Agenda

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 13 MARCH 2020 AT 10.00 AM
COMMITTEE ROOM 1, ISLINGTON TOWN HALL, UPPER STREET, LONDON N1 2UD

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MEMBERS

Councillor Alison Kelly (London Borough of Camden) (Chair)
Councillor Tricia Clarke, London Borough of Islington (Vice-Chair)
Councillor Pippa Connor, London Borough of Haringey (Vice-Chair)
Councillor Sinan Boztas, London Borough of Enfield
Councillor Alison Cornelius, London Borough of Barnet
Councillor Lucia das Neves, London Borough of Haringey
Councillor Clare De Silva, London Borough of Enfield
Councillor Linda Freedman, London Borough of Barnet
Councillor Osh Gantly, London Borough of Islington
Councillor Samata Khatoon, London Borough of Camden

Issued on: Wednesday 4 March 2020

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
13 MARCH 2020

THERE ARE NO PRIVATE REPORTS

PLEASE NOTE THAT PART OF THIS MEETING MAY NOT BE OPEN TO THE PUBLIC AND PRESS BECAUSE IT MAY INVOLVE THE CONSIDERATION OF EXEMPT INFORMATION WITHIN THE MEANING OF SCHEDULE 12A TO THE LOCAL GOVERNMENT ACT 1972, OR CONFIDENTIAL WITHIN THE MEANING OF SECTION 100(A)(2) OF THE ACT.

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

4. DEPUTATIONS

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

6. MINUTES (Pages 7 - 20)

To approve and sign the minutes of the meeting held on 31st January 2020.

7. IMPLEMENTING NORTH CENTRAL LONDON'S NHS ESTATE FOR LOCAL PEOPLE (Pages 21 - 36)

Following a presentation to JHOSC in June 2019, there was a request

for a further update on NCL estates, including examples of work carried out to date.

This report sets out current progress and provides further details of how the estates work is supporting improvements to health and care for residents across NCL.

8. NORTH CENTRAL LONDON CARE HOMES (Pages 37 - 48)

There is a strong case for joint working between the NHS and local authorities to improve outcomes for care home residents in North Central London and this report sets out some of the work undertaken so far and addresses some opportunity areas of future development.

9. NORTH CENTRAL LONDON MENTAL HEALTH - SUPPORTING RESIDENTS AND REDUCING ATTENDANCE AT ACCIDENT & EMERGENCY (Pages 49 - 60)

This report sets out the priorities of the NCL work on Mental Health and provides further details of services that are working to better support residents and reducing attendance at A&E by people with mental health conditions.

10. IMPLEMENTING ELECTRONIC PATIENT RECORDS - BENEFITS REALISATION (ROYAL FREE NHS FOUNDATION TRUST) (Pages 61 - 98)

This is an updated report from the Royal Free on Electronic Patient Records (EPR) to identify the benefits of the scheme from the perspective of patients and health staff, and including insight from officers and clinical practitioners.

11. WORK PROGRAMME AND ACTION TRACKER (Pages 99 - 108)

This paper provides an outline of the 2019-20 work programme and action tracker of the North Central London Joint Health Overview & Scrutiny Committee.

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

AGENDA ENDS

The date of the next meeting will be Friday, 26 June 2020 at 10.00 am in Committee Room 2, Hendon Town Hall, The Burroughs, London NW4 4AX.

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 31ST JANUARY, 2020** at 10.00 am in Council Chamber, Haringey Civic Centre, High Road, London N22 8LE

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Tricia Clarke (Vice-Chair), Pippa Connor (Vice-Chair), Sinan Boztas, Alison Cornelius, Lucia das Neves and Linda Freedman

MEMBERS OF THE COMMITTEE ABSENT

Councillors Clare De Silva, Osh Gantly and Samata Khatoon

ALSO PRESENT

Councillor Melvin Collins from Hounslow, Chair of North West London JHOSC

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 Councillors Alison Cornelius and Clare De Silva.

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

Councillor Connor declared that she was a member of the Royal College of Nursing (RCN) and that her sister worked as a GP in Tottenham.

3. ANNOUNCEMENTS

Webcasting

The Chair announced that the meeting was being broadcast live to the internet and would be capable of repeated viewing. Those seated in the Chamber were deemed to be consenting to being filmed. Anyone wishing to avoid appearing on the webcast should move to the back of the room.

4. DEPUTATIONS

None.

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

There were none.

6. MINUTES

Consideration was given to the minutes of the meeting held on 27th September 2019.

A Committee member commented and the Committee agreed that in relation to item 6 Future Priorities for North Central London the agreed future priorities highlighted on page 46 of the agenda should be included:

- Reducing childhood obesity
- Improving mental health of children and young adults,
- Reducing inequalities and preventing illness;
- Improving air quality;
- Improving sexual health;
- Reducing the impact of violent crime;
- Improving mental health,
- Improving the quality of specialised care;
- Making health and care more personalised and joined up at every stage of a Londoner's life from birth to end of life;
- Improving the health of homeless people, and

In relation to item 9 Patient Transport the Chair had agreed to set up a meeting with David Slowman, Healthwatch and other interested parties.

RESOLVED –

THAT subject to above amendments the minutes of the 27th September 2019 meeting be approved and signed as a correct record.

7. PROPOSED MOVE OF MOORFIELDS EYE HOSPITAL'S CITY ROAD SERVICES

Consideration was given to a report of the North London Partners in Health and Care.

Jo Moss, (Director of Strategy and Business Development), Nick Strouthidis, (Consultant Ophthalmic Surgeon, Medical Director, Moorfields Eye Hospital NHS

Foundation Trust), Dr Dee Hora, Portfolio GP, Moorfields Consultation Clinical Lead, North Central London Planned Care Clinical Lead, London Clinical Senate Council Member and Emily Brothers, Oriel Advisory Group Chair (patient representative) presented the item to the Committee.

The Committee was informed that:

- The presentation was on the outcome of the statutory public consultation on proposals to relocate City Road Hospital Services to a new hospital and research centre on the site of St Pancras Hospital, just north of King's Cross and St Pancras stations in central London.

- The aspiration was to develop an integrated site combining the key strengths of both Moorfields Eye Hospital and their academic partner (UCL Institute of Ophthalmology) so that the combined services were integrated resulting in excellent clinical services and ground breaking research at this new site.

- NHS commissioners and Moorfields consulted people on the proposals during a 16 week period from 24th May to 16th September 2019. The period of consultation had been extended from 12 to 16 weeks based on the recommendation of this Committee to allow for the holiday period. The consultation was unprecedented in its scale and wide ranging as the hospital touched most parts of the Country in one form or another. There were 99 events and meetings, 2 radio interviews, 84,487 direct letters to patients, 17 articles in newspapers, there were discussion workshops and field visits to explore issues concerning accessibility of the proposed location, workshops to explore the potential design of the proposed new centre and these were adapted to audience needs. As part of an assessment of impacts on equalities and health inequalities, over 40 meetings were conducted with people with protected characteristics and rare conditions to improve the understanding of specific needs associated with the move. Total responses received from the various methods of consultation came to about 4,600.

- The Oriel Advisory Group (OAG) (a patient and public representative group) was established in January 2019 to advise on the process and plans. The Chair of the OAG was a member of the consultation programme board and provided feedback on the consultation to the Committee. The Chair of OAG informed the Committee that a consistent theme came from the written and discussion feedback from the consultation. This was that Oriel supported the proposition to move Moorfields Hospital to the St Pancras site providing an opportunity to improve the patient experience. The key issues of importance for those consulted were getting to and from the site from a major transport hub independently which fulfilled their way of independent living, the design of the building, importance of accessibility to the site from the last half mile, the location of the hospital and how to get there from particular points including reviewing and improving links to bus, rail and other means of support such as

a shuttle service drop-off and pick-up areas, creating a hazard free environment with tactile marking, a Green line similar to what was currently available at the City Road site, navigation technology linked to smart phones and good signage which was clear and accessible.

The Chair commented that she had been very impressed with the way the consultation had been carried out and conducted, she noted that the public and the Committee's concerns had been listened too. There were still concerns about the last half mile and working with Transport for London.

Responding to the chair's question about whether Oriel had felt listened too, the Chair of Oriel concurred that she had also been very impressed with the level of consultation. The advisory group had been involved right through the process, engaging in discussions with staff and commissioners. There had been changes in the method of consultation, where it was found that working with established organisations with better links made the process more effective. Anything that could improve learning was considered for example a great deal of work was carried out on various accessible consultation documents. Learning gained from the consultation indicated that use of the documents was a more complex way of presenting the information whereas doing it on a face to face basis was more effective. There was still work to be done in making the technology easier to use.

Responding to further questions from Committee members, officers from the Trust gave the following responses:

- One of the benefits of the move to the new site was a reduction in the Carbon footprint which would be done in a much more efficient and effective way. It had not been made clear in previous documents, however going forward the importance of a high standard of sustainability would be made much clearer in the narrative.
- In respect of the risks of increasing costs due to delays, the business case for the project would be in 2 stages to mitigate the risk of costs. It was assumed that in this case there would a 25 per cent contingency of the total cost. Then in about 18 months' time another business case would need to be submitted once there was certainty around the sale proceeds of the City Road site and confirmed proposal from a construction team on how much they would charge to build a new building. It would only be at that point once there was certainty about these two significant financial figures would approval be given to proceed with the project. At that point the percentage of contingency allowed would be reduced to about 10 per cent of the project. It would be a real risk but there were mechanisms in place to help manage and mitigate the risk from occurring.
- The Trust partners would not be able to do anything about the business case until the Commissioners had made a decision about the public consultation but subject to that it was hoped that the trust would proceed with the business case in March.

