NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Dominic O'Brien, Principal Scrutiny Officer

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Monday 11th November 2024, 10:00 a.m.
Committee Room 4, Islington Town Hall, London N1 2UD

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. 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 12 below).

4. 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

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

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

6. MINUTES (PAGES 1 - 22)

To approve the minutes of the North Central London Joint Health Overview and Scrutiny Committee meetings on 25th July 2024 and 9th September 2024 as a correct record.

7. ACTION TRACKER (PAGES 23 - 100)

To review progress against action points from previous meetings in 2024/25.

8. WHITTINGTON/UCLH COLLABORATION (PAGES 101 - 128)

To provide an overview of the ongoing collaboration between the Whittington Health NHS Trust and the University College London Hospitals NHS Foundation Trust.

9. NCL ICS FINANCIAL REVIEW

To provide a finance update for the NCL including the overall strategic direction of travel, 2024/25 figures for the NCL ICB and for NHS Trusts that provide services to NCL patients.

Report to follow.

10. WINTER PLANNING (PAGES 129 - 146)

To provide an overview of 2024/25 winter planning in North Central London.

Details also included about the Your Local Health Team campaign.

11. WORK PROGRAMME (PAGES 147 - 154)

This paper provides an outline of the 2024-25 work programme for the Committee.

12. NEW ITEMS OF URGENT BUSINESS

13. DATES OF FUTURE MEETINGS

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

Dominic O'Brien, Principal Scrutiny Officer
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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Thursday, 31 October 2024

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Agenda Item 6

MINUTES OF THE MEETING North Central London Joint Health Overview and Scrutiny Committee HELD ON Thursday, 25th July, 2024, 10.00 am - 1.05 pm

PRESENT:

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

ALSO ATTENDING:

Cllr Ketan Sheth (London Borough of Brent)

13. 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'.

14. APOLOGIES FOR ABSENCE

None.

15. ELECTION OF CHAIR

The floor was opened for any other nominations for Chair. No nominations were received. The current Chair, Cllr Pippa Connor, was re-elected.

16. ELECTION OF VICE-CHAIRS

The floor was opened for any other nominations for Vice Chairs. No nominations were received. The current Vice Chairs, Cllr Larraine Revah and Cllr Tricia Clarke, were re-elected.

17. URGENT BUSINESS

None.

18. DECLARATIONS OF INTEREST

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

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

There were no other declarations of interest.

19. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

20. TERMS OF REFERENCE

Cllr White raised questions regarding the set-up of the committee and clarification of resources and finance. It was stated that officer resources in Haringey were quite pressured. A suggestion was made that other boroughs could contribute to the resourcing of the committee. It was also noted that other important regulations were missing from the Terms of Reference. It was then suggested that the Terms of Reference should have a refresh incorporating stakeholder views.

Cllr Connor then suggested that all Committee councils should have discussions with their boroughs as to resourcing. **(ACTION)**

Cllr Ketan Sheth (London Borough of Brent) offered to meet with the Chair to talk through best practice in other boroughs. **(ACTION)**

It was then proposed that Haringey's Scrutiny Office would put together a working group and then draft recommendations as to the new Terms of Reference for the Committee's approval. **(ACTION)**

21. MINUTES

In response to the Committee's request for updates on outcomes data and metrics in Mental Health, the Principal Scrutiny Officer Dominic O'Brien, explained that the updates from departments had not been forthcoming. Discussion as to why this was followed.

Cllr Connor was then asked to follow up with CEOs of the various areas to help with timely updates from departments. **(ACTION)**

Minutes of the JHOSC Meetings from 18th March, 30th May and 31st May 2024 were then **AGREED** as a true and accurate account.

22. START WELL UPDATE

Anna Stewart updated the Committee as to the progress of the Start Well project. The project had moved into its consultation phase and an update was given on the interim report. A summary of the stakeholder feedback is given here.

- 67% of stakeholders agreed that change was needed to address current challenges facing services.
- Overall agreement that all neo-natal clinics should offer the same amount of care (at least at Quality Level 2).
- However, there was less support from stakeholders for consolidating maternity and neo natal services from 5 to 4 sites.

The Committee's formal response to the interim report was requested by August 16th. **(ACTION)**

The floor was opened to the Committee for questions.

Cllr White questioned the framing of the results of the stakeholder feedback. Although the beginning of the feedback phase seemed open ended, there was a clear policy direction proposed through the case for change with the closure of one of the units. It was explained by Sarah Mansuralli that although stakeholder feedback was sought, the process was about developing the case for change, and defining the baseline of services that should be delivered. None wanted to see the units close, but stakeholders understood Level 2 Quality of Care was needed. However, this quality of care was not possible with 5 units open. Wynne Leith then added that with a smaller number of births, the numbers of deliveries would be diluted around the whole of north London. This in turn would deskill many consultants and the level of care would be at risk. Cllr White then responded that it could be made more explicit in the report that the proposals are being led by experts rather than stakeholders.

Discussion then turned to the quality of stakeholder feedback. Cllr Chakraborty required clarification as to the degree of engagement and representation and questioned whether 'reach' had been included as a 'response' in the consultation. The Committee was assured that this had not been the case. 'Reach' had been separated out from overall response statistics.

Cllr Connor then outlined that this was an *interim* report. The Committee was then advised to give feedback appropriate for a draft and not final report.

Cllr Cohen asked why the consultation had not been about closing a facility rather than the open approach that had been favoured by ICB. It was reiterated that the aim of the consultation was to look fairly at all the viable options and make sure the proposals were well informed and designed, using staff expertise and patient experience as its basis.

Cllr Clarke was pleased that 67% of stakeholders had accepted the need for change. She suggested that responses may have been skewed as feedback from the Royal

Free was included. (Royal Free Maternity and Neo Natal Services closure was deemed by all as the most likely). However, Ms Stewart denied that responses were skewed or particularly negative from the staff at the Royal Free. She outlined that there were other units that were under consideration for closure, so it was unlikely to have skewed results.

Cllr Revah noted that most of the statistics were in percentages and that a clearer picture could be given if numbers were given. Also, more detailed qualitative feedback was needed with comments included. Cllr Revah also asked for a delay in the report feedback as she wanted to discuss it with Camden's Health Overview and Scrutiny Committee (HOSC) Ms Steward stated that Camden's viewpoint had already been considered as had a rich range of feedback and that this meeting was a way to provide comments from HOSC. More detailed feedback will be in the final report.

Cllr Atolagbe pointed out that more money would be needed for these proposals. Ms Mansuralli agreed that more money would be needed for the closures. She emphasised that the reasoning behind the closure proposals was not about efficiencies but improving the quality of care that could be offered to patients.

Cllr Jones questioned the practicalities of the proposal to 'join up' policies and procedures between Royal Free and Barnet hospitals. Ms Stewart affirmed that the ICB would incorporate broader feedback into an action plan about how policies and procedures can be aligned. The final report would have more details on this. **(ACTION)**

Cllr Sheth then asked about feedback from his areas of Edgware, Brent and Harrow, and what the next steps were in taking that forward. Anna Stewart stated that the feedback would go into the modelling of the Universal Pathway. It was divulged that travel concerns and access to services dominated the localised feedback. However, stakeholders weren't adverse to the closure of the Birthing Centre in Edgware if it meant they could access wider services and a higher quality of care in another area. Cllr Sheth was assured that engagement with residents of his borough would continue.

Cllr Connor then noted that time had not allowed for Committee questions on the Children's Surgical proposals. She then highlighted questions and comments from the Committee and requested written responses to the below.

- The Committee was keen to know how the views of 'hard to reach audiences' and those not able to give feedback had been considered in the proposals. **(ACTION)**
- It was also stated that the business case should consider following up with stakeholders after the proposals have been implemented. A timescale for this should be detailed in the next report. **(ACTION)**
- The business case should also consider the knock-on effects with other hospitals and detail the extra support needed by other services. **(ACTION)**

Cllr Chakraborty asked for the date by which the final report would be published. Ms Steward stated that the report would be released in early autumn. The ICB would tell the Committee when it was published.

A formal response by the Committee on the interim report was AGREED to be given by 16th August. **(ACTION)**

23. PRIMARY CARE ACCESS

The report was introduced by Katie Coleman which is summarised below:

- Primary care or GP Services made up more than 90% of all NHS activity in North Central London, and 95% of all activity in the NHS.
- GP services in North Central London carried out more than 800,000 appointments and of those 740,000 were 'in- hours' appointments. 50% of targets were dealt with on the day.
- In North Central London, GPs were responding to an increase in demand, however it was noted that GP services were attaining pre- pandemic levels of service.
- Patient satisfaction with GPs services were declining across the country.
- It was noted that adequate recruitment and retention of GPs, as well as consistent funding of the service must be focused on, if not, GPs would not be able to keep up with demand.

The Committee was then asked for comments and questions on the report.

Cllr Connor stated that the report was extensive and needed some focus. It would be useful to include a summary of points for the Committee to consider.

Cllr Clarke also pointed out that there was no mention of the GP Federation in the paper. Katie Coleman responded that GP Federations were vital for GPs to have a consistent approach to healthcare. The GP Federations have a strong voice in North Central London in working collaborations. This is being developed further by the ICB.

Residents in Cllr Revah's ward had difficulty seeing their GPs - sometimes waiting 3-4 weeks for an appointment. Cllr Revah also stated that there are issues with patient confidence in the ability of GPs to diagnose illness over the phone. Face-to-face appointments are preferred. Katie Coleman responded that over 69% of GP appointments are face to face. And although there are still some issues with seeing patients within a suitable period, levels are returning to pre- pandemic levels.

Cllr Chowdhury reiterated that the residents in his ward also had issues with getting appointments. His own experience was that patients would give up waiting in the telephone queue for an appointment. He stated that also the online consultation forms are not easy to access or use. Not all people have access to digital channels and

therefore access to emergency appointments for all, was questioned. He also raised that his feeling was that some GP surgeries are taking more patients than their capacity allows. Ms Coleman responded that it is a requirement that GP practices respond to patients on the day with information, signposting to other services or an appointment. She also stated that GPs are not allowed to deny locals access to their services, so were unable to limit patient numbers. She, however, admitted that the system was not perfect. The ICB was working with GP practices to decrease variances in how patients experienced the service across the locality. It was pointed out that funding was at the lowest level, but the service was experiencing an increase in demand. Regarding online consultations, she acknowledged the challenges patients experienced, and suggested that work may be done around training receptionists to support patients.

Discussion then turned to access for those who found digital access hard or not possible. Cllr Chowdhury suggested there may be some role for Voluntary sector organisations to help. Ms Coleman affirmed that work was already being done with some organisations to include older people. More details on the voluntary organisations working with the ICB were requested by the Committee. **(ACTION)**

Cllr Cohen then questioned the Pharmacy First approach, as he understood it certain pharmacies had hit back at this approach – as seeing a pharmacist was not a substitute for seeing a GP. Ms Coleman responded that the Pharmacy First approach was supported by over 96% of pharmacists across the nation. All have undergone training to treat seven acute presentations in patients. Some pharmacies will have the ability to prescribe in the future. Cllr Cohen stated that perhaps the ICB should sponsor a communications campaign to increase uptake in the Pharmacy First service.

The discussion then turned to the availability of patient records. Cllr Atolagbe recounted her own experience of the out-of-hours service. She related that access to GP records was not given to the out-of-hours service, making a diagnosis impossible. Ms Coleman then responded that the London Care Records will give access to patient records to all providers. It was also noted that all patients will be given access to their own file digitally as of October 1st, 2024.

Cllr Chakraborty then questioned the ‘digital first’ approach. He asked whether access to apps and online consultations actually help more patients get an appointment sooner, or whether it was just the timeliness of responses to the patient that was recorded. He also asked what recent technology had been implemented for primary care staff and whether this had improved outcomes for patients. Ms. Coleman responded that digital inclusion was something the ICB was aiming for. Technology in primary healthcare settings is used to track capacity and understand demand – this was being used as evidence.

As time was short, Cllr Connor then asked for written responses to Committee comments and questions as set out below.

- More details were needed from the IBC around improving the patient experience and decreasing long waiting times. Also, details about patients who remain under primary care because of long waiting lists for secondary care. **(ACTION)**
- It was stated that better consistency with the same doctor was needed for those with chronic medical conditions. **(ACTION)**
- It was affirmed that from experience, councillors hear patients do not easily access apps or online forms. Training and support are needed to increase uptake amongst residents. Also, the right level of training should be delivered for practice receptionists to become information-givers and gatekeepers. **(ACTION)**
- More details were requested on Physicians Associates. How supervision was being enforced and what the pressures were on GPs. **(ACTION)**
- A communications plan for pharmacies was then suggested to increase uptake in the expanded services they offer and reduce pressure on GPs. **(ACTION)**
- Details were requested as to how the ICB is responding to a recent report into the safety of online consultations. **(ACTION)**
- More research was needed into how many residents do not have access to a smart phone. Details were also needed was to the work being done to ensure their inclusion. **(ACTION)**

24. DENTAL SERVICES

The Committee then received an update on NCL access to dental care, introduced by Mark Eaton and Jeremy Wallman. Previous committee meetings had expressed concerns about funding, NHS contracts, and access for children's dental health services.

The report is summarised as below.

- The Dental, Optometry and Community Pharmacy Services were brought under ICB management in 2023 and had undergone a transformation programme.
- An extra £600k has been allocated to dental services that offer support to more vulnerable residents such as asylum seekers, rough sleepers, and those in residential care. It also went toward reducing waiting times for children and young people who need more specialist care.
- Patients in acute pain can access urgent appointments through NHS 111. A commitment has been given by the ICB to support Looked After Children and the development of Child Friendly Practices in dentistry.
- Additional investment has been made in preventative work and in supporting children with SEND.

- Community Dental Services have been used to reduce the number of patients needing to be treated in more specialist centres. Only 8% of patients referred for specialist care resulted in treatment in a hospital setting.
- The main focus for the ICB since delegation has been on expanding access to Primary Dental Services including helping practices to develop new skills, increasing workforce capacity, and reducing the number of practices handing back their contracts.
- Future work includes improving oral health for those with diabetes (who are particularly vulnerable to loss of teeth), and piloting work to identify illnesses such as cardiovascular disease in patients with oral health issues. Also, a new cross-agency pediatrics pathway will lead to improved outcomes for children and young people.

Mr. Eaton explained that the ICB could not change the contract it held with Primary Care Dentists. It was not a statutory requirement for dentists to take on NHS patients, or to deliver any NHS activity against their contracts, with some practices actively blocking NHS patients. Substantially more could be earned by dentists taking on private patients than those on the NHS. However, it was noted that better access to NHS services exist within London than in rural areas.

Cllr White asked whether there could be some incentives for dentists to take on NHS patients. Mr. Eaton responded that for an NHS patient a dentist would earn around £28 for each unit of dental activity, but for the same work the dentist could earn anywhere between £30 and £300+ privately. This acted as a disincentive for many to see NHS patients. Mr. Wallman also reiterated that dentists were not obliged to see patients under the NHS, indeed registration was very informal in some practices. However, this was a national policy issue and cannot be addressed locally by ICBs.

Cllr Clarke commented that although dentists were not getting paid more for seeing NHS patients, £28 was still expensive for most residents. For those on the breadline there were still questions as to whether they were receiving any dentistry at all. This was acknowledged by Mr. Eaton and Mr. Wallman as an area of concern.

Cllr Clarke then requested more in-depth detail around the delivery of dental treatment to the most vulnerable. Mr. Eaton and Mr. Wallman clarified that access by rough sleepers and asylum seekers was achieved through link workers. Children and young people in Looked After Care had statutory health checks. Cllr Clarke suggested that perhaps this could be linked to dental health services.

It was agreed that another update specifically on access to dental care services for vulnerable groups would be given to the committee. **(ACTION)**

Cllr Connor then asked for written responses to questions from the Committee.

- Cllr Revah requested more information on the definition of ‘exempt’ also what special provision there was for those with Diabetes. **(ACTION)**
- Cllr Chakraborty requested the ICB view on the opportunities to roll out preventative schemes in the community – such as supervised brushing amongst children. **(ACTION)**
- In reaction to the 111 dental services item in the report, Committee requests for a list of dentists taking NHS patients, as well as those skilled in child friendly practices - Cllr Connor highlighted that this information needed to be common knowledge amongst residents. There was a strong recommendation from the Committee that the ICB should investigate a Communications budget to start looking at making these pathways more accessible to residents. **(ACTION)**
- She also expressed concern at the state of dentistry. Some residents did not access dental services because of the cost, and this would have big implications on long term health. **(ACTION)**

25. WORK PROGRAMME

Cllr Connor pointed out the present time constraints at the meeting. It was then agreed that the committee would reconvene at a later date, to discuss the work plan and terms of reference in more detail. **(ACTION)**

26. DATES OF FUTURE MEETINGS

- 9th September 2024 (10:00 am)
- 11th November 2024 (10:00 am)
- 3rd February 2025 (10:00 am)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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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 ……

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NCL Joint Health Overview & Scrutiny Committee – Action Tracker 2024-25

MEETING 2 – 9th September 2024

No.	ITEM	STATUS	ACTION	RESPONSE
23	Work Programme	**TO BE CONSIDERED FOR 2025/26 WORK PROGRAMME**	Meetings to be extended to up to three hours in duration, should the agenda items require this. Democratic Services and ICB to be consulted on the possibility of adding an additional meeting to the annual JHOSC schedule.	Democratic Services teams in the 5 NCL Boroughs are currently consulting on the resources for the JHOSC and this will be fed into that discussion ahead of the meeting schedule and work programme being developed for 2025/26.
22	North London Mental Health Partnership	**AWAITING RESPONSE**	Further information was requested on: a) More detail on the finances associated with the merger, in particular the expected impact on the surplus/deficit and any anticipated risks. b) Evidence of how people with disabilities were being involved with working groups and consultations. c) Details on how CAMHS would fit alongside the new structure and how patients would be able to navigate this. d) Most recent headline waiting list figures to be provided. e) Update on action to address concerns about breakdown in communications between families and keyworkers in some cases. f) Assurances sought that a report on suicide prevention would be considered by NLMHP and appropriate action taken (Not sure what the timescale for this report is expected to be?)	

			g) More evidence of the internal due diligence that the Partnership had done for the merger, including Quality Governance and changes in the key clinical areas. h) Evidence that local focus on care would not be lost as a consequence of merger.	
21	Estates & Infrastructure Strategy	**IN PROGRESS**	Update to be provided on St Pancras Transformation Programme.	Briefing to the Chair/vice-Chairs of Committee took place in October 2024. A follow-up briefing is expected to take place in January 2025.
20	Estates & Infrastructure Strategy	**COMPLETED**	a) Cllr James to speak to the planning inspector for health centres at Enfield Council about land being reviewed in Enfield to ensure that the ICB was aware of opportunities to acquire sites. b) It was suggested that all Boroughs should make the ICB aware of any divestments. More details were to be provided on how NCL Estate teams operate and how they work with local authority teams.	a) This has been actioned. b) - The Borough Integration Units will be the local representative of the ICB as part of a matrix with other functions within the ICB, such as Quality, Service Development and Analytics (as examples). BIU leadership meets regularly with colleagues from Councils, particularly Adult Social Care, Children and Families and Public Health but as an anchor organisation have wider links with areas such as Community Wealth building, Planning, Housing, as examples. The details of leaders within the BIU team as follows: • Director lead for Enfield, Haringey and Islington (East) – Clare Henderson • Director lead for Barnet and Camden (West) – Simon Wheatley • Assistant Director Barnet – Dan Morgan

				• Assistant Director Camden – Jo Reeder • Assistant Director Islington – Rhian Warner • Assistant Director Haringey – Tim Miller • Assistant Director Enfield – Peppa Aubyn
19	Estates & Infrastructure Strategy	**COMPLETED**	Further information was requested on: a) Details of the membership of the Estates Forum in each Borough. b) Plans to include keyworker housing at Finchley Memorial Hospital. c) An update on keyworker housing at the St Anns site. d) NCL ICS people strategy – how will NEET individuals would be chosen for the employment, who would refer them and how they would be supported. e) Further details to be provided of sites being sold, the buyers of the sites and how the funds would be reinvested. f) Details of the critical infrastructure risk and any particular areas of or backlog and the risk associated with this. g) Details of the ICB engagement strategy to be provided.	a) Response provided as **ATTACHMENTS C1 to C5.** b) Response provided as **ATTACHMENT D.** c) Response: “There will be 22 units of accommodation which will be available for use of NLMHP / NLFT staff, as the St Ann’s site housing development progresses. The first units should be available by 2026. The units will be owned by Peabody, but the NLMHP / NLFT will have the nomination rights, i.e. the Trust will be able to allocate these units to some of its staff, to help in staff recruitment / retention. This was agreed in the original land sale agreement with the GLA.” d) Response: WorkWell is a service open to anyone with a disability or health condition who lives in Barnet, Enfield, Haringey, Camden and Islington (or is registered with a GP or Job Centre within this area).

