NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Dominic O'Brien, Principal Scrutiny Officer

Monday 3rd February 2025, 10:00 a.m.
Conference Room, Enfield Civic Centre, Silver Street, Enfield EN1 3XQ

Direct line: 020 8489 5896
E-mail:dominic.obrien@haringey.gov.uk

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 10 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 - 26)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meetings on 9th September 2024 and 11th November 2024 as a correct record.

7. HEALTH INEQUALITIES FUND

To provide an update on the Health Inequalities Fund including details about projects in the community that are supported by the Fund.

Report to follow.

8. WORKFORCE UPDATE

To provide an update on workforce issues in NCL.

The most recent previous update to the Committee on this issue was on 29th January 2024. To view the minutes from this discussion please see Item 46 at: https://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=697&MId=10545&Ver=4

Report to follow.

9. WORK PROGRAMME (PAGES 27 - 34)

To provide an outline of the 2024-25 work programme for the NCL JHOSC.

10. NEW ITEMS OF URGENT BUSINESS

11. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

- 7th April 2025

Dominic O'Brien, Principal Scrutiny Officer
Tel – 020 8489 5896
Email: dominic.obrien@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Friday, 24 January 2025

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Agenda Item 6

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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MINUTES OF THE MEETING North Central London Joint Health Overview and Scrutiny Committee HELD ON Monday, 11th November, 2024, 10.00 am - 1.00 pm

PRESENT:

Councillors: Pippa Connor (Chair), Jilani Chowdhury, Chris James, Andy Milne and Matt White

ALSO ATTENDING:

Sarah Mansuralli (Chief Strategy & Population Health Officer)

Duncan Jenner (Head of Communications ICB)

Clare Dollery (Acting CEO – Whittington Health)

David Probert (CEO – University College London Hospitals)

David Cheesman (Programme Director – Whittington/UCLH)

Gary Sired (Director of System Financial Planning – NCL ICB)

Anthony Browne (Director of Finance for Strategic Commissioning – NCL ICB)

Richard Dale (Executive Director of Performance- NCL ICB)

Mita Joshi (Head of Operations and Assurance – NCL ICB)

Chloe Morales Oyarce (Head of Communications & Engagement – NCL ICB)

Dominic O'Brien (Principal Scrutiny Officer)

Serena Shani (Interim Principal Committee Co-ordinator)

38. 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'.

39. APOLOGIES FOR ABSENCE

Apologies for absence was received from Cllr Rishikesh Chakraborty (Barnet), Cllr Philip Cohen (Barnet),Cllr Larraine Revah (Camden), Cllr Kemi Atolagbe (Camden), Cllr Patricia Clarke (Islington).

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 could not be ratified.

40. URGENT BUSINESS

None.

41. DECLARATIONS OF INTEREST

The Chair declared that her sister was a doctor within the Tottenham area. Also, that she was a member of the Royal College of Nursing.

Cllr Chowdhury also declared his son was a doctor in Kent.

42. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Principal Scrutiny Officer indicated that there had been a question from a resident of Barnet and read out the below.

"Given that the primary reason for absence from work is illness and the COVID pandemic is still ongoing – and is still causing illness and long-term health problems, do you think that reducing the spread of COVID with cleaner air in schools, and healthcare and public settings will be beneficial to the economy? "

The Principal Scrutiny Officer indicated that there had been no answer so far from the Integrated Care Board as sufficient notice had not been given. The Chair then asked the ICB to provide a written response to the question above. **ACTION.**

43. MINUTES

The Committee noted the minutes to the previous meeting however they could not be formally approved as the meeting was inquorate.

44. ACTION TRACKER

The Committee took note of an update on the Terms of Reference and the sharing of resources for the Committee between councils. The Chair strongly recommended that the members of the Committee speak to their respective CEOs or Finance Directors on this matter. **ACTION**

The Chair also proposed that the theme of co-production should be considered in all reports and items. **ACTION**

The Principal Scrutiny Officer notified the Committee that Start Well had published a report and that feedback from the Committee was needed by 29th November 2024. **ACTION**

45. WHITTINGTON/UCLH COLLABORATION

The Acting CEO of Whittington Health introduced the report to the Committee. Main points summarised below.