- In relation to the public consultation process the Gypsy traveller Community and black community were fully considered within the full health and equality integrated impact assessment. The issues that came out of that report indicated that there was as much of a potential positive benefit as a negative impact. For example the City Road site had a number of inhibiting factors for patient groups with certain protected characteristics and there was an opportunity to change this when working with those groups.
- As well as all the public consultation events a lot of thought went into where those events were held and mechanisms used to reach particular population groups that could be a little more difficult to reach and those groups that might not have been so forthright in coming to events. There was also a desktop exercise at the same time, so those things were considered together in order to have a full consideration of all potential population groups that could be affected. A broader view was taken than those listed in the Equalities Act and that was why these groups were more fully considered.
- The consultation on this project required an enormous amount of planning and attendance at numerous other meetings and events. It has served as good learning point for other events and projects.
- At the outset it had not initially been thought through about the many different groups requiring consultation. However the learning from pre consultation meetings provided a fuller understanding of the many different groups affected. There was now a much fuller list of all the groups that could be potentially accessed. Having the complete fuller long list at the beginning of the process would allow more thorough engagement. There was always more that could be done in reaching out to all the communities.
- Accessibility was one of the most important issues during the consultation, as a result towards the end of the consultation two different workshops were held specifically on accessibility. Colleagues from the RNIB and Guide dogs were invited to get their expertise and input in to how to mitigate the issues highlighted. Also involved were the design team that had been appointed from the Oriel perspective, at that point nobody from TfL, the Highways Authority or local authority was included because the Trust was not able to get into the detail of that until the consultation process had concluded. Subject to the decision of the Commissioners in the next few weeks, the intention would be to rapidly start those conversations again so the Trust could get into the detail about what was feasible to come to solutions. In terms of who would fund this, it would be part of the business case so in effect it would be the joint project that would be funding this. There was provision in the contingency for this at the next stage of the project it would need to be much clearer in the contingency plan what the proposals were. At the moment there was a very long list of ideas and different solutions. In 12 to 18 months' time there would need to be clarity as to which of those proposals would be implemented. So clarity about the proposals would be better.
- There would be no costs to patients in the long run. A discussion that was required with TfL was an increase in the number of bus routes as concerns had been raised by patients coming from the Eastern part of London about

increase costs of travel because the bus routes from East London to the proposed new sites were not as good and cost of travelling by tube was more expensive. These were conversations that needed to be had with TfL.

- The new centre would take over all the functionality of the hospital and would also include a research centre and an education facility. All the clinical functions taking place at City Road would be transferred to the new site. It would generate modern pathways and more methodologies for treating patients.
- The new centre would be broadly the same size as the space at City Road. The actual physical building would be a bit bigger because it would be integrated with UCL, so it would be a bit bigger than the current hospital. The language used was deliberately chosen not to call it a hospital but a centre to portray the radical different new ways of working.
- It was projected in the business case that there would a 3.1% year on year increase in the number of out-patients. It was entailed that to cover this, there would be a similar increase in the number of staff to see those patients.

Councillor Melvin Collins from Hounslow, Chair of North West London JHOSC, declared a non pecuniary interest as he had been a patient of Moorfields Hospital since 1948. He raised concerns that the new site would be a centre for research and education to the detriment of the patient and their clinical needs. He asked for a lot more reassurance that the services for the patient would be retained and maintained alongside research and education because all three went hand in hand. Reiterating previous comments by a Committee member he was of the view that removing the word 'hospital' meant that Research and Education had more prominence in the centre than the hospital and that all proceeds from the sale of the building would be used for the new site.

Responding to the queries raised by Councillor Collins, officers from the Trust commented that they provided the fullest assurance that the primary aim was to provide the best possible care of the patient particularly, those with eye and vision problems. It was all about the care of the patient the footprint of the site was largely to do with clinical services.

In respect of ambulatory care, at the moment Moorfields had 5 hospital beds which would be retained at the new site. There was no intention to remove the in-patient facilities. It would not be able to function as an eye hospital if there were no in-patient facilities. The ambition relating to research and educational facilities was on the understanding that the centre could not excel in delivering health care how it wished, without having the ability to partner more closely with the ability to educate health care and science professionals of the future. Research was vital to the improvement of healthcare and the disconnect that currently occurred because of this was holding the trust back from breakthrough in invention and innovation. It was all about the ambition to drive through better care for people with eye problems.

In terms of the busts from the old site, the hospital had been around for over 220 years and it was proud of its history and forebears these would be recognised on the new site.

In terms of the patient experience, the current site was very old and inflexible, the clinics were necessarily located in ways that could not help people move around easily. The new build would provide this opportunity.
Any money from the sale of the old site would be invested in the new site. There would also be work with Islington Council to ensure that any use of the old site would be in line with the requests and the needs of the local residents.

The letter written on behalf of NCL JHOSC which was its reflections on the Moorfields consultation, was circulated to Committee members. It was suggested and agreed that the following additional wording be added to paragraph 5 of the letter ' we encourage that you continue to widely engage with all communities, even those hardest to reach and to note and share any learning including engagement with those groups'

It was also suggested that:

- 'when getting to the next stage in the process- the design stage- co-production with the various groups continued; and
- Given the aims of both Camden and Islington to reduce carbon emissions, the highest standards of sustainability are achieved in the new development,'

Are included in the letter.

The Chair commented that the NHS Foundation Trust had done very well with the consultation and thanked the officers for all their hard work. There were some issues which had been raised but she asked that their learning and methodology is shared with other organisations.

RESOLVED –

THAT the report be noted.

8. NORTH CENTRAL LONDON HEALTH AND CARE INTEGRATION

Consideration was given to the report of North London Partners in Health and Care (NLP), the report was introduced by the Independent Chair.

To questions from Members, Mike Cooke the Independent Chair and Will Huxter, Director of Strategy NCL CCG gave the following responses:

Concerns had been expressed about the merging of Clinical Commissioning Groups (CCGs) into one. However, there had been complaints in the last few years about how the system worked with a lot of staff wrapped up in day- to- day transactional

arguments and no member had requested to maintain the status quo. There had been one borough leading on behalf of the others in relationship with some of the very big providers which it was not quite equipped to do. The merger would bring together all that capacity and capability to do things once. To point to the relationships and improve the relationships both commercially, contractually and where patient care quality would be at the heart of this with the big providers. Bringing staff together in that way would be a really good thing.

Questions had been raised about one aspect of the Governing Body. The Governing Body was a mirror of what happens within the 5 governing bodies at the moment. There was not a lot of change proposed just that it would happen once. Healthwatch representation around Governing Bodies would be there in the future. There were some statutory rules which applied to CCG Governing Bodies that included who could and could not be voting members. Local Authorities (LA) could not be voting members. Normally portfolio holders attended current governing body meetings the proposal was that this would continue on the one seat basis. The portfolio holders had chosen to rotate this but did not have to, it could be done on a different basis. There was a Joint Committee in common which portfolio holders were invited to, their attendance was quite low. The CCG Governing Body would be meeting 4 times a year to consider the commissioning of some very important things like Mental Health Services but it would not be doing what it is doing now. This Committee will be overseeing things from a system point of view which would continue to be important. The point of governance and governance engagement would be at borough level, Health and Wellbeing Boards would be even more important than they are now and Partnership Boards were springing up at borough level and North Central London (NCL) level and would be at the forefront in this new system. In terms of openness, transparency and accountability, it would mirror the current arrangements. The GP elected clinical representatives felt passionate about involving residents in their decisions.

One of the pieces of work led by Barnet Directorate of Public Health was to look at health inequalities borough by borough and provide an overall picture across NCL. It was known that whether looking at activity or outcomes there were pockets of the population less well served by current services than they should be. There was relative low level of investment in community services in some part of the patch than others. Consequently people were not getting quite a good service, so the ambition was absolutely one of improvement. The ambition was to consistently deliver high quality services for everyone.
At previous NCL JHOSC meetings there was discussion around the approach being taken around Elective Orthopaedics and it was a precursor about the approach intended for Strategic Commissioning for the future, looking right across the piece then looking with residents about what the most appropriate configuration organisational services should be.

In relation to staffing, the restructure was still on going, it was filtering down to the lower levels. There was a requirement for cost reduction by 20% which the restructure would achieve. There was no short term ambition to be draconian, in

about 18 months' time there would be a need to look again at the restructure to determine whether this was the right structure and people were in the right place. The intention was to achieve this through natural wastage.

In terms of privatisation – the NHS was a complex situation in terms of its relationship with GPs and their status as independent entities who ran their own small businesses. The ambition in NCL was to make sure the clinical work that needed to be done for residents and patients was done by NHS providers in NCL wherever possible. There were lots of financial benefits and privatisation was not part of the thinking whatsoever.

Answering a further question about the structure required to reflect the needs of local people, the Independent Chair commented that it was a perennial issue, where local government interfaced with the NHS the opportunity for democratic oversight intertwined with democratic accountability beyond JHOSC did not exist on a local level. He felt that the best way of working together to ensure the needs of residents were placed at the centre of everything that was done, was by working closely together in partnership so that democratically elected representative members could represent their constituents around the partnership table. Making sure that all NHS organisations consult on and design services around residents, making sure residents were part of the design process. There were number of examples of this that were starting to happen such as the Moorfields Hospital move, local approaches in Haringey and Camden Citizens Assembly.

A member pointed out that in referring to local accountability, Health and Wellbeing Boards was not mentioned in the table within the report.

The Chair informed Committee members that discussion about the structure of local accountability could be discussed further at the informal consultation meeting which the Independent Chair had offered to host.

ACTION BY: Independent Chair

RESOLVED –

THAT the report be noted.

