NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

Friday 26 January 2018 10:00 a.m.
Committee Room 4, Camden Town Hall, Judd Street, London WC1H 9JE

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Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Alison Kelly (Chair) and Samata Khatoon (L.B.Camden), Abdul Abdullahi and Anne Marie Pearce (L.B.Enfield), Pippa Connor (Vice Chair) and Charles Wright (L.B.Haringey), Jean Kaseki and Martin Klute (Vice Chair) (L.B.Islington)

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack, Pete Moore and Vinothan Sangarapillai

AGENDA

1. NORTH CENTRAL LONDON JHOSC - AGENDA PACK (PAGES 1 - 20)

2. NC LONDON JHOSC - SUPPLEMENTARY AGENDA (PAGES 21 - 52)

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 26 JANUARY 2018 AT 10.00 AM
COMMITTEE ROOM 4, TOWN HALL, JUDD STREET, LONDON WC1H 9JE

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
E-Mail:	**vinothan.sangarapillai@camden.gov.uk**
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MEMBERS

Councillor Alison Kelly (London Borough of Camden) (Chair)
Councillor Pippa Connor, London Borough of Haringey (Vice-Chair)
Councillor Martin Klute, London Borough of Islington (Vice-Chair)
Councillor Alison Cornelius, London Borough of Barnet
Councillor Abdul Abdullahi, London Borough of Enfield
Councillor Jean Roger Kaseki, London Borough of Islington
Councillor Samata Khatoon, London Borough of Camden
Councillor Graham Old, London Borough of Barnet
Councillor Anne-Marie Pearce, London Borough of Enfield
Councillor Charles Wright, London Borough of Haringey

Issued on: Wednesday, 17th January 2018

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 26 JANUARY 2018

AGENDA

1. APOLOGIES

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Members will be asked to declare any pecuniary, non-pecuniary and any other interests in respect of items on this agenda.

3. ANNOUNCEMENTS (IF ANY)

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

5. MINUTES

(Pages 5 - 12)

To approve and sign the minutes of the meeting held on 24th November 2017.

6. DEPUTATIONS (IF ANY)

7. NCL ESTATES STRATEGY

To consider an update on the NCL estates strategy.

REPORT TO FOLLOW

8. LUTS SERVICES

To receive information about the LUTS service.

9. NCL RISK REGISTER

To consider the North-Central London risk register.

REPORT TO FOLLOW

10. WORK PROGRAMME

(Pages 13 - 20)

To consider the work programme for the municipal year 2017-18.

11. DATES OF FUTURE MEETINGS

Meetings in municipal year 2017-18:

- Tuesday, 6th February 2018 (special)
- Friday, 23rd March 2018

Proposed dates for meetings in municipal year 2018-19:

- Friday, 20th July 2018
- Friday, 5th October 2018
- Friday, 30th November 2018
- Friday, 11th January 2019
- Friday, 15th March 2019

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

AGENDA ENDS

The date of the next meeting will be Tuesday, 6 February 2018 at 2.00 pm in Committee Room 4, Town Hall, Judd Street, London WC1H 9JE.

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 24TH NOVEMBER, 2017** at 10.00 am in Enfield Civic Centre, Silver Street, Enfield EN1 3XA

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Martin Klute (Vice-Chair), Alison Cornelius, Abdul Abdullahi, Jean Kaseki, Samata Khatoon, Graham Old and Anne Marie Pearce

MEMBERS OF THE COMMITTEE ABSENT

Councillor Charles Wright

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Charles Wright and apologies for lateness were received from Councillor Samata Khatoon.

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Pippa Connor declared the she was a member of the RCN and that her sister worked as a GP in Tottenham. Councillor Alison Cornelius declared that she was a trustee of the Eleanor Palmer Trust, which operated a care home in Barnet.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of any items of urgent business.

5. MINUTES

Consideration was given to the minutes of the meetings held on 19th September and 22nd September 2017.

RESOLVED –

(i) THAT the minutes of the meeting held on 19th September 2017 be approved as a correct record;
(ii) THAT the minutes of the meeting held on 22nd September 2017 be approved as a correct record.

6. DEPUTATIONS

The Committee heard from a deputation led by Dr Kate Middleton on the LUTS (lower urinary tract symptoms) service.

Dr Middleton stated that the LUTS clinic had stopped taking on paediatric patients. This meant that children were missing out on treatment they could have had. She said that the LUTS patients' group had been contacted by parents who were concerned about their children's infections, which were not responding to other treatments.

Siobhan Harrington, the Chief Executive of the Whittington, responded to the deputation. She reiterated the Whittington's commitment to re-opening the clinic to new patients. However, she said that the treatments Professor Malone-Lee had been offering had not been recognised as evidence-based. She said that there needed to be a proper national research study to develop an evidence base.

Councillor Klute asked whether the adult pathway would be in partnership with UCLH. Ms Harrington said that it would be.

Members asked what would be required for the clinic to re-open. Ms Harrington said the Board and the commissioners would have to be satisfied about safety and governance.

Members queried the differing approaches being taken to adult and children's treatment. Ms Harrington said that Professor Malone-Lee had said he would not treat child patients. The deputees said that this was as a result of the restrictions imposed upon him by the Medical Director at the Whittington Hospital. Ms Harrington responded that the guidance from the RCP (Royal College of Physicians) report had been that children be treated under the guidance of a paediatrician in a tertiary setting such as Great Ormond Street Hospital.