				Please see the stakeholder communication pack **(ATTACHMENT E)**. We are in the process of developing a more detailed set of FAQs that will have been tested by stakeholders and this will follow shortly. More information and details of how to refer into the WorkWell service can be found on our website here: https://nclhealthandcare.org.uk/keeping-well/workwell/ e) Details of disposals strategy development provided in **ATTACHMENT F**. f) Details of Critical Infrastructure Risk prioritisations review provided in **ATTACHMENT F.** g) ICB People & Communities Strategy provided as **ATTACHMENT G1.** ICB Community & Voluntary Sector Strategy provided as **ATTACHMENT G2.**
19	NMUH/Royal Free merger	**AWAITING RESPONSE**	Further information was requested on: a) The lines of governance accountability (including an organisational chart illustrating how this would work after the merger) and how sub-committees would feed into the Board. b) How NMUH governors and staff reps could feed into the governance process. c) Clarification on the longer-term plans for where Barnet patients would be treated. d) Details on the plans to safely merge the Electronic Patient Records.	

			e) Further evidence about the consultation of patient groups.	
18	NMUH/Royal Free merger	**ADDED TO WORK PROGRAMME**	Possible issues to be considered in future update item: a) For the Committee to examine a case study into a less prominent area of care to ascertain how it was monitored before and after changes to the service, what the local priorities were and their impact on how clinical decisions were made. b) For further discussion on financial risk and, including how the debts of the Royal Free Group when be held within the merged Trust.	Added to work programme.
17	Minutes (Barnet update)	**AWAITING RESPONSE**	Cllr Cohen reported that a consultation in Barnet on primary care access had recently been concluded and that the results were expected to be published in September. He would update the Committee when this was available.	
16	Minutes (Actions)	**TO BE IMPLEMENTED IN FUTURE MEETINGS**	The Committee requested that the action point sheet should be published as a separate agenda item for future meetings.	To begin from Nov 2024.
15	Minutes (Mental Health action points)	**AWAITING RESPONSE**	Regarding the update from the ICB on a previous mental health item (in March 2024), additional information was requested: • Item 3 (Voluntary & Community Sector contract terms) – The response noted that the Committee could be updated further throughout the year as this workstream was developed.	Item 3 – Added to Work Programme.

			• Item 5 (Supported Accommodation for People with Severe Mental Health Needs) – Further information was requested on how the Mental Health Trusts were working with local authorities to resolve the shortage of supported accommodation that was described. • Item 8 (Mental Health Support Teams in Schools Coverage) – Information was requested on which schools were supported.	
14	Minutes	**TO BE ADDED TO NOVEMBER 2024 AGENDA PAPERS**	The minutes of the meeting were not approved as the meeting was not yet quorate in the early stages when this item was discussed. The minutes would therefore need to be formally approved at the November meeting.	

MEETING 1 – 25th July 2024

No.	ITEM	STATUS	ACTION	RESPONSE
13	Dental Services	**COMPLETE**	Concerns were expressed that some residents did not access dental services because of the cost and that this would have implications for long term health.	Response from Mark Eaton, Director of Strategic & Delegated Commissioning (NCL ICB): "This is a joint area of concern for both the NHS and Local Authorities. The resolution of this will require coordinated action but needs changes to be made to funding and the contracts via a national policy change."
12	Dental Services	**PARTLY COMPLETE**	The Committee recommended that improved communications with residents was required about a) available care pathways and b)	a) Awaiting response. b) Response from Mark Eaton, Director of Strategic & Delegated Commissioning (NCL ICB): "Supervised brushing is a very

			preventative actions such as supervised teeth brushing for children.	effective preventative approach and falls within the shared remit between the NHS and Local Authorities for Oral Health Promotion. The NCL ICB is working with Local Public Health Teams across NCL to develop a consistent programme in this area given the relatively low costs v high benefits.”
11	Dental Services	**AWAITING RESPONSE**	Information was requested on the definition of ‘exempt’ and any special provision for patients with diabetes.	
10	Primary Care	**COMPLETE**	Details were requested on the ICB response to a recent report into the safety of online consultations.	Responses provided in **ATTACHMENT B.**
9	Primary Care	**COMPLETE**	The Committee recommended that improved communications with residents was required to increase uptake in the expanded range of services provided by pharmacists.	
8	Primary Care	**COMPLETE**	Further information was requested on supervision for Physician Associates and pressures on GPs.	
7	Primary Care	**COMPLETE**	The Committee recommended: - more support for residents who cannot easily access apps/online forms in order to increase uptake. - inclusive policies for residents who do not have access to a smartphone.	

			- the right level of training should be delivered for practice receptionists to become information-givers and gatekeepers.	
6	Primary Care	**COMPLETE**	The Committee suggested that better consistency with the same doctor was needed for those with chronic medical conditions.	
5	Primary Care	**COMPLETE**	More information was requested about improving the patient experience, decreasing long waiting times and about patients who remain under primary care because of long waiting lists for secondary care.	
4	Start Well	**AWAITING PUBLICATION OF REPORT**	NCL ICB to provide the Committee with the final full report following the consultation exercise. At the time of the meeting, only an interim report was available. Final report expected to be published in autumn 2024.	Oct 2024 update – Report is now expected to be published in early November.
3	Start Well	**COMPLETE**	Committee to provide formal response by letter to NCL ICB on the interim report following the consultation exercise.	Letter submitted to NCL ICB in August 2024. This letter included all of the main comments/recommendations made at the meeting. See minutes of meeting for further details. Letter provided as **ATTACHMENT A**.
2	Terms of Reference	**IN PROGRESS**	Discussions to be held with Boroughs on resourcing of support for JHOSC.	This has been passed to the Monitoring Officer at Haringey for discussion with the other 4 NCL Boroughs.

1	Terms of Reference	**IN PROGRESS**	New draft terms of reference for the JHOSC to be developed.	The Committee met on 8th Aug 2024 to provide initial input and 3rd Sep 2024 to consider a first draft. A second draft has been completed. The section on the resourcing of the Committee are currently under discussion and the draft terms of reference will be submitted for ratification by the Boroughs after this issue has been resolved.

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Dear Anna,

Further to the recent meeting of the North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC) on 25th July 2024, I am writing to you on behalf of the Committee to summarise our main areas of focus relating to the NCL Start Well programme.

The Committee previously received information about the Start Well programme at a meeting in November 2023 at which you provided details of a forthcoming public consultation regarding proposed changes to maternity and neonatal services and children's surgery. At this meeting, the Committee was informed that, due to various factors (including a declining birth rate, an increased number of complex births, an imbalance of demand across services leading to over/underutilisation of particular units and the fabric of estates not meeting best practice standards), the existing model for these services was no longer sustainable in NCL. The proposed changes included:

- Moving to a model with four units providing maternity and neonatal care instead of five units. This would mean the closure of maternity and neonatal services at either the Royal Free Hospital or the Whittington Hospital.
- This would mean having three Level 2 units and one specialist Level 3 neonatal intensive care unit at University College London Hospital (UCLH).
- There would no longer be a Level 1 unit or a stand-alone birthing centre.
- Pathways for paediatric surgical care would be streamlined.

After consideration of the report and discussions at the meeting, the Committee made a series of recommendations relating to the consultation process including:

- The need for the public to be made aware of the underlying support of NHS Trusts for the proposals, including Trusts directly affected by the potential closure of a unit as this was particularly relevant to any local debate on this issue.
- The importance of clarity over the capital funding being provided under either of the main two options and the need to address any potential risks over the longer-term of insufficient capital funding to support the ongoing cost of Start Well programme, including any possible hidden costs.
- To engage with residents over the development of mitigations for people who may be affected by additional transport costs.
- To closely monitor and report back to the JHOSC on the ongoing modelling of patient flows as current predictions may not necessarily match the choices that patients subsequently make in future years.

Following the conclusion of the consultation process, which ran from December 2023 to March 2024, an independent organisation (ORS) conducted an analysis of the feedback received. Further details about the consultation process and the key findings from an interim report from ORS was provided to the Committee meeting in July 2024. We understand that the full evaluation report will be available in autumn 2024.

The Committee has understood that the direction of travel outlined through the consultation has been clinically-led and has acknowledged the potential benefits of the changes overall. However, the Committee also wishes to emphasise that there are some remaining areas where further details and clarification will be required as the process moves forward, most notably on the additional financing that would be provided to improve the remaining units and also the ongoing modelling of the anticipated patient flows resulting from the proposed changes.

The Committee also acknowledges the efforts that have been made through the consultation process to engage with potentially impacted groups, including those who may find it more difficult to provide feedback or who are potentially less willing or able to engage. Having established connections with these groups, the Committee highlighted the importance of continuing this dialogue during and after the implementation of the proposed changes to ensure that any ongoing concerns are captured and addressed. This could include, for example, monitoring any transport issues that they may experience and ensuring high attendance rates at antenatal classes.

Finally, the Committee wishes to reiterate that its comments at this stage are based only on having seen the interim report on the consultation results and that we await the full analysis report which is expected to be made available later this year.

On behalf of the Committee, I would like to thank you and your team for your continued engagement on this issue and I look forward to further discussions in the coming months.

Yours sincerely,

Cllr Pippa Connor
Chair of the North Central London Joint Health Overview & Scrutiny Committee

How does the ICB support patients waiting for elective care to contact their care teams without this impacting on workload for GP Practices?

There is information **on the NCL ICB public facing website** for patients. This helps them to contact Trusts directly for appointment information and links them with Trust patient advice and liaison teams.

NCL ICB continues to work with primary and secondary care to improve the patient journey between providers. Clinical Interface Groups based around each of the four Trusts co-chaired by the Medical Director of the Acute Trust and a GP. There is attendance from Local Medical Committee representatives and GP Federations.

We have undertaken a collaborative exercise to identify interface challenges faced by patients and practices. One priority is to update contact details on clinic letters and discharge summaries to make it easier for patients to get in touch with the teams caring for them if they have questions regarding their follow up care. The digital team at the ICB is also exploring functionality within the NHS App which could help patients who wish to use this see their upcoming appointments, results and plans.

How is the ICB supporting GP Practices to offer continuity of care to patients who will most benefit from it?

The ICB recognises the value that continuity of care offers, particularly to patients with more complex needs such as those with multiple long term conditions. We also recognise that a constant focus on improving access to episodic care risks eroding practice capacity to deliver continuity by asking practices to prioritise episodic appointment capacity. NCL ICB firmly believes in the importance of protecting practice capacity for proactive and planned care alongside our work to improve patient experience when accessing their practice.

Delivering personalised care and support continuity of care is one of the main goals of our NCL-wide long-term conditions locally commissioned service (LTC LCS). 100% of NCL GP practices have signed up to deliver the LTC LCS, which has invested significant funding into General Practice to allow them to support people living with certain long-term conditions in a more holistic way. Our initial focus is on metabolic and respiratory conditions including asthma and heart disease. Patients are proactively contacted and supported to manage their health effectively and prevent health issues from worsening, wherever possible through personalised care plans. The benefits of this approach extend far beyond individual care - they contribute significantly to our ICS ambition to improve population health.

What is the ICB doing to support practices to improve patient access to the NHS app?

Consistent implementation of the NHS App across all practices in NCL is recognised within the ICB as pivotal to managing demand within Primary Care more effectively, benefiting both practices and residents. For residents the key benefits of the NHS app are the ability to easily:

- View own GP health record
- Book appointments
- Order repeat prescriptions
- Securely message their GP practice

To support GP practices to offer the NHS App functions to more of their patients, the ICB has stood up a team of Digital Change Facilitators (DCF's) with the specific task of raising the adoption and maturity of digital enablement tools within Primary Care. Over the next 8 months the DCF's will be supporting practices in the implementation of 'best practice' configuration of the App, as well as other tools such as online consultations, text messaging and cloud-based telephone systems.

Throughout the programme, the DCF team will use the NHS App Dashboard as well as other data sources from vendors to ensure the programme is 'data-led', focusing initially on those practices with the lowest adoption/maturity. The team will use the national guidance documents, case studies and implementation material to support improvement in the 147 practices within NCL that have less than 60% adoption of the NHS amongst their registered patients.

How does work to improve access to the NHS App relate to plans to improve digital inclusion in General Practice?

We are aware that some residents may have issues navigating or accessing the NHS App and wider digital tools. Others may have good digital skills and the ability to access, but are not aware of it.

Working with voluntary sectors colleagues, we are thinking about how we can promote the App, including directing people to existing information or videos about what the **NHS App can be used** for and **how to register and use it**.

Where patients may have more significant issues relating to 'digital exclusion', we have developed an 'NCL Digital Inclusion Framework'. We have been working closely with our Councils (including Digital and Adult Learning teams) and voluntary sector partners to shape our plans.

We are now working with our partners in NCL and in London to consider how we better promote existing services that exist in NCL to support people to access devices, Wi-Fi and digital skills. We will ensure that the NHS App is part of these offers.

We have recently invested £100,000 in projects to be rolled out in each borough to improve people's digital skills and improve access to the NHS App. The scheme in Haringey (already in place) is a collaboration between primary care led by the Haringey GP Federation, Haringey Council's Adult Learning Services, the wider NHS and the voluntary sector to promote access to the NHS App and access for people to improve their digital skills and access to gifted devices/data to do so.

We are looking at range of opportunities to coordinate and further resource partners across the Borough and attract external funding or resources, e.g. commercial partnerships, to do so, as part of our detailed planning between Councils and the NHS.

How is the ICB supporting non-clinical staff working in General Practice to develop care navigation skills?

We recognise that care navigation is an essential function for General Practice to manage access to appointments, as well as to direct patients to other services that can best meet their needs as appropriate.

In 2023/24 a national care navigation training package was offered by NHS England and 39% of our practices took up this offer. We also know that many other practices funded their own care navigation training and development for their staff.

We have since asked the NCL Training Hub to scope practice need for care navigation training or support in more detail. This will allow us to better understand whether and what additional support may be required to ensure every practice can develop effective care navigation.

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

What is the latest position with ICB plans to improve supervision of ARRS roles, particularly Physicians Associates? What are practices doing to make it clear that people they know they are being seen by a PA?

NCL ICB is working closely with the NCL Training Hub to ensure the **Supervision guidance for primary care network multidisciplinary teams** is embedded within PCNs and Practices employing a multidisciplinary team.

NCL ICB commissioned the NCL Training Hub to undertake an evaluation of MDT supervision models focused on patient safety, ensuring high quality care, robust risk management, staff wellbeing and retention. As part of this evaluation the Training Hub led a survey with all professions delivering and in receipt of supervision, designed workshops to supervisors of PCN roles in partnership with the Multi-professional Educator Group (MPEG) and developed bi-monthly Educator Lead meetings and a NCL Mentor Group for the PCN Workforce Education Leads.

With Legislation passed through House of Lords for GMC to regulate Physician Associates (PAs) in February 2024, NCL ICB in partnership with NCL Training Hub are supporting practices and PCNs

to respond to the BMA and RCGP recommendations. We have dedicated resource pages on our GP Website, GP bulletin and presentations via the GP Webinar with a focus on induction, supervision, triage and scope of work undertaken by PAs.

NHSE is developing a public awareness campaign on the role of Physician Associates and within NCL we have developed a GP patient communication kit (currently in final sign off). This toolkit includes Website information, Leaflets and posters, Reception FAQs sheet, Checklist recommendation.

How is the ICB communicating and promoting the Pharmacy First services to patients?

In support of the National Delivery Plan for recovering access to primary care, the ICB is developing a 12-18 month communications and engagement campaign focussed on general practice and primary care.

The campaign will raise awareness of the different ways residents can access care through services such as Pharmacy First. Launching in September, the campaign will promote Pharmacy First and signpost a range of other health and care services at key points in the year.

Recognising the importance of our local stakeholders, we will brief local authorities in due course, provide campaign materials and ask for your support in reaching residents across our five boroughs. As part of this campaign, we will also be working with local voluntary and grassroots organisations to connect with local communities.

How is the ICB responding to the recently published HSSIB report on the safety of online consultations?

The HSSIB report on **Digital tools for online consultation in general practice** was published on 25th July 2024. We will need to consider our longer-term response to support GP Practices to ensure they are offering online consultations safely, working closely with stakeholders including NHS England, to whom the majority of recommendations are directed.

The ICB always considers the part providers and patient groups play in procurement processes and is focused on safe and effective implementation of digital tools (including online consultation). We often provide bespoke support to each Practice and discuss their needs so we might tailor accordingly.

We recognise online consultations should be offered to patients alongside other access routes including telephone and face to face. This is an essential part of the *modern general practice* operating model that we are supporting our practices to implement. We will continue to promote the need for practices to offer a variety of access and consultation routes to meet patient needs.

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NHS
North Central London
Integrated Care Board

BARNET LOCAL ESTATES FORUM (LEF)
TERMS OF REFERENCE

1. Purpose of the Group

The purpose of the steering group is to:

- Engage all partners to identify potential estate opportunities and schemes
- Steer the development of key Barnet premises developments.
- Monitor alignment and delivery of the Local Estates Strategy and update as appropriate
- Communicate estates needs and identify available solutions
- Provide estates expertise and input to support integration
- Identify sources of and access to capital funding
- Develop a Forward Plan for proactive strategic estates management

2. Membership:

- The LEF will be co-chaired by the NHS Integrated Care Board (ICB) Director of Place

Name	Role
Adam Driscoll	LBB
Andrew Garner	Infection Prevention and Control Lead, NCL ICB
Angela Henry	LBB
Candice Bryan	LBB
Carol Kumar	Assistant Director for Primary Care Planning, Operations and Improvement, NCL ICB
Chris Smith	LBB
Danny Rowell	BEHMT
Darren Summers	TBC
Dhiren Ganesh	Senior Portfolio Optimisation Manager, NHSPS
Diane Macdonald	Deputy Director of Strategic Estates Finance, NCL ICB
Emma Manby	Estates and Facilities Transformation Lead - CLCH
Eric Fehily	Director of Estates & Facilities, BEHMT & C&I NHSFT
Faye McElwain	Town Planner, NCL ICB / HUDU
Gary Gibson	Customer Relationship Manager, CHP
Henry Claridge	Strategic Estates Lead, NCL ICB
Ian Daccus	Estates and Facilities Strategic Partnership Director - CLCH

Ian Sabini	Estate Programme Lead, NCL ICB
Janet Djomba	Interim Director of Public Health, LBB
Jonathan South	ICT Senior Programme Manager – NCL ICB
Karla Damba	Strategic Estates Lead, NHSE
Leo Grunhut	Senior Property Manager, NHSPS
Maggie Robinson	Estates Directorate - Head of Property, Royal Free
Michelle Leach	Head of Property, Whittington Health
Nabila Qayum	Strategic Estates Support, NCL ICB
Nicola Theron	Director of Estates, NCL ICB
Perdeep Purewakl	Health & Safety Manager, Estates & Facilities, BEHMT & C&I NHSFT
Rachael Oriowo	Estate Finance Support, NCL ICB
Sal Waheed	LBB
Sam Cooke	Senior IT Project Manager, NCL ICB
Sarah Soan	Primary Care Planning, Operations & Improvement Senior Manager – NCL ICB
Shaun Kisten	BEHMT
Simon Wheatley	Director of Place (West), NCL ICB
Sophie Harrison	Assistant Director of Strategy (Estate), Whittington Health
Su Nayee	Assistant Head of Primary Care: Commissioning & Contracting, NCL ICB
Susan Curran	Head of Strategic Housing – Growth Team, Customer and Place, LBB
Tamara Djuretic	LBB
Tawnia Massari	LBB
Vanessa Piper	Assistant Director of Primary Care: Commissioning & Contracting, NCL ICB
Victoria Smart	Strategic Estates Support, NCL ICB

3. **Decision Making Function**
   - The LEF is an Advisory/ non decision making group
   - This Group shall make recommendations to decision making committees within the respective organisations and report through an agreed Council/ICB Governance structure
4. **Frequency**
   - The LEF should meet quarterly – broadly aligned to the months of June, September, December and March
5. **Format**

- The LEF is an engagement forum for all partners across the integrated care system.
- Stakeholder from the wider system have the opportunity to attend/ contribute/ present on particular items.
- Meetings may take place virtually or in-person, as appropriate.
- Membership can be revised and members can be added with the year

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North Central London
Integrated Care Board

CAMDEN LOCAL ESTATES FORUM (LEF)

TERMS OF REFERENCE

1. Purpose of the Group

The purpose of the steering group is to:

- Engage all partners to identify potential estate opportunities and schemes
- Steer the development of key Camden premises developments.
- Monitor alignment and delivery of the Local Estates Strategy and update as appropriate
- Communicate estates needs and identify available solutions
- Provide estates expertise and input to support integration
- Identify sources of and access to capital funding
- Develop a Forward Plan for proactive strategic estates management

2. Membership:

- The LEF will be co-chaired by the NHS Integrated Care Board (ICB) Director of Place, West

Name	Role
Simon Wheatley	Director of Place (West), NCL ICB
Alex Warner	CHP Clinical Chair, GP
Alison Edgington	St Pancras Hospital - C&I
Ammara Hughes	CHE – Joint Clinical Director
Andrew Reece	Head of Camden CLDS, LBC
Andrew Triggs	Principal Planner, LBC
Benita Mehra	Head of Estates, Tavistock and Portman
Bethany Nelson	CHE, GP Federations
Brian O'Donnell	Strategic Lead - Planning Policy and Implementation, LBC
Chris Lehmann	Head of ASC Strategy and Commissioning, LBC
Colin Harb	NCL St Pancras Hospital Programme, NCL ICB
Dan Pope	Chief Planning Officer, LBC
Dee Hora	Clinical Director of Place – Camden, NCL ICB
Dhiren Ganesh	Senior Portfolio Optimisation Manager, NHSPS
Diane MacDonald	Deputy Director of Strategic Estates Finance, NCL ICB
Faye McElwain	Town Planner, NCL ICB / HUDU