- The vision of the collaboration was to use the collective strengths of the Whittington and UCLH to better serve the community and improve the sustainability of services across the two organisations. The collaboration was not driven by changes to organisational form and/or cost savings.
- More opportunities were being considered to join multiple clinical teams together and reduce duplication in back office, non-clinical services.
- There was a long history of collaboration between the two institutions especially within the pandemic, which had resulted in excellent patient outcomes.
- The Acting CEO emphasised the collaboration meant that the two institutions would still be treated separately, however collaboration had meant successes – for instance when joint appointments had provided back up to services when recruitment for vital specialised areas had been difficult. This approach had worked especially well and put Whittington Health 34th in the Patient Cancer Experience table.
- She explained that the Whittington Health had also set up the Virtual Ward – a service that helped patients who could be looked after at home to remain home under clinical supervision. The equivalent was found in the UCL as the ‘Hospital at Home’ scheme.
- She stated that due to the collaboration there had been a reduction in waiting and theatre time, patients could be cared for in their own homes with the Virtual Ward and Hospital at Home scheme. The collaboration had improved services where patient care had been impacted. It had also opened research opportunities across the two organisations.
- The team was considering more NHS partnerships – and a clinical dialogue was occurring across the two organisations.
- The management also recognised the risks to the increase in collaboration. This included ensuring that there was adequate clinical support across the two organisations, support for charges for patients, alignment with JHOSC, adequately resourcing the merger, and assessment as to whether patients were being best served.
- She stated that there were active communications going on across the organisations to bring out collaboration ideas.

- Harmonising corporate functions such as finance, legal, procurement and instating joint people officers were a priority for the collaboration.

The floor was then open to questions.

Cllr White requested clarification on a statement contained within the report that pointed to “the establishment of a more aggressive Hospital at Home scheme”. He pointed out that there were risks to this as patients or their families could not be held responsible for their own care. The Acting CEO emphasised that the service would be for patients well enough to be discharged from hospital and who could be treated in their own home. The patient was monitored for a maximum of two weeks. The Acting CEO took the example of the ‘delirium pathway’ in which patients sometimes experienced confusion as a result of infection. Experiencing this in hospital made the confusion much worse. At home a full risk assessment could be made as to whether the patient could be looked after by carers or family. Cllr White indicated that there was still a substantial risk as doctors would not be able respond quickly to emergencies. The Acting CEO clarified that a Rapid Response Unit also operated alongside the Home at Hospital Scheme. The team had a two-hour response time. In response to questioning as to whether these were hitting their targets the Acting CEO offered to send round data – including rapid responses in the LTN areas which was also requested. **ACTION** .

The Acting CEO emphasised that the Home at Hospital scheme was a Home Monitoring Service and not Intensive Care at home. It would allow patients to recover at home whilst being monitored. Discussion then turned to the Delirium Pathway. The Chair emphasised that this was a highly intensive process - as with dementia. Although in cases such as these, it was beneficial for the patient to remain at home, however the family would take over the pressures of 24-hour nursing care. This would then have an impact on Adult Social Services. The Chair questioned whether there had been an honest appraisal of how the families would be coping in these Virtual Wards. The Acting CEO replied that all the pathways had been set up by Multi-Disciplinary Teams who had carefully considered the risks as well as whether the right level of support was present at home. The patient would not be discharged until they had started to improve - and did not need specialist care. Reassurance from the Acting CEO was given that the families were being taken care of and it was stated that there had been very positive feedback from families so far. Cllr White then pointed out that the burden of care should not be transferred to unpaid families instead of professionals. The Acting CEO then assured the Committee that patients were not expected to be ill for long on the Hospital at Home scheme.

The Committee then requested that the panel return responses and follow ups of the Hospital at Home scheme; also details of the times, response times, staff involved, as well as details of the kind of support families caring for a patient may need. It was then outlined that Virtual Wards such as ran alongside the Step-Down Service rehab

provision. The Officer panel offered to include an update of Virtual Wards as part of the update of the Hospital at Home Scheme. **ACTION**

In response to a further query, it was outlined by the Officer Panel that it was not currently expanding the collaboration principles to other hospitals and trusts. However, this may be considered in the future.

Discussion then turned to Finance, and the risks associated. It was stated that the Whittington had a £10 million deficit whereas UCLH operated at a surplus of £45 million. The Programme Director at UCLH responded that the collaboration was not considering spending substantial money - but instead aiming to achieve savings and efficiencies. In this way they did not perceive the differences in balance as a risk. A question was raised as to how the efficiencies would impact on staff and patient services. The Programme Director at UCLH stated that he did not anticipate any changes. There were efforts to reduce agency staff however there were no obvious examples of where services or staffing would be impacted.