9. GENERAL PRACTICE STRATEGY FOR NORTH CENTRAL LONDON

Consideration was given to the report of the North London Partners the report was introduced by Dr Katie Coleman, the Clinical Lead for the NCL Health and Care Closer to Home programme and Keziah Bowers, the Programme Manager for NCL Health and Care Closer to Home programme.

Responding to questions from members the Clinical Lead for the NCL Health and Care Closer to Home programme and the Programme Manager for NCL Health and Care Closer to Home programme gave the following responses:

- In relation to the Primary Care Network the main concern related to money, the service was being asked to do a lot more with no money.
- The situation relating to the service was that the new contract had been centrally negotiated with NHS England and the General Practioners Committee and was directed down into general practice and the Primary Care Network as such there was limited influence with these negotiations. The responsibility of NCL was to look at the opportunities and understand how they could be enhanced and work with general practice to work through some of the complexities.
- Recently NHS England conducted a period of engagement around the requirements for Primary Care Networks around 2020/21 asking for feedback, this feedback was collated from NCL and fedback nationally what practices and clinicians had said.
- In relation to finance and funding and the concerns around no additional resources, the contract that was negotiated in January 2019 and implemented in July 2019 came with a significant amount of additional funding which was attached to additional staff. Over the course of the 5 years additional staff would be supported to be employed into general practice in order to address capacity issues and to start to deliver on the specification that were linked to this new enhanced service. The aspiration was 70% of those additional staff would be centrally funded through the new enhanced service and the new contract and 30% would be funded at a practice level. The risks and concerns that had been identified was that when the new specifications came out, there was an expectation of additional funding which did not materialise so any additional resources would be linked to these additional people. These people needed to be employed and in place before the funds were released. These significant concerns were picked up in the feedback to the consultation.
- There were additional concerns in London relating to London weighting which had not been accounted for in the additional funding and the expectation that funding would be the same across the Country placed significant additional risk to General Practice in London.
- The additional aspect was that many of the outcomes expected to be delivered with this enhanced service were system led outcomes. They were not solely reliant on General Practice they could only be delivered by systems working together. So to expect Primary Care General Practice to bear the risk on their own, carry the cost of the additional 30% was not in the best interest of the system. There was a need therefore to look collectively across all the providers to determine how the risk could be shared and work as a system. This had been relayed to NHS England.
- The additional concerns highlighted were that when you looked at London, Physio's, Pharmacists and other providers they were often paid at a higher rate than what had been identified in the specification, it has not really been

determined how the system could support and address these issues. This was something that needed to be done across NCL in conjunction with all the partners.

- There was significant reduction in GP Partners across London and the country and the concerns were how to encourage young GPs to stay in NCL and to continue to deliver care to NCL. Fellowship programmes, peer support and mentoring programmes to encourage people to stay in London had started to take place.
- Providing direct funds and collaborative support to failing practices to raise the bar and improve care to local residents.
- Increasing visits to Care Homes to increase the care and support of people in Care Homes.
- Anticipatory care and personalised care, Identify what was important to people, strengthen what they have and what they do in their local communities.
- Even though there were significant risks, there was a real strong offer in NCL.

The Chair commented that it was a work in progress, reminding them to put residents at the heart of everything they were doing and invited the Clinical Lead for the NCL Health and Care Closer to Home programme and the Programme Manager for NCL Health and Care Closer to Home programme back to a future meeting to provide an update. For future updates the Vice Chair asked that commentary be provided on the risk of the Primary Care Network not holding together.

ACTION BY Clinical Lead for the NCL Health and Care Closer to Home programme, and the Programme Manager for NCL Health and Care Closer to Home programme

RESOLVED –

THAT the report be noted.

10. ROYAL FREE LONDON FOUNDATION TRUST FINANCIAL UPDATE

Consideration was given to a presentation on the Royal Free London Trust's finances.

Tim Callaghan (Director of Financial Performance and Deputy Chief Finance Officer, RFL) and Deborah Sanders (Interim Chief Executive, Barnet Hospital) addressed the Committee on behalf of the Royal Free. They provided an update on the Trust's finances.

The Director of Financial Performance informed the Committee that the organisation was in a system which had financial challenges. Royal Free Hospital (RFH) was a large provider in the sector which had its own financial challenges. A significant

change this financial year compared to last year was that it was able to accept a plan from a regulatory perspective. From an overall sector perspective RFH was on plan to meet its savings target of £61m. If this was achieved £31.8m of additional funding would be made available. For this financial year it remained at and slightly above the internal trajectory, there was no particular cause or risk associated with the rest of the year. At the end of this financial year it would have hit 4 consecutive years of recovery back to a position which would achieve long term financial sustainability. This was highlighted on page 116 of the agenda.

The following responses were provided to Committee members questions:

- In terms of deficit projection, RFH was given a trajectory for financial improvement requesting that the organisation move in the right direction. RFH has been on a deficit improvement trajectory for a number of years and as long as it kept achieving those milestones there was a centralised national resource as an incentive for achieving those improvements.
- In relation to the acronyms this was noted and a glossary would be provided next time to explain the meaning of words.

ACTION BY Director of Financial Performance and Deputy Chief Finance Officer, RFL

- EBITDA referred to a summarised position within the income and expenditure statement with inflows and outflows before all the impacts of capital costs and depreciation costs of the buildings and estates were included. This theoretically sets a level platform for organisations overall operational financial performance without taking into account the buildings and environment costs. FRF and PSF were used for sustainability funding.

- In terms of savings and quality, a very well embedded quality impact assessment process was expected which was very sensible to have. The monthly savings proposals which had worked its way up through the divisions, were reviewed by senior officers in the organisation. It was only as and when senior colleagues from the Clinical perspective were comfortable with the proposals would the savings plan proceed. The savings plan could not proceed until it was signed off by a director.
- Alongside that there was an independent view provided by a Clinical Advisory Group which was made up of senior clinical staff from across the organisation that did not have any managerial responsibility, so it was felt they were not conflicted in any way. They carried out regular reviews of all the schemes as they went forward to give an independent view on whether they thought there might be any clinical quality impact. The chair of the group reported on a quarterly basis to the Group Executive of the Committee. There had been instances of where schemes had been put forward and turned down through either of these processes because of concerns about impact on quality.

- In relation to whether money could be put back in to a service, the issues with performance were not because of cuts, there were many other reasons why performance was impacted. The ability to invest was something that was constantly being balanced for example something that was impacting on cancer performance was access to diagnostics, investing in new MRI's that was something that would help. It was a situation of constantly balancing out where money was invested in this financial context.

- In relation to agency staff, they were a very important part of the staffing. The organisation worked really hard to make sure that reliance on agency staff was reduced as much as possible. The biggest use of agency staff had been in Nursing and Midwifery. However with significant savings on the agency premium the organisation had been able to use that money to invest in permanent staff. Nurse turnover and vacancy rates were probably the lowest they had been for years the key to which was retaining those staff and there were various schemes in place to retain staff. There was always work to do on this.

The Chair commented that there was a question posed for all the Trust which had been asked before and were still waiting for an answer, this related to sale of capital assets by the Trust and the question related to where the money was and where it was going too. There were concerns that the capital receipts would be used to underwrite revenue deficits. It was a warning that this question would be coming up again.

RESOLVED –

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

11. WORK PROGRAMME AND ACTION TRACKER

Consideration was given to the work programme and action tracker.

Members agreed that items they wanted to consider at the March meeting were:

- Estates Strategy report
- Electronic Patient Records
- Workforce in the Care Home Setting
- Reducing A&E Attendance

It was agreed that the Diabetes Services and Support Services be considered at the meeting in June. Supporting residents with allergies would be included on the Work Programme once the report on the recent incident came out. The informal meeting to be hosted by the Independent Chair NCL CCG merger should also be included on the Work Programme.

RESOLVED –

THAT the work programme be amended, as detailed above.

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

None.

The meeting ended at 12.14 pm.

CHAIR

Contact Officer: **Sola Odusina**
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MINUTES END

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE **Improving NCL's NHS estate for local people**	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE** 13 March 2020

SUMMARY OF REPORT

Following a presentation to JHOSC in June 2019, there was a request for a further update on NCL estates, including examples of work carried out to date.

This report sets out current progress and provides further details of how the estates work is supporting improvements to health and care for residents across NCL.

Contact Officer:

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RECOMMENDATIONS

1. To note the report and progress made to date, highlighting any particular issues to be covered in future meetings of JHOSC.

- Appendix A - Improving NCL's NHS estate for local people

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Improving NCL's NHS estate for local people

JHOSC 13 March 2020

Nicola Theron, STP Director of Estates
Richard Dale, Programme Director NCL STP

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NHS

Context and introduction

Following a presentation to JHOSC in June 2019 there was a request for a further update on NCL estates work including examples of work carried out to date.

This presentation sets out the progress we have made and provides further details of how our estates work is supporting improvements to health and care for residents in NCL.

