putting the records in a test environment, however she emphasised that one system would mean in the future that records could be updated just once and securely. It would also mean opportunities for Research and Development.

Cllr Connor then interjected that accurate data on patient records, for her was critical. She asked that in future the Committee needed some clarity and confidence that inaccuracies were being monitored and acted on in a timely manner. She wanted to ensure that accuracy was not only for those who enter the correct pathways but also for those who turn up unexpectedly at reception. Dr Osuji responded that inaccuracies did not happen often. However, admitted that getting corrections done were a challenge. Patients should use the NHS App so that they could be in control of their records.

Cllr White interjected that he was impressed with the Diabetes services that the NMUH offers. He highlighted that the cost must be high to provide a preventative service, but in the long term would save the NHS money - as diabetics would be less likely to get heart disease, kidney dialysis etc. He wanted to know how the Panel would decide which was best – the more expensive preventative or the usual symptom-specific treatments.

Dr Osuji responded that the aim was that everyone should have access to seamless care, even if they are in the warranted or unwarranted variation groups. She added that there are seventeen levels of consensus needed for clinical practices. She stated that they must make sure that everyone should have access to new drugs and treatments However, Prevention is hardest to deliver.

Cllr Connor stated that it would be beneficial for the Committee to take a case study in the less obvious areas of care, to understand how care is delivered in the area; and see how it was monitored before, and after, any changes to service. She added that it would be useful to know what local priorities are and their impact on how clinical decisions are made in a particular area – also how this would affect warranted and unwarranted variation. **ACTION**

Discussion turned to Item 7 and the structure of corporate governance. Cllr James wanted more clarification regarding this. She added that it would be helpful to see an organisation chart after the merger about what the lines of accountability are. **ACTION**

Cllr Cohen then requested clarification on where Barnet patients should go once the merger has been finalised and what the longer-term plans are. Also, whether the Committee could see the plans to safely merge the EPRs. **ACTION.** He requested further information on whether the plans to unify the EPRs access would also include GPs so that they would know who to refer to at the Royal Free Hospital. Dr Osuji stated that one clinical conversation must happen about the patient no matter where they are. She added that GPs have their own pathway of referrals for specialist access and that will not change. However, how they refer onwards would be faster

with the unified EPR. Ultimately the EPR would improve efficiency. She stated that it would take 18 months to implement to the new EPR system.

Discussion then turned to transport. Cllr Revah asked whether there would be a possibility of transport for patients to and from NMH and RFLG. Mr Landstrom responded that there were no planned changes to the configuration of transport, as it was felt that the demand was not there. He added that the Group had worked closely with Healthwatch and Oncology concerning this. He stated that if things were to change, they would plan a formal consultation. However, he added that there were issues with accessible access to the Group's sites.

Cllr Milne then asked if there would be anything that would stop the merger from happening. Mr Landstrom replied that if NHS England did not recommend the merger after due process the merger would be scrapped.

Cllr Connor summed up and raised another point the panel was not able to discuss in depth – this was the financial risk. The NMUH was in surplus however the RFLG was in deficit. She wanted assurance that the debts of the RFLG would not affect the NMUH's budget. Mr Landstrom admitted that there were issues with debt in the RFLG however there have been some successful measures to reduce that debt and there are plans to break even in a few years. However, he emphasised that this would not be a concern. Cllr Revah asked for an opportunity to talk further about this, as she was concerned as to the reasons why there was a deficit. **ACTION**

Cllr Connor also raised that it would be useful to the committee to have a future paper on what engagement has been carried out for the merger. She emphasised that there was not enough evidence presented to see what patient groups had been consulted. **ACTION**

34. NCL ESTATES AND INFRASTRUCTURE STRATEGY 2024

North Central London Integrated Care Board (NCL ICB):

Bimal Patel - Chief Finance Officer of NCL ICB
Owen Sloman - NCL Strategic Estates

The Chief Finance Officer of NCL ICB introduced the topic. Main points included were:

- The Estates Plan now includes the infrastructure plan. Infrastructure also covers IT and workforce, as well as physical assets. There are 42 ICS infrastructure plans, and each region will be adding to this.
- A lot of the plan has already been delivered.
- There was a 'critical infrastructure risk,' however, the team were successful in getting more capital. There was a £177 million base allocation, and the team were successful in securing another £48 million.

- The ICB wanted to work closer with Local Authorities to find out what the best way was of disposing assets - and reinvesting in Health and Social Care.