Gary Beacham	Delivery Director GOSH
Hannah O'Brien	Director QTS/CNWL
Henry Claridge	Strategic Estates Lead, NCL ICB
Jack Phillips	Camden Borough Partnerships Programme Manager, NCL ICB
Jo Ohlson	CHP, GP Federations
Jo Wilson	Director QTS/CNWL
John Higgins	ASC Programme, LBC
Kamran Bhatti	Primary Care Commissioning Manager, NCL ICB
Karla Damba	Strategic Estates Lead, NHSE
Kristian Nicholson	Estates, UCLH
Leo Grunhut	Senior Property Manager, NHSPS
Maggie Robinson	Head of Estates, RFLPS
Mags Heals	GP
Martin Olomofe	Head of Asset Management, LBC
Mary Manuel	Head of the LHUDU
Michelle Leach	Head of Property – Whittington Health
Nabila Qayum	Strategic Estates Support, NCL ICB
Nicola Theron	Director of Estates, NCL ICB
Noe Ardanaz	Head of CIP Programme Office, LBC
Philippa Robinson	Regional Director - London, CHP
Rachael Oriowo	Estates Finance Support, NCL ICB
Rachel Styles	Head of Estates, UCLH
Simon Wheatley	Director of Place (West), NCL ICB
Sophie Harrison	Assistant Director of Strategy (Estate) – Whittington Health
Steve Harris	Head of FM, LBC
Steven Rennie	Camden Integrated Care Executive – Project Manager, LBC
Tom Aslan	Outgoing GP System Rep
Victoria Smart	Strategic Estates Support, NCL ICB
Zeina Al-Derry	Gospel Oak Regen Team, LBC
Zoe Dunn	Gospel Oak Regen Team, LBC

3. Decision Making Function

- The LEF is an Advisory/ non decision making group
- This Group shall make recommendations to decision making committees within the respective organisations and report through an agreed Council/ICB Governance structure

4. Frequency

- The LEF should meet quarterly – broadly aligned to the months of June, September, December and March

5. Format

- The LEF is an engagement forum for all partners across the integrated care system.
- Stakeholder from the wider system have the opportunity to attend/ contribute/ present on particular items.
- Meetings may take place virtually or in-person, as appropriate.
- Membership can be revised and members can be added with the year

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North Central London
Integrated Care Board

ENFIELD LOCAL ESTATES FORUM (LEF)

TERMS OF REFERENCE

1. Purpose of the Group

The purpose of the Steering Group is to:

- Engage all partners to identify potential estate opportunities and schemes
- Steer the development of key Enfield premises developments.
- Monitor alignment and delivery of the Local Estates Strategy and update as appropriate
- Communicate estates needs and identify available solutions
- Provide estates expertise and input to support integration
- Identify sources of and access to capital funding
- Develop a Forward Plan for proactive strategic estates management

2. Membership:

- The LEF will be co-chaired by the NHS Integrated Care Board (ICB) Director of Place, East and the London Borough of Enfield (LBH) TBC

Name	Role
Clare Henderson	Director of Place, East, NCL ICB (Co-chair)
TBC	LBE (Co-chair)
Aneesh Maini	TBC
Carol Kumar	Assistant Director for Primary Care Planning, Operations and Improvement, CMO & Place Directorate, NCL ICB
Chris Kelly	Development Manager, NMUH
Dermot Whelan	Head of Regeneration & Growth Strategy, LBE
Diane Macdonald	Deputy Director of Strategic Estates Finance, NCL ICB
Dr Fahim Chowdhury	Clinical Director Edmonton PCN
Dr Harry Grewal	Clinical Director Enfield Care Network PCN
Dr Riz Noor	Clinical Director West Enfield Collaborative PCN
Dr Sanjay Patel	Clinical Director Enfield Care Network PCN
Dr Sarit Gosh	Clinical Director Enfield Unity PCN
Dr Ujjal Sarkar	Clinical Director Enfield Unity PCN
Dr Yogasakaran Arjuna	Clinical Director Enfield South West PCN
Eric Fehily	Director of Estates and Facilities, NLMHP
Faye McElwain	Town Planner, NCL ICB / HUDU
Glenn Stewart	Assistant Director of Public Health, Enfield Council
Jeremy Philpot	Director of Estates, BEHMHT
Joanne Drew	Director of Housing and Regeneration, Enfield Council

Karla Damba	Estates Delivery Team – London Region (North Central London), NHS England
Maggie Robinson	Director of Property, RFL Property Services
Michelle Leach	Head of Property, Whittington Health
Nabila Qayum	Strategic Estates Support, NCL ICB
Natalya Palit	Area Plans Manager, Enfield Council
Nicola Theron	Director of Estates, NCL ICS
Richard Gourlay	Director of Strategic Projects, NMUH
Sarah Soan	Programme Manager, Primary Care, NCL ICB
Sophie Harrison	Assistant Director of Strategy (Estate), Whittington Health
Sophie Jenkins	Strategic Estates Support, NCL ICB
Su Nayee	Assistant Head of Primary Care: Commissioning & Contracting, NCL ICB
Usha Banga	Primary Care Contracting Manager, NCL ICB
Vanessa Piper	Assistant Director of Primary Care: Commissioning & Contracting, NCL ICB

3. Decision Making Function

- The LEF is an Advisory/ non decision making group
- This Group shall make recommendations to decision making committees within the respective organisations and report through an agreed Council/ICB Governance structure

4. Frequency

- The LEF should meet quarterly – broadly aligned to the months of June, September, December and March

5. Format

- The LEF is an engagement forum for all partners across the integrated care system.
- Stakeholder from the wider system have the opportunity to attend/ contribute/ present on particular items.
- Meetings may take place virtually or in-person, as appropriate.
- Membership can be revised and members can be added with the year

North Central London
Integrated Care Board

HARINGEY LOCAL ESTATES FORUM (LEF)

TERMS OF REFERENCE

1. Purpose of the Group

The purpose of the Local Estates Forum is to:

- Engage all partners to identify potential estate opportunities and schemes
- Steer the development of key Haringey premises developments.
- Monitor alignment and delivery of the Local Estates Strategy and update as appropriate
- Communicate estates needs and identify available solutions
- Provide estates expertise and input to support integration
- Identify sources of and access to capital funding
- Develop a Forward Plan for proactive strategic estates management

2. Membership:

- The LEF will be co-chaired by the NHS Integrated Care Board (ICB) Director of Place and the London Borough of Haringey (LBH) AD of Adult Social Care

Name	Role
Clare Henderson	Director of Place, NCL ICB (Co-chair)
Sara Sutton	AD Adult Social Care, LBH (Co-chair)
Nadine Jeal	Clinical and Care Director, NCL ICB
Nicola Theron	Director of Estates, NCL ICB
Mike Stone	Strategic Estates Lead, NCL ICB
Nabila Qayum	Strategic Estates Support, NCL ICB
Diane Macdonald	Deputy Director of Strategic Estates Finance, NCL ICB
Karla Dama	Strategic Estates Lead, NHSE
Sophie Harrison	Assistant Director of Strategy (Estate), Whittington Health
Michelle Leach	Head of Property, Whittington Health
Eric Fehily	Director of Estates and Facilities, BEHMT
Paul Butler	Chief Executive Officer, Selby Trust
Jack Skinner	Development Manager, Selby Trust
Gary Gibson	Customer Relationship Manager, CHP
Chris Kelly	Trust Estates Development Manager, NMUH
Leo Grunhut	Senior Property Manager, NHSPS
Dhiren Ganesh	Senior Portfolio Optimisation Manager, NHSPS
Mary Manual	Head of LHUDU
Faye McElwain	Town Planner, NCL ICB / HUDU
Cassie Williams	Chief Executive Officer, Federated4Health
Benita Mehra	Director of Estates, Tavistock & Portman

Kerry Bourne	Programme Manager, CHP
Lucinda Courtier	Programme Lead, LBH
Orphelia Kinshott	Neighbourhoods Programme Lead, LBH
Rob Kryszowski	Assistant Director, Planning, Building Standards & Sustainability, LBH
Sarah Lavery	Head of Property, LBH
Amanda Grosse	Head of Strategic Asset Management, LBH
Sarah Lovell	Head of Area Regeneration - North Tottenham, LBH
Toussainte Reba	Head of Area Regeneration – South Tottenham, LBH
Pippa Gueterbok	Head of Area Regeneration - Wood Green (Interim), LBH
Bryce Tudball	Interim Head of Planning Policy, Transport & Infrastructure, LBH
Tim Solomon	Principal Planner, LBH
Max Tolley	Assistant Planning Officer, LBH
Dr Will Maimaris	Director of Public Health, LBH
Marlene D'Aguilar	Health in All Policies Officer, LBH
Florence Guppy	Strategic Lead: Community Enablement, Connected Communities, LBH
David Joyce	Director of Housing, Regeneration and Parking, LBH

3. Decision Making Function

- The LEF is an Advisory/ non decision making group
- This Group shall make recommendations to decision making committees within the respective organisations and report through an agreed Council/ICB Governance structure

4. Frequency

- The LEF should meet quarterly – broadly aligned to the months of June, September, December and March

5. Format

- The LEF is an engagement forum for all partners across the integrated care system.
- Stakeholder from the wider system have the opportunity to attend/ contribute/ present on particular items.
- Meetings may take place virtually or in-person, as appropriate.
- Membership can be revised and members can be added with the year

North Central London
Integrated Care Board

ISLINGTON LOCAL ESTATES FORUM (LEF)

TERMS OF REFERENCE

1. Purpose of the Group

The purpose of the Local Estates Forum is to:

- Engage all partners to identify potential estate opportunities and schemes
- Steer the development of key Islington premises developments.
- Monitor alignment and delivery of the Local Estates Strategy and update as appropriate
- Communicate estates needs and identify available solutions
- Provide estates expertise and input to support integration
- Identify sources of and access to capital funding
- Develop a Forward Plan for proactive strategic estates management

2. Membership:

- The LEF will be co-chaired by the NHS Integrated Care Board (ICB) Director of Place and CEO, London Borough of Islington (LBI)

Name	Role
Carol Kumar	Assistant Director for Primary Care Planning, NCL ICB
Clare Henderson	Director of Place, NCL ICB (Co-chair)
Diane MacDonald	Deputy Director of Strategic Estates Finance, NCL ICB
Faye McElwain	Town Planner, NCL ICB / HUDU
Gary Gibson	Customer Relationship Manager, CHP
Jaid Gibson	Senior Property Manager, Whittington Health
Jane Abraham	Acting Director, New Homes Delivery, LBI
Karim Pabani	Interim AD, Asset Management
Karla Damba	Strategic Estates Lead, NHSE
Kyriacos Yerou	Strategic Estates Support, NCL ICB
Leo Grunhut	Senior Property Manager, NHSPS
Malcolm McFrederick	Camden & Islington NHSFT
Michelle Leach	Head of Property, Whittington Health
Nabila Qayum	Strategic Estates Support, NCL ICB
Nicola Theron	Director of Estates, NCL ICB
Peter Martin	Strategic Development Manager, Royal Free London FT
Phil Wrigley	Head of Primary Care Planning and Operations, NCL ICB
Prosper Mafu	Camden & Islington NHSFT
Rhian Warner	Assistant Director for Place (Islington), NCL ICB
Sarah Soan	Primary Care Planning, Operations & Improvement Senior Manager, NCL ICB
Sophie Harrison	Assistant Director of Strategy (Estate), Whittington Health
Stephen Biggs	CEO, LBI (Co-chair)

Steven Caplan	Interim Director - Corporate Landlord and New Homes Delivery, LBI
Toni Orloff	Chief Operating Officer, Islington GP Federation

3. Decision Making Function

- The LEF is an Advisory/ non decision making group
- This Group shall make recommendations to decision making committees within the respective organisations and report through an agreed Council/ICB Governance structure

4. Frequency

- The LEF should meet quarterly – broadly aligned to the months of June, September, December and March

5. Format

- The LEF is an engagement forum for all partners across the integrated care system.
- Stakeholder from the wider system have the opportunity to attend/ contribute/ present on particular items.
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New homes for NHS staff will be built adjacent to a NCL hospital

North Central London Health and Care
Integrated Care System

NCL is supporting the building of up to 130 affordable new homes for NHS staff on a site adjacent to Finchley Memorial Hospital. The project is led by Community Health Partnerships. The London Borough of Barnet has given outline planning approval. Resident engagement has started for the submission of the reserve matters application, which continues a landscape- led approach providing green space accessible by the community.

The current plan is that construction begins in August 2025 with practical completion for February 2028.

The initiatives support both an efficiency agenda and the underlying need to address the workforce gap, recruiting and retaining the staff NHS providers need.

- It is being developed on “brown” land, in line with current policy
- Planning specifically references housing for NHS staff, supporting NCL ICB workforce retention & recruitment challenges
- The land sits within a community hospital setting, is a timely proof of concept of the NHS supporting the housing agenda
- The redevelopment is being led by the London NHS Charities who recognise the strategic importance of this site & project
- NHS to explore how to replicate elsewhere

Plan for proposed new homes for NHS staff adjacent to Finchley Memorial Hospital

Population Health | Quality | Efficiency

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Disposals strategy development - integral to the ICS infrastructure strategy

North Central London Health and Care
Integrated Care System

Currently, disposals of assets could be viewed as opportunistic or ad hoc, relating to new builds. The ICS is developing a strategic system approach to disposals which will result in a suitably sized, high-quality estate and maximise the level of core CDEL funding available to the system for strategic priorities. The impact of the pandemic has affected the speed and volume of disposals at NCL Providers. Elective recovery and Urgent and Emergency Care funding mean that some sites that were previously considered surplus are being reviewed before a final decision to dispose is taken.

From a Local Authority perspective, NHS divestment is also an opportunity to deliver new projects for affordable housing, with the caveat that NHS considerations, in particular the need for primary care, need to be factored in.

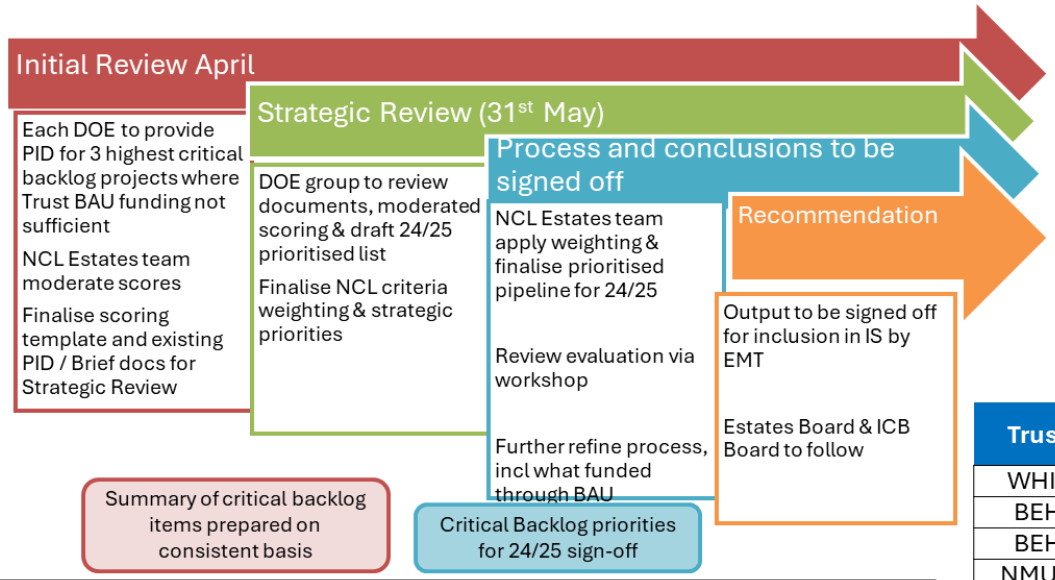
Trust	Site
C&I	St Pancras Hospital
MEH	City Road
RNOH	Western Development Zone Stanmore
CLCH	West Hendon Clinic
Other	Disposals in development

Our key Provider disposals centre on the Oriel / St Pancras redevelopment programme – the St Pancras Hospital (C&I) and City Road (MEH) sites. Housing is a key wider determinant in population health. A major disposal for residential redevelopment, the Western development zone at RNOH, has stalled due to the withdrawal of PFI funding routes. The Trust is exploring alternative options with the NHSE disposals team. Our key local care disposals include Plots A and B at Edgware Community Hospital, a NHS Property Services site. Plot A has planning permission for residential. NHSPS will re-invest a proportion of the net proceeds to improve the remaining hospital site. There are other sites that have been identified for potential disposal, but these lower value sites are under review or subject to feasibility studies.

Divestment from tail primary care estate is also a significant opportunity, particularly in areas where there is sufficient existing coverage of ‘core’ and ‘flex one’ estate.

Critical Infrastructure Risk prioritisation review

North Central London Health and Care
Integrated Care System



Summary	Allocation
Total CIR cost in year	£41.5m – 52 schemes *2 schemes excluded
Trust allocation to BAU in year	£27.3m – 37 schemes
Trust asks & not fully funded in year	£14.3m – 13 schemes
Remainder to be allocated later	£1.8m

- Estates Board led process, incl good input from trust & ICB estates & finance leads
- Evaluation process took place to prioritise bids submitted, incl wider public sector input
- SMB supported process & output
- Important to raise visibility of CIR & need to improve data quality & impact of CIR on ICB risk register
- To note, WH fire CIR not allocated, but critical, separate discussions underway

Trust	Scheme	24/25 Funding Required
WHIT	Ventilation	£1,200,000
BEH	Ligature Risk Remedial Action Programme	£2,700,000
BEH	Fire Precautions	£850,000
NMUH	Fire Safety	£1,900,000
RFH	Fire and Life Safety Systems	£1,125,000
RNOH	Diagnostic Imaging Equipment Replacement Projects (DIRP)	£1,750,000
NMUH	Modular Buildings	£1,320,000
RNOH	Theatre Compartmentation	£500,000
C&I	Health Based Place of Safety (HBPos)	£850,000
C&I	Fire Precautions	£1,100,000
NMUH	ITU & HUDU Infrastructural Compliance Works	£1,000,000
		£14,295,000*

WorkWell in North Central London

Stakeholder communications resources

1 October 2024

North Central London
Health and Care
Integrated Care System

Contents

About WorkWell

WorkWell is a new work and health service which begins in North Central London (Barnet, Camden, Enfield, Haringey, and Islington) on 1 October 2024.

As a work and health programme, it sits alongside other employment and health services within Barnet, Camden, Enfield, Haringey and Islington. The last page of this document signposts you a range of these additional services.

The WorkWell service aims to support at least 3,000 NCL residents with health conditions or disabilities to enter, remain in, or return to work. It offers personalised support from Work and Health Coaches, access to services like physiotherapy and counselling, and advice on workplace adjustments.

The voluntary programme is open to anyone, regardless of benefit status, whose ability to work is affected by health conditions or disabilities. Participants must be 16 years of age or older.

WorkWell is needed: 1 in 5 people signed off work for more than four weeks do not return to work. The programme forms part of a broader strategy to integrate health and work advice at the local level, potentially reducing economic inactivity due to periods off work due to ill health and sickness. It aligns to the Government's ambitions to support people back to work and to the findings of the **Independent Investigation of the NHS in England** (*12 September 2024, Lord Darzi, Department of Health and Social Care*). Lord Darzi's report highlighted:

- Being in work is good for wellbeing and good for the economy.
- More than half of the current NHS waiting lists for inpatient treatment are working age adults.
- There are long waiting lists for mental health and musculoskeletal services which are the biggest causes of long-term sickness.

To address the challenge, the review brings to the fore the need to better integrate health and employment support services and the importance of tailored, individual services.

The review was followed by the publication of **Our greatest asset: The final report of the IPPR Commission on Health and Prosperity** (17 September 2024, IPPR), which also argues that better health is Britain's greatest untapped resource for economic growth and national prosperity.

About the resource pack

This communications pack provides key messages and copy for stakeholders to promote WorkWell to the following audience groups:

- Individuals who are facing health-related work challenges
- Employers and managers who would like support for an employee
- Healthcare professionals who would like support for an individual
- Employment specialists who would like support for an individual

Who is this pack is for

This communications resource pack is designed for WorkWell programme stakeholders across the five boroughs in North Central London – Barnet, Camden, Enfield, Haringey, and Islington. It is specifically designed for use by:

- Public sector and healthcare organisations within the North Central London Integrated Care System
- Local authorities' job, skills, training, public health and inclusive economy teams
- Employment support organisations
- Voluntary and community sector organisations

How to use this pack

This pack is a tool to help stakeholders communicate about WorkWell effectively to their target audience(s).

The goal is to clearly communicate the benefits of WorkWell and how individuals can access support for themselves or for others. If you have any feedback, suggestions or questions about using this pack please contact Losarina.Kelly@nhs.net. Additional resources for your promotional activities will be made available in the coming weeks.

Here's how to use this pack

1. ***Understand the programme***: please start by familiarising yourself with the key messages. This will ensure you have a solid understanding of WorkWell and its benefits.

2. ***Identify your target audience:*** please determine which of the four main audience groups you're addressing: individuals needing support, employers, healthcare professionals, or employment specialists.

3. ***Use audience-specific content:*** utilise and tailor the audience-specific sections to target your messaging appropriately. Each section contains key messages, website copy, and newsletter copy tailored for that particular group.

4. ***Adapt for your channels:*** the pack includes suggested copy for websites and newsletters. Please adapt this content for your preferred communication channels, such as social media, email campaigns, or presentations.

5. ***Customise the content:*** while the provided content is ready to use, feel free to adjust it to better fit your organisation's tone and style. You can also add local context or specific examples relevant to your audience.

6. ***Use as a reference:*** when creating your own promotional materials or responding to enquiries about WorkWell, use this pack as a reference to ensure consistency in messaging.

7. ***Incorporate into existing materials:*** if you have ongoing health and employment initiatives, consider how you can incorporate WorkWell information into these existing materials to reach your target audiences.

8. ***Stay updated:*** WorkWell may evolve over time. From time to time we will update this pack as needed to ensure you have access to the most current information.