Discussion then turned to how recruitment was carried out. It was stated that from a UCLH perspective recruitment was not usually an issue for specialist roles. The organisation took a decision to stop overseas recruitment and instead train up nurses straight from colleges in the UK. The organisation's policy was to retain nurses they had trained – this approach to recruitment had been extended to specialist roles. It was emphasised that there was no consideration of where applicants lived, and opportunities were still open to candidates from around the world including international medical graduates.

The Chair expressed appreciation for the inclusion of a risk register in the report. She asked for clarification on the mitigations in place against the loss of material income especially around orthopaedic work which was being treated by the surgeons at UCLH. The Programme Director stated that the model of care was being adjusted to ensure that patients were receiving the right care. The two organisations had a transparent, open book approach on accounting and the two Finance Directors were working closely together. The approach would be assessed over the year.

It was Remembrance Day. A two-minute silence was observed.

46. NCL ICS FINANCIAL REVIEW

The Director of Finance Strategy and Planning introduced the report on the system financial position. He outlined that the ICB NCL System were the system finances of nine providers and the ICB. This report covered the financial positions of all these organisations amalgamated. He outlined the outcomes of the Outturn in 23/24 . He stated that the plans had been achieved despite the high level of cross organisational efficiencies that was required to balance the books and also industrial action that had occurred twice that year. Funding to cover the industrial action had been received and he also stated that there had been a surplus. UCLH had received some late payments

which had affected the budget – however this has also benefited this year's status as Capital Allocation had been made 'pound for pound' plus an additional £25m in Capital Funding in 2024/5.

He explained that the ICB had inherited a historic £100 million deficit – from all the organisations that made up the ICS. However, an agreement had been made, that if balanced books were achieved in the first two financial years of the new amalgamated organisation, then the historic debt would be written off. This had been achieved.

In response to questions as to the way the hospital finances were viewed together within the ICS Financial Systems, and the nature of incentives for individual hospitals running a high deficit to go back to a more positive balance. It was stated that there were no penalties for hospitals in deficit - all hospitals were treated the same. Work was being carried out to improve the situation of those in a worse position. It was also pointed out that any hospital in deficit would always be under greater scrutiny.

The Director of Finance Strategy and Planning also stated that funding had been successful to cover the costs of industrial action over year. The Capital Programme was then discussed. In response to queries, the Finance Director emphasised that put simply - £180 million in Capital Funding was allocated per year however it could be rolled over into the next year, as long as allocation was carried out within that year. These projects would still be subject to change and slippage – and inflation and price rises. The Chief Strategy and Population Health Officer also clarified that in addition to updated equipment (such as MRI scanners), the Capital Fund would also fund New Builds and Business As Usual Maintenance. These projects could be carried over into the next year but would also have to be allocated in this financial year. He emphasised that this year there had been concerns that spending plans would not cover the Capital Fund, however the organisation had received three further streams of funding, and this had helped the Trust achieve its goals. In addition, the team had put aside £14m as a contingency and audited any risk issues.

Clarification was sought by the Chair as to whether another surplus should be sought next year in order to receive extra funding that the surplus would unlock. The Finance Director affirmed that it would be sought but could not be guaranteed at this stage. Reconfirmation would be sought from all the Trusts in regard to efficiencies to manage the system position. In addition, in context with other ICBs in the UK the trust was performing well financially.

The medium-term financial forecast was then discussed. It was outlined that this would cover four years. The expectation was that the allocation for the trusts would occur as usual next year however the year after the allocation would for the next three years. The Director stated that a number of assumptions had been made – such as a no increases in funding over the next few years. However, he outlined, there were assumptions for which it was hard to make a prediction over – such as inflation and supplier price rises. He stated that for management this was a useful exercise as conceptually finances could be also balanced against productivity and corporate aims.

The Committee sought clarification as to why essential council services had suffered due to the adverse economic climate, however there seemed to be little or no effect on the NCL ICB budget. Furthermore, it was questioned as to whether the move to patients being cared for in their own homes was one of the reasons why. In this context reassurance was asked for to ensure that care was not being placed onto unpaid family carers and councils in order to balance the NHS books.