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NCL's estates overview

- NCL has an active investment and funded pipeline (current value £1.1bn*) with a significant number of unfunded projects
- NCL seeks to release value from buildings and sites that are no longer needed for health services (current value £570m*)
- At NCL and trust level, disposal receipts are recycled into new buildings
- All capital spend needs effective clinical leadership, with population health data supporting that spend
- Our aim is to manage and accelerate delivery, while also limiting the revenue implications
- We need to demonstrate leadership, capacity, effective governance and partnership working to gain Health Infrastructure Plan** funding
- Estates investment brings the opportunity to secure strategic workforce and digital outcomes

* Values all indicative and as at March 2020

** Funding from the Department of Health to invest in health infrastructure and facilities

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Estates progress 2019

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Governance & Leadership

- Established estates structures, oversight and workstreams
- Improved leadership with Director of Estates and SROs
- Working toward single CCG

Vision for care

- Orthopaedic review will improve quality and efficiency of services and estates
- Mental Health improving inpatient and community services
- Maternity review to commence
- Estates Locality Planning finding space for OOH services

Optimisation

- Continuing improvements at Finchley MH producing better care and £1m saving
- Edgware CH masterplan developing
- Core estate programme identified actions to address £1.5m voids

Value for reinvestment

- 2,600+ housing units created through site release
- 1,000+ housing units anticipated by 2025
- Research to calculate key worker housing demand
- £230m+ receipts achieved for reinvestment
- c. £200m receipts anticipated by 2025

Priority Projects Primary & Community

- Barnet – Colindale schemes supporting 4,000+ new homes, received significant S106 funds
- Islington – Village Practice on track to create 600+ more appointments/week, Andover & Archway progressing at pace
- Haringey - progressing design & business cases - Tottenham Hale, Green Lanes and Wood Green – new integrated health centres for population growth
- Enfield – Meridian Water supporting growth of 14,000 homes (Phase 1)
- Camden – focus for updated priority schemes

Investment funding

- Continued success with One Public Estate and S106 in Barnet
- £500k OPE funding secured for a programme across Islington and Haringey
- £1.2m funding from Community Health Partnerships
- £100m+ Wave 4 STP funding
- £20m+ awarded to primary & community schemes

Priority Projects - Acute

- BEH St Ann's redevelopment Phase 1 on time - new inpatient facility in 2020 and 400+ homes
- 119 beds at RNOH delivered under budget & on time
- £14m RFL acute decontamination reconfiguration completed

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NCL investment programme

- 53 live investment projects, current investment of £561m, including:
  - 31 provider led (including St Pancras, Oriel, St Ann's)
  - 8 new build primary care projects using NHS England's Estates and Technology and Transformation funding
  - 7 smaller primary care internal projects funded by NHS England Improvement Grants
- Variety of funding sources:
  - Core Department of Health Public Dividend Capital
  - S106/Community Infrastructure Levy/Local Authority
  - Third party developers/GPs
  - NHS Property Services /Community Health Partnerships
- All projects bring different revenue implications
- Approval processes for each project are considerable
- Each project carries considerable risk

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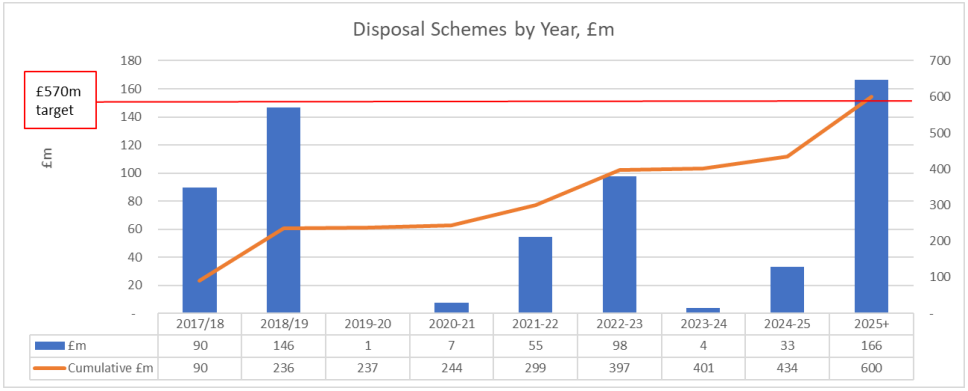
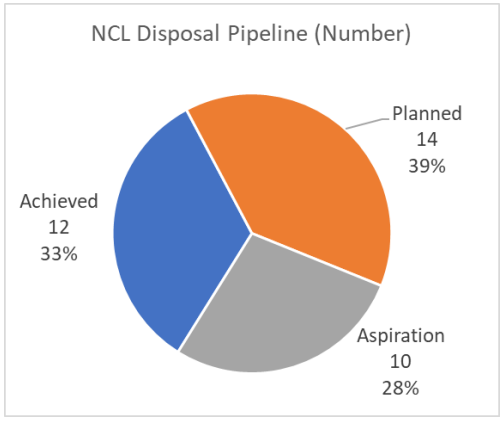
NCL's focus on releasing value from NHS surplus sites

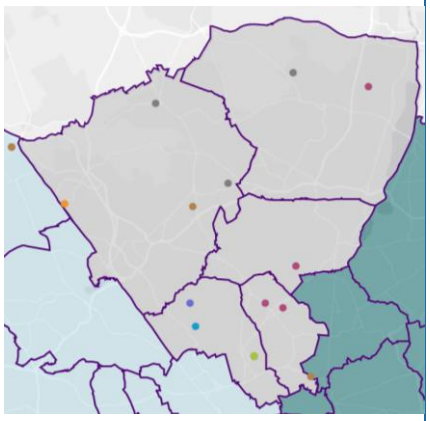
NHS

NCL Surplus Update Summary



	2017/18	2018/19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025+
£m	90	146	1	7	55	98	4	33	166
Cumulative £m	90	236	237	244	299	397	401	434	600





Naylor review targets:

- NCL was assigned a target share of disposal receipts of £570m. This is nearly one-quarter (21%) of the national target. DHSC calculated this to equate to 4,704 housing units.

High level statistics

- Nine sites in in the 2018 Estates Strategy have been sold. Overage receipts were achieved when some sites were sold on after disposal.
- Five sites were withdrawn. This was to retain for a healthcare use or for temporary use to support current healthcare sites
- 12 sites were added to the pipeline since 2018; 7 of these have been sold
- 2,686 housing units have been or will be created from pipeline sites. This is 57% of the target

Other achievements:

- We are working with Healthy Urban Development Unit to map disposals across the system, to consider wider system opportunities and maximise the potential for integrated services working partners including councils

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NCL Investment and Disposals

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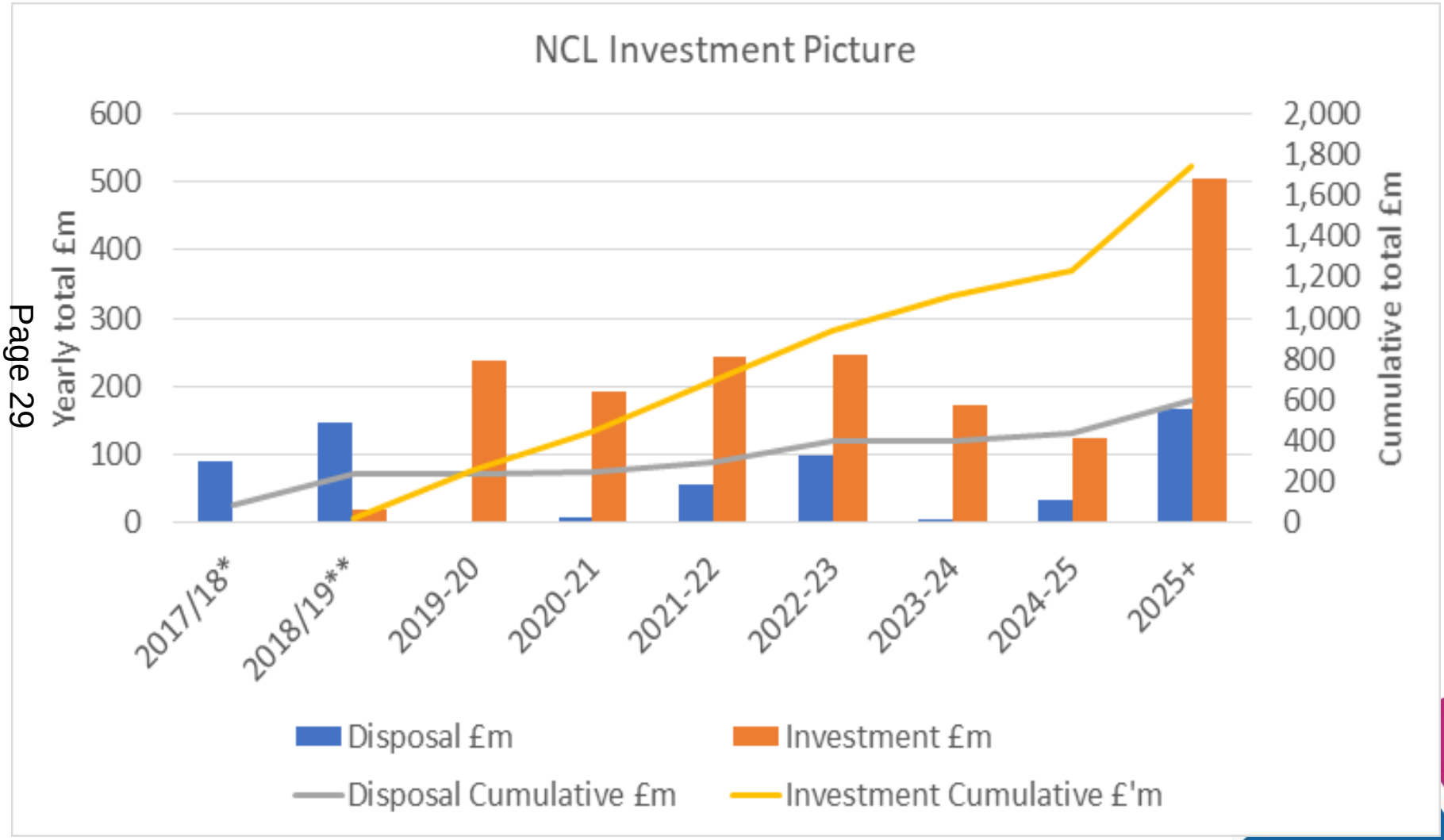

** Investment data was not available for 2017/18*
*** Investment data for 2018/19 is incomplete*

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Recent NCL estate investment

NHS

GOSH - Zayed Building Research

UCLH - New Eastman dental hospital

BEH – St Ann's Hospital Haringey

RNOH – Stanmore new wards

Hornsey Health centre – configuration

Amwell group practice – configuration

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NCL recent case studies

NHS

New Investment into specialist London Hospital – UCLH

- The Royal National Throat Nose and Ear Hospital & Eastman Dental Hosp. have benefited from a new state-of-the-art building on Hutley Street
- The new centre opened October 2019 and is one of the largest specialist centres of its kind to provide integrated service supporting UCLH's reputations for world leading care.