Key messages for all audiences

- 1 in 5 people who are signed off work for more than 4 weeks do not return to work; and there are nearly three million people off work due to health challenges.
- WorkWell is a new service designed to offer personalised support to people with health conditions or disabilities who are:
    - Looking to start a new job
    - Needing support to stay in their current role
    - Planning to return to work after an absence
- The service is available to residents in Barnet, Camden, Enfield, Haringey, and Islington.
- Participation is voluntary and independent of benefit status. Participants must be 16 years of age or older.
- WorkWell provides tailored support: one-on-one sessions with dedicated Work and Health Coaches, alongside additional services such as physiotherapy, counselling, and other specialist support.
- Nationally, WorkWell is part of a broader strategy to integrate health and work support at the local level.

- WorkWell is part of a national pilot scheme: it is a partnership between North Central London Integrated Care Board, local authorities, intermediaries and voluntary sector organisations across Barnet, Camden, Enfield, Haringey and Islington, and is sponsored jointly by Department for Work and Pensions and Department of Health and Social Care.

Audience-specific messages and copy

Individuals needing support

Key messages

- If you have health challenges or a disability and would like to work, WorkWell can help you start a new job, stay in your current role, or return to work.
- The service is tailored to your individual needs and health conditions.
- Participation is voluntary and will not affect your benefits status.
- Participants must be 16 years of age or older.

Website copy

HEADLINE: Discover your path to health and work success with WorkWell

COPY:

Are you living in Barnet, Camden, Enfield, Haringey or Islington [***delete borough as appropriate***] and facing health challenges that impact your work life? WorkWell is here to support you.

WorkWell offers:

- Tailored, one-on-one support from a dedicated Work and Health Coach and access to specialist services like physiotherapy and counselling

- Advice on workplace adjustments to enhance your job performance

Whether you're looking to start a new job, need support in your current role, or are planning to return to work after an absence, WorkWell can help. The service is completely voluntary and is designed to fit your individual needs. Participation is voluntary and independent of benefit status. Participants must be 16 years of age or older.

Take the first step towards a better work life. Register for WorkWell today: https://nclhealthandcare.org.uk/workwell and you will receive a call within two working days to get you started on your journey.

Newsletter copy

Facing work challenges due to health concerns? WorkWell, a new service for residents in Barnet, Camden, Enfield, Haringey or Islington [***delete borough as appropriate***]. It offers personalised support to help you with health challenges so that you can thrive in the workplace. From tailored, one-on-one coaching to specialist services, WorkWell is here to guide you towards work success. Learn more and express an interest in joining WorkWell via https://nclhealthandcare.org.uk/workwell

Employers supporting employees

Key messages

- 1 in 5 people who are signed off work for more than four weeks do not return to work.
- Help your organisation / business and employees by connecting staff who need additional support due to health conditions or disabilities to WorkWell
- WorkWell supports people to stay in work or return to work after an absence.

- WorkWell can help you and your managers to support employees with health conditions or disabilities by advising on reasonable adjustments and workplace solutions.
- For employees, WorkWell provides tailored, one-on-one support with dedicated Work and Health Coaches, and access to services such as physiotherapy, counselling, and other specialist offers.
- Supporting employees through WorkWell can improve retention and productivity.
- Participation is voluntary and will not affect benefits status.
- Participants must be 16 years of age or older.

Website copy

HEADLINE: Help your workforce thrive in the workplace with WorkWell

COPY:

As an employer in Barnet, Camden, Enfield, Haringey or Islington [***delete borough as appropriate***], you can play a crucial role in supporting employees with health conditions or disabilities. WorkWell is here to help you create a more inclusive and productive workplace.

How WorkWell benefits employers:

- Tailored support plans and expert advice about reasonable adjustments for employees
- Support for employees to stay in work or return to work after an absence
- Improved employee retention and productivity

By supporting an employee through the WorkWell programme, you demonstrate your commitment to employee wellbeing and create a more resilient workforce.

See how WorkWell can benefit individuals in your team:
https://nclhealthandcare.org.uk/workwell

Newsletter copy

Discover how WorkWell can help you support employees with health conditions or disabilities. From return-to-work strategies to workplace adjustments, WorkWell offers expert guidance to create a healthier, more productive work environment. Find out more at https://nclhealthandcare.org.uk/workwell

Healthcare professionals supporting others

Key messages

- 1 in 5 people who are signed off work for more than four weeks do not return to work and more than half of the current NHS waiting lists for inpatient treatment are working age adults.
- The WorkWell programme complements your care by addressing an individual's health-related work challenges.
- With consent, you can express interest in the service on behalf of an individual who might benefit from work-related health support.
- The longer-term ambition is to integrate a referral pathway within EMIS, with a number of PCNs trialling the approach in the coming weeks: any PCNs which would like to take part in the EMIS trial can contact losarina.kelly@nhs.net.
- The voluntary programme is open to anyone, regardless of benefit status.
- Participants must be 16 years of age or older.
- It forms part of a broader strategy to integrate health and work advice at the local level, potentially reducing economic inactivity due to sickness.

Website copy

HEADLINE: Healthcare professionals are invited to connect people into new health and work service, WorkWell

COPY:

As a healthcare professional in North Central London (Barnet, Camden, Enfield, Haringey or Islington), you understand the impact of work on a person's health and wellbeing. WorkWell is your partner in addressing the work-related aspects of people's health, and the impact of health challenges on people's ability to work.

How WorkWell supports healthcare professionals:

- Complements your care by addressing work-related health challenges
- Provides specialist support, including physiotherapy and counselling
- Offers a simple way to connect eligible people to the service

Good employment supports people's overall health and wellbeing. By connecting eligible people to WorkWell, you're providing them with an additional resource to improve their overall health, quality of life and pathway to good employment.

Participation is voluntary and will not affect benefits status. Participants must be 16 years of age or older.

Find out more and connect individuals to WorkWell here: https://nclhealthandcare.org.uk/workwell

Newsletter copy

A new work and health service began in North Central London on 1 October 2024. It aims to support individuals with health conditions or disabilities to enter, remain in, or return to work.

GPs, social prescribers and other healthcare professionals can express interest on behalf of individuals who could benefit from support via: https://nclhealthandcare.org.uk/workwell.

The longer-term ambition is to integrate a referral pathway within EMIS, with a number of PCNs trialling the approach in the coming weeks: any PCNs which would like to take part in the EMIS trial can contact losarina.kelly@nhs.net.

This new service addresses work-related health challenges for North Central London residents, complementing your care with specialist support and resources. Discover how WorkWell can benefit people you support: https://nclhealthandcare.org.uk/workwell

Participation is voluntary and will not affect benefits status. Participants must be 16 years of age or older.

Employment specialists

Key messages

- 1 in 5 people who are signed off work for more than four weeks do not return to work and more than half of the current NHS waiting lists for inpatient treatment are working age adults.
- WorkWell provides additional resources for your clients facing health-related work challenges.
- The service offers specialised support that complements your offer and expertise.
- Collaboration with WorkWell can lead to better outcomes for your clients, by connecting people who need additional support due to health conditions or disabilities to WorkWell.
- Participation is voluntary and will not affect benefits status.
- Participants must be 16 years of age or older.

Website copy

HEADLINE: Expand your toolkit with WorkWell – support for workers and job seekers with heath conditions and disabilities

COPY:

As an employment specialist in North Central London (***delete as appropriate: Barnet, Camden, Enfield, Haringey or Islington***), you're dedicated to helping clients succeed in the workplace. WorkWell is here as a complement to your services, particularly for clients facing health-related work challenges.

How WorkWell supports employment specialists:

- Provides additional resources for clients with health conditions or disabilities
- Offers specialised health and work support to complement your services
- Collaborates with you to achieve better outcomes for shared clients
- Simplifies the process of connecting clients with health-related work support

By connecting clients to WorkWell you can offer your clients a more comprehensive range of support, increasing their chances of work success. Participation is voluntary and will not affect benefits status. Participants must be 16 years of age or older.

You can connect your clients to WorkWell via https://nclhealthandcare.org.uk/workwell

Newsletter copy

A new service has started in North Central London (***delete as appropriate: Barnet, Camden, Enfield, Haringey or Islington***) to enhance your support for clients with health-related work challenges. WorkWell offers specialised resources and collaboration opportunities to help your clients in North Central London achieve better work outcomes. Learn more about WorkWell at https://nclhealthandcare.org.uk/workwell

Accessing WorkWell

For all audiences, include the following information on how to express an interest in joining WorkWell, for themselves or for someone else people:

- Visit https://nclhealthandcare.org.uk/workwell
- Follow the link and fill out the simple expression of interest form
- A team member will contact the individual within two working days
- Alternatively call the WorkWell team on 0808 196 2386
- For some residents in Barnet, their postcode may be on the border of our service, which means they may not be eligible to take part in the North Central London programme. If so, they can express and interest in the WorkWell in North West London.
- Participation is voluntary and will not affect benefits status. Participants must be 16 years of age or older.

Remember: If you complete the Expression of Interest Form on behalf of an individual, it is important that you have the person's full consent. Please also check data sharing policies and agreements in your own organisation before sharing any personal information on behalf of the person you are supporting.

Additional support

Consider including links to local employment, skills and training programmes:

- Barnet: Jobs, training and skills | Barnet Council; Boost Barnet; Vocational Rehabilitation Service for Long COVID and neurological conditions.
- Camden: Good Work Camden
- Enfield: Employment and skills | Enfield Council
- Haringey: Health related employment support | Haringey Council
- Islington: Islington Working Portal

For Barnet, Enfield, and Haringey residents, you can also mention the availability of Thrive into Work, an Individual Placement and Support programme for individuals who have been out of work for some time due to health conditions or disabilities.

Thank you for using this pack of resources. If you have any feedback, suggestions or questions about using this pack please contact Losarina.Kelly@nhs.net. Additional resources for your promotional activities will be made available in the coming weeks.

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NHS
North Central London
Integrated Care Board

Working with our People and Communities Strategy 2022/23 to 2025/26

September 2022

Contents:

1. Context

The purpose of this strategy is to outline North Central London Integrated Care Board's (NCL ICB) commitments, approach, and principles to community engagement and empowerment. Transitioning to an Integrated Care System (ICS) and ICB has provided us with a unique opportunity to fundamentally change the way we work as a system and improve the quality of life and health of all in our diverse communities.

We have the opportunity to address health inequalities, acknowledge and support community-based development, collaborate with communities to build social capital and assets, and encourage people and communities to come forward to 'have their say' on the development of the highest quality care services and issues which are important for them.

As a system we recognise and value the benefits of this community-focused approach, in particular through our work at Place; our Working with People and Communities Strategy harnesses the thinking and best practice already being shaped by our Borough Partnerships, as well as at a pan-borough level.

This strategy has been developed in collaboration with our partners, including Healthwatches, Voluntary, Community and Social Enterprise (VCSE) sector and with people and communities across north central London (NCL). This collaborative approach is central to our future ICS commitment to placing people and communities at the heart of what we do.

2. Introduction

We are committed to investing in community engagement and empowerment approaches to ensure our plans and local services reflect the needs and priorities of our population, to tackle the inequalities still experienced by some communities and to ensure we are listening and acting upon the wide-range of community and patient feedback we receive by commissioning and providing high-quality services for all in our NCL population. These strategies support the delivery of the NCL ICS Population Health Improvement Strategy.

Working with communities to co-design solutions that prolong good health, prevent avoidable ill health and address health inequalities will help our services to meet local demand and build assets within our local communities. To be an effective health and social care system it is essential that we adopt this approach - understanding that partnership working with our local communities and VCSE now will ensure a financially stable and resilient system for the future.

The strategy is intended to provide a strategic framework to shape and inform how the ICB approaches, plans, resources and evaluates community engagement and community empowerment programmes. It is designed to serve as an overarching framework to ensure that high-quality community empowerment work is embedded across the ICS at a multi-geographical footprint: at NCL, borough and neighbourhood level. The strategy will support the ICB to focus the right resource in the right places to achieve our aims and uphold the principles set out below. We cannot do this without our VCSE partners. They are crucial partners in championing, engaging with and ultimately delivering this approach. As such, we have also developed a Working with VCSE Strategy, which gives more detail around our commitments to building a strong and thriving VCSE across NCL.

We have included best practice examples throughout this document to demonstrate how we are already addressing and delivering the principles and ways of working laid out in this strategy.

3. Working as an Integrated Care System

The statutory duties of North Central London Clinical Commissioning Group (NCL CCG) relating to public involvement transitioned to the NCL ICB on 1 July 2022 and this document lays out how we will meet those duties. We want to build on the strong foundations laid by NCL CCG, our local councils, NHS trusts and Primary Care Networks (PCNs), to both expand and improve our approach to community engagement. We will do this through a variety of mechanisms designed to facilitate strong community engagement and empowerment and support the development of VCSE as a key strategic partner of the NCL ICS.

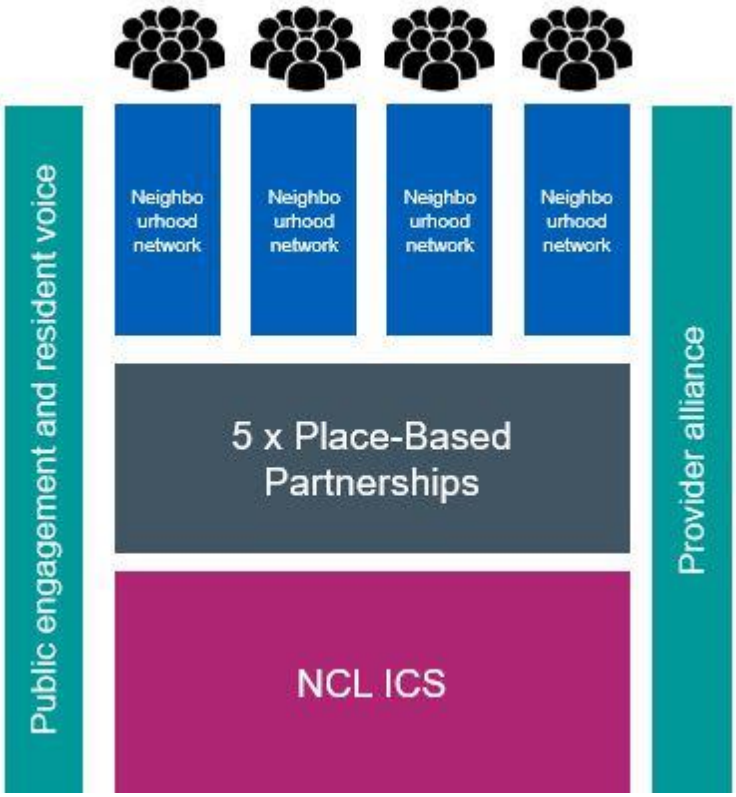
NCL ICB, as a partner within the NCL ICS, is committed to supporting delivery of the ICS's aim to help residents to 'start, live and age well'. This holistic perspective on communities' lives recognises that a range of wider determinants have a significant impact on individuals' health, wellbeing and life chances, and emphasises the importance of taking a strength-based approach to motivate and support people to make changes themselves, e.g. enabling self-care or being more physically active.

We know we could do more to encourage some people, often from under-served communities or groups, to access services earlier and before a crisis such as a hospital attendance or admission. The reasons for this are wide-ranging and complex, but we know we need to improve equity of

access, outcomes and experience. Through listening to and working with local communities, plus partnering on programmes with our VCSE, we can take a more holistic view of communities' needs and skills and crucially, start to address these needs. This is vital to building sustainable and thriving communities. What we describe in this strategy not only supports the development of social value within our local communities, but also has a positive financial impact on the whole system, thereby ensuring that we adopt an approach that will see long-term return on investments.

An important focus will be how we work with people and communities through the Borough Partnerships in our five boroughs; Barnet, Camden, Enfield, Haringey and Islington. These Borough Partnerships - which includes our Trusts and PCNs, Councils and VCSE - proactively promote community engagement and empowerment approaches so that we can ensure we are delivering high-quality services which meet care needs and building social capital through a range of mechanisms, such as ensuring individuals' voices are heard and listened to, and the co-design and production of services and solutions.

All partners across the ICS have responsibilities to engage and work with their residents and patients. We will be working in partnership to ensure we make the best use of our resources and that we align how we engage and work with our local communities.



4. Vision and Principles

Vision

We will support people to live healthier and more independent lives in thriving local communities by working in partnership with local people and communities to design solutions and services around their priorities, needs, experiences and strengths.

Principles of working with people and communities

- We communicate with our local communities through clear, accessible and culturally competent, public-facing information on our vision, priorities, plans and progress, to build understanding and trust.
- We proactively seek to understand communities' and people's priorities, experiences and aspirations for health and care.
- We put people and communities at the centre of our planning, decisions, and the design and delivery of services and wellbeing projects.
- We proactively seek to hear from the diverse communities in NCL and build relationships with those who are socially excluded, vulnerable or who experience the greatest barriers to accessing services and the highest health inequalities.
- We use community development approaches that empower people and communities, building on community assets and strengths to improve health and wellbeing and reduce inequalities.
- People are supported to look after their own health, including through enabling access to wellbeing and self-care opportunities across NCL.

5. Approach: How are we going to do this?

We will use a range of mechanisms for engaging and empowering the diverse people and communities that live in NCL. We commit to using the best method(s) and activities to reach and work with our local communities, elevating their voices and harnessing their unique skills and experiences to develop and design local services and solutions, and to support people to successfully look after their own health and wellbeing. We will do this throughout the ICS – working across NCL on system barriers and solutions, working at Borough and working at Neighbourhood in collaboration with our Primary Care Networks (PCNs).

As NCL ICB, and through the ICS, we will:

5.1 Inform and communicate

We commit to regularly informing people about what we are working on and how we are working together across the ICS.

We pledge that local communities and people will know how they can be involved and the range of ways they can help to shape the way we are working at Neighbourhood, Borough and NCL level. Most importantly, we will ensure this information is available through a variety of media, including but not limited to, websites, newsletters, webinars, face-to-face meetings and sessions, social media, and through our staff and partners.

We will ensure the information available is culturally sensitive and accessible – and that it is developed in formats that meet the communication needs of our local communities.

We also commit to using clear and jargon-free language to describe what we mean.

We will work with local people and communities to understand their views and feedback on the ways in which these views have shaped services. We will consistently work to raise the voice of local communities in all that we do and improve our communications and engagement to better accommodate their needs.

5.2 Raise the voices of our local communities

We will ensure that local people can engage with us in a way that suits them, by taking a multi-faceted approach, and ensuring that our engagement is inclusive by proactively reaching out to those who have the greatest barriers to accessing services and having their voice heard. We will do this through:

5.2.1 Engagement

We commit to seeking and hearing the voices and experiences of local communities, thereby developing rich insight into our local communities' lives, their concerns, needs, understanding and skills. Engagement will be undertaken in a variety of ways, including public events, focus groups, surveys, and more contemporary and creative social, digital and mixed media approaches.
We will ensure community insight and research informs and shapes our commissioning, transformation, and integration plans, improving the quality of local health and care services and our communities' experiences within them.

We will ensure we build on COVID-19 pandemic learnings and embed what has worked well in terms of online engagement, but also ensure that digital inclusion issues are given significant weight when planning engagement work.

Best practice example: Enfield Patient Participation Group Networks
Patient Participation Groups (PPGs) work in partnership with GP practices to improve services for patients in primary and community care: every member practice in Enfield has an active Patient Participation Group, with a quarterly network meeting for all PPGs in Enfield chaired by an elected patient. The network was started in 2014 to enable the election of a PPG member onto key decision-making boards. The elected PPG Chair continues to be an active participant of the Enfield Borough Partnership, and sits on a number of committees and meetings to represent the patient voice.

Enfield has recently received additional funding, through an NCL Health Inequalities Fund, for a PPG development programme in 2022/23. Chair of Arnos Grove Medical Practice and the elected PPG network chair is leading on this project with the Enfield engagement lead.

The programme is supporting PPGs to understand their development needs and offering support to meet these and to improve diversity of the membership of PPGs, particularly in the most deprived wards and to help the PPGs reach out to registered patients, either in their own practices or across the neighbourhood Primary Care Networks.

Alongside this, we are improving the way PPGs communicate with each other and work across the borough – strengthening the patient voice within primary care and within Primary Care Networks – by strengthening this network approach. The PPGs work together as a network on certain

engagement topics with patients. This year the focus will be on understanding patients' experiences of access to NHS services.

5.2.2 Co-production

Communities are fundamental to building social capital and community assets, and should be integral to designing and delivering collaborative solutions and services, with the statutory sector.

Co-production is a way of working with people and communities in equal partnership to design services. We will work with people at the earliest stages of service design, development and evaluation, acknowledging that people with lived experience and their carers are expertly placed to advise on what support and services will make a positive difference to their lives.

We will champion this way of working across the ICS.

5.2.3 Consultation

Consultation is a formal and statutory process we must undertake if we propose a significant change to, or decommission, a service.

We commit to speaking with and listening to local communities at the very start of the process; this includes those who most use the services, face significant barriers to accessing services or face the highest health inequalities, alongside those people who may benefit from a service but who are not doing so through choice. We will also make sure that we are engaging with the diversity of voices and communities reflective of NCL and commit to ensuring that we engage across the breadth of the nine protected characteristic and social inclusion groups.

We explore their needs, concerns and hopes for services and this becomes a crucial part of evidence, shaping any proposed service changes. Additionally, we use the intelligence we already have from community engagement, so that we make the most of people's time and respect their valuable contributions.

As a final step in the consultation process, we are committed to sharing proposed plans for service change with local people, evaluating their insight on the details of the proposed service change and demonstrating how their feedback (alongside other evidence base and needs) has shaped the proposals.

5.2.4 Deliberative and participative models

We will utilise deliberative and participative models, such as Citizen Assemblies, as part of our wider engagement approach. We will include this approach as part of large-scale service transformation programmes. As these models are considered, developed and adopted we will ensure they are informed by culturally competent methodologies and so do not replicate current gaps in engagement with diverse and under-served communities.