The Chief Strategy and Population Health Officer responded that budgets were activity-related and therefore hard to forecast. In order to help plan for demand trends in population were analysed. It had shown there was an increase in 'unplanned for', non-elective care. Furthermore, patients were staying for longer in hospital as needs were more complex. She also stated that there was a huge drive for elective care in the NHS – and where there were delays in waiting times - interventions had occurred and additional capacity had been put on. She also explained that mental health was another crucial pressure area for the NHS. They were observing that key societal pressures such as the cost of living and economic crises. These pressures had an affect on adults and children alike in terms of increases in depression, stress and anxiety and more demand for children and adult's mental health services. She also stated that interventions could be used however this would mean that the NHS would have to spend more money that would otherwise be allocated for more elective, secondary care.

The Chief People and Population Health Officer then drew the Committee's attention to The NHS Better Care fund for local organisations and prevention/ intervention projects. There were two allocations of up to £13m and an additional £7m for projects. This she said recognised that interventions were a vital part of keeping A&E pressures and length of stay to a minimum. The Director for Finance for Strategic Commissioning stated that they had recognised an urgent need to invest in Community and multidisciplinary care in order to address the future pressures . He stated that Virtual Wards were also an important part of addressing the management of care in a sustainable way. He pointed out that there had been incremental investment from 2021. This had meant that the organisation was slightly ahead of the rest of London. This has already shown some results in the form of a positive impact on the key performance indicators.

Another question was asked on the total cost of the industrial action-it was responded to that £4.5 m this year was covered by funding. Last year direct costs were also funded in total £80m.

The Chair pointed out that funding issues in hospitals had a direct impact on the delivery of prevention services – no matter how much was being put in. She used the example of the Wood Green Health Hub. She asked further whether there were any oversight on the opportunities for a joined up approach to deliver prevention and health services at the ICB level, or whether it was still a case of individual budgets in each hospital in the trust being paramount. The Director of Finance for Strategic

Commissioning responded that the proposed Wood Green Hub had been predicted to be a huge cost pressure. It was not just the Whittington Hospital budget that was considered in this case. Each organisation in the trust had a financial element in the project – and it had been deemed as too expensive. The Chair pointed out that in cases such as these, it would be helpful to understand the learning that had been done as to why the projects such as these had hit the buffers.

Efficiency savings in relation to the financial plan was then discussed in detail. Questions were raised as to the nature of these efficiency savings - whether these meant staff cuts or services affected. The Director of System Financial Planning stated that there were a large variety of different activities that this would include. The upshot of which would mean that services would be delivered in a more efficient way. The Director offered to come back to the Committee with more analysis and examples on this.

The Chair made a recommendation on behalf of the Committee that more information be provided as to the nature of these efficiency savings. She requested a written response and in addition a response to last year's question as to whether there was to be any direct impact on services. **ACTION**

A question was raised as to the 2024/25 commitment of a £3m reallocation of funding from Acute Care Services to Community Services across the five boroughs. It was pointed out that this was a particularly low amount of money for a hospital setting. It was clarified that the Community Investment Fund would have a £225m baseline. This was deemed necessary as the investment had to be carried out in a sustainable way.

In response to a question as to whether the £3m reallocation meant the removal of acute beds, the Director of Finance for Strategic Commissioning outlined that beds would not been removed however with more emphasis being given to Community intervention projects this was something they would expect to see at a later date.

The Chief Strategy and Population Health Officer also pointed out that as were seen more in a community setting, the success of which would not necessarily be measured by the reduction of patients using emergency hospital services but also a reduction in length of stay which averaged 12 days. It was the clarified that the savings would be attached to the efficiencies of the usage of the bed days -as there were days that beds were not being used in the most efficient ways.

The Director of Finance for Strategic Commissioning, then responded to questions from the Committee as to whether £3m allocation across the 5 boroughs was enough. With reference to slide 11 of the report, it was clarified that £3m was the contribution from the Acute Care Department. In reality a much higher level of funding had been allocated- approximately totalling £15m. The Director pointed out that this sum would not meet demand, however the extra money would divert and manage patients coming into hospitals with a higher level of complexity in a more sustainable way.

The Chair then RECOMMENDED that a future paper be prepared on acute care and community services in the next financial report. The report should include an overview of pressures and risks associated with this. **ACTION**

Discussion then turned to a sustainable Voluntary Sector Investment Framework. The Finance Director explained that this framework was a 360 degree view of all the money going into the voluntary sector from the ICB, Trusts and council services including Adult Social Services. This was so that services and finances could be mapped and tracked.