Investment into mental health – new in patient unit at St Ann's, BEH

- Blossom Court, five years of hard work has delivered a new inpatient facilities due to open in July, and will be one of the best mental health wards in the county, with phase 2 to follow
- The GLA bought the surplus land to create new family houses and flats for local people, 50% of which are affordable housing
- 22 of the flats will be available to the trust to help recruitment

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NCL recent case studies

NHS

Zayed Centre for Research into Rare Diseases – GOSH

- Opened in Oct 2019, the Zayed Centre for Research into Rare Diseases in Children provided facilitated for 500 researchers and clinical staff;
- The research facility provides eight-storeys of academic research workspace, seminar and meeting spaces, specialist laboratories and outpatient clinics for children and young people.

Phase 1 of the Stanmore development – RNOH

- The Stanmore Building (TSB) is the first building to be built as part of the hospital redevelopment on the Stanmore site;
- The TSB accommodates Adult Acute and Children and Young People wards, with embedded therapy and multi-disciplinary team areas;
- First patients benefited from the new space in December 2018;
- The building was delivered on time and within budget.

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NCL recent case studies

NHS

Investment into primary care - Haringey CCG

- Two new clinical rooms at Bridge House and Fernlea practices, and three clinical rooms at Westbury practice;
- For these seven room and associated space to support an extra c10,000-13,000 patients, reflecting projected population growth;
- Using core estate harder, so no impact on CCG costs whilst improving quality of care .

Investment into Barnet Hospital Urgent Treatment Centre – Barnet CCG

- CCG and Royal Free London have successfully secured c.£900K of s106 funds to fund a new urgent treatment centre;
- Fantastic example of commissioners and trust working in collaboration on a transformational project to better manage the increasing demand on A&E services at this busy hospital.

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Estate strategy and next steps

- NCL's Estate Strategy refresh being finalised (March/April 2020), to include:
  - NCL investment plan, including priorities projects
  - Emphasis on investment in the community estate
  - Those assets that are surplus to requirements
- Further work underway to explore:
  - Backlog maintenance requirements
  - Revenue funding required for scheme development
  - Developing a consistent approach to S106/Community Infrastructure Levy funding
  - Further develop our approach to council-led, shell and core delivery
  - Refine the priority projects ready for approval process by Autumn 2020

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Glossary

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HIP – Health Infrastructure Plan, funding from Department of Health

ETTF –Estates, Technology and Transformation Funding, from NHS England

IG –Improvement Grant Funding, from NHS England

OPE – One Public Estate funding from Department of Housing, Communities and Local Government

DH PDC – Department of Health Public Dividend Capital

NHSPS/CHP – NHS Property Services and Community Health Partnerships (The two NHS property companies)

HUDU – Healthy Urban Development Unit

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North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	London Boroughs of Barnet, Camden, Enfield, Haringey and Islington

REPORT TITLE

Working to improve lives for residents of Care Homes in North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE** 13 March 2020

SUMMARY OF REPORT

There is a strong case for joint working between the NHS and local authorities to improve outcomes for care home residents in North Central London. This report sets out some of the work undertaken so far and addresses some opportunity areas of future development.

Contact Officer:

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RECOMMENDATIONS

1. To note the report and progress made to date, highlighting any particular issues to be covered in future meetings of JHOSC.

- Appendix A - Care homes in North Central London

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NHS

Working to improve lives for residents of Care Homes in North Central London

Emerging joint work and case studies of work so far

NCL Joint Health and Oversight Scrutiny Committee

March 2020

- Richard Dale, Programme Director NCL STP
- Richard Taylor Elphick, Adult Social Care Programme Lead, North London Councils
- Dan Windross, Assistant Director, Community and Transformation, Islington CCG

BARNET LONDON BOROUGH ENFIELD Council ISLINGTON Haringey LONDON Camden

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Context: Care homes in North Central London

- NCL has around **6,000** care home beds (around 2,500 nursing and 3,500 residential beds) - more than the number of acute beds in the sector.
- NCL local authorities currently buy approx. 1000-1100 nursing placements and 1600-1700 residential placements (based on snapshot data from London ADASS).
- NCL CCGs currently spend approx. **£40m-50m** – representing approach 700-800 nursing home placements.
- Many of the placements made by CCGs and Councils are with the same providers.
- NCL care home residents have significant use of acute care services and primary care.

Given the above, there is a strong case for joint working between the NHS and local authorities to improve outcomes for our care home residents. This presentation sets out some of the work so far and some areas of future joint work.

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Case for change

Residents within our care homes are the frailest people living outside of hospital. The "average" resident is 85yrs old, has at least 6 LTCs, is on at least 7 medications and will have a combination of physical frailty, disability and mental health needs. We need to ensure that we provide pro-active health care to enable people to live well within their home.

Quality of provision can be improved

- 15-20% of NCL homes "require improvement" according to CQC ratings
- Health In-reach services commissioned across NCL vary
- HealthWatch work with care homes also shows variations in experience.
- Workforce is a significant concern due to high turnover and vacancy rate
- Recruitment and retention of registered managers and nurses is a challenge
- Data and intelligence on care home performance is not always shared effectively across health and social care

This has an impact on wider health services

- NCL care home residents are high users of acute health services – this activity exceeds benchmarks suggesting some activity is potentially avoidable

This is constrained by other 'system' factors

- We have an undersupply of nursing home beds in NCL - leading to high fees and out of area placements
- Workforce challenges in community health services, such as, primary care, district nursing and allied health professionals makes it harder to deliver a consistently effective pro-active service.

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Aims and emerging principles of NCL work

We seek to support residents to live as **independently** as possible and achieve **excellent experience and outcomes**

We undertake a joint responsibility to **support and enable care homes** to deliver the best and most efficient service they can

NCL Care Home Principles

We commit to an **integrated approach** to care homes, with the NHS, local authorities and providers all operating as **system partners** jointly involved in planning and problem-solving

We strive to deliver **parity of access** to health and care services for all our residents, which are also **responsive** to those needs as they fluctuate over time, including end of life care

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Overview of work so far

- Lots of work on-going across NCL around care homes however, we need to bring these together and take a joint approach to have the biggest impact for residents. Work so far is highlighted on the following pages:
  - Supporting a quality social care workforce through developing career pathways (slide 4)
  - Work to help sector recruit and keep good staff through a new care jobs portal (slide 5)
  - Allowing care home staff to access clinical advice through a "star line" (slide 6)
  - Investment in an end of life care service (slide 7)

- Important to recognise that NCL care home market is made up of largely independent businesses and Councils and CCGs collectively commission approx. 50% of beds – so collaboration is key.

- Areas of greatest opportunity:
  - Supporting the nursing workforce
  - Work to improve quality, develop consistent enhanced support and coordinate quality assurance
  - Work to address gaps in supply
  - Build on the Councils work through wider collaboration with the CCGs to manage the care home market
- Potential to have greater impact through working together with system work on integration.

Supporting a quality social care workforce

Supporting care home nurses

Capital Nurse – passport into leadership
Supporting care home nurses to feel empowered, motivated and confident leaders through a series of workshops. Over 70 nurses took part in two cohorts.

"The course has changed me … It gives me more confidence in myself and how to lead and how to deal with the system. And the info I didn't have before, the opportunity to create relationships with other care home staff and to improve myself"

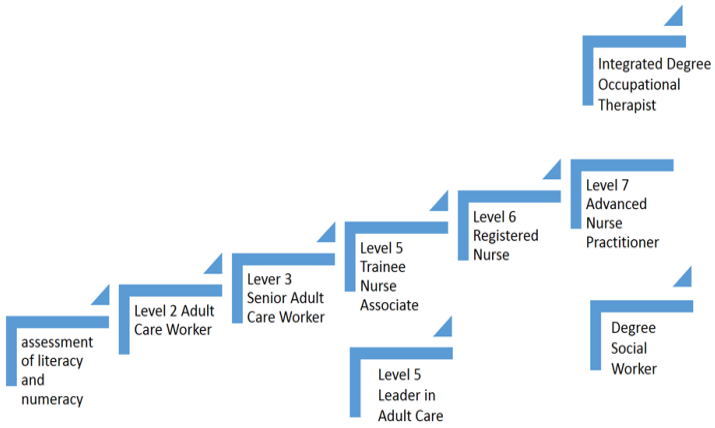
Nurse educator team
A small team that work across nursing homes and primary care to support the development and embedding of clinical skills to better meet residents needs in care homes.
Supporting nursing homes to:
Embed group clinical supervision; better identify early signs of deterioration; further develop person centred care