Best practice example: NCL Residents' Health Panel

In 2019, we launched an online citizens' panel, known as the NCL Resident's Health Panel, recruiting approximately 900 members who are broadly representative of our local communities. The NCL Residents' Health Panel is one route through which the ICB is able to engage with a diverse range of people and to hear from people that are seldom heard. It is one of the tools we use to seek representative, robust views and reliable evidence to support decision-making on service change/design, including formal consultation.

Enhancing our Residents' Health Panel is integral to our Working with People and Communities Strategy. As part of our work plan for 2022/23 we will further develop our panel to ensure better use and involvement in a wider range of activities at both local and system level, including:

- *Undertaking a review of how our panel has been used to date, levels of participation from members, where engagement activities have worked well and identifying gaps where benefits have not been realised.*
- *Developing and implementing a formal system to gather feedback about how panel insights have been used in commissioning decisions to improve outcomes.*
- *Developing a coordinated programme of work in line with partners (NHS trusts and primary care, our five councils, VCSE and Healthwatch) and collating a forward view of projects and programmes of work.*
- *Looking at cross-cutting themes such as digital inclusion and health inequalities, to align with our system priorities.*

5.3 Support our communities to live well: empower people and communities

We are committed to working with local people and communities to understand what matters to them for their health and wider quality of life. In partnership, we want to develop sustainable and innovative solutions that bring support and services into communities, rather than expecting our diverse communities to come to us.
The COVID-19 pandemic exacerbated and shone a light on long-standing inequalities and deprivation within communities. Alongside this, there has been much wider recognition of the latent power and untapped assets that exist in these communities.

The impact of the pandemic has changed the way we work across all sectors in NCL, including how we work with each other and the local communities we serve. Together with our new ICS responsibilities, this will mean a fundamental shift in our engagement approach, the way we deliver services and the way we share voice and power with our local communities.

We are at the start of this journey, but our ambition is to build the foundations for this approach, working across our ICS to identify opportunities to strengthen local decision making. By focusing on supporting communities to live well and addressing health inequalities, we commit to empowering our local communities.

Best practice example: Community Research & Action Programme
It is widely recognised that certain communities face specific barriers to accessing statutory health and care services, which plays a significant factor in widening health inequalities and contributes to poorer health outcomes. The Community Research & Action Programme raises the voices of local communities and invests in grass-roots VCSE and communities, to deliver a community-asset-building and engagement programme to tackle health inequalities. The programme supports local communities to access the health and wellbeing support they need through key signposting, and co-designed community interventions. Through it, we gather vital insight into our communities' lives, and their lived experiences of accessing health and care services and wellbeing support, to underpin ICB and ICS, and Borough Partnership priorities and decisions. It creates a systematic approach to working with our local communities and to collating and evaluating their experiences.

The approach originated in Islington in 2014 and is now being developed locally across all five boroughs in NCL. It includes a collaborative of VCSE organisations, with a lead facilitating organisation and a range of grass roots VCSE (who receive funding through the programme.)

Outcomes of the programme include:

1. *Research and evaluation of the lived experience of our local communities: their needs, skills and assets to inform, shape and design ICB and ICS work programmes.*
2. *Upskilling VCSE through both peer training and additional training (via workshops) on the local NCL health and social care system.*
3. *Navigation: supporting local communities to access statutory services and a range of health and wellbeing borough-based support and information.*
4. *Community capacity building / co-designing community interventions: offering hands-on interventions so that local communities can access the support they have identified they need. The impact of these interventions is measured via a wellbeing intervention measure, which measures how a person's confidence has increased. Outputs: better access to services and improved health and wellbeing amongst our most disadvantaged communities.*

5.3.1 Community empowerment approaches

If we are really to tackle the issues which matter to local people and communities – particularly those who face the highest health inequalities and live in areas of greatest deprivation – we must begin to shift our focus to working with our communities to address their needs and priorities, and most importantly, to recognising the skills and strengths they bring.

If we can recognise local people as active participants in their own wellbeing and that of their communities, rather than recipients of a service, we have a far greater chance of tackling health inequalities in a way that is meaningful for our communities. This approach gives local people choice and control over how they manage their health and demonstrates that local people have responsibility for their health and wellbeing.

In NCL, our response to the pandemic highlighted that where we had already developed and resourced programmes which worked with and empowered local communities through the improvement of access to statutory services, connecting local people into wellbeing support and building local community resilience we were able to immediately mobilise – collectively across statutory partners, local VCSE and communities – to address the immediate crisis needs of the pandemic such as supporting most vulnerable in our communities through delivery of medicines & food and empowering local communities with clear health messaging, training to accessing online services & developing meaningful online social connections.

We commit to building on this approach and the areas of best practice across NCL so that we can collaborate with our local communities in the design and delivery of hyper-local wellbeing initiatives and strong public services. It is an approach which starts with people's strengths rather than their deficits, and builds on community resilience, research and insight, lived-experience and the assets that exist in the community.

Best Practice Example: Healthy Neighbourhoods

Healthy Neighbourhoods is a collaboration between the statutory sector – primary care, NHS and council – and voluntary sector engaging and working with local people aimed at promoting individuals' health, wellbeing and life chances in a way that makes sense to them because the approach and solutions are designed with communities and their representative groups. The model

is initially being rolled out in east Haringey (around the 20% most deprived neighbourhoods, often the most diverse) as part of the NCL Health Inequalities Fund programme.

The objectives of Healthy Neighbourhoods is to collaborate to:

- *Build capacity and infrastructure for ongoing community engagement to understand health-related issues in communities, to co-develop solutions, and to build capacity within the community to deliver care and support. This engagement not only develops the solutions associated with Healthy Neighbourhoods, but also encourages individuals to 'have their say' on a range of other health- and care-related topics, e.g. on primary care, their local hospital etc.*
- *Deliver a set of co-designed and targeted initiatives to address the identified health-related priorities in these communities developed between grassroots community, VCSE and statutory sectors locally.*

We are currently in the mobilisation phase of the model, and are working collaboratively with VCSE, local people and communities to blueprint our approach. For example, VCSE local representatives helped design how we might approach support for people with low mental wellbeing: rather than label the solutions as 'mental health solutions' we have invested in activities based around interests, hobbies and leisure people may enjoy. We build relationships with local people and through these can also discuss their low mood. Often relationships are built with someone from a similar background. This approach represents practical help to address their wellbeing, e.g. the link between physical activation and improved mental wellbeing or connecting to others, as well as a way of building trust to discuss mental health issues and thus reduce perceived stigma.

6. Accountability and transparency

Integrated Care Board

As an ICB, we commit to meeting our statutory duties and the requirements set out by NHS England in the *ICS Working with People and Communities Guidance.* Our community engagement and empowerment work will be reported to, and assured through, the ICB Board. The overarching areas we will report on, for assurance, include:

- Activity, outputs, outcomes and spend on ICB community engagement, research and community empowerment programmes.
- How the outputs and outcomes of this work have influenced decision making, service design and development, assuring quality of services, resource allocation and transferring resource to maximise the value of engagement.
- Priorities or needs identified as part of community research that were not identified by statutory services, and the community action taken in response to this; and

All ICB committees will ensure that proposals and decisions are rooted in local communities' needs and aspirations and that they follow best equalities practice as per our *Equality & Diversity Strategy.* Papers brought to committees will be required to demonstrate robust evidence of community engagement and empowerment approaches.

Integrated Care System

A range of ICS forums have been developed, through which we can report and be held accountable on meeting statutory duties around community engagement and empowerment. Key forums include:

- NCL Community Partnership Forum: meeting since September 2021, with membership including the ICS Chair, ICB Chief Executive, VCSE partners and NCL VCSE Alliance members, Healthwatches, public members, people with lived experience and partners from across the ICS. This forum will be key to ensuring effective community and citizen participation in the work of the wider ICS. The aim is for it to be an active expert reference group on community engagement, as well as a forum for discussion and debate on emerging proposals and strategies. Members of this forum will also have the opportunity to be involved in other key strategic groups across the ICB – as community participants. Members of the forum have been involved in the development of this strategy.

- The five NCL Healthwatches will play a key role in working with us as an ICB - providing rigorous assessment to the way community voice shapes our approach and services. We are providing additional resource to support the five HealthWatches to work with us strategically across NCL and ensure their local community knowledge and insights can inform our work as an ICB and ICS.

- NCL VCSE Alliance: we have developed and are continuing to build on a VCSE Alliance model for NCL Integrated Care System. As a first step, the five VCSE umbrella organisations across NCL came together, and in early 2022 the Alliance broadened to include a representative organisation from each borough for mental health, homelessness, disability, deprivation, refugee and migrant and LGBTQ plus communities. We are working with the Alliance to ensure they can raise the voice of the VCSE within NCL ICS, support us to identify key system priorities and the barriers and blocks for the VCSE to work with ICB and ICS - informing our system development. They act as a facilitator between Borough Partnerships VCSE and NCL ICB and NCL ICS – with strong engagement and roots at Borough and Neighbourhood. The Alliance has endorsed this strategy. For more detailed information on how VCSE will be involved in our governance please see NCL ICB *Working with our VCSE Strategy*.

- NCL ICS Population Health Improvement and Health Inequalities Forum: plays a pivotal role in helping understand the needs of our population, setting priorities aligned to these needs and exploring how we can respond using evidence-based insight and intelligence to help improve population health. We will use this Committee to raise the voice of, and explore issues that, specifically affect communities who face high health inequalities. This will include communities' and VCSE ideas around what we prioritise and how issues might be addressed. This reflects our commitment that community voice is heard within the decision-making forums of the ICB.

- NCL ICB engagement steering group: we are forming a new steering group which will have assurance and oversight for delivering the commitments made in this strategy and our Working with our VCSE Strategy. This will include overseeing the strategies' delivery plans and all ICB community engagement & empowerment work. Through this the group will assure that ICB has a clear investment plan for engagement, makes best use of resources, invests strategically in the VCSE & community engagement programmes, develops

community programmes that have clear measurable outcomes and to assure that our community engagement drives forward improvements in population health for our local communities and raises the voices of local communities in the design, planning & delivery of health & care system. Membership will include representatives from across Engagement, population health, Communities and wider commissioning directorates including borough partnerships, NCL HW role and VCSE Alliance.

- Developing a communications and engagement network for the North Central London ICS: we are developing a network approach to communications and engagement across the ICS, which will include clear principles, approaches and processes to underpin collaborative working across partner organisations. Through an in-depth review with partners, we will define how NCL ICS communications and engagement priorities will be set, how activity will be collaboratively planned, delivered and reported, and also, collectively resourced by ICS partner organisations.

Borough Partnerships

All five Borough Partnerships have a board that oversees, amongst other areas, working with communities and VCSE. All boards have VCSE and Healthwatch representation and are exploring local community input either via a community panel or community participants.

7. Resourcing and funding

We are committed to sufficient ICB staff resource and funding to deliver the aims and approaches set out in this strategy. We will continue to invest in delivering community engagement and community empowerment programmes as an ICB, as an integral part of our commitment to improving population health and addressing health inequalities.

We commit to ICB commissioning teams budgeting for sufficient engagement and co-design activity related to their programmes. We will also develop and deliver these activities with partners in the ICS, in order that we make the maximum use of our collective resource as an ICS.

The ICB Communications and Engagement team and ICB Communities team will support the organisation to forward plan, deliver and report on best practice engagement and community empowerment methodologies and programmes that tackle health inequalities and make sure local communities are at the heart of all we do. We will work in partnership with colleagues across the various organisations which make up the Integrated Care System.

We envisage local VCSE involvement in a range of community engagement and empowerment work. When we ask these sectors to support community engagement activity, resource proportionate to the level of activity will be made available for this. More detailed information is available on our commitment into investment in VCSE, and the NCL VCSE Alliance, in the NCL ICB *Working with VCSE* strategy.

8. Support to deliver the strategy and approach

The vision, principles and approaches set out in this strategy will be championed at every level of our system, and in all that we do. As part of this the ICB Communications and Engagement team, in collaboration with our system partners, will offer training and tools to support colleagues and partners to deliver high-quality community engagement, co-design and empowerment.

Our aim is to develop a strong level of knowledge across the system around engagement and empowerment methodologies, and how to apply these when working with local communities and VCSE in setting priorities, creating solutions and the design, delivery and development of both the organisation and services. This will be aligned with training on delivering our equality duties, such as undertaking robust equality impact assessments.

9. Evaluate

We recognise the huge breadth of insight provided by our partners, including VCSE and Heathwatches, and will further develop our processes to evaluate community all engagement and empowerment work being undertaken by ICB – both at an NCL level and Borough level. As part of this, we will develop outcome measures that reflect our engagement principles, including evaluation of the inclusivity of our work.

We will build strong and trusted relationships with our communities and measure if the way we are working is genuinely improving people's experiences of care, and supporting our communities to lead lives that they define as 'well.'

We will involve other organisations such as Healthwatch, our VCSE partners, and our local communities in developing outcomes, both in defining outcomes and in assessing our delivery of these. We will also learn from innovative best practice around community research and evaluation models.

We commit to developing:

- Processes to centrally collect and report on insights to inform ICB and ICS plans, programmes and ultimately decisions, including developing an insights bank;
- Evaluation on the impact of our community engagement and empowerment work, learning from previous programmes and projects to continuously improve the reach and impact of our work with local communities.

10. Delivering our strategy in 2022/23

This document is intended to provide a long-term strategic framework to shape and inform how the ICB approaches, plans, resources and evaluates community engagement and empowerment programmes. We will collaborate with partners to develop a more detailed 2022/23 delivery plan, to progress and embed this in the ways we work as an ICB, and across the ICS.

Our approach and way of working will be underpinned by the development of a number of programmes, frameworks and toolkits to ensure we are consistent and aligned across the system. Development of these products will be co-designed with stakeholders and our local communities across 2022/23.

Key elements of the 2022/23 delivery plan will include:

1. The development of a range of tools, guides and policies that will underpin and embed the approaches outlined in this strategy, including:
   - co-production tools,
   - community empowerment approaches training,
   - guide to service development and service change engagement;
   - guide to public consultation;
   - public reimbursement policy and
   - evaluation, impact and feedback framework.

2. The delivery of a range of programme activity, including:
   - Development of detailed Borough Partnership plans for working with people, communities, and local VCSE, aligned to this strategy.
   - Delivery of a community research and action programme, working with local VCSE in each borough, targeted to raise the voices of local communities who experience high health inequalities and/or barriers to accessing services.
   - Identification of, and support for, relevant ICB programmes and projects where engagement, co-production or consultation is required, to ensure the best practice approaches in this strategy are embedded.
   - Further development of methods to ensure ICB decision-making processes support community empowerment (i.e. how this can be part of needs assessment, priority setting and resource allocation process)
   - Developing a new ICB process to collect and report community insight: to collect quantative and qualitative intelligence from all ICB community engagement and involvement work – combined with population health data as bi-annual borough reports with a NCL summary report on key themes. This will inform the Population Health Improvement Strategy and ICB plans and decisions, ensuring community and VCSE voice is at the heart of plans and decisions; and
   - Further development of assurance methods aligned to ICB governance, including the role of the VCSE Alliance and how VCSE and local communities are a part of decision making.

3. A focus on measuring and evaluating outcomes and impact, such as:
   - Using a ‘You said, we did’ approach to demonstrate an effective feedback loop.
   - Ensuring a strong link between implementation of this strategy and delivery of the NCL Population Health Outcomes Framework and Improvement Strategy;
   - Evidencing how local decision making can be enabled as a result of community engagement initiatives; and
   - Review and Refresh our delivery plan annually.

11. Glossary of terms: What is an Integrated Care System?

North Central London Integrated Care System (ICS) is the name of the NCL system as a whole. An ICS is a way of working, not an organisation.
Partners within the NCL ICS include:
Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector

NHS North Central London Integrated Care Board (or ICB) allocates NHS budget and commissions services. This is the organisation that NCL CCG staff will transfer to, and will be chaired by Mike Cooke, with Frances O'Callaghan named Chief Executive.

The **North Central London Health and Care Partnership**, is the Integrated Care Partnership, a joint committee with the councils across the five boroughs. This committee is responsible for the planning to meet wider health, public health and social care needs and will lead the development and implementation of the integrated care strategy.

System

Provider collaboratives involve NHS trusts and primary care (including acute, specialist and mental health) working together. UCL Health Alliance incorporates all NHS trusts and primary care in NCL.

Place

Place-based partnerships or **borough partnerships** include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care.

Neighbourhoods

Primary care networks will expand to incorporate general practice, community pharmacy, dentistry and opticians.

If you would like to receive information included in this document in another format, or have any questions on this document, please contact the NCL ICB communications and engagement team via nclicb.communications@nhs.net

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NHS
North Central London
Integrated Care Board

Working with our Voluntary, Community and Social Enterprise Sector Strategy 2022/23 to 2025/26

September 2022

Contents

Foreword from the NCL VCSE Alliance

As the VCSE Alliance for North Central London, we are delighted to be asked to write the foreword to the North Central London Integrated Care Board Strategy for working with the sector. Alongside other voluntary sector colleagues from across the five boroughs, we have been heavily involved in the development of this strategy, which we welcome as a positive development for the system.

Sector colleagues will undoubtedly have contrasting experiences from the past when there were five discrete Clinical Commissioning Groups, but there is now a palpable sense of things moving in a uniformly positive direction under the new Integrated Care System. Any work that takes place in the early 2020s will inevitably be informed by the COVID-19 pandemic, and we write this conscious that joint working across the system was both challenged, shaped, and ultimately strengthened by the way all partners worked together to respond to the unprecedented circumstances of 2020 and 2021. That unique period of time fostered new and better ways of working, demonstrated the ability of the sector to pivot quickly to respond to circumstances, and helped system partners to understand the unique strengths of the voluntary sector. Therefore, it feels like an auspicious time for a strategy of this nature to be produced, and there is a real hope that it will help to preserve the flexible, trusted, and productive partnership working that emerged through COVID-19.

Inevitably, there will be challenges. A real question, which systems up and down the country are currently grappling with, is how do we create truly equal partnership when money and power are distributed unequally between system partners? There are no simple answers to this, but we would urge our statutory sector partners to be ambitious in terms of involving and working with the voluntary sector. Through COVID-19, we demonstrated our reach into communities and our ability to add value, expanding the sense of what is possible. If all of us can hold onto that experience, and be genuinely open to more equal and innovative ways of working, we will all be able to play our part in transforming the offer to the citizens of North Central London.

Caroline Collier, Chief Executive Inclusion Barnet and Chair of the NCL VCSE Alliance.

1. Context

There are many thousands of Voluntary, Community and Social Enterprise (VCSE) sector organisations in North Central London (NCL), ranging from large national charities to much smaller local organisations, and with an incredible breadth of focus.

Collectively, the sector plays a crucial role in understanding, supporting and championing the needs of our communities. VCSE partners work closely with statutory health and care organisations across NCL to help shape plans, decisions and services, as well as providing a range of innovative local services and solutions themselves.

The COVID-19 pandemic has had a significant impact on the health and wellbeing of many residents living in our boroughs, and has exacerbated health inequalities in under-served communities. It has also underlined the unique and vital role that VCSE organisations play in reaching diverse communities; providing information, support and services, particularly to those who are under-represented in accessing statutory services and who experience the greatest health inequalities. The sector has been integral to the design and delivery of the COVID-19 vaccination programme, and led local activity to build trust to support equitable access and uptake. There is significant learning we can take forward from this in terms of how the health system works with VCSE.

As we form the North Central London Integrated Care Board (NCL ICB), working as part of the NCL Integrated Care System (NCL ICS), it is vital we build on existing strong relationships with the VCSE sector and on best practice approaches to partnership working, particularly harnessing the experience of local authority colleagues.

We must also look to remove some of the barriers that currently make it difficult for VCSE organisations to collaborate with us as strategic partners. Doing so will ensure the sector's unique capabilities are an integral part of how the new health and care system operates, and will allow us to work together to tackle health inequalities in a way that is meaningful for our communities.

2. Introduction

This strategy has been co-designed with the NCL VSCE Alliance and the commitments included have received significant support from VSCE organisations across north central London. The ideas and approaches described are based on learning and best practice from across NCL ICS partners, in particular local authority colleagues. There has been involvement and input from ICB colleagues, joint commissioners in our councils, borough teams and VCSE organisations, to develop the strategy.

This strategy will support both the new NCL ICB and our system partners (including the VCSE sector) to set an ambitious vision for the future. It is intended to align with, and build on, the significant work already taking place locally, as well as learn from approaches being taken in other areas of the country.

The strategy will provide a framework for working in partnership with the VCSE on shared objectives to improve population health and tackle inequalities, by:

- Ensuring VCSE organisations can participate as a strategic partner in the ICS.
- Providing best practice principles on working with the sector and individual organisations.
- Taking a strategic approach to resourcing and investing in collaboration with VCSE.
- Ensuring that opportunities for the VCSE can be realised in a very practical way across NCL, at both a borough and neighbourhood level.
- Through delivery of this strategy, we are committed to working together as an ICS to support a strong and thriving VCSE sector whose unique skills and contribution to the health and care system are recognised, respected and resourced appropriately. We recognise that our local VCSE are the conduit to addressing health inequalities, hearing from, supporting and ultimately empowering our most deprived and vulnerable local communities.

Through effective collaboration with our VCSE, we will achieve a greater and stronger reach into local communities, which in turn will amplify the work of local community services. Through better resourced community support and intervention before local people reach the health and social care system, we can ensure a reduction in the numbers of local people falling into crisis. This collaboration supports our local communities to manage their own health and wellbeing, so that they do not have to unnecessarily access services for preventable health and social care concerns. This strategy supports the delivery of the NCL ICS Population Health Improvement Strategy.