Members noted that organisations other than the Whittington would need to be involved in re-starting the service for new patients and that Paul Sinden, the Director of Performance and Acute Commissioning for North Central London, was responsible for the commissioning of the service. They decided to request that service commissioners and representatives of Great Ormond Street Hospital be

invited to attend a future meeting of the Committee to discuss their approach to the LUTS service.

RESOLVED –

(i) THAT the deputation and comments above be noted;

(ii) THAT Great Ormond Street Hospital and commissioners be invited to attend the JHOSC to discuss the LUTS service.

7. WORKING TOGETHER IN NORTH LONDON TO ADDRESS SOCIAL CARE CHALLENGES

Sanjay Makintosh (Programme Lead, North London Councils) and Dawn Wakeling (Director of Adult Social Services, LB Barnet, and Strategic Director for Adults in the NCL STP) addressed the Committee and spoke to their presentation.

They highlighted that there were major social care challenges nationally, and there were staffing shortages which were particularly significant in London.

Mr Makintosh said that there was a drive to secure more nursing home provision. However, one of the difficulties in securing this was the difficulty in recruiting registered nurses to work in nursing homes. There were schemes in place to encourage people with foreign qualifications to sit for UK ones to enable them to be registered.

Councillor Connor commented that although hospitals were keen to move people out of hospital and into care homes, CCG funding often did not move with the patient in sufficient quantities to fund this. She said that care homes were in danger of closing due to insufficient funds, while there was marked demand for their services.

Councillor Cornelius commented that the organisation she was a trustee of was considering turning its care home into a nursing home, as it was running a deficit due to the low price paid for care home provision.

It was noted that the recent budget had allocated £2.8 billion extra to the NHS, with £300 million available for this winter; however officers were not sure yet as to what this would mean in terms of funds for use in North Central London.

Members noted that there had been a decrease in care home beds in Barnet. Officers said that this had been for a number of reasons, including CQC intervention. Councillor Old said that at one point there had been talk of a planning policy in Barnet to restrict the construction of new care homes in the borough due to the pressure they placed on other services. Additionally, due to the greater number of bed spaces available in outer London boroughs such as Barnet, other local authorities placed people from their borough into Barnet care homes.

Members asked about people being discharged from hospitals to go home and whether they were able to be discharged with the relevant equipment. Ms Wakeling said that there was a community equipment service which was jointly funded by the Council and the CCG. Ms Wakeling stated that provision of equipment was not driving delays. People were more likely to be waiting for a home care package to be arranged or for a residential care place. Of particular relevance was the lack of Occupational Therapists who were able to assess the needs of patients. A member commented that there had been an underspend in the community equipment fund in their borough, and said this may have been in part because of the delays in people being assessed as to what equipment they needed.

Members commented that they would like to hear more about social care finances as well as nursing and care homes, workforce planning and the strategic approach being taken in the sub-region.

RESOLVED –

(i) THAT the presentation and the comments above be noted;

(ii) THAT a report come to the JHOSC in six months' time with information about finances, nursing homes, care homes, workforce planning and the strategic approach being taken across the sub-region.

8. PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS

Consideration was given to a report on draft principles of consultation and to a draft consultation paper on Procedures of Limited Clinical Effectiveness (PoLCE).

Will Huxter, Director of Strategy for the North Central London (NCL) Clinical Commissioning Groups (CCGs), introduced the reports. Members commented that they welcomed the principles but had concerns about how information could be conveyed to patients about consultations. There was a danger that the CCGs only heard from a small number of people or groups otherwise.

Members noted that there was a duty on health bodies to consult with health scrutiny committees over a 'substantial variation' of services, and this had to be done over a fixed timescale. If they were unable to resolve their differences with the health bodies over their proposals, health scrutiny committees possessed the power to refer proposals for substantial variations to the Secretary of State.

Members from Enfield reported that Enfield CCG was moving ahead with PoLCE – but that three treatments included in the PoLCE scheme beforehand had been removed. A member of the public commented that they had not been removed but deferred.

Mr Huxter and Jo Sauvage (Chair of Islington CCG and Co-Clinical Lead for North London Partners in Heath & Care) said that each borough's CCG was able to progress PoLCE matters in its own way. However, officers in North Central London wanted to avoid inconsistency and so the other four boroughs would have a similar approach to Enfield. They were simply at an earlier stage in the pre-consultation process than Enfield CCG was.

Members noted that the procedures in the original Enfield document which had been removed in the later one were knee replacements, hearing treatments and scarring treatments. Mr Huxter said that if these procedures were to be added back to the PoLCE list, officers would bring it to the relevant scrutiny body.

Members expressed disappointment with the fact that Enfield seemed to be proceeding more rapidly than the other four boroughs with this. They wanted the CCGs to work together to the same timescales. Mr Huxter undertook to raise their concerns with Enfield CCG.

Members of the public present made a number of comments. They said that mention should be made of the financial factors that were causing increasing attention being given to preventing procedures deemed as of limited effectiveness; they also wanted to see the amount of money that would be saved by adding each treatment to the PoLCE list, and to see figures on the number of people who would be affected and how severely. There was also a request for Equalities Impact Assessments (EIAs) to be produced, as there were concerns that disadvantaged groups could be affected negatively by this policy.