Developing great jobs in care

Promoting good jobs in care

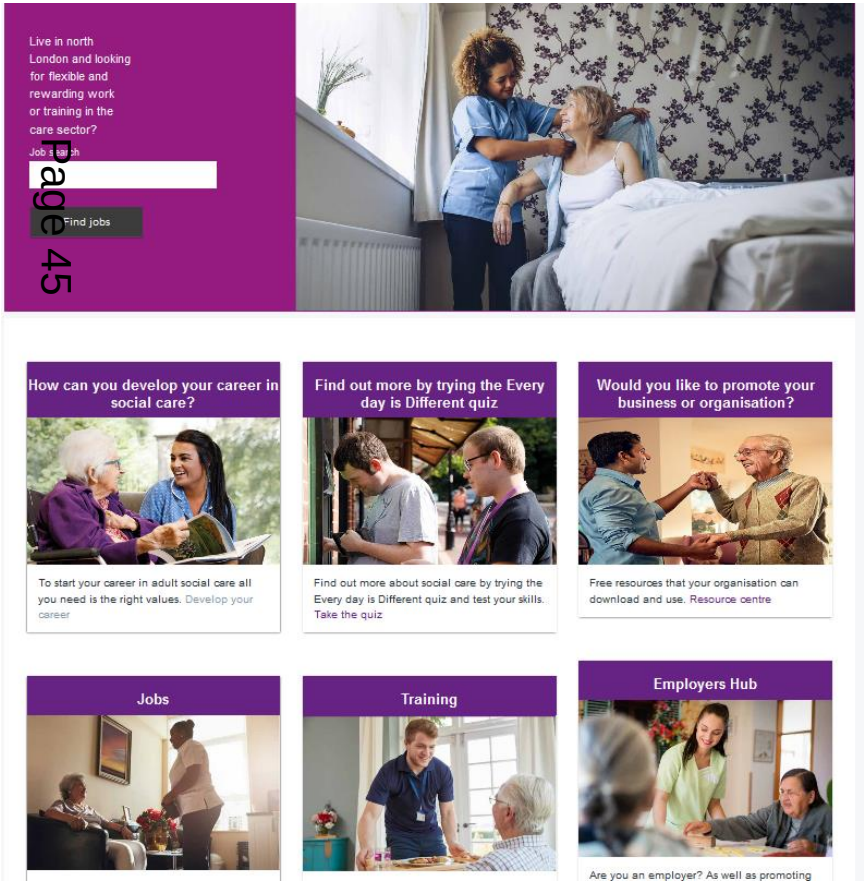
A tailored apprenticeship pathway that meets the needs of social care providers – improves the skills of staff - and offers progression opportunities to our residents.

"There's loads of paths you can go down…"



Helping the sector to recruit and keep good local staff

Proud to Care is a local jobs portal, easy to use and free that brings together the care jobs in North Central London.



- Open Days and information days;- ,matching job support agencies and providers; promoting care home open days
- E-bulletin:- we issue a fortnightly e-bulletin, bringing the sector all the local news and training opportunities
- HR practices :-training on writing advertisements , from a values based perspective. Looking at how to reduce staff turnover and reliance on agency staff
- Valuing our hard working staff :-Videos and tweeted pictures

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Supporting care home staff with clinical advice

- We were the first area in England to launch new model to ensure the different systems for urgent care can speak to each other . 'Star divert numbers' enable clinical staff to get through to a clinical expert for urgent advice and support by dialling the appropriate number.
- Care home staff can dial NHS 111 "star 6" and get put through to a clinician. This supports better care and decisions about how to support residents stay well in the community and avoid admission to hospital.
- In 2019, there was an average of 335 calls to NHS 111 *6 per month. There will be further work to promote this service to care homes staff.
- A pan-London review of the NHS 111 star divert numbers found 99% of staff who had used NHS 111 *6 to access prompt clinical advice would use the service again.
- *"Prompt and helpful, a good service, especially for out of hours and weekends." (111*6 user)*

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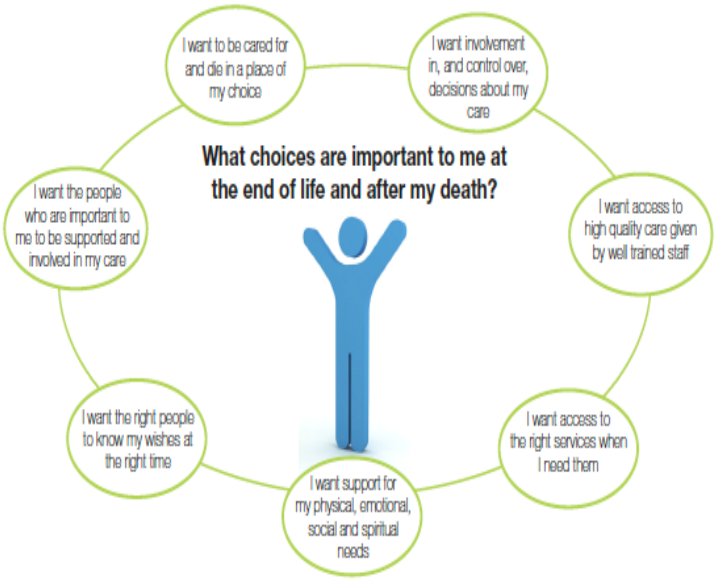
Expanded End of Life Care Services

- In 2019 NCL CCGs invested in an expanded end of life care nursing service. This meant an additional 15 specialist palliative care nurses working closely with the hospitals, community services, Care Homes and local hospices.
- This will support those at the end of their lives to make choices about their care.
- The service focusses on improving the skills of nursing staff to manage clinical crises or end of life care, including the use of digital solutions.
- Creation of shared plans about a patients wishes (Coordinate My Care plans) more than doubled in 2019-20 compared to 2018/19.
- London Ambulance Service views of coordinate my care plans have more than tripled in August 2019 compared to August 2018.
- There has been an 11% reduction in patients who have died in hospital with three or more admissions in their last ninety days of life, resulting in a 9% reduction in admissions for this group across NCL in 2019-20.



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Next Steps

- Continued work to support the nursing workforce across health and care.

- In September 2016 the National NHS *Enhanced Health in Care Homes Framework* (EHCH) was launched. It describes a suite of evidence-based interventions designed to be delivered within and around a care home in a coordinated manner in order to improve the wellbeing and care of care home residents. This will be considered as part of the work of the development of primary care in North Central London.

- Care home providers should be seen as **system partners** and involved in planning and problem-solving – we have jointly funded a provider reference group to support them in designing solutions.

- Supporting care homes across NCL to demonstrate robust information governance to better share information and work as part of a system.

- Work underway to join up information and intelligence on quality across NCL.

- Emerging work on joint pieces of service improvement across health and social care, including stronger links to primary care.

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	London Boroughs of Barnet, Camden, Enfield, Haringey and Islington

REPORT TITLE

NCL Mental Health: Supporting residents and reducing attendance at A&E

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE** 13 March 2020

SUMMARY OF REPORT

Following a presentation to the JHOSC in September 2019 there was a request for further specific information on tangible actions being taken to support residents with mental health conditions and in particular reduce attendances at A&E departments.

This presentation sets out the priorities of the NCL work on Mental Health and provides further details of services that are working to better support residents and reducing attendance at A&E by people with mental health conditions.

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- Appendix A - NCL Mental Health: Supporting residents and reducing attendance at A&E

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NHS

Mental Health

JHOSC 13 March 2020

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Context/introduction

Following a presentation to the JHOSC in September 2019 there was a request for further specific information on tangible actions being taken to support residents and reduce attendances at A&E.

This presentation sets out the priorities of the NCL work on Mental Health and provides further details of services that are working to better support residents and reducing attendance at A&E by people with mental health conditions.

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Mental health priorities

Our system response to the NHS Long Term Plan identified three priority areas:

- Core community services for people with complex needs due to serious mental illness (psychosis, personality disorder and severe mood and anxiety disorders) - in partnership with expanded primary care mental health and services delivered by voluntary and community sector organisations
- Children and young people's crisis services – achieving 100% coverage of 24/7 crisis services
- Early Intervention in Psychosis (EIP) services – in line with national standards

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How we are reducing attendance at A&E by people with mental health conditions?

1. Crisis alternatives, resolution and home treatment teams
2. Mental health liaison services
3. Health based places of safety
4. Nurse-led children and young person's crisis service

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Crisis alternatives, resolution and home treatment teams

- £1.6M to boost provision in 2019/20 and £2.1M in 2020/21
- More adults and older adults receiving crisis interventions in the community
- Developing "crisis alternatives" through to 2023/24, such as crisis cafés and crisis houses
- Opportunity to address inequalities through co-design

Crisis cafes provide a brief intervention for people with significant mental health distress, as an alternative to hospital admission. The cafes connect people to a range of local support including NHS services and services provided by voluntary and community organisations

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Crisis services – case studies

- Rivers Crisis House in Camden has a specific remit to attract young black men (approximately 30% of service users are BME men)

- Haringey an NHS, Local Authority and Third Sector partnership runs an award-winning initiative called "Project Future" which works with young black men involved in gang violence, seeking to address underlying mental health and social issues.

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Health-based places of safety

- New service at Highgate Mental Health Centre in Camden opened in December.
- Additional to service at Chase Farm Hospital in Enfield.
- Dedicated unit away from A&E to receive handover from London Ambulance Service or Police.

Camden and Islington NHS Trust Chief Executive, Angela McNab, said: I think the one thing that defines a good Place of Safety is ensuring that **service users and their carers are seen and treated with dignity during what can be an extremely distressing period in their lives**. This is what our vision has been for our new Place of Safety and I know, that is what our staff will pride themselves on delivering, whatever the challenges they face".