The strategy development is the start of the journey; delivering its ambitions will take long-term commitment. As we start to implement the strategy in 2022/23, the five Borough Partnerships (Barnet, Camden, Enfield, Haringey and Islington) will be vital to ensuring that local approaches and plans are mutually supportive.

This strategy should be read alongside our ‘Working with our People and Communities’ Strategy, recognising that the ambitions set out there will only be achieved through working closely with the VCSE sector.

3. Principles

1. We ensure that the VCSE are a strong, strategic partner in the North Central London Integrated Care System, and that the voice of the VCSE is heard and has impact.
2. We take a strategic approach to VCSE investment, making the best use of funding and resources to support a well-resourced, strong and thriving sector.
3. We support the VCSE to work alongside statutory and mainstream services, to ensure diverse communities have access to care in a way that reflects their needs.
4. We invest in community-led and strengths-based projects.
5. We have effective, scalable contracting and procurement processes, which support and enable the VCSE to work with us – from larger organisations to grassroots community organisations.
6. We ensure sustainable funding for our VCSE so that we develop community programmes that support and empowers local communities and the sector.

4. Approach: our commitments to working with VCSE

The approaches and commitments set out in this section have been co-developed with our VCSE, with input from commissioning and local authority colleagues. They have been identified as key to ensuring a strong and thriving sector with the skills and capabilities to play a strategic role within the NCL ICS. They support a continued focus on building strong partnerships with VCSE and working together to deliver local services, improve diverse communities' access and experience of these, and empower our communities to improve outcomes and tackle inequalities.

The five areas described below are interdependent. We have separated them out for the purpose of this document, in order to clearly demonstrate our commitment to working with the sector and the approaches we will take for each area.

4.1 VCSE as an equal strategic partner

We are committed to the VCSE sector being an equal strategic partner in the ICS. We will ensure their voices are heard and have influence within both the ICS and Borough Partnerships, as these develop.

The thriving VCSE sector in NCL has multiple roles and is heavily localised at place and neighbourhood and targeted at specific groups and communities; this is a huge asset. We must harness this incredible network of knowledge, experience and perspectives to influence and shape NCL and borough priority setting and decision-making.

The NCL VCSE Alliance was formed in 2021/22, comprising the five VCSE umbrella organisations, plus a representative organisation from across the NCL boroughs for homelessness, disability, deprivation and refugee and migrant communities. We are committed to working with the Alliance to ensure the voice of the VCSE is heard within NCL ICS, support us to identify key system priorities and the barriers and blocks for the VCSE to work with ICB and ICS - informing our system development.

The role and place of VCSE is a key element within our governance arrangements for the ICB; this includes VCSE Alliance membership on our key ICB Committees, to ensure their ability to influence plans and priorities. We will also share cross-learning from the development of the GP and Provider Alliances.

We will continue to develop other effective two-way conversation channels, ensuring the VCSE sector is aware of ICB plans and programmes and can be involved in their development. We recognise the variety of the sector and so will continue to explore creative methods of engaging with VCSE. It is crucial we do not expect organisations to come to us but that we reach out to VCSE, ensuring that we can hear from grass roots organisations.

Ensuring the VCSE have a strong voice within the ICB and ICS development, will strengthen the voice of the diverse communities living across our boroughs. Our VCSE organisations provide crucial community insight into our local diverse populations and we want to build on these skills and relationships so that we systematically work with them to raise the voice of local people in the development of services, population health improvement and supporting local communities to live well.

We commit to working with the sector and our wider partners to:

1. Develop the NCL VCSE Alliance, as well as a strong network of VCSE forums in each borough, with two way information and engagement flow, and creative thinking around how grassroots organisations are involved in our work.
2. Ensure there is representation from the voluntary sector at the ICB and other appropriate governance arrangements, e.g. within Borough Partnership Boards.
3. Develop clear and collaborative processes to directly feed the voice and community insights of the VCSE into ICS and ICB and influence decision-making.
4. Co-develop clear outcomes and evaluation criteria for this VCSE Alliance model, which demonstrate what success looks like and can be measured against.

4.2 Working in partnership with VCSE to design and deliver innovative community-focused and strengths-based models of care

There are stark inequalities across NCL around access to and experience of care, and health outcomes, and we recognise that the current configuration of services and solutions could better meet the needs of our diverse communities. The COVID-19 pandemic has exacerbated the health inequalities faced by some of our communities, and further highlighted ways in which statutory services sometimes do not equally serve our communities, particularly those facing the highest health inequalities and deprivation.

The pandemic has also highlighted the importance of the relationships and support that exist around communities outside of traditional public sector services. The VCSE have been invaluable in supporting the most vulnerable in our communities through the pandemic, and this work continues. The sector mobilised across NCL to deliver medicines and food; when immediate needs had been met, they used this momentum to address the impact on wellbeing, offering befriending services, online coffee mornings, and WhatsApp groups. They worked to share messaging around staying safe, how to access services and supported the roll-out of the vaccine programme.

VCSE organisations across NCL are well-placed to work with our diverse communities to tackle the issues which matter at a neighbourhood level, through community-focused, strengths-based and place-based models of care. They are the experts in understanding that local people are active participants in their own wellbeing and that of their communities (rather than simply recipients of a service), and working with communities to address their needs and priorities. They have unique skills and perspective and many are part of the communities they work with.

In NCL, our VCSE sector is already integral to the design and provision of a wide range of services and solutions that support population health and wellbeing, and create community connections to statutory services. A range of VCSE-led community programmes already exist, some of which are commissioned through the ICB and local councils. These programmes include in-depth community research work to understand the impact of the pandemic, the NCL Health Inequalities Fund and Public Health investments. Many more are resourced through external funders, public fund-raising and community action.

Transitioning to an ICS and ICB presents a unique opportunity to work towards more strengths-based and community-based solutions and services, and to ensure a greater level of engagement, collaboration and mutual support between statutory and VCSE sectors in delivering these. This work will be informed by well-established approaches to working with and commissioning the sector already used by our local authorities, and also by actively seeking innovation.

Looking forward, as an ICB we will create a strategic investment approach to align the multiple opportunities available, support market development of the sector and champion innovation in how we invest and resource. This must enable working with the wide range of grass roots organisations. With the sector experiencing a high level of demand and with capacity constraints, their value and contribution must be recognised and fairly funded.

The ICB will work collaboratively with local authorities to support and champion the VCSE; developing stronger and more informed relationships with the sector.

We commit to working with the sector and our wider partners to:

1. Align community engagement and empowerment programmes for greater impact, including: NCL Health Inequalities Fund, NCL ICB Community Research & Action Programme, Community Connectors, vaccine community engagement programmes.

2. Help develop the plans of our five Borough Partnerships for community engagement and empowerment programmes, ensuring NHS approaches and investment aligns with local councils' current investment in VCSE.

3. Support the sector to collaborate with statutory and mainstream services to ensure diverse communities have access to care in a way that reflects their needs, recognising there are existing pockets of best practice to build on.

4. Develop innovative NHS investment arrangements which support a more preventative and strengths-based approach to delivering care and services, in collaboration with the statutory sector (building on existing work, such as the Health Inequalities Fund).

5. Be proactive in our collaboration with the VCSE sector, to adopt a system-thinking approach to investment in which we collaborate to develop, learn and improve solutions together, ensuring that the VCSE sector play a vital role in providing feedback on behalf of communities and groups.

4.3 Developing investment, procurement and contracting processes that support a strong and thriving VCSE

To achieve the ICS and ICB ambitions around tackling health inequalities, as a system we need to ensure resources are shared equitably and have the most impact, supporting those who are most vulnerable in our community. We also need to ensure local VCSE organisations are in a position to access the multiple opportunities that are now available within the health and social care system, encouraging community-based asset building and resourcing from external funding.

We can enable this by taking some practical steps to facilitate more effective collaboration around investing between the ICB and VCSE. These steps include ensuring that our commissioning and procurement processes do not act as a barrier to delivering innovatively with the VCSE, and that our tender processes are open and transparent, with sufficient lead-in times. We must also develop ICB colleagues' skills and expertise on working with the VCSE from engagement through to strategic investment.

We commit to working with the sector and our wider partners to:

1. Co-design a VCSE Investment Framework with the VCSE Alliance, which reflects and is aligned to Borough initiatives across NCL.

2. Collaborate across the ICB to develop a revised approach to VCSE procurement and contracting, including:
    a. Investment in more preventative and strengths-based approach.
    b. Long-term, sustainable investment for community and strengths-based projects (a minimum of three years) to ensure the work can embed in local communities.
    c. A well-thought through exit process for when funding is not to be renewed/continued. This should be in line with local councils' best practice.

3. Where appropriate, take a 'VCSE first' approach; investing in local NCL VCSE organisations, rather than external consultancy agencies. Where this is not possible, we will seek to fund in partnership with a VCSE organisation.

4. Developing ICB colleagues' skills and expertise in working with the VCSE, from engagement through to strategic investment. This will include staff training and best practice sharing (through the framework).

4.4 Support building infrastructure, resource and expertise across the sector

We commit to supporting the development of this sector; building on VCSE infrastructure and resources at Borough and Neighbourhood level and working with local authorities to ensure a joined-up approach, which aligns with the work they already do in this field.

We commit to sharing best practice through the VCSE Alliance and Borough networks/forums, and to continuing to embed the voice of the VCSE in the ICB's work programmes and governance structures.

We also commit to working alongside a range of organisations that reflects the diversity of our communities; supporting larger strategic VCSE organisations as well as community-focused and driven grass roots organisations.

As part of this work we will support the development of strong VCSE partnerships and collectives across the ICS, to amplify the voices of diverse communities and share skills and resources to the greatest effect.

Given the breadth of work the VCSE sector in NCL undertake, and the size and diversity of the sector, we appreciate the need for a nuanced approach to how we invest in solutions and services and how we understand impact. We will seek advice from the sector, to ensure we are working with the full range of organisations.

We commit to working with the sector and our wider partners to:

1. Support VCSE infrastructure development: a combination of common approaches/principles across NCL, aligned with Borough capacity building for the sector.

2. Support VCSE collaboration and partnership models in NCL to enable organisations within a borough to work together (coordinated through lead organisations, where appropriate)– making it easier to:
    a. be an active partner in Borough Partnerships and ICB programmes,
    b. collaborate on funding bids,
    c. manage contracting processes and sharing of funds across organisations,
    d. share skills and expertise across organisations,
    e. raise the voices of local communities.

3. Deliver annual events / engagement activity with VCSE partnerships to review the investment, priorities and outcomes, to ensure these remain inclusive and aligned to communities' needs.

4.5 Evaluate

We are committed to demonstrating the impact that working with our VCSE has, together with the social value they bring to the health and social care system.

We will establish a shared understanding of the needs of our communities and will continue engaging to measure if the way we are working is supporting a strong and thriving VCSE, and therefore genuinely improving people's experiences of care and supporting our communities to live good quality lives.

We will involve stakeholders such as Healthwatches and VCSE partners, and our local communities to define outcomes and assess our delivery of these. We commit to learning from innovative best practice around community research and evaluation models.

We will study current work underway nationally to develop local ways of measuring the long-term financial (positive) impact of investing in strength-based models and understand that we may need to invest more initially to see outcomes later.

We commit to working with the sector and our wider partners to:

1. Evaluate the impact of our community work, learning from previous projects to continuously improve the reach and impact of our work with local communities.

2. Work across the NCL ICS to share research skills and insights and support VCSE to gather robust data, evidence and evaluation.

3. Establish processes to centrally collect and report on insights to inform ICS and ICB plans, programmes and ultimately decisions, including the development of an Insights Bank.

4. Develop outcomes frameworks which are community-led.

5. Conclusion

Strengthening the way we work in partnership with the VCSE sector will help us achieve the aims of the NCL Population Health Improvement Strategy, to improve local communities' health and wellbeing and tackle inequalities.

This strategy has been developed with input from a wide range of stakeholders and reflects existing best practice, but also barriers identified as critical to tackle, to shape our future working with the VCSE sector. The Strategy build on the strong foundations already in place in each borough and a crucial part of delivery will be through the five Borough Partnerships, working with local VCSE and Councils. Delivering the aims of this Strategy will require resource in both funding and staff, and collaborative approaches across partner organisations.

The ambitions outlined here will require long-term commitment and we will start putting the strategy into action in 2022/23. A delivery plan for 2022/23 will be developed, involving our VCSE, ICS partners, and Borough Partnerships and ICB staff. This delivery plan will be reviewed and refreshed annually.

Work in 2022/23 will include, but is not limited to, the following:

- Developing a strategic approach to ICB investment in the VCSE sector;
- Developing a VCSE Investment Framework with the VCSE Alliance, which incorporates best practice VCSE contracting and procurement processes;
- Building on and developing Borough Partnership's community engagement and VCSE partnership plans, including effective processes to share insight and learning between borough-level VCSE forums and the NCL VCSE Alliance and developing VCSE involvement in priority setting and plans;

- Supporting the development of VCSE collaboration / partnership models in NCL to enable organisations within a borough to work together;
- Training for ICB staff on best community engagement and empowerment practices and on how to work with the VCSE.

If you would like to receive information included in this document in another format, or have any questions on this document, please contact the NCL ICB communications and engagement team via nclicb.communications@nhs.net

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University College London Hospitals and Whittington Health Collaboration

Improving the health of our local community through closer collaboration

Joint Health Overview & Scrutiny Committee Meeting

11th November 2024

NHS Whittington Health NHS Trust

NHS University College London Hospitals NHS Foundation Trust

Agenda Item 8

Contents

SECTION 1
CONTEXT AND APPROACH

Background

The collaboration between UCLH and WH was originally formalised in 2017 though a memorandum of understanding (MOU). The MOU described the complementary strengths of both organisations and the opportunity to leverage them to better deliver services and support a population approach to healthcare. Substantial partnerships have emerged between the two providers in areas including community services, paediatric dentistry, pathology, cancer, orthopaedics and general surgery. In addition there are long-standing collaborations in other areas including medical training, red cell haematology and tuberculosis screening. The pandemic provided further opportunities for the Trusts to work together and a joint chair was appointed in April 2020.

Although the collaboration has achieved significant success, there is a recognition that there is more than could be done to join up additional care pathways and work more closely to better improve health and access for the shared population.

The 2022 Health and Social Care Act formalised the requirement for an integrated approach to health and care, with provider collaboratives established to promote partnership working for the benefit of patients. The UCLH and WH collaboration is part of a broader set of partnership arrangements with the North Central London Integrated Care System (ICS) which aim to improve population health. Given UCLH and WH's close proximity, collaborating at the service level creates further opportunities to deliver services together for the local population, as well as addressing points of vulnerability and sustainability in services, and maximising combined resources to deliver more care.

A Partnership Development Committee was established in May 2023 with the primary purpose of creating a long term vision for the partnership, developing a plan to achieve this vision and overseeing the successful delivery of the priorities.

Vision, objectives & approach

A dedicated programme team was established in May 2024 and has initially focused on working closely with clinical teams to help establish a clinically compelling case for collaboration*. The team is also exploring opportunities for back-office harmonisation but this has only recently commenced and remains at an early stage.

The programme team has defined collaboration as *working together to improve clinical outcomes and ensure greater sustainability for local services.*

Vision

- To use our collective strengths to improve the health of our community and deliver excellent patient care for our combined population.

Objectives

- Enhance patient outcomes
- Improve access and experience
- Reduce duplication and unwarranted variation
- Improve staff resilience & create a flexible workforce so both organisations are better equipped to address external pressures

Approach to date :

- Prioritise work with clinical teams (ahead of back office) to ensure clinically compelling case
- Focus on bilateral opportunities but remain cognisant of NCL wide plans e.g. pathology, MSK etc
- Focus primarily on clinical vanguards & enthusiasts

*This approach echoes the North London Mental Health Partnership which changed its early focus on back-office harmonisation (which was expected to be less controversial) to working with clinical teams to ensure a more compelling and engaging case for change.

Scope

Although both Trusts have emphasised that that the focus of the collaboration will be on improving clinical outcomes and ensure greater sustainability of services, there were inevitable questions and concerns about what the collaboration would mean for local services and whether staff should worry about job security.

Both Trusts have therefore been clear about what is in and out of scope and emphasised that the collaboration is not driven by changes to organisational form and/or cost savings. A Joint Chief People Officer was appointed across the partnership in April 2024 to address the common strategic workforce challenges facing both organisations but both Trusts remain independent bodies and there are no plans to recruit further joint posts.

The collaboration is also limited to working across just Whittington Health and UCLH, in order to achieve pace. The team is therefore concentrating on bilateral opportunities across the two trusts, rather than involving other trusts within the integrated care system (ICS) such as the Royal Free London.

It is important to provide assurances that both Trusts continue to engage with ICB wide clinical strategies or projects, for example the proposed new model for MSK which is discussed later in this report.

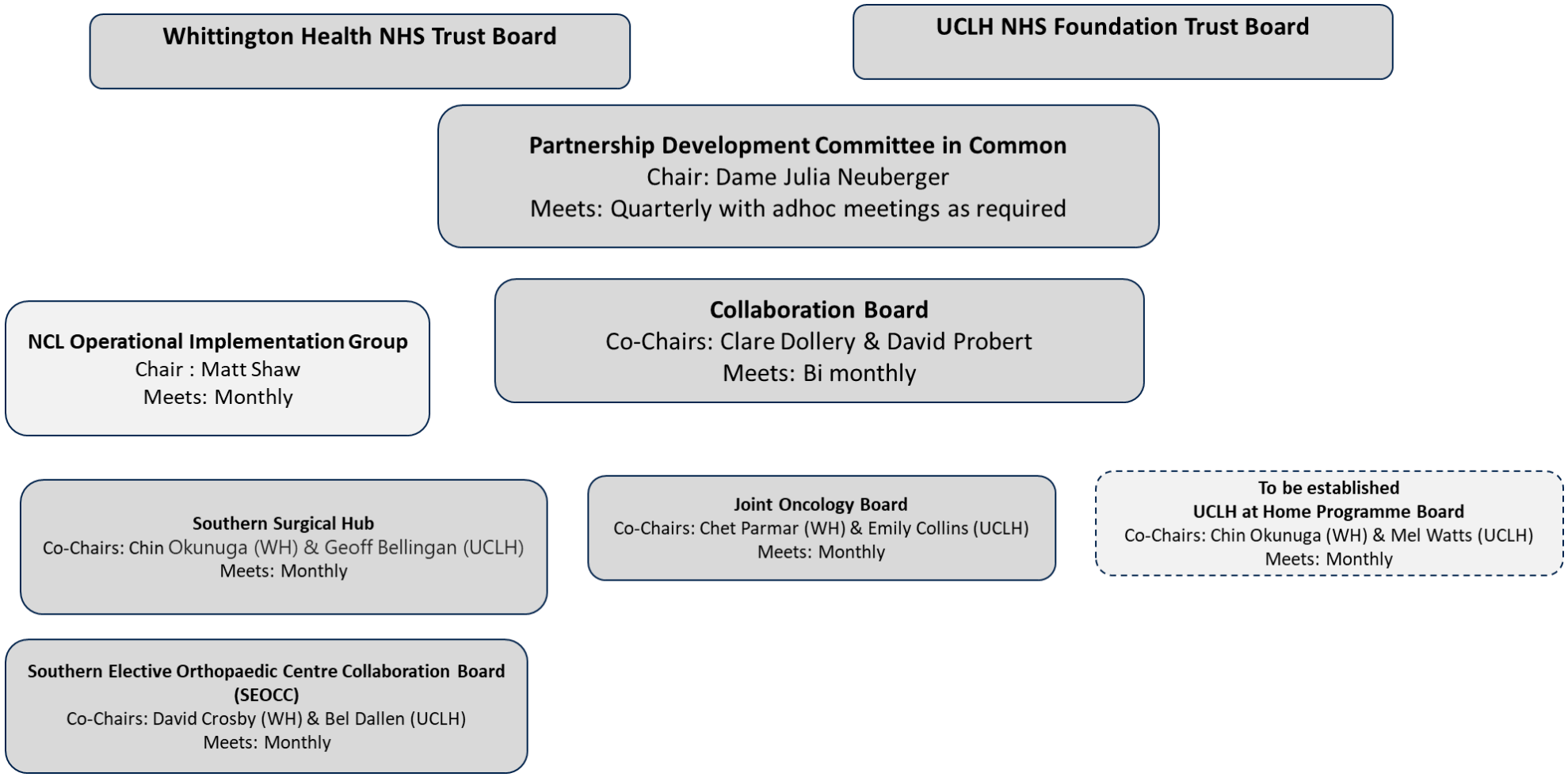
In scope

- Clinical services
- Non clinical (back office) services
- Existing NCL frameworks (eg MSK, pathology)

Out of scope

- Organisational form
- Direct engagement with other acute providers in NCL eg Royal Free London

The following governance arrangements are in place to provide scrutiny of the collaboration programme and provide assurance that plans are delivered



Stocktake of collaboration maturity

The table below summarises where individual specialties and services are across both Trusts on the pathway to mature collaboration. The left-hand column includes a number of well-established joint services that have developed organically over the last five years including, the tuberculosis MDT, joint breast MDT and the joint Eastman Dental and community dental service.