Cllr Connor then asked why the Infrastructure Strategy had been now merged with the Estates strategy. She enquired whether this was something that NHS England had wanted to get to grips with what was going on across all 42 ICB sites, or whether it was helpful for the ICB to assess estates and infrastructure together. The Head of NCL Strategic Estates affirmed that it was the NHS England who wanted to see these two workstreams together, however he also stated that it was helpful to evaluate both workforces and digital, as well as physical assets as much of them are integrated together. Also, because the Trust has some very ambitious green plans to deliver – so in his opinion it made sense.

Discussion then turned to finances. The Chair then asked whether the £48 million was in addition to the £177million allocation – and whether this would be allocated for Primary Care. The Chief Financial Officer responded that some of the additional money would go to 2 or 3 strategic Primary Care sites, as it would stop patients coming into Emergency Departments.

Cllr Cohen then asked about the Estates Forum in each borough. It was agreed that personnel in each team would be circulated to the Committee. **ACTION**

Cllr Cohen then stated that he had been asked by constituents, whether there were still plans to include keyworker housing at Finchley Memorial Hospital. The Head of Strategic Services indicated that he did not have the details but could update the Committee- **ACTION**

Cllr James indicated that Enfield Council was going through every piece of land they owned – she advised the officer panel to act quickly if they would like to acquire some of the divested land. Cllr James said she would liaise with Property Services at Enfield Council to make sure the NCL ICB was kept informed. **ACTION**

Cllr Connor then asked the Committee to go back to the respective boroughs to make sure that the Estate team had sight of any divestments. **ACTION.** Cllr Connor added that it would also be good to know how the NCL Estate teams operated. How Council-led schemes and Section 106s operated was then talked about. It was decided that a note would be given to the Committee about how The Estate and Council teams could work and who they should be feeding into. **ACTION**

Cllr Clarke then asked about the People Strategy. She wanted to know further information on how those Not in Education, Employment or Training (NEET) were going to be chosen, who would refer them and how the ICB would be supporting them. **ACTION**

Cllr Revah then asked about the St Pancras Transformation. The Chief Finance Officer responded that an update would be provided. **ACTION**.

Discussion then turned to the ICB's engagement strategy. Questions were raised as to whether there was duplication of consultation of the same groups in the Local Authority consultation and the ICB's consultation. It was then agreed that the Head of Communications would update the Committee further as to the ICB's Engagement Strategy. **ACTION**

The Chair talked further about the need to understand when and where sites were being disposed of. The Chief Finance Officer would provide a list to the Committee of all sites being sold, and to whom it was being sold to; and, how the money was being reinvested. **ACTION**. Cllr Connor then asked for an update on the Keyworker housing on the St Ann's site. **ACTION** She also wanted the ICB to provide more details about the critical infrastructure risk, what this means, and whether there were any areas of backlog or risk. **ACTION**

35. NORTH LONDON MENTAL HEALTH PARTNERSHIP

North London Mental Health Partnership (NLMHP)

Jinjer Kandola MBE - Chief Executive Officer

Natalie Fox - Deputy Chief Executive

Vincent Kirchner - Chief Medical Officer

Andrew Wright - Chief of Staff

Deputy Chief Executive, Natalie Fox, provided an update as to the status of the merger. Main points were:

- The NHS assessment was complete, and the merger had formal sign off at Board. The merger has been pledged and will occur on the 1st of November subject to a Secretary of State signing.
- The two Trusts have been working closely since 2019.
- Clinical pathways have been built and staff have developed close relationships that have benefited patients.
- There have been talks with the Unions regarding TUPE of staff from one organisation to another.

The Chair started the discussions by looking at the finances and the potential savings the merger would make. She asked for more information regarding this namely where the savings would come from. The Deputy CEO responded the 'Return On Investment' would happen from the amalgamation of corporate services. Instead of two HR and payroll systems one system for one organisation would make savings. She stated that if the merger were not to occur then the organisations would move into deficit. The merger would lead to a year on year saving of 9.2% and a surplus for the

organisation. The Chair wanted to know more detail on the Finances associated with the merger. **ACTION**

The Chair also indicated that the Estate Strategy had not been approved – she wanted to know where this left the merger and wanted more details re this. The Chief of Staff replied that they had a new Estates Strategy for the organisation and were working closely with the ICB. The strategy included the refurbishment of St Ann's, Highgate Health Centre, and Chase Farm Mental Health Unit. He stated that the overall priority is Chase Farm, as this has been deemed as not fit for purpose. Discussion turned to the TUPE process and more details were teased out about the legalities of the merger.