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Mental health liaison services (MHLS)

- £1.25M transformation funding in 2020/21 – to support individuals presenting at emergency departments by having mental health assessment within 1 hour and care plan within 4 hours
- Expansion of provision of adult services at all five acute trusts
- MHLS staff delivering training to doctors, nurses, therapists, midwives and security teams at acute NHS trusts to improve holistic care of patients with mental health needs
- Peer support worker model at North Middlesex

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Nurse-led children and young person's crisis service

- New service started in summer 2019 at Barnet General, North Middlesex and Royal Free Hampstead for evenings and weekends
- Offers crisis assessment and brief response to Children and Young People attending A&E "out of hours"
- Expanded offer over winter including to Whittington and UCLH

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North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	London Boroughs of Barnet, Camden, Enfield, Haringey and Islington

REPORT TITLE

Implementing Electronic Patient Records – Benefits Realisation (Royal Free NHS Foundation Trust)

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE** 13 March 2020

SUMMARY OF REPORT

An updated report from the Royal Free on Electronic Patient Records (EPR) to identify the benefits of the scheme from the perspective of patients and health staff, and including insight from officers and clinical practitioners.

Following report in January 2019.

Contact Officer:

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RECOMMENDATIONS

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- Appendix A - Implementing Electronic Patient Records – Benefits Realisation

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Implementing EPR – Benefits Realisation

NHS
Royal Free London
NHS Foundation Trust

world class expertise local care

NHS
Royal Free London
NHS Foundation Trust

1. Introduction

2. Benefits Realisation

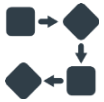
- Patient Safety

- Clinical Practice Groups (CPGs)

- Streams

world class expertise local care

What is our Global Digital Exemplar (GDE) ?



Reduce unwarranted clinical variation through digitisation of 20 care pathways

Open the most digitally advanced hospital in the NHS at Chase Farm in 2018

Implement population health management across NCL STP

Interoperability *e.g. HIE* and innovation *e.g. Google Health Streams*

Clinical Practice Groups (CPGs)

What we are trying to achieve:

Reducing unwarranted variation; increasing warranted variation

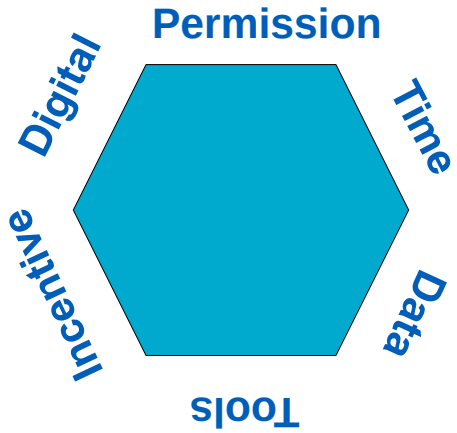
Initially within the hospital system;

then with partners across the

health and social care system

How we are trying to achieve it:

“Bringing clinicians around the data and giving them the opportunity to improve”



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Old Chase Farm Hospital

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New Chase Farm Hospital

We provide:

- out-patient services
- an urgent care centre
- an older persons assessment unit
- chemotherapy day unit
- a dedicated day surgery area
- 8 operating theatres including 4 ‘barn theatres’
- 50 surgical in-patient beds, including 42 single rooms

New Chase Farm Hospital

- HIMSS EMRAM 6 accredited
- Paperless at the point of care
- Enhanced patient navigation
- Integrated medical devices
- Innovative digital solutions
- New IT infrastructure

Digital Transformation of Chase Farm Hospital

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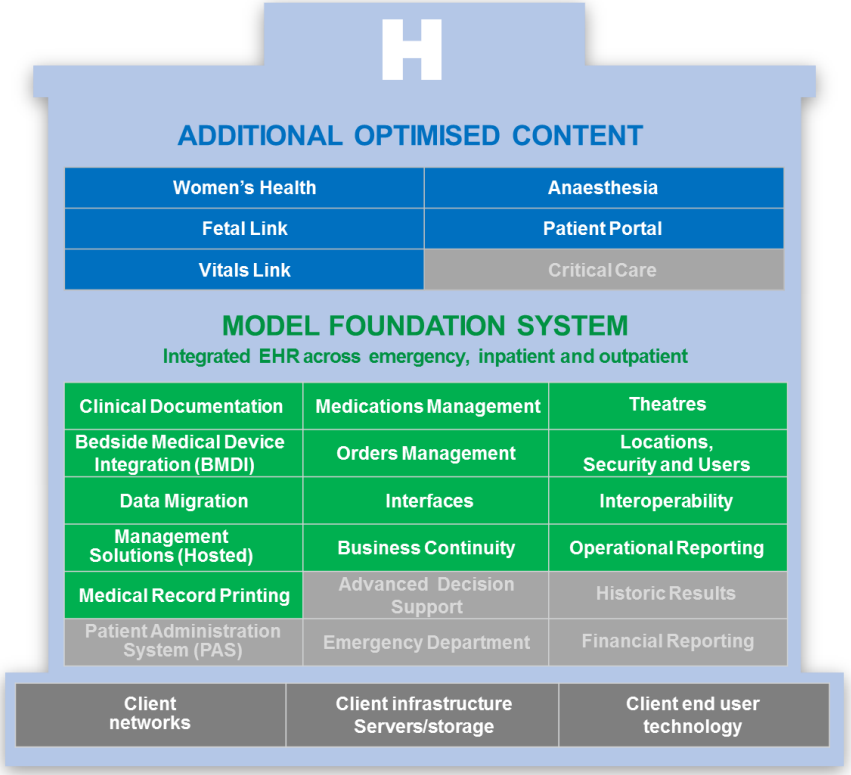
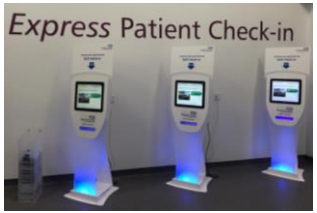
Implementing Model Content EPR

- **25** solutions deployed
- **4** first of type in UK
- Across **5** hospitals
- In **11** months



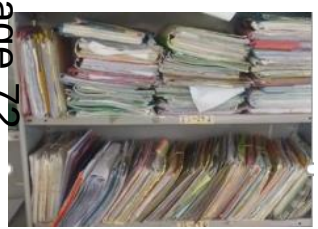
Cost Benefits



Intouch Out-patient Flow

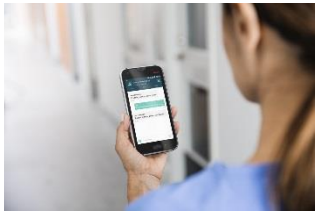
£650K recurrent cost saving by reducing from 13 OP receptions and 28 wte to 1 concierge and 3 wte

99.7% e-outcoming of appointments



Medical Records Library Closure

£600K recurrent cost saving



Ascom Digital Nurse Communication Platform

13wte nursing cost avoidance

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1. Introduction

2. Benefits Realisation

- Patient Safety

- Clinical Practice Groups (CPGs)

- Streams

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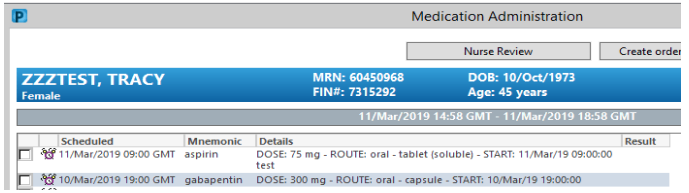
EPR Patient Safety Benefits

- Barcode Medication Administration (BCMA)
- Drug-Allergy Interaction Alerts
- Drug-Drug Interaction Alerts
- Dose Range Checking Alerts (DRC)
- VTE assessment
- Anti-microbrial stewardship
- Gentamicin Calculator

Barcode Medication Administration (BCMA)

1. Scanning the patient's wristband to ensure the **right patient** is receiving the medication.

2. Only medications that are due appear for the nurse to administer. This ensures the medications are given at the **right time**.



3. When the nurse scans the medication it will confirm the following details are **right**:

- **Drug**
- **Dose**
- **Route**

Barcode Medication Administration (BCMA)

Metric	HIMSS 6 Target	HIMSS 7 Target
Patient scanned	75%	95%
Medication scanned	50%	95%

Patient mismatch alerts January 2020 = 1037

Total number of prescriptions = 88,085

Patient mismatch= wrong patient scanned

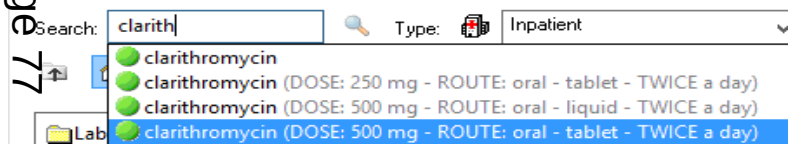
Drug mismatch alerts January 2019 = 4813

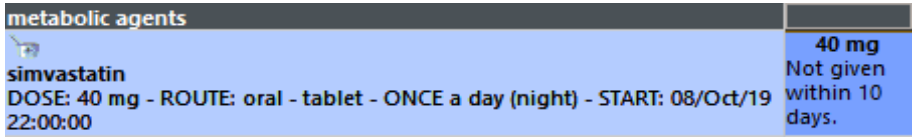
Drug mismatch= wrong drug, form, route scanned

Drug-Drug Interaction

Decision support has improved patient safety by alerting clinicians and preventing the prescribing of potentially harmful combination of medicines.