Members emphasised the importance of the PoLCE consultation document being in plain English if it was to go to the general public. They expressed the view that defining whether a procedure was of limited clinical effectiveness was a medical question, not a matter that the public or councillors would be able to meaningfully comment on. They asked about the medical opinions sought on this.

Dr Sauvage said that there were differing levels of medical evidence on the PoLCE procedures. The proposals had gone to the Health & Care Cabinet to get their medical views. There was also someone from the National Institute for Clinical Excellence (NICE) at that meeting. Members asked if the PoLCE guidance would differ from the NICE guidance and, if so, why.

Members asked if referral managers were involved in the process. Dr Sauvage said different CCGs had different methods of handing referrals. However, the aim was to ensure consistency amongst GPs and to encourage them to broach the issue of non-surgical interventions with patients.

Members wanted to see effort made to obtain the views of a range of GPs on the PoLCE policy and their professional views on why there was 'undue variation' in the approach taken to these procedures. Members also wanted to see engagement with

community and voluntary sector organisations and efforts made to contact hard-to-reach groups if the public were being consulted.

Members had significant concerns about the draft consultation paper and the approach being taken by the CCGs. They asked that information come back to the JHOSC about the views of GPs and the EIAs for the proposals. This might be able to take place at the March meeting or it might require a special meeting to be called to fit in with the 12-week timescale for formal consultations if a formal consultation was initiated. In addition, they wished to receive the outcome of the response of the public consultation before agreeing their response, and this would need to be arranged following the end of the consultation period.

RESOLVED –

(i) THAT the reports and the comments above be noted;

(ii) THAT a report come back to the JHOSC giving the views of GPs and the information from Equality Impact Assessments on the PoLCE proposals.

9. ESTATES STRATEGY

Consideration was given to a report on the NHS estate in North Central London.

The Chair expressed disappointment with the lack of information in the paper. Another member commented that the appendix was 18 months old and that he hoped matters had moved on since then.

Members expressed concern that the Whittington seemed to be taking its own individual approach to estates, as did the Camden and Islington NHS Foundation Trust. They wanted to see more alignment of the estates strategies of different organisations.

Members said that they wanted to see a link between NHS estates and the housing strategy. They were concerned about the need to improve the provision of housing for staff and residents.

Councillor Klute expressed concern that the Department for Health was presuming that £2 billion of estates would be sold. This seemed a high target.

The Chair commented that she welcomed the commitment David Sloman had made at a previous meeting that the Royal Free NHS Foundation Trust would be reinvesting the revenue from land sales.

Officers highlighted that a memorandum of understanding had been reached on estates devolution, which would mean that revenue from the sale of NHS estate in

London, even if it was not owned by foundation trusts, could be used within the capital.

Members of the public spoke on this item. One individual expressed disappointment that the report did not mention the Naylor Report. He said there was pressure for sales of NHS land and buildings in London because of the high land values in the city. He argued that surplus NHS estate should be used for primary care facilities or for affordable housing. There was concern that only 14% of the housing on the St Ann's site would be 'affordable housing'.

Members wanted to see senior Local Authority officers having a 'greater line of sight' into the NHS estates process. They did not feel this was happening at the moment.

The Committee wanted to see a more detailed report on estates at its January meeting.

RESOLVED –

(i) THAT the report and the comments above be noted;

(ii) THAT a report come to the 26 January 2018 JHOSC meeting on the NHS estate in North-Central London.

10. WORK PROGRAMME

Consideration was given to the Work Programme report.

Members agreed that the agenda items for the January 2018 meeting would be:

- Risk Register
- NHS estates
- LUTS services (involving Great Ormond Street and commissioners)

Councillor Kelly would lead on the risk register and estates items and Councillor Klute would lead on the LUTS item.

Items for the March meeting would be:

- Ambulance Services
- Joint Commissioning
- Adult Social Care
- PoLCE consultation (if available at that time and if a special meeting is not required for it).

Councillor Abdullahi would lead on ambulance services, Councillor Kelly on joint commissioning and Councillor Connor on adult social care.

It was suggested that the July 2018 meeting have items on GP services in care homes and the NHS 111 out-of-hours service.

RESOLVED –

THAT the amended work programme be agreed.

11. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no other items of business.

12. DATES OF FUTURE MEETINGS

Future meetings of the JHOSC will be on:

- Friday, 26th January 2018 (Camden)
- Friday, 23rd March 2018 (Islington)

The meeting ended at 1pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
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MINUTES END

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**

REPORT TITLE
North Central London Joint Health Overview and Scrutiny Committee: Work Planning 2017-18

REPORT OF
Committee Chair, North Central London Joint Health Overview & Scrutiny Committee

FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 26th January 2018

SUMMARY OF REPORT

This paper provides an outline of the 2017-18 work programme of the North Central London Joint Health Overview & Scrutiny Committee

Local Government Act 1972 – Access to Information

The following document(s) has been used in the preparation of this report:

No documents that require listing were used in the preparation of this report

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RECOMMENDATIONS

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

- Note the contents of the report
- Agree the work programme for the remainder of 2017-18

1. Introduction

1.1. This paper provides a summary of the work undertaken by the North Central London Joint Health Overview and Scrutiny Committee (JHOSC) during the current municipal year and provides an outline of key areas of interest for the 2017-18 work programme.