Cllr Cohen then asked more about the organisational risks involved – he wanted to ensure that patients were being consulted, that the implications on waiting times were being considered but also how much local identity would be lost, and the risk to patients.

The Chief Medical Officer responded that patients would go to the same places to receive treatment. The merger would standardise the service – patients would be able to be admitted where they lived, rather than 100s of miles away if there were no facilities available. The merger would also mean that those well enough could receive Care in the Community. Cllr Cohen asked how many had been placed outside of London. The response was around ten so far. The Chief Medical Officer emphasised that although the numbers were small - this would have a big impact on treatment and life for these patients.

Discussion then turned to waiting lists. Cllr Revah asked whether the waiting list times would still be the same. The Deputy Chief Exec Ms Fox indicated that the Trusts were working on the waiting lists and that they would be published for the first time this year. The Committee wanted to know whether carers and those with disabilities were consulted about the merger. The Deputy CEO responded that they had talked to one thousand people in all. They were waiting on the results of a carers assessment which had asked how the two trusts could do things differently. This included some people with disabilities.

Cllr Revah then enquired how the Trust had felt that it learned from its mistakes and how the panel were monitoring lists. The Officer Panel responded that mistakes were fed back to the senior management team. Senior managers would then feed into professional groups and assess whether the Trust was meeting the need of the patients.

Cllr Revah also raised concern that people with disabilities were not really represented in the consultations. The Chair agreed and asked that the Officer Panel present them with evidence as to how people with disabilities are being involved with working groups and the consultations **ACTION.**

Cllr Milne asked how the Trust shared best practice. The Chief Medical Officer replied that at SMT (is this Senior Management Team?) level the London regional groups compare practice and evaluate services on a regular basis.

Discussion then turned to the steps that were being taken to ensure that the service was attractive to staff. The Officer Panel asserted that there was a good educational offer within the Trust, opportunities within research and development also the organisation was looking at constantly improving and the values and staff behaviours reflected that.

The Committee then raised questions about Child & Adolescent Mental Health Services (CAMHS) and how services were to be delivered in the area. The CEO responded that there is a fragmentation between how services are delivered in Barnet, Enfield, and Haringey (BEH) and how they are delivered in Camden and Islington. Ms Fox highlighted that the merger would not include CAMHS. The Chair then asked the officer panel to provide more detail, as Cllr Clarke was concerned that the merger may make mental health services more difficult to navigate for patients with different providers. **ACTION.**

Cllr Revah asked further about how long the waiting lists were. Ms Fox replied that they would be different in every borough. Cllr Revah asked for the Panel to provide these figures as soon as possible. **ACTION**

Cllr Connor questioned the panel further about the practice of Assertive Outreach and where this would sit in terms of the new approach to patient care. However, the CEO replied that this issue was in fact separate to the merger.

Cllr Connor then asked whether there was going to be a new approach to families and carers as part of the merger. She stated that there had been many instances of a breakdown in communication between the families and the key worker that had led to distress for the patient. The Chief Medical Officer replied that most keyworkers work well with families. He stated that if there are no safeguarding concerns, the keyworkers should all understand that the service and treatment must operate holistically. He admitted that the message to keyworkers should be strengthened. Cllr Clarke requested the Panel update the Committee in November. **ACTION**

Cllr Revah recounted an incident where a particular borough had a high amount of mental health issues some of which had resulted in suicides. She added that the borough was under investigation, and she wanted assurances from the Panel that once published, the report would be looked at by the SMT to ensure that whatever issues caused this would not happen in the five boroughs. **ACTION**

Cllr Connor then summed up. She highlighted in addition to the actions stated above that further information would be needed on:

- Quality governance and what the changes in the key clinical areas were. **ACTION**

- Centralisation and the risk to individual care – evidence was needed to ensure local focus was not lost. **ACTION**

36. WORK PROGRAMME

The Chair asked the Committee what items should be on the Workplan for the next two years. The topic of 'Winter Planning' came up as a major issue to be scrutinised. Discussion then turned to whether the meetings were too long or too short for the time allocated to them.

An idea was raised that extra meetings may be the answer however extra resources would be needed if this was the case.

After discussion it was proposed that, due to the workload of the Committee, the number of regular JHOSC meetings per year should be increased from five to six per year and the meetings themselves be extended to three hours long. The Scrutiny Officer noted that this would need to be discussed with the ICB and also with NCL Democratic Services teams. **ACTION**

37. DATES OF FUTURE MEETINGS

- Mon 11th Nov 2024 (10am)
- Mon 3rd Feb 2025 (10am)
- Mon 7th Apr 2025 (10am)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……