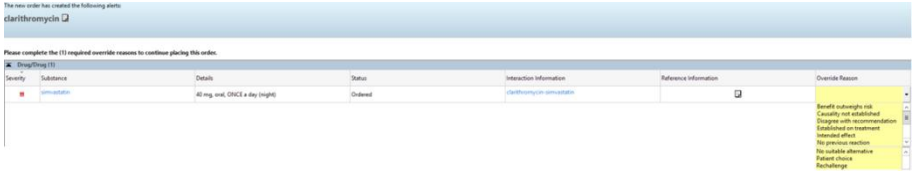
1. Patient is prescribed medication



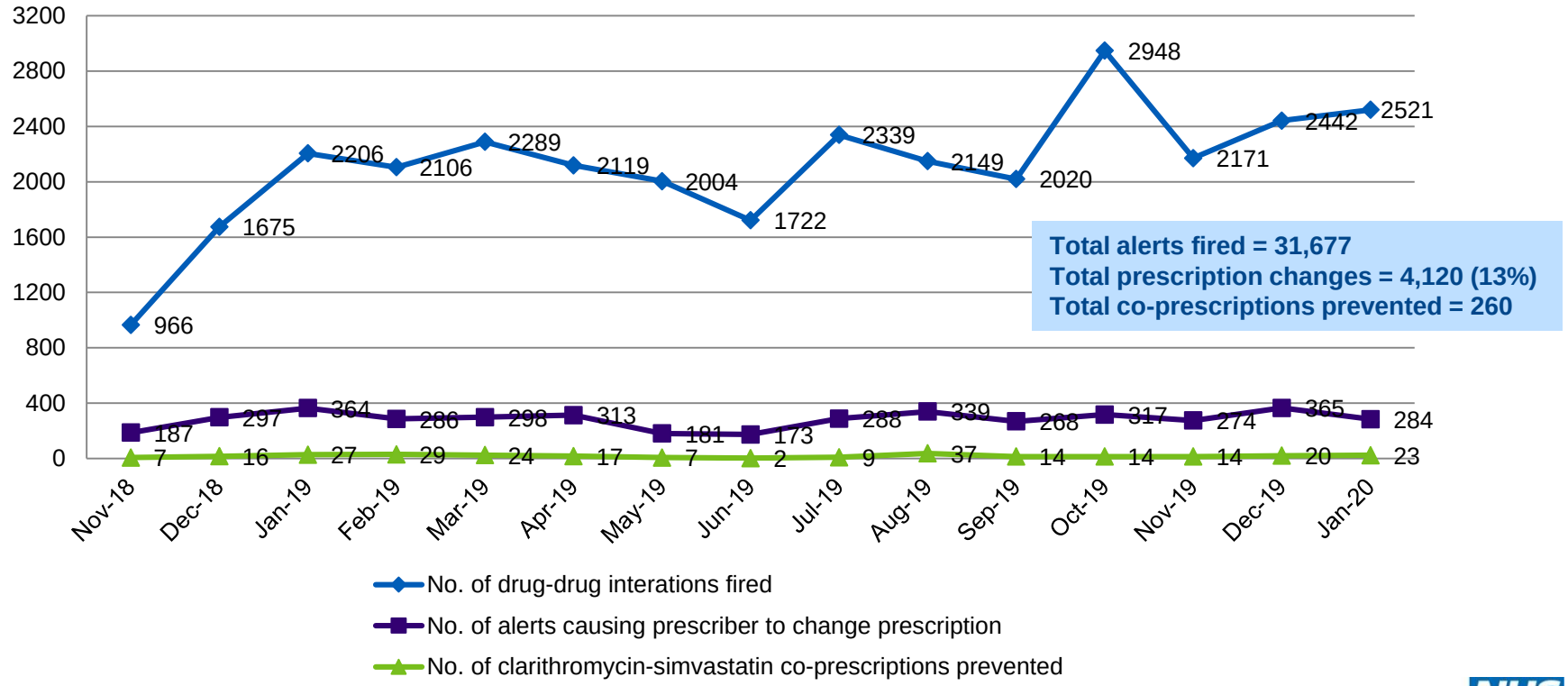


2. Prescriber attempts to place an order for a medication that interacts with the current medication

3. Decision support alerts prescriber to the interaction. The prescriber is able to use their clinical judgment to override the alert and continue with the prescription.



Drug-Drug Interaction Alerts

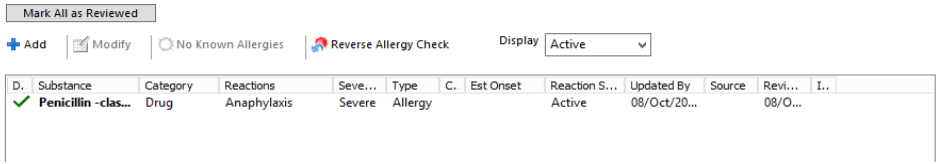


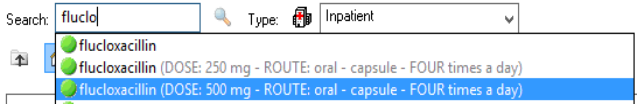
Total alerts fired = 31,677
Total prescription changes = 4,120 (13%)
Total co-prescriptions prevented = 260

Drug-Allergy Interaction

Decision support has improved patient safety by alerting clinicians and preventing the prescribing of medicines the patient is allergic to.

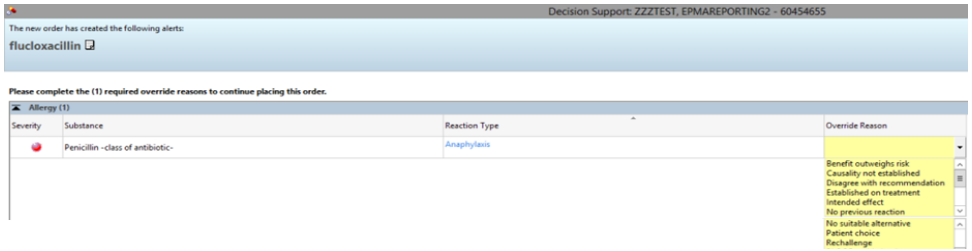
1. Document allergy status. This is mandatory before prescribing any medication.



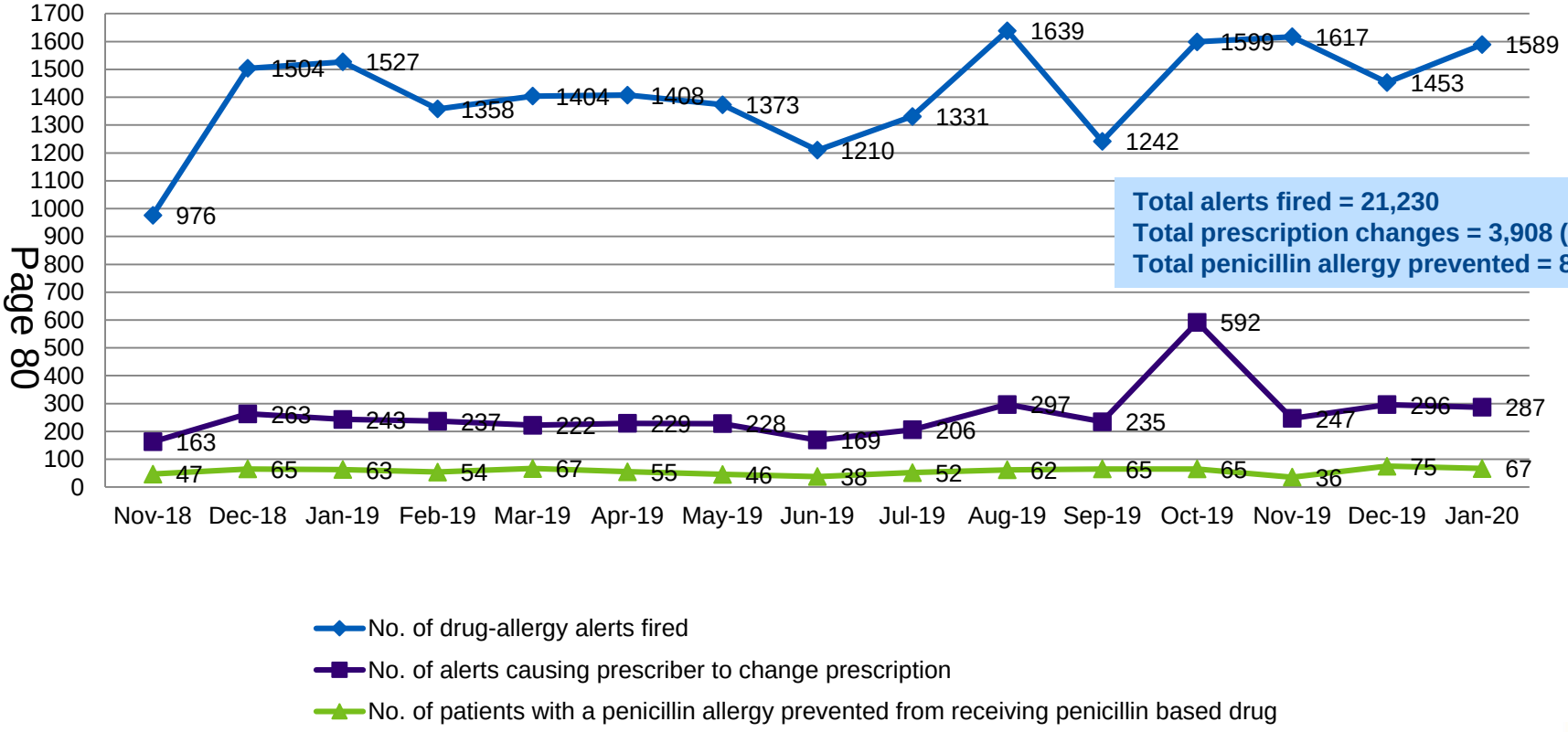


2. Prescriber attempts to place an order for a medication the patient is allergic to.

3. Decision support alerts prescriber to the allergy status. The prescriber is able to use their clinical judgment to override the alert and continue with the prescription.



Drug-Allergy Interaction Alerts



Total alerts fired = 21,230
Total prescription changes = 3,908 (18%)
Total penicillin allergy prevented = 857

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