2. Terms of Reference

2.1. The Committee has been set up with the following 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 area of Barnet, Camden, Enfield, Haringey and Islington;
- 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 work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

3. Meeting dates for 2017-18

3.1. The following dates have been scheduled for the committee's meetings in 2017-18

- Friday, 7th July 2017 (Haringey) 10am
- Tuesday, 19th September 2017 (Camden) 6:30pm
- Friday, 22nd September 2017 (Barnet) 10am
- Friday, 24th November 2017 (Enfield) 10am
- Friday, 26th January 2018 (Camden) 10am
- Friday, 23rd March 2018 (Islington)10am

Appendix A: Committee agenda

Friday, 7th July 2017 (Haringey)

Item	Lead Organisation
NCL Sustainability and Transformation Plan: Final plan including finance; Lead - Councillor Alison Kelly	NCL STP Project Management Office
NCL Sustainability and Transformation Plan: CCGs Joint Committee; Lead - Councillor Alison Kelly	NCL STP Project Management Office

Tuesday, 19th September 2017 (Camden)

Item	Lead Organisation
Camden and Islington NHS Foundation Trust Estates Strategy Lead - Councillor Alison Kelly	Camden and Islington NHS Foundation Trust
St Ann's Hospital Estates Strategy Lead – Councillor Pippa Connor	Barnet, Enfield and Haringey Mental Health NHS Trust

Friday, 22nd September 2017 (Barnet)

Item	Lead Organisation
Royal Free London financial update	Royal Free London NHS Foundation Trust
NCL Sustainability and Transformation Plan: Staffing and workforce Lead - Councillor Alison Kelly	North London partners
NCL Sustainability and Transformation Plan: Engagement Update	North London partners
North Central London approach to commissioning procedures of limited clinical effectiveness	North Central London CCGs
Dementia Pathway: To report following a meeting between borough commissioners to share good practice on provision within each borough including relevant statistics and work with acute providers*;* Lead – Councillor Graham Old	Borough CCGs and joint commissioners;

Friday, 24th November 2017 (Enfield)

Item	Lead Organisation
NCL Sustainability and Transformation Plan: Working together in North London to address social care challenges Lead – Councillor Pippa Connor	North London partners
North Central London consultation principles and updated approach to commissioning procedures of limited clinical effectiveness	North Central London CCGs
CL Sustainability and Transformation Plan: Estates Strategy Lead – Councillor Pippa Connor	North London partners

Friday, 26th January 2018 (Camden)

Item	Lead Organisation
Lower Urinary Tract Symptoms (LUTS) Service Lead – Councillor Martin Klute	
NCL Sustainability and Transformation Plan: Estates Strategy Lead - Councillor Alison Kelly	North London partners
NCL Sustainability and Transformation Plan: Strategic Risk Management Lead - Councillor Alison Kelly	North London partners

Tuesday, 6th February 2018 (Camden)

Item	Lead Organisation
North Central London approach to commissioning procedures of limited clinical effectiveness Lead – Councillor Pippa Connor	North London Partners

Friday, 23rd March 2018 (Islington)

Item	Lead Organisation
Ambulance Services Update Lead - Councillor Abdul Abdullahi	London Ambulance Service
NCL Sustainability and Transformation Plan: CCG Joint Commissioning Committee Update Lead – Councillor Alison Kelly	North London Partners
NCL Sustainability and Transformation Plan: Adult Social Care Lead – Councillor Pippa Connor	North London Partners

Appendix B: Additional areas of interest suggested at previous meetings for future consideration:

- NCL Sustainability and Transformation Plan:
    - CAMHS
    - Individual Workstream engagement and working together with local people
    - Equalities
    - CCGs joint commissioning committee – 6 month update requested at July 2017 meeting (due Jan 2018)
    - Mental health
- Health devolution
- Patient safety
- NMUH – Achievement of Foundation Status
- 7 day NHS
- Stop Gap Services (Maternity)
- Sexual Health Services
- NHS Providers
- Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute
- Health Tourism at the Royal Free; Lead – Councillor Alison Cornelius
- LAS including handover procedures and times following trial in A&E; NHS England; and changes to LAS targets for reaching patients
- Ambulance private providers
- Out of hours
- 111 (for July 2018)
- GP service in care homes (for July 2018)
- Screening and immunisation follow up including working with local authorities
- Missed GP Appointments
- Accountable Care Organisations
- Congenital Heart Disease Surgery national changes

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 26 JANUARY 2018 AT 10.00 AM
COMMITTEE ROOM 4, TOWN HALL, JUDD STREET, LONDON WC1H 9JE

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
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SUPPLEMENTARY AGENDA

Issued on: Monday, 22 January 2018

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 26 JANUARY 2018

SUPPLEMENTARY AGENDA

7. NCL ESTATES STRATEGY

(Pages 5 - 18)

To consider an update on the NCL estates strategy.

REPORT TO FOLLOW

9. NCL RISK REGISTER

(Pages 19 - 32)

To consider the North-Central London risk register.

REPORT TO FOLLOW

AGENDA ENDS

The date of the next meeting will be Tuesday, 6 February 2018 at 2.00 pm in Committee Room 4, Town Hall, Judd Street, London WC1H 9JE.

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NORTH LONDON PARTNERS in health and care

NCL NHS Estates

Simon Goodwin
NCL Chief Finance Officer
26th January, 2018

NORTH LONDON PARTNERS in health and care

This update will cover

- What does Devolution mean for NCL?
- What does the Naylor Report mean for NCL?
- Update on the main Estates priorities in NCL
- Governance
- Next Steps in the next six months

NORTH LONDON PARTNERS in health and care

What does Devolution mean for NCL in terms of Estates?