The Chair then RECOMMENDED that for the next financial review a future paper be prepared to update the Committee with more detail as to the distribution of funds amongst the Voluntary Sector. In addition, more information was requested as to the lines of communication between departments and how financial decisions were reached. An assessment of the impact of these funds on services (including if monies had been diverted from another department) was also requested. **ACTION**

The Chair also then asked for a written response from the Officer Panel on :

- The impact of the financial decision on those with disabilities.
- The impact on revenue on any capitalisation projects.
- Any direct impact on services.

47. WINTER PLANNING

The Director of Finance for Strategic Commissioning introduced the report.

- This report was part of the annual emergency services planning. Emergency activity was up and there had been an improvement in performance averaging 76%.
- There had been consistent challenges when it came to ambulance hand over delays. However, performance again had improved with now over 89% of ambulance hand overs being done within 45 minutes. However, he emphasised that category two hand overs were still quite problematic and needed to be worked on.
- Hospital occupancy was still high at 98% - this, he explained, created issues.
- The report was dynamic and contained proactive actions to help manage the influx of patients.
- Southern hemisphere COVID and Flu population modelling had informed the assumptions.
- The Head of Operation and Assurance added that the plan built on last year's achievements - and also reflected the NHS England Recovery Plan.
- Work included:
    - Better communication across departments, so that all understood interdependencies where needed.

- An intervention approach to promote a reduction in demand on hospitals. This would ensure that the most vulnerable patients were supported.
- Extra capacity was also engaged especially in children and young people's services.
- Flu and COVID vaccination programmes were also rolled out and extra engagement activities were being used to encourage take up of vaccinations.
- Pharmacy First had been maximised to reduce reliance on primary care.
- Work had been carried out with care homes to ensure that patients only attended hospital if absolutely necessary.
- 111 increased its capacity and has piloted an AI triage.
- Targeted appointments have led to a 6% improvement.
- Infection control policy was very robust.
- This year has seen a robust comms plan to support this work.

The floor was open to questions.

Discussion turned to vaccinations and methods to engage all groups to encourage take up of vaccines. The Executive Director for Performance stated that issues were complex. Working with the Public Health Directors in each borough was vital for the team to understand the different needs and concerns of communities – and also where they could build stronger relationships of trust. Targeted work was being carried out to reach communities who were distrustful of vaccines. He stated that this approach had seen an increased uptake. The Executive Director for Performance pointed out that in London the NCL had closed the gap of uptake vaccines in many communities. He then suggested that information be circulated to the Committee about the nature of the NHS targeted work with communities, vaccine uptakes and the details of why there had been resistance from different communities. **ACTION.** The Chair suggested that work through nursery staff and family hubs had seen good results. The Executive Director of Performance and Transformation agreed that the 'family effect' had seen good results. Although there was national guidance on this targeted work – nursery staff had not been included but this was something that the trusts were discussing further.

Discussion turned to the nature of the issues with vaccine uptakes. A question was raised as to whether the issues were about availability or about distrust. The Executive Director of Performance responded that it depended on different communities. There had been instances were when the availability of vaccines had increased – and an uptake in vaccines had also occurred. However, there were also issues with communities receiving news from disreputable sources – and this was where targeted work and building relationships was key. He emphasised that increasing opportunities to have positive conversations around vaccines would help people make the right choices.

The Chair then asked about the nature of ‘Care Transfer Hubs’ . The Head of Operations explained that these were a virtual interdisciplinary group of partners and professionals who integrate care for patients from acute, community and less acute settings. She emphasised that these hubs exist in all boroughs but with different iterations. These hubs ensure that duplication of assessments from different agencies would not occur and that delays could be identified early, and the whole process ran smoothly and efficiently. The Chair then asked whether funding was attached to these hubs so if a delay in discharge was identified the matter could be dealt with there and then. The The Executive Director for Performance stated that in these circumstances the Personal Health Budgets would be used.

A question was asked then about the nature of ‘High Impact Interventions’ . The Head of Operations responded that one of these interventions were the use of Urgent Response Cars. The cars would ensure that patients would see a GP/ medical professional within two hours and reduce the need for an ambulance. The Executive Director for Performance stated that the biggest impact on hospital numbers was seen in Islington when the Urgent Response Car and Virtual Ward was used together to monitor and treat patients instead of taking to A&E. It was then stated that the model would be looked at as part of a review to see if it could be rolled out to other areas. Another intervention was the Silver Triage Model which was able to triage and possibly assess patients in care homes – to ensure that they did not have to go through to hospital if it was not necessary.