Collaborative success stories*	Areas that need attention/support	New opportunities
• Tuberculosis MDT • Joint breast MDT • WH oncology service now most improved in London (National Cancer Patient Experience Survey) as a result of UCLH support • Eastman Dental Hospital & community dentistry • Place based respiratory medicine • Consolidation of hips & knees into the Orthopaedic Southern Hub • General Surgery (inc LGI) pathway • Nuclear medicine at WH • Aligned gynaecology pathways • Joint haematology appointments • Critical Care Network	• Establish integrated surgical model with joint theatre capacity plan (through Southern Surgical Hub) • Community neurosciences (led by Queen Sq) • Virtual wards	• Community / edge of hospital support for UCLH • WH rheumatology • Joint approach to endometriosis pathway including access to UCLH robot • Access to neurophysiology • WH CAMHS support for children with mental health needs admitted to UCLH • Joint dispensary
Next steps: • *Joint comms approach underway to promote success stories and share learning* *NB: Success stories listed have often been achieved organically	*Next steps:* • *Agree access & financial model to WH theatre capacity & priority areas eg urology* • *Help promote the service to users eg community neurosciences* • *Develop roadmap for cancer vision* • *Ensure alignment with existing networks (Southern Surgical Hub, NCL long term conditions) & use as a vehicle for collaboration* • *Ensure closer alignment re: partner expectations for virtual wards*	*Next steps:* • *Early discussions about areas of mutual benefit are underway accepting that there might not always be an appetite to collaborate* • *Understanding best fit for fragile services - joint appointments, consolidation or franchise?*

Stocktake of collaboration maturity

Five priority areas have been derived from table 1 based on the following criteria:

- Support needed to support operationally challenged area or service;
- Key strategic importance to one or both partners; and
- Opportunity to deliver a quick win as a result of previous focus and attention

Each priority area is described in further detail in the section 2 of this report.

Collaborative success stories*	Areas that need attention/support	New opportunities
• Tuberculosis MDT • Joint breast MDT • WH oncology service now most improved in London (National Cancer Patient Experience Survey) as a result of UCLH support • Eastman Dental Hospital & community dentistry • Place based respiratory medicine • Consolidation of hips & knees into the Orthopaedic Southern Hub • General Surgery (inc LGI) pathway • Nuclear medicine at WH • Aligned gynaecology pathways • Joint haematology appointments • Critical Care Network	• Establish integrated surgical model with joint theatre capacity plan (through Southern Surgical Hub) • Community neurosciences (led by Queen Sq) • Virtual wards	• Community / edge of hospital support for UCLH • WH rheumatology • Joint approach to endometriosis pathway including access to UCLH robot • Access to neurophysiology • WH CAMHS support for children with mental health needs admitted to UCLH • Joint dispensary
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	Operationally challenged area	Key strategic importance	Potential quick win
1. Successfully deliver a joint theatre capacity plan	Yes		
2. Increased community provision from WH		Yes	
3. Modernising cancer service at WH	Yes	Yes	
4. Establishing resilient gynaecology pathways	Yes		
5. Joint outpatient dispensary across UCLH and WH			Yes

SECTION 2
FIVE PRIORITY WORKSTREAMS

Five priority workstreams (1/2)

Priority workstreams	Objective	Benefit(s)
1. Successfully deliver a joint theatre capacity plan	• Reduce UCLH's PTL by providing WH theatre capacity direct to UCLH's surgical teams	• Reduced waiting list • Reduced reliance on private sector
2. Increased community provision from WH	• Improve community-based support for UCLH patients, using WH's expertise as an integrated care organisation	• Consistent pathways regardless of where the patient lives • Establishment of a more aggressive hospital at home model with step up provision for patients on UCLH's emergency pathway
3. Modernising cancer services at WH	• Establish a resilient and sustainable service for WH patients that benefits from UCLH cancer expertise	• Patients will no longer travel past their local hospital for treatment, unless clinically essential • Enhance the existing WH service as a result of closer links with the centre of excellence at UCLH

Five priority workstreams (2/2)

Priority workstreams	Objective	Benefit(s)
4. Establishing resilient gynaecology pathways across UCLH & WH	• Establish a new robotic surgical pathway supported by joint appointments and new clinical rotations. • Establish improved, faster access to specialist service with appropriate community based discharge support when required	• Improved recruitment for WH • Reduced backlog of long waiters at UCLH • Better utilisation of capacity across both sites as a result of shared posts • Better access to research opportunities and communities of practice
5. Joint outpatient dispensing service across UCLH and WH	• Explore the creation of a wholly owned subsidiary that runs the OP services across a number of hospitals, starting with a joint model for UCLH-WH and potentially expanding this further in the future • Establish an evidence-based case for change determining whether joint outpatient dispensing model could deliver mutual benefit for the partnership	• Reduced reliance on private sector • Integrated approach supports a joint oncology model

SECTION 3
CRITICAL SUCCESS FACTORS

Successful delivery of the priority workstreams will be dependent on a range of critical success factors including:

- Clinical support for the changes
- Support for changes from patient groups
- Excellent communication
- Alignment with / support from NCL Integrated Care Board
- Resourcing

Clinical support

The collaboration has focused on improving clinical pathways rather than back-office functions to establish a clinically compelling case. As a result, the collaboration team works closely with doctors, nurses and allied health professionals from both Trusts.

A growing number of consultants have joint and honorary* contracts across both UCLH and WH which can help break down organisational barriers, enhance fragile services, streamline pathways and ensure that resources are used more effectively. Although the current proportion of joint appointments (as a percentage of all staff) remains quite low an increasing number of joint appointments are expected over the next six to 12 months. The following specialties are supported by consultants with either a joint or honorary contract:

- General surgery
- Orthopaedics (excluding spinal surgery)
- GI medicine
- Haematology
- Oncology
- Uro-gynaecology

Both Trusts have also agreed a new memorandum of understanding (MOU) making it easier for all staff to work across the two organisations

*An honorary contract can be used for individuals coming for a period of work, research or training at a partner organisation, but will not be paid directly by the organisation

Factors to support successful delivery

Patient engagement and support from local patient groups

Both Trusts have a good track record of patient engagement and often score well with patient surveys. For example, in the recent National Cancer Patient Experience Survey, WH jumped the highest number of places in London in terms of their national ranking and are now ranked the same as the Royal Marsden. This improvement would not have been possible without the support of the UCLH oncology teams.

Both trusts have committed to putting patients before their organisations and the collaboration team has begun early discussions with the following groups:

- Joint Patient Partners (with UCLH WH staff and patients)
- NCL Cancer Alliance
- Healthwatch leads across Camden, Islington and Haringey
- Whittington Voices

Patients have told us that they would like to see improvements in the following areas:

- Consistent services regardless of where they are provided
- More consistent administrative support across different specialties
- Better communication between the hospitals and referring GPs

Now that the priority workstreams are better established, there is an expectation that there will be increased engagement efforts.

NCPES 2023 Rankings

Benchmarking scoring

Questions above expected range were given a value of +1, questions within expected range were given a value of 0 and questions below expected range were given a value of -1

NHS North Central London Cancer Alliance

Rag rating :- improvement from 2022, drop from 2022

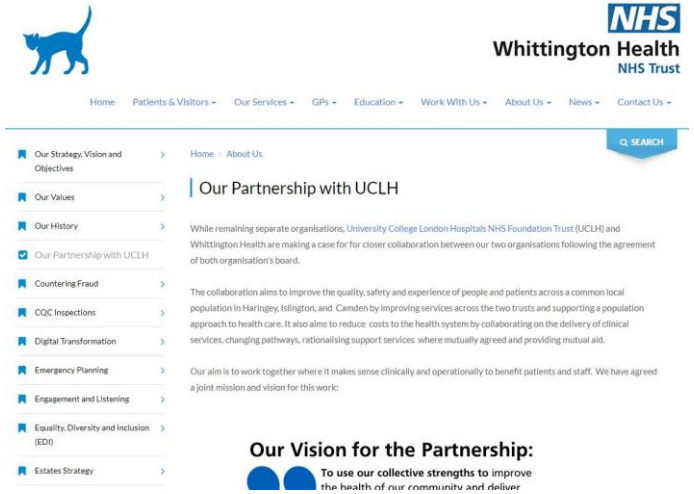
National Rank (out of 131)	London Trusts	Ranked Score	Number of questions: Above Expected Range	Within Expected Range	Below Expected Range	Respondents	2022 National Rank	Change in Rank 2023 vs 2022
41	Kingston Hospital	4	4	57	0	149	77	36
47	The Royal Marsden	2	11	41	9	1337	13	-34
47	**Whittington Health**	**2**	**3**	**57**	**1**	**119**	**86**	**39**
55	St George's University Hospitals	1	3	56	2	673	7	-48
63	Epsom and St Helier University Hospitals	0	2	57	2	173	77	14
63	The Hillingdon Hospitals	0	2	57	2	117	53	-10
74	Homerton Healthcare	-1	0	39	1	17	86	12
82	Chelsea and Westminster Hospital	-2	1	57	3	333	104	22
82	Croydon Health Services	-2	1	57	3	134	77	-5
91	**Royal National Orthopaedic Hospital**	**-4**	**1**	**49**	**5**	**31**	**86**	**-5**
98	**Royal Free London**	**-5**	**1**	**54**	**6**	**716**	**129**	**31**
101	**Moorfields Eye Hospital**	**-6**	**3**	**41**	**9**	**44**	**70**	**-31**
109	King's College Hospital	-11	0	50	11	380	114	5
109	**University College London Hospitals**	**-11**	**4**	**42**	**15**	**1144**	**114**	**5**
115	**North Middlesex University Hospital**	**-13**	**0**	**48**	**13**	**270**	**112**	**-3**
118	Barking, Havering and Redbridge University Hospitals	-15	0	46	15	396	93	-25
121	London North West University Healthcare	-16	0	45	16	278	86	-35
125	Barts Health	-21	0	40	21	474	110	-15
126	Guy's and St Thomas'	-22	1	37	23	979	94	-32
129	Imperial College Healthcare	-26	1	33	27	713	117	-12
130	Lewisham and Greenwich	-29	0	32	29	264	128	-2

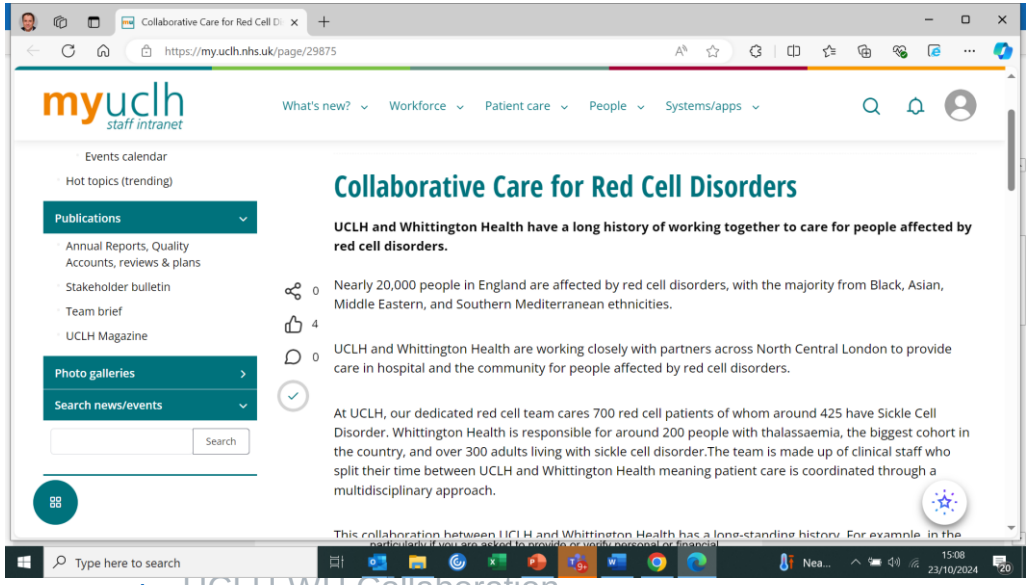
4

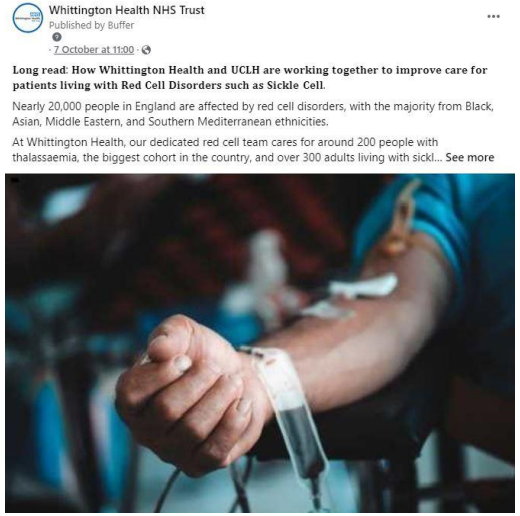
Excellent communication (1/2)

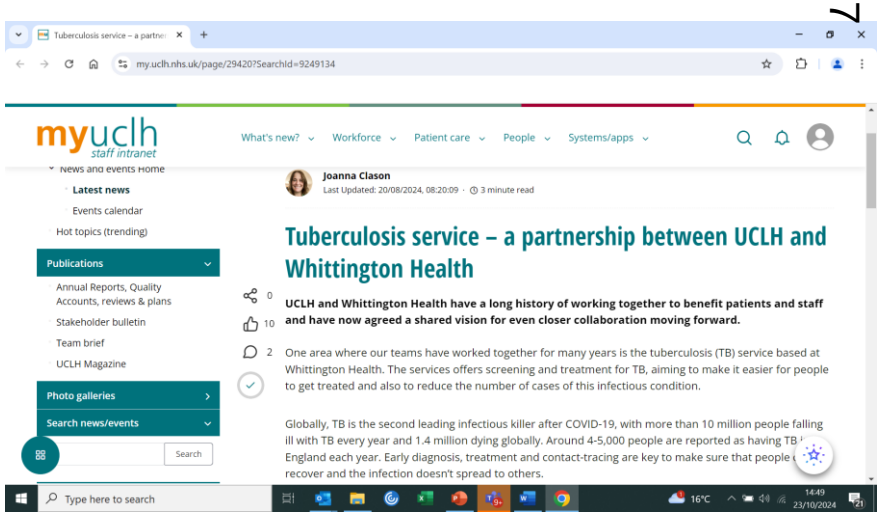
Communicating well with patients, staff and key stakeholders is key if the collaboration is to be a success, with demonstrable improvements in outcomes. The WH and UCLH communications teams have a track record of working together and have agreed a joined-up approach to promoting stories about the collaboration. This process is expected to develop further into even more aligned communication releases.

Special sessions with local staff representatives have also taken place to ensure that there is clarity about the approach taken and reassurances that future organisational form remains out of scope.









Factors to support successful delivery

Excellent communication (2/2)

6

‘Virtual wards’ help patients to recover at home

The UCLH@Home service is helping patients like 80-year-old Margaret Stone to continue their recovery in their own home under the care of their hospital team.

UCLH@Home is a nurse-led ‘virtual ward’ that is run in partnership with Whittington Health NHS Trust. The service enables clinically stable patients to go home from hospital and complete the remainder of their acute care in the community, while remaining under the care of UCLH.

This may include patients who need regular intravenous antibiotics, or heart-failure patients requiring ongoing monitoring after returning home.

For Margaret Stone, who has been an inpatient at UCLH many times in recent years for her lung conditions, being cared for by UCLH in the comfort of her own home was a really positive experience.

“Although I’ve had wonderful treatment when I’ve had to stay in UCLH, I much prefer to be in my own home with my own things. When my lung problems recently took a turn for the worse and I needed to be looked after by the hospital team, I was really grateful to be given the option to be cared for at home,” Margaret said.

“The nurses from the UCLH@Home service made sure I was well cared for. They visited me at home every day for four or five days, to give me my medication and make sure I was getting better.”

Nigel Steventon, UCLH@Home matron, explains some of the benefits of the service: “Patients often tell us they prefer to be looked after in their own home and we acknowledge that a prolonged stay in hospital is not always the best thing for them.

“Virtual wards like UCLH@Home have a key role to play in freeing up hospital beds for those that need inpatient care, while providing safe, home-based care for stable patients.”

Margaret Stone with nurse Prudence Martin

7

Whittington Health
8,132 followers
2mo •

Proud of the fantastic work by our joint TB service with University College London Hospitals NHS Foundation Trust! This collaboration shows how teamwork can make a real difference in our community.

University College London Hospitals NHS Foundation Trust
49,991 followers
2mo •

UCLH and Whittington Health have a long history of working together to benefit our patients and staff.

Our joint #tuberculosis (TB) service is just one of many cases where our teams have collaborated together to positively impact our community.

Based at Whittington Health, the service offers outpatient and inpatient services for TB patients including those with complex medical needs, such as children, prisoners, HIV and TB infections together, homeless people and multi-drug resistant TB. Since 2019, the team has held over 23,000 patient consultations and

Factors to support successful delivery

The collaboration remains closely aligned with NCL Integrated Care Board clinical strategy (1/2)

Pathway	ICB priority	Collaboration link
Acute	• Improving access to urgent & emergency care	• WH runs its own virtual wards to Islington and Haringey residents but also provides a virtual ward service (UCLH at home) for patients attending UCLH
Elective	• Reduced waiting times and the total numbers of patients waiting for treatment	• Joint theatre plan utilising spare WH capacity to improve access and reduce waiting list size for general surgery, urology and gynaecology patients
Cancer	• Improved cancer waiting times • Better clinical outcomes • Increased access to clinical trials	• Repatriation of cancer patients currently being treated in the private sector due to lack of surgical capacity at UCLH • Joint appointments now in place so that both trusts can provide oncology care closer to home for those patients who live near WH, and improved access to clinical trials at WH

Maternity	• NCL Start Well Programme with focus on:
	  • Maternity
	  • Neonates
	  • Paediatric surgery
		• New joint pathway for women requiring c-section based at WH
		• WH is preparing for potential increase in births as a result of Start Well reconfiguration of maternity services
		• 7 new neonatology cots will open at UCLH (from 2028) as well as a new birthing unit
		• New Reproductive Medicine Unit with expanded fertility service will open at UCLH (from 2026)

Factors to support successful delivery

The collaboration remains closely aligned with NCL Integrated Care Board clinical strategy (2/2)

Pathway	ICB priority	Collaboration link
Community	• Establishing a more responsive and consistent model for patients with musculoskeletal needs across NCL	• WH & UCLH have agreed joint clinical model covering referrals from Camden, Islington and Haringey. • WH's community services for adult and children (both physical and mental health) are rated good and its community dental and end of life care is outstanding
Population health	• Ensuring that all residents in North Central London live healthy and fulfilling lives	• WH is an integrated care organisation which can improve population health by providing high quality services closer to home and speeding up communication between community and hospital services and tailoring services for ethnicity and deprivation inequalities • UCLH is primarily an acute and specialist centre but has created a Health Hub in the ground floor atrium of University College Hospital site providing links to community groups and other sources of advice for patients and staff

Resourcing

Both Trusts remain committed to the collaboration and have already invested directly into patient care across the partnership. The table below summarises the investment to date and includes new posts in theatres which are currently being recruited. :

Specialty area	Profession	Staff whole time equivalent (wte)
Oncology	Medical support	2
Oncology	Pharmacy support	1
Theatres	Additional theatre staff	36
Joint virtual wards	Nursing staff	35
Weekend support for acute urology at WH	Medical support	3
Pathway support	Multi-disciplinary support	4

Investment has been to deliver additional activity in an efficient way and has been directed at improving outcomes, enhancing the patient experience, increasing capacity and reducing the reliance on acute hospital care.

SECTION 4
RISKS

Risks

Risks relating to the collaboration are included in a central risk register and are also reported through each Trust's respective risk management and board assurance frameworks. The collaboration risk register is reviewed on a monthly basis by the Collaboration Board (chaired by both CEOs) and is also presented for information to the Provider Development Committee (chaired by the WH and UCLH chair).

The following risks currently have the highest risk score:

- Collaboration opportunities stall / remain undelivered due to lack of management bandwidth (at either Trust) and/or business as usual (BAU) pressures
- Organisational income (at Trust level) adversely affected by new pathways e.g. with the consolidation of specialist orthopaedic work

Despite both risks scoring nine, there is suitable mitigation and the necessary controls in place including:

Mitigation	Controls

• Assurance that financial impact remains a key criterion for any service change arising from the collaboration
• Any pathway changes would require approval at local Trust level
	• Regular reports are presented to:
	  • Directors of Strategy (monthly)
	  • Collaboration Board (bi-monthly)
	  • Committee in Common (bi-monthly)
	• In addition any change that had the potential to result in loss of material income would need to reviewed by the respective Trust Board.