Devolution Commitments

1

A **London Estates Board (LEB)** to provide a single forum for NHS estate discussions in London, and in which to exercise devolved powers, including delegated business case approvals.

- The LEB was formed in December 2016 and meets bi-monthly to discuss estates matters.
- The LEB includes representatives from NHSE, NHSI, DH, HMT, STPs, CCGs, Providers, GLA, local government, NHS PS, CHP and OPE.
- The LEB is working with STPs and local areas to develop an up-to-date asset register and project list, and is brokering discussions to accelerate progress on identified priority sites.

2

A **London Estates Delivery Unit (LEDU)** to consolidate and align regional and regionally-based national resource to augment local/NHS trust estate expertise, planning and delivery capability.

- The LEDU was established in May 2017 and brings together all five STP areas, alongside representation from NHSE, GLA, property companies and OPE.
- A clear set of common estate themes have been identified for London as well as the requirements to manage and implement change.
- The LEDU has set up working groups to develop guidance, policy and clarity on numerous different estate matters.

3

Capital receipts generated by the London system **being retained within London** for reinvestment in health and care.

- National partners have agreed in principle to NHS Trusts and Foundations Trusts in London retaining capital receipts, on the basis that the LEB will identify how to reinvest these receipts to support agreed system-wide health priorities.
- The LEB is working with STPs to develop a pan-London capital plan based on robust local and sub-regional estates capital strategies.

4

Partnership working to **optimise the utilisation of the NHS estate.**

- A number of NHS sites are not being used to their full potential, with an estimated 15% of total NHS assets under-utilised.
- With support from local, London and national partners, the LEDU is working to prepare a London report on NHS estate utilisation.
- Once complete, the LEB will consider the recommendations set out in the report.

Phase 2 functions and what this means for NCL

Phase 2 Functions	Phase 3 Gateway Criteria	Requirements of NCL to enable progress to Phase 3
Continue to provide **single forum for NHS estates** discussions and enable whole system strategic estates planning, building a London view from local and sub-regional estates strategies	**Established business case support function**	
Support local and sub-regional areas to **develop clear estates strategies** aligned to clear commissioning strategies.	**Clear local and sub-regional estates strategies aligned to commissioning strategies**	The LEDU is working with STPs to assess the resourcing need to support business plan development. As part of this, practitioner training has been proposed for all Steering Group members. NCL to continue to support this work as required, and commit relevant NCL representatives to attend training.
Develop a **clear capital plan for London**, drawing from local and sub-regional estates strategies and ETTF bids. Supported by a clear list and status **of prioritised capital cases** under development.	**Clear capital plan for London**	NCL to review local estates strategies holistically to ensure that they are in alignment relevant commissioning strategies.
Develop a prioritisation framework for decisions.	**Pipeline of sites and agreed prioritisation framework**	NCL to continue to work to produce a strategic estates plan, built up from a clear clinical strategy, which will feed into the London capital plan.
Develop a **robust and professional business case support function** within the LEDU to support local and sub-regional areas.	**Agreement from national partners for the LEB to commence shadow running.**	NCL working to prepare a complete prioritised pipeline of sites, using a standardised prioritisation methodology as agreed with the LEDU.
Support sub-regional and pilot estates boards to take on **robust governance and accountability** functions to a sufficient standard to enable delegations and devolutions from national partners to be made to sub-regional level.	**Evidenced collaborative working**	NCL continuing to work collaboratively with the LEDU, LEB and London and national partners on estates matters, to focus on how they can work together to unlock site-related issues and deliver progress.
Consider **the recommendations of a London report on NHS estate utilisation.**	**Agreed governance and key appointments**	NCL agreeing a strong and established governance structure which brings together CCGs as well as Trusts, including the appointment of key roles.
Work with **national partners** to explore how **incentives** for the health and care system to release surplus land can be optimised.	**Signed MoU relating to internal delegations.**	
Work with DH, NHSPS and CHP to develop an approach for NHSPS and CHP investments and sales, which balances national and London needs and priorities.	**LEB membership review**	
Work with DH and sub-regional areas to ensure that when **surplus NHS sites are released**, this is done with due consideration of wider local health economy and public sector opportunities.		

What does the Naylor Report mean for NCL?

1) **Establish a powerful new NHS Property Board** which provides leadership to the centre and expertise and delivery support to Sustainability and Transformation Plans (STPs). It should be a strategic organisation, at arms-length from the Department of Health and structured so that it empowers speedy executive action and professional credibility within the sector. To include a regional structure, which is aligned with NHS England (NHSE) & NHS Improvement (NHSI) and brings together functions of NHS Property Services (NHS PS), Community Health Partnerships (CHP) and other fragmented NHS property capabilities into a single organisation.

Response: Not yet happened

2) **Establish the NHS Property Board in shadow form immediately** (involving key staff from NHS PS and CHP) and substantively by April 2018. It should consider if the functions and residual assets it inherits from the abolition of Primary Care Trusts (PCTs) should be divested back to providers. In the interim NHS PS and CHP should focus on addressing their well-documented operational challenges.

Response: No discussions underway yet in London

3) **The NHS Property Board should urgently bring together and expand the current strategic resources**

into a new national strategic planning and delivery unit to support local areas and strengthen capacity to deliver major projects.