In response to his opinion on the biggest concerns for Winter Planning, the Executive Director for Performance responded that the biggest area of growth and concern was around getting the right support for older people over 65. He emphasised that the Winter Plan did address this with robust processes however this section of the population was the most vulnerable. Outreach was to be conducted to all frail over 75s through the GPs and Community Services – to provide information on Community responses and a clinical check in.

A question was then asked about the nature of the Local Healthcare Team National Campaign. The Head of Communications and Engagement explained that this was a long-term campaign was around raising public awareness about the different types of medical care professionals that help patients stay well in the winter. It was an integrated campaign that had been rolled out to stakeholders and the public to advertise the different roles (other than GPs) who can help patients. The Campaign has been evaluated in a number of ways including Community Outreach, work with partners and a Community Voices Panel (which included thousands of local residents). The Head of Communications stated that her team would keep evaluating the absorption of messages. A question was raised as to whether this had its own funding stream. She stated that funding had been allocated from the Winter Planning Fund and Primary Care Fund.

Discussion then turned to GP's receptionist training and whether this had a discernible impact on waiting times and had been absorbed by patients. The Head of Communications stated that the Local Healthcare Team Campaign included resources for GP Receptionists and Practice Managers which would support Receptionists to help patients. The Head of Communications offered to return to the Committee with more information on this. **ACTION**

Discussion then turned to waiting times for patients in ambulances to be discharged into A&E. The Executive Director for Performance admitted that in the past this had been a major issue in the Winter months, however across London all hospitals had signed up to a policy of a waiting time of no more than 45 minutes with anything longer than a two hour wait as a breach of this policy – this was to keep the most ambulances on the road. The aim was to get the waiting time for discharge into A&E down to a 30-minute wait.

The Chair then mentioned that although ambulances were being freed up, patients still faced a long wait often in a corridor – she asked about the pressures this put on Emergency Department staff. The Executive Director for Performance stated that this did put extra pressure on staff however this was now being managed. Chief Medical Officers and Nurses were being asked to map out processes for situations such as this – and managers were informed, and patients monitored and recorded.

The Chair requested:

- In future reports, more detail be added to the Summary of High Impact Interventions. **ACTION**
- She also requested further information on vaccinations and what the trusts were doing to address issues of misinformation and mistrust in communities. She requested more information specifically on how nurseries/family hubs and schools were doing to address this mistrust on a local level. **ACTION**
- More information was requested on the Community Voices Panel. **ACTION**
- An update was also requested on the aim by the Trusts to bring down the waiting time for patient discharges to A&E from ambulances. **ACTION**

48. WORK PROGRAMME

The Principal Scrutiny Officer then introduced the updated Work Plan for 2025.

i- 3rd February 2025.

- The agenda would include a workforce update including a staff representative.
- It was also requested that an update on smoking cessation and vaping be added to the agenda. Queries from the Committee included whether vaping was adequate for smoking cessation and how health bodies were managing vaping as a health concern- especially amongst young people. Discussion

turned as to whether vaping was used as a smoking cessation tool. It was affirmed that this was the case and can still be prescribed by doctors. It was commented also that National Government Guidance was not clear however there were steps being taken in central government to review the guidance. It was suggested to add this to the agenda after new guidance had been issued.

- The efficiency of online GP consultations and how accessible this was for the elderly and more.

ii- 7th April 2025.

- It was decided that this would be community-based meeting as per previous April meetings.
- Items on mental health and dementia would also be discussed.

Discussion then turned to developing technology and its use in chronic long term health conditions. It was suggested whether it was possible to scrutinise the day-to-day interactions with manufacturers of technology especially in terms of confidentiality and information sharing. It was decided amongst the Committee that a written response be asked from the ICB first, and inclusion on an agenda for a later date discussed after this had been received.

49. DATES OF FUTURE MEETINGS

- Mon 3rd Feb
- Mon 7th Apr

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2024-2025	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 3rd February 2025

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 7th April 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 7th April 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
Health Inequalities Fund	An update on the Health Inequalities Fund including details about projects in the community that are supported by the Fund.	NCL ICB

7 April 2025

Item	Purpose	Lead Organisation
Community-based meeting	TBC	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.

- Smoking cessation & vaping.
- The efficacy of online GP consultations (including 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.)
- Developing technology and its role in the management of long-term chronic conditions.
- 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.
- 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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