Risk register for WH & UCLH collaboration (as of 25/10/24) – 1/2

Theme	Risk	Likelihood	Consequence	Risk score	Mitigation	Controls
Patient & public engagement	Opposition from patient groups and their representatives to proposed changes arising from the collaboration	2	4	8	• Any pathway changes would require engagement with local patient groups eg NCL Cancer Alliance Patient Group • The programme team maintain regular dialogue with Trust level PPI teams and borough-based groups	• Any issues can be escalated via Trust, borough or (if necessary) system partners
Joint strategic direction	The joint strategic approach to work more collaboratively has an unintended adverse impact on: • Patient choice • Viability of local services • Co-dependencies with other services • Staff anxiety resulting in increased turnover / poor retention	2	4	8	• Systematic review of planned outcome metrics to ensure that any adverse variation is identified and addressed quickly • Thorough engagement with stakeholders in local government, borough partnerships, Health & Wellbeing Boards and the wider ICB	• Any issues can be escalated via system partners at borough or ICB level
Financial	Partnership unable to resource the costs associated with the collaboration	2	4	8	• WH has recruited programme support on a permanent basis • Current team (2wte) relatively small with no indirect cost • Any investment opportunities (eg cancer staffing, additional theatre lists) will require approval at local Trust level	• Programme budget is capped at 2wte and held by Dirs of strategy • No plans for devolved programme budget beyond that held by Dirs of Strategy
	Organisational income adversely affected by new pathways e.g. with the consolidation of specialist orthopaedic work	3	3	9	• Where appropriate the programme would seek a risk share arrangement to avoid unilateral losses • Financial impact remains a key criteria for any service change arising from the collaboration • Any pathway changes require approval at local Trust level	Any issues can be escalated to local finance leads or (if necessary) the Collaboration Board

Risk register for WH & UCLH collaboration (as of 25/10/24) – 2/2

Theme	Risk	Likelihood	Consequence	Risk score	Mitigation	Controls
Distraction of BAU pressures	Collaboration opportunities stall / remain undelivered due to lack of management bandwidth and/or pressures of BAU	3	3	9	• Robust governance framework in place supported by regular review by Dirs of Strategy	Regular reporting to: • Dirs of Strategy • Collaboration Boar (mthly) • Committee in Common (Quarterly)
Resistance from clinical teams	Clinical teams resist working together as a result of concerns that patient pathways may be adversely affected	2	4	8	Programme approach based on: • Need for mutual benefit when considering pathway changes. • Emphasis on improved patient outcomes / access rather than organisational change/cost improvement	Any issues can be escalated to local clinical managers or (if necessary) the Collaboration Board
Stakeholder engagement	Progress stalls because ICB partners and elected representatives raise concerns about WH-UCLH collaborative approach/impact elsewhere in NCL	2	4	8	• ICB is represented at a number of collaborative meetings eg Southern Surgical Hub • Prog Dir regularly shares approach with NCL Operational Implementation Group • Programme Dir has regular dialogue with ICB Exec Dir of Performance & Transformation • Dedicated session in place to brief ICB CEO	Any issues can be escalated to Dirs of Strategy or (if necessary) the Collaboration Brd

SECTION 5
WAY FORWARD

Way forward:

- Both Trusts will develop demand and capacity plans for 2025/26 that are based on shared access to theatre capacity;
- Develop a joint approach to patient engagement so that it better reflects the patient's own journey across multiple NHS providers;
- New joint consultant appointments expected across a range of specialties including oncology, urogynaecology, rheumatology and urology;
- Consider where increased one team working could provide stability for fragile services ensuring that standard operating policies are consistent and clear;
- Improve transfer of clinical information across both sites access to better reflect patient pathways and treatment requirements;
- Consolidate research and development opportunities and ensure that where appropriate more patients are offered access to clinical trials; and
- Continue to harmonise corporate functions eg aspects of finance, legal, procurement, estates and HR reducing duplication and unwarranted variation.

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North Central London Health and Care
Integrated Care System

NHS

JHOSC NCL Winter 2024/25 Planning

11 November 2024

Introduction

North Central London Health and Care
Integrated Care System

In preparation for winter 2024/25 NCL has worked to evaluate and refine last year's dynamic plan (the winter play book) **building on the NHSE recovery plan for urgent and emergency care services which was published in January 2023 and the recent seven Urgent and Emergency Care (UEC) priorities**. Recognising the breadth of UEC pathways we have included all parts of the system in our Winter Plan with a focus on proactive actions informed by data to target the interventions.

Local and Place plans and the ICS system plan were informed by outputs from a system event held on 5 September 2024 with senior operational and clinical representatives from across the ICS. The winter plan on a page is set out on slide 4.

Preventative work through vaccinations as the most effective way to prevent infectious diseases is a critical part of our plans. As such, **we continue to engage with our population and tailor of delivery** to make it as easy as possible for everyone to receive these vital vaccinations.

Introduction continued

North Central London Health and Care
Integrated Care System

Furthermore, **we have increased primary care capacity** via schemes that will deliver proactive care in autumn to support at-risk cohorts to stay well in winter. **NCL is one of the only systems to direct winter capacity funding to primary care systematically.** Progress against our proactive care actions is summarised in slide 5.

Implementation of our winter plans will be overseen by the COO level NCL Flow Operational Group and in turn overseen by the NCL Flow Board. Alongside this, **the NCL System Coordination Centre and system wide OPEL action cards will help manage operational risk in real time** with system CEO oversight via the system management board.

Planning process for winter 2024/25

North Central London Health and Care
Integrated Care System

The approach for developing the winter 2024/25 plan is outlined below

Gap analysis against the 2-Year UEC Recovery Plan

Across acute, mental health and community providers, focussing on:

- progress against the priority actions
- plans to address gaps
- understanding how local actions will impact local performance improvement trajectories

ICS UEC Winter System event.

Aims

1. Link regional priorities to local intentions.
2. Ensure joined-up working across the system and understanding of interdependencies.
3. Test system resilience to identify enhancement actions.
4. Identify how we use RAiDR (digital platform) to move to a more proactive model.
5. Agree how we optimise existing resources in the context of limited or non-available funding.

NCL Winter Playbook

Refining last year's dynamic plan by:

- building on the priorities set out in NHSE UEC Recovery Plan and the Ten High Impact Interventions.
- incorporating outputs from the system event.
- reviewing data to understand trends and target interventions.

Mobilising Proactive Care Actions

1. Primary care actions targeted at the most vulnerable
2. Helping people to stay well via vaccination programme and use of Pharmacy First
3. Reducing conveyancing from care homes
4. Reducing ambulance conveyances to hospitals
5. Reducing pressures on EDs by supporting patients with urgent but non-life-threatening conditions.
6. Increasing infection prevention and control to maintain bed capacity and flow

NCL Winter Playbook on a page

North Central London Health and Care
Integrated Care System

1) To support planning, coordination and insight across the system we will:

- Develop system level scenarios and evidence-based modelling to test and assure plans
- Put in place leading indications to be tracked weekly and guide system oversight and week to week operational decision making
- Systematise the use of Raidr (electronic real time data) for operational pressures to support real time relief for sites

2) The response is already underway, with proactive care actions being led through place forums:

- Primary care actions targeted at vulnerable communities (inc LTC LCS)
- Work with partners to target CYP low level acuity
- Work to increase Vaccinations in vulnerable
- Enhanced use of pharmacy first
- Work with care homes to support unwell but not acutely ill residents
- Development of pre-conveyancing modes through LAS
- 111 resilience and capacity

3) These are complementary to actions in acute and MH settings based on the national high impact actions

- **Same Day Emergency Care**: Reducing variation in SDEC provision
- **Frailty**: Reducing variation in acute frailty service provision.
- **Inpatient flow and length of stay (acute)**: Reducing variation in inpatient care and length of stay
- **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay
- **Care Transfer Hubs**: Implementing a standard operating procedure and minimum standards for care transfer hubs.
- **Intermediate care demand and capacity**: Supporting the operationalisation of ongoing demand and capacity planning.
- **Virtual wards**: Standardising and improving care to prevent admission to hospital and improve discharge.
- **Urgent Community Response**: Increasing volume and consistency of referrals.
- **Single point of access**: Driving standardisation of urgent integrated care coordination.
- **Acute Respiratory Infection Hubs**: Support consistent roll out of services, prioritising acute respiratory infection.

4) This will require a refreshed way of working with system partners in line with the BCF and other agreements through enhanced working at place level with partners via local flow groups.

5) These will be supported by system processes and governance:

- Refreshed UEC governance with links to place and daily calls with sites
- New system wide OPEL frameworks to support rapid escalation
- CNO led IPC forum to support management of risk and capacity closure

Progress on proactive care actions

North Central London Health and Care
Integrated Care System

Actions	Progress
Primary care	• PCN schemes to support winter 2024/25 have been selected based on local population needs. These are being mobilised. • Through autumn, PCNs are identifying and contacting vulnerable groups, to keep them well through the winter. See slide 8 for detail.
CYP	• Targeted primary care capacity boost for Children and Young People (CYP) has been agreed and is being mobilised
Vaccinations	• Covid-19 Vaccination delivery has commenced; efforts are being made to ensure a geographical spread that reaches all target populations, with an estimated capacity of 90,000 vaccinations per week. • Proactive efforts to address vaccination inequalities and hesitancy are being undertaken (see slide 6 for further information).
Pharmacy First	• Meetings between provider leads and local pharmacy representatives to enhance collaboration and service alignment have been arranged, supplemented by local meetings to ensure localised coordination and service optimisation. • Providers have been given communications outlining the local pharmacies in proximity to each provider, along with specific services and referral pathways available through Pharmacy First.
Care homes	• The NCL Silver Triage service continues to support older people living with frailty and reduce unnecessary admissions to hospital for older people, by providing access to geriatricians to advise and guide ambulance paramedics in assessing older people living in care homes.
Pre-conveyancing models from LAS	• ICC Hub: LAS is actively working on implementing a remote clinical hub in NCL to provide rapid access to senior clinical decision-makers who can direct patients to the most appropriate care pathways.
111 Resilience and Capacity	• Targeted utilisation improvement work, leading to 6% increase in NHS111 slot utilisation. Furthermore, NHS111 has integrated AI-supported triage through Visiba, with three pathways currently in use, including upper respiratory tract infections and MSK
Infection Prevention and Control	• Local IPC governance frameworks in place to maintain safety of patients, service users, staff and others. • Establishing IPC leads across NCL primary care and care/nursing homes and LAS.

Vaccination delivery

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1. Learning and Evaluation from HI approaches to date.

NCL will review the learning from the Spring 2024 campaign, including:

- Vaccination at **short stay inpatient units** where uptake was low.
- Opportunistic vaccination to the **immunosuppressed** cohort at hospitals
- Increased use of **MECC** (blood pressure/BMI/loneliness/diabetes risk assessment)
- Use of **non-health related activities** to attract underserved populations. E.g Cost of Living support.
- **Pop-up and mobile bus sessions** at new locations within NCL.

We will also learn from our **comms campaign**, which included:

- Worked with partners to **disseminate translated materials**
- A targeted approach to VCSE organisations representing diverse communities **to sign up for our comms mailing list** so that community and faith leaders can spread the word within their communities.
- **NCL walk-in website** to advertise pop-up clinics and mobile bus clinics

2. Identification of ongoing health inequalities

Data and Health Analytics

Local intelligence

NCL continues to experience variation between groups in terms of vaccination uptake. During the Spring 2024 campaign:

- **7.7% difference** in vaccination uptake between the NCL population as a whole and those from an ethnic minority background (HealtheIntent)
- **18.4% difference** in vaccination uptake between the NCL population as a whole and the immunosuppressed cohort (foundry).
- An hospital audit in February 2024 showed 62% of short-stay inpatients required a covid-19 or flu vaccination. 49% of vaccinations delivered to inpatients were non-White British.

3. Future planning Autumn 2024

Spreading
Sustaining
Scaling

NCL has a wealth of experience and expertise in delivering vaccinations to **underserved communities.** Building on the previous learning and depending on resources available, NCL is planning to:

- use **data based approach** to retain vaccination sites across NCL to ensure equity of access
- retain a central **outreach team** through the lead provider model to enable flexibility to target groups of lower uptake
- continue **place based/borough level immunisation and vaccination groups.** These groups will develop and implement hyperlocal plans for Autumn/Winter Covid vaccinations.
- Primary Care Networks will deliver a **call and recall** approach for vaccinations including immunosuppressed and marginalised groups.
- Actively contribute to the **London Vaccination Steering Groups** to learn from others and realise benefits pan-London.
- UCLH will **evaluate the effectiveness of outreach efforts** by partnering at London level with the NHSE regional team, academic partners, and ICSs.

- Programme Team has worked in partnership across system and place levels to increase access and reduce inequalities
- Key Factors that underpin the outreach approach include:
  - The clinic location and community targeted is data driven
  - Flex delivery dates and times to ensure equity of access (i.e. school holidays and religious festivals)
  - A local booking system facilitates appointment planning. Advertised ‘walk-in’ access targets those facing digital exclusion.
  - Tailoring of communication to ensure the service is accessible (working with London Vaccination Steering Groups)
  - Translated digital leaflets are provided via the UKHSA website and hard-copy leaflets in the top twelve NCL spoken languages.
  - Collaboration with stakeholders at local level, innovating to expand the offer and advertising of additional health and non-health services (such as cost of living advice) at outreach clinics to incentivise attendance amongst the intended population.
- UCLH delivers influenza vaccination, blood pressure checks, smoking cessation advice, loneliness checks, BMI checks and diabetes risk assessments

Borough partnership working

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We continue to be NCL's lead agency for system communications and engagement in all matters related to vaccinations and through our weekly meetings and communications circulate all the key messages and collateral required for each of our boroughs to run vaccination campaigns locally

Recent highlights

- Integrated place and system vaccination and prevention steering groups
- Stepping-up promotion of public health interventions at time of rising case numbers (wider vaccinations)
- Readying communications for any period of surge activity that may be needed
- Regular weekly meetings and email updates for system partners
- Local communication and engagement focus – complemented by outreach capacity
- Focussed engagement of communities such as homeless people and those seeking asylum




Primary care winter plans

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Primary care actions are targeted at proactively supporting vulnerable communities. Primary Care Networks are reviewing their local population needs, and mobilising local schemes in autumn, to support at-risk cohorts to stay well in winter.

Proactive care for at-risk cohorts (winter readiness)

- Identification and outreach to the severely frail, housebound, over 75 not seen in the last two years, and LTC LCS high-risk + complexity cohorts to help prepare them for winter.

PCN-level triage hub

- Dedicated triage capacity at PCN level to manage telephone and online consultation demand.

Targeted paediatric capacity boost, for low acuity demand

- Clinical capacity ringfenced for paediatric cohorts with an increased need for appointments during winter.
- Plans are in development for an at-scale offer to support children and young people to stay well in primary care in winter.

General capacity boost

- Additional sessions to increase appointment capacity in PCN member practices or the PCN enhanced access service to help meet the increased demand for appointments during winter.
- Can include additional planned care capacity where this will support winter pressures, such as wound care clinics.

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Appendices

Appendix A: Summary of High Impact Interventions

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1. **Same Day Emergency Care (SDEC)**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, seven days per week.
2. **Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay (acute)**: reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. Note: pathway 0 is a simple discharge with no formal input from health or social care required once the patient is home.
4. **Community bed productivity and flow**: reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
5. **Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6. **Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning.

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7. **Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
8. **Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
9. **Single point of access**: driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
10. **Acute respiratory infection hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in emergency departments and general practice to support system pressures.

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YOUR LOCAL HEALTH TEAM

Objectives of Your Local Health Team campaign

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- improve trust and understanding among residents and stakeholders that the Integrated Care System in North Central London is taking action to improve the health of local people.
- improve recognition and understanding of the breadth of local services on offer to support the health and wellbeing of residents
- provide information to support residents to feel confident about how to improve their health and access appropriate services
- rise above the plethora of existing campaigns
- be local and resident focused, adaptable and distinctive and work alongside ICS branded materials

Themes

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- How to access care – raise awareness of the three different ways to contact general practice and the equitable triage process that supports these
- Meet the team – different skilled professionals providing a range of services.
- Right care, right place – empowering patients to seek help in the most appropriate setting and consider services such as Pharmacy First, the NHS App, NHS 111, and self-care
- Get vaccinated, get protected – in Phase 1, focusing on flu, COVID-19, and respiratory syncytial virus (RSV) vaccinations

Campaign hub, co-branded leaflets

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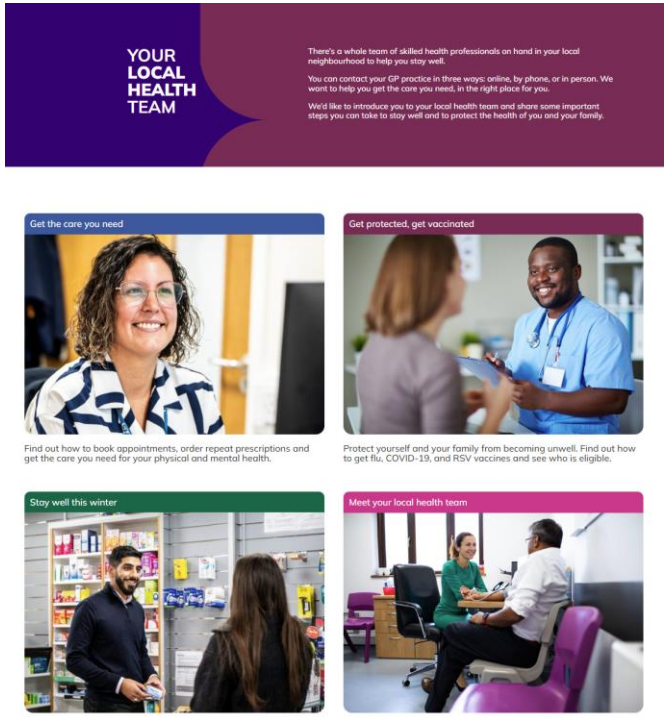

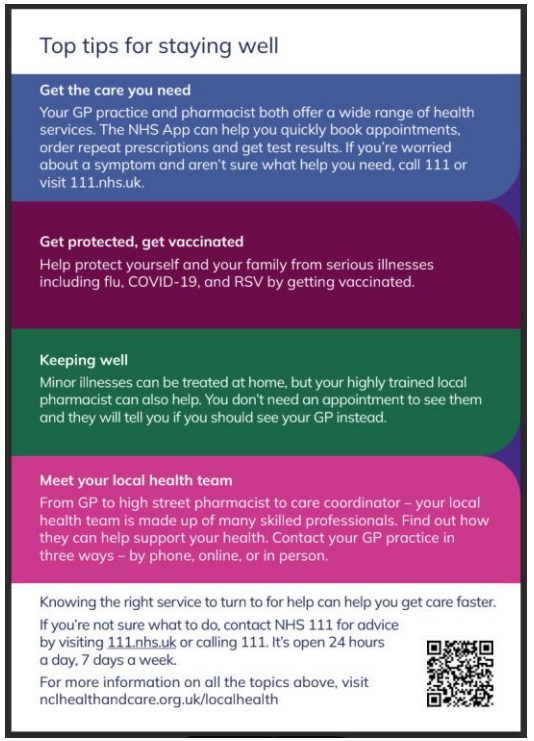

Social media featuring NCL staff

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Social 1080 x 1350
Short Message | One Liner

As well using a range of social media platforms, the campaign will be featured in outdoor advertising (bus stop adverts and digital screens) and adverts in Council magazines.

The five NCL Councils and the NHS providers are all supporting the campaign.

Engagement and evaluation

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Community engagement

- Advocacy approach via trained champion focussed on our most underserved communities, particularly around North Mid Hospital. In addition, Barnet has low satisfaction around general practice and aims will include changing this and building more trust with health services

Evaluation

- NHS App downloads
- Tracking QR codes
- Community Voices Panel survey – 1,000 local residents

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** 11th November 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) Confirm the agenda items for the next meeting which is currently scheduled to take place on 3rd February 2025.

1. Purpose of Report

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

1.2 The next meeting of the JHOSC is scheduled to take place on 3rd February 2025. 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	Lead Organisation
Start Well	For the Committee to receive an update on Start Well which is a long-term change programme focusing on children & young people's and maternity & neonatal services in a hospital context. The most recent previous update was considered by the Committee in November 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77973	NCL ICB
Primary Care Access	An update on primary care services in NCL.	NCL ICB
Dental Services	An update on dental services in NCL.	NCL ICB

9 September 2024

Item	Purpose	Lead Organisation
Estates Strategy Update	To receive an update on the NCL Estates Strategy including finance issues. The most recent previous update was considered by the Committee in November 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77972	NCL ICB
North London Mental Health Partnership	To receive a report detailing the proposed merger of Barnet, Enfield & Haringey Mental Health NHS Trust and Camden & Islington NHS Foundation Trust.	NLMHP
North Mid/Royal Free merger	To receive a report detailing the proposed merger of the North Middlesex University Hospital NHS Trust and the Royal Free London NHS Foundation Trust.	North Mid & Royal Free

11 November 2024

Item	Purpose	Lead Organisation
UCLH/Whittington collaboration	To receive a report detailing the collaborative relationship between the Whittington Health NHS Trust and the University College London Hospitals NHS Foundation Trust.	UCLH & Whittington

Finance Update	To receive a detailed finance update to include latest figures from each Hospital Trust in NCL and the overall strategic direction of travel. The most recent previous update was considered by the Committee in September 2023: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=77009	NCL ICB
Winter Planning Update	To provide an overview of the planning for winter resilience in NCL for 2024/25. To include details of the 'Your Local Health Team' campaign.	NCL ICB

3 February 2025

Item	Purpose	Lead Organisation
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	NCL ICB

7 April 2025

Item	Purpose	Lead Organisation
Community-based meeting		NCL ICB

Possible items for inclusion in future meetings

- Terms of Reference – revised version for JHOSC ToR to be discussed/approved by Committee.
- St Pancras Hospital update – Expected to be scheduled in 2025/26.
- NMUH/Royal Free merger – Last item heard on Sep 2024. Possible follow-up areas: a) For the Committee to examine a case study into a less prominent area of care to ascertain how it was monitored before and after changes to the service, what the local priorities were and their impact on how clinical decisions were made. b) For further discussion on financial risk and, including how the debts of the Royal Free Group when be held within the merged Trust.

- 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.
- Smoking cessation & vaping.
- Strategic role of GP Federations.
- Vaccination initiatives tailored to specific local needs in each NCL Borough including outreach work with community pharmacies.
- Paediatric service review.
- 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.
- Increases in number of people being charged for services that they were previously able to access free of charge through the NHS (e.g. dentistry/ear wax syringing).
- Mental Health & Community/Voluntary Sector – In August 2024, the ICB/Mental Health Trusts provided an update on Community & Voluntary Sector contract terms. It was noted that further updates could be provided to the Committee as this area of work developed.

2024/25 Meeting Dates and Venues

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

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