Response: Awaited

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4) **The NHS Property Board should be the primary voice to the system on estate matters** and should work with national bodies to ensure that the system receives clear and consistent messages about the importance of developing a modern fit for purpose estate, releasing land and addressing backlog maintenance.

5) **The NHS Property Board should produce improved guidance on estates planning and disposals** for the NHS, covering the scope of estates planning, accessing private sector expertise, models for affordable housing for NHS staff and partnerships with both housing associations and developers.
Response: Awaited

6) **The NHS Property Board should produce improved guidance on building standards so they support the Five Year Forward View (5YFV) and deliver value for money.** This should gather evidence on the most appropriate estate models through the vanguards programme and should prioritise new guidance on primary care facilities.
Response: Awaited

7) **The NHS Property Board should improve transparency and intelligent use of data.** This should include extending the minimum estates dataset to cover all NHS funded care, improving the quality of existing data collections and taking ownership for the future development of the benchmarking developed as part of this review.
Response: No change as yet

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8) **The NHS Property Board, in partnership with other national bodies, should review processes to ensure they are proportionate and effective.** It should particularly consider the business case process, which is often seen as cumbersome, and a block to estates development.

Response: Processes have not yet changed to reflect this

9) **STPs should develop affordable estates and infrastructure plans**, with an associated capital strategy, to deliver the 5YFV and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board should support the development of these plans.

Response: Underway across both NCL and London as a whole

10) **STP estates plans and their delivery should be assessed against targets informed by the benchmarks developed for this review**. STPs and their providers, which fail to develop sufficiently stretching plans, should not be granted access to capital funding either through grants, loans or private finance until they have agreed plans to improve performance against benchmarks.

Response: This will follow on from 9

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11) At a minimum, the Department of Health (DH) and HM Treasury (HMT) **should provide robust assurances to STPs that any sale receipts from locally owned assets will not be recovered centrally provided the disposal is in agreement with STP plans.** This report recommends that HMT should provide additional funding to incentivise land disposals through a "2 for 1 offer" in which public funds match disposal receipts.

Response: The '2 for 1 offer' has not been implemented. No change yet in authorisation/decision-making processes re receipts

12) NHSE and NHSI should provide guidance on the relative roles of providers and STPs with respect of estate matters.

Response: No new guidance as yet

13) NHSE and the NHS Property Board should ensure primary care facilities meet the vision of the 5YFV. This should consider linking payments to the quality of facilities and greater use of fit for purpose standards. The NHS Property Board should support GPs to meet these standards, taking advantage of private sector investment.

Response: Good ambition, feels like there is an increase in primary care capital availability

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14) Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need. The NHS Property Board should support this.

Response: Welcome aspiration, nothing yet materialised though

15) Urgent action should be taken to accelerate the delivery of a large number of small scale and low risk developments to deliver housing.

Response: GLA becoming more involved, housing began to be discussed at London Estates Board

16) All national bodies should work together, sharing intelligence, to develop a robust capital investment plan for the NHS by summer 2017. This should maximise value for money and make a strong case for securing both the public and private investment the NHS needs.

17) Substantial capital investment is needed to deliver service transformation in well evidenced STP plans. We envisage that the total capital required by these plans is likely to be around £10bn, in the medium term, which could be met by contributions from three sources; property disposals, private capital (for primary care) and from HMT. **Introduction**

Sir Robert Naylor, 31.03.2017: www.gov.uk/government/publications/nhs-property-and-estates-Naylor-review

Estates Projects in NCL

- STP Priorities
- The big Capital schemes
  - St Ann's
  - St Pancras
  - Moorfields
  - Edgware Community Hospital
  - Finchley Memorial Hospital
- Disposals
- Voids

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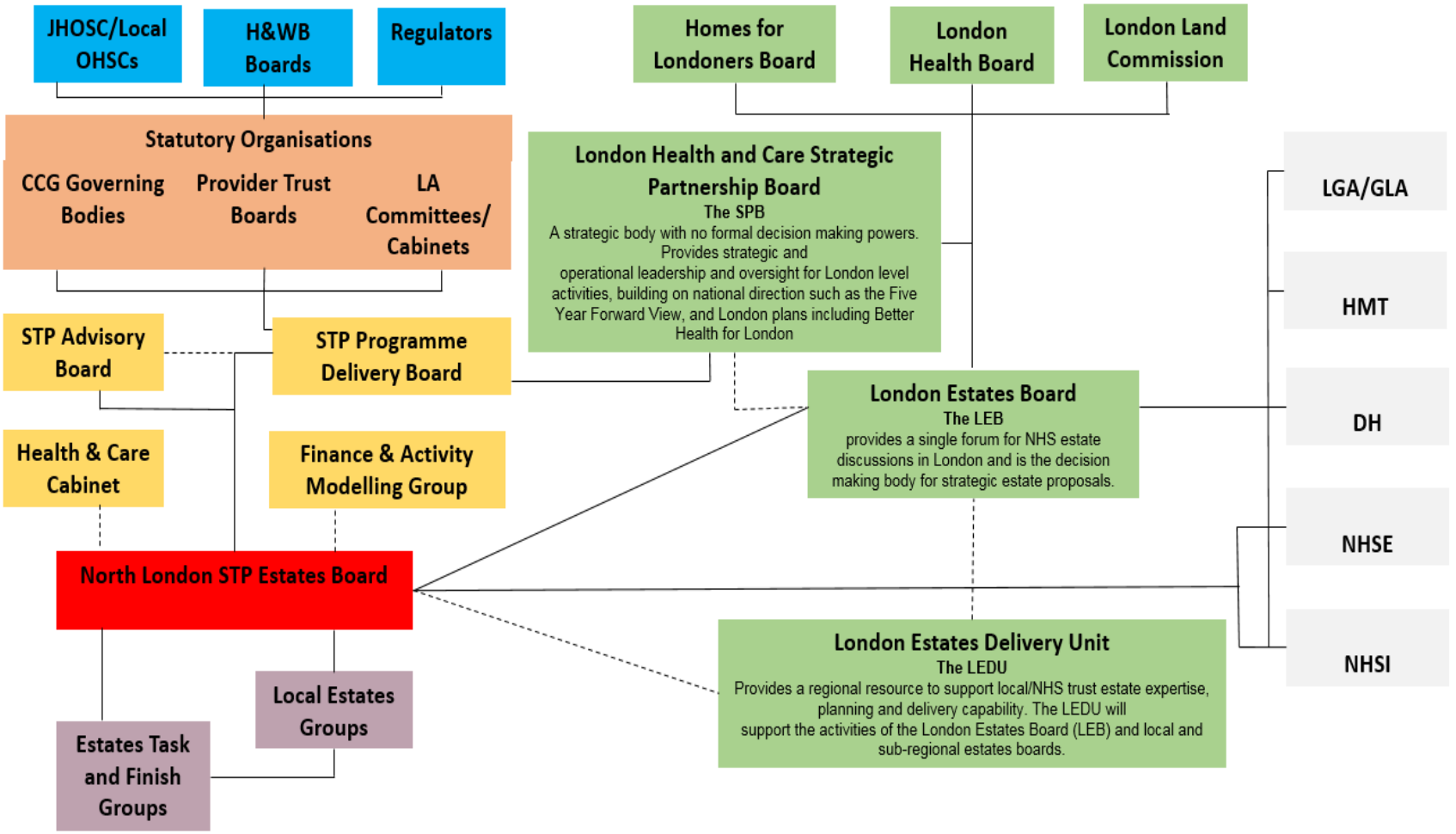
North London Estates Board Governance Structure and Operating Context



Next Steps

- Progress the big capital schemes
- Refresh the Estates Strategy
- Continue with void reduction work

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Joint Health Oversight and Scrutiny Committee

26 January 2018

Strategic risk management across North London Partners in Health and Care

Outline of pack

- Purpose of paper
- What: Our definition of strategic risk management
- Why: The importance of strategic risk management
- Where: Risks across programmes and organisations
- Leadership and governance across North London Partners
- How:
  - Role of the programme board
  - Process (for active monitoring and management)
- View of current strategic risks
- Challenges
- Next steps: improvements to risk management

Purpose of paper

This paper is designed as briefing for the Joint Health Overview and Scrutiny Committee on the North Central London (NCL) sustainability and transformation plan (STP) approach to strategic risk management. It outlines the approach to risk management and rationale for risk management across the programme.

It provides a view of the current high level risks and the next steps to review risks and management of these.

N.B. This work aligns with but not duplicate the creation of an NCL CCG risk register, for risks the CGGs are best placed to managed collectively such as retention of workforce.

What: definition of strategic risk management

- Strategic risk management is the active management of the strategic factors that could prevent or impact the ability of North London Partners in delivering the programme aims.
- Risk management is a crucial part of the approach, structures and processes of the partnership and those involved in delivering the programmes of work.
- Sits within the formal governance of the programme as part of how we want to work effectively and transparently with partner organisations and local governance bodies

Why: The importance of strategic risk management

Across North London Partners, effective risk management should lead to:

- Improved likelihood of meeting aims and objectives of programme
- More consistent decision-making based on good quality information
- Clearer lines of accountability across the partnership
- Avoidance of costly or avoidable mistakes
- Improved value for money – through ensuring focus on key barriers to success and increasing likelihood of delivery
- Increased ability to respond quickly and effectively to changes

Where: Risks across programmes and organisations

Risks can emerge from across the 13 programmes of work (listed overleaf) or from interdependencies between them. Therefore, in order to manage this effectively, the workstreams are represented on the STP programme board by each Senior Responsible Officer (SRO) (see next slide for clinical and SRO leadership).

In addition to programme risks, the programme could be impacted by individual organisaitons risks. Although the programme is not responsible for managing these, the STP programme board should also be sighted on any impact on oganisational risks via it's membership.

Leadership and governance across North London Partners

NORTH LONDON PARTNERS in health and care

NCL Programme Board (SROs)

NCL Clincial Cabinet

Input and membership of clinical working groups from across NCL CCGs and Providers

Clinical workstreams board/steering groups	Prevention	Planned care	Health and care closer to home	Mental Health	Children and young people	Maternity	Cancer	Urgent and Emergency Care
Clinical leads	Dr Karen Sennett (Islington) Dr Tom Aslan (Camden)	Dr Richard Jennings, (Whittington) Dr Ahmer Farooqi (Barnet)	Dr Katie Coleman, (Islington)	Dr Vincent Kirchner (C&I) Dr Jonathan Bindman (BEH) Dr Alex Warner (Camden)	Dr Oliver Anglin (Camden)	Professor Donald Peebles Mai Buckley (Royal Free)	Professor Geoff Bellingan (UCLH)	Dr Samit Shah (Islington) Dr Chris Laing (UCLH)
SROs	Dr Julie Billet (Camden and Islington)	Prof. Marcel Levi (UCLH)	Tony Hoolaghan (H&I)	Paul Jenkins (TAVI)	Charlotte Pomery (Haringey LA)	Rachel Lissauer (Haringey)	Kathy Pritchard Jones UCLH Dr Clare Stephens (Barnet)	Sarah Mansuralli (Camden)

How: management of strategic risks

Role of the STP Programme board

- The STP programme board is the escalation point for risks and defines the tolerance for management of risks across the programme
- Members of the programme board are assigned key strategic risks
- The board scans horizon for overlooked risks and appropriate management of these as well as receiving regular reports on risks being managed at a workstream level
- The board works within the principles for good governance set out for the NCL STP (see appendix 2)
- The board also delegate management of lower level risks appropriately in line with the risk process (below)

Process (for active monitoring and management)

- Risks are managed at a workstream level with senior responsible officers (Board level directors or equivalent) responsible for these unless escalated to the programme board due to level of risk (see risk scores on next slide).
- Workstream level risks are assigned a lead to take forward appropriate mitigating actions and report on progress.

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The matrixes here are used throughout the programme to score, escalate and manage risks.

Risk Assessment Matrix

Impact		Likelihood				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Catastrophic	5	5	10	15	20	25
Major	4	4	8	12	16	20
Moderate	3	3	6	9	12	15
Minor	2	2	4	6	8	10
Negligible	1	1	2	3	4	5

Risk level	Approach
Extremely high	Immediate action required and regular monitoring by the workstrean and STP programme board
High	Action required and regular monitoring at programme and if appropriate programme board
Medium	Programme lead to manage and monitor and maintain strict controls, additional action is discretionary
Low	Review at regular intervals action discretionary

View of current risks

The below are the current high level risks across the programme that have been identified and owners assigned. More detailed work on management of these will form part of a full review of risks to take place over the coming months.

Risk	Category	Likelihood	Impact	Owner
We do not work effectively with local communities to design and implement successful changes	Reputational	3	5	Helen Pettersen
Plans do not enable sector to meet control total	Financial	4	3	Simon Goodwin
Operational issues during winter prevent longer term planning and change	Operational	4	3	Paul Sinden
Partner organisations are not effectively involved	Reputational	2	5	Helen Pettersen
Changes proposed do not have impact required	Clinical/Financial	2	5	Jo Sauvage/Richard Jennings & Simon Goodwin
Complexity of various different (unaligned) regulatory frameworks slows or stalls progress	Legal	3	3	Will Huxter/Helen Peterson

Challenges

Risk management is ineffective when it is an add-on rather than integrated with other strategic and management processes. It is ineffective if the following exists:

- 'Silo' working rather than strategic approach at programme, organisational and board levels
- Lack of systematic approach i.e. risk management is not automatically embedded in strategic and day-to-day decision making
- Lack of understanding of benefits of effective risk management, its purpose and relevance for organisations involved in the programme
- Where it is considered purely a compliance exercise
- Lack of individual responsibility, lack of interest in, or awareness of risks and their management
- Weak or absent risk management processes or reporting
- Lack of clear reporting of risks and their management through organisation to senior management and strategic board

We know that as we move into implementation, we need continue to actively manage and improve processes to overcome the above challenges.

Next steps: improvements to risk management

- As we move to further implementation, we are looking to refresh and improve our risk management approach
- This will include a review of risk identification and management processes against public sector best practice
- This will link with the work on an NCL CCGs risk register – aligning risk scoring and escalation to ensure clear ownership of risks (without duplicating)
- We will be working with leads identified to ensure adequate management of risks identified
- In line with best practice on transparency we will aim to publish our strategic risk register - aim is to publish once review complete in April 2018

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Appendix 1: Governance principles

Agreed principles of governance across the programme

Principles of governance

The proposed set of principles for the NCL STP system governance, which have been developed collaboratively and endorsed by the STP Programme Delivery Board and Transformation Board are outlined below:

- ***Participation:*** Representation and ownership from health and social care organisations, local people and lay members to clearly demonstrate collaborative and representative decision making.
- ***Collaboration:*** All parties will work collaboratively to deliver the overall NCL STP strategy, in the best interests of the wider system and local people.
- ***Engagement:*** Local people will be engaged and involved in the NCL STP governance to ensure their feedback and views are considered in the decision making processes. This engagement should operate at 2 levels; individual level and organisational level (i.e. via patient representative forums and other local community groups).
- ***Accountability:*** Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation of work to the groups with the relevant expertise and authority to deliver it.
- ***Autonomy:*** Recognise the autonomy of the health and social care partners of the NCL STP. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS as a whole (e.g. legal responsibility for consultation on service changes). Ensure alignment with the local organisations' governance and decision making processes recognising statutory and democratic procedures.
- ***Subsidiarity:*** Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit for doing so.
- ***Professional Leadership:*** Demonstrate strong professional leadership and involvement from clinicians and social care to ensure that decisions have a robust evidence based case for change and senior level support.
- ***Accessibility:*** Ensure complete transparency in all decision making to support the development of mutual trust and openness between organisations. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups to ensure consistency.
- ***Good Governance***: Recognise that good system level governance will require robust planning and horizon scanning to ensure that proposals are presented to the statutory organisations in a timely way, that align with their local governance and decision making processes. However, where necessary local organisations will try to be flexible to support the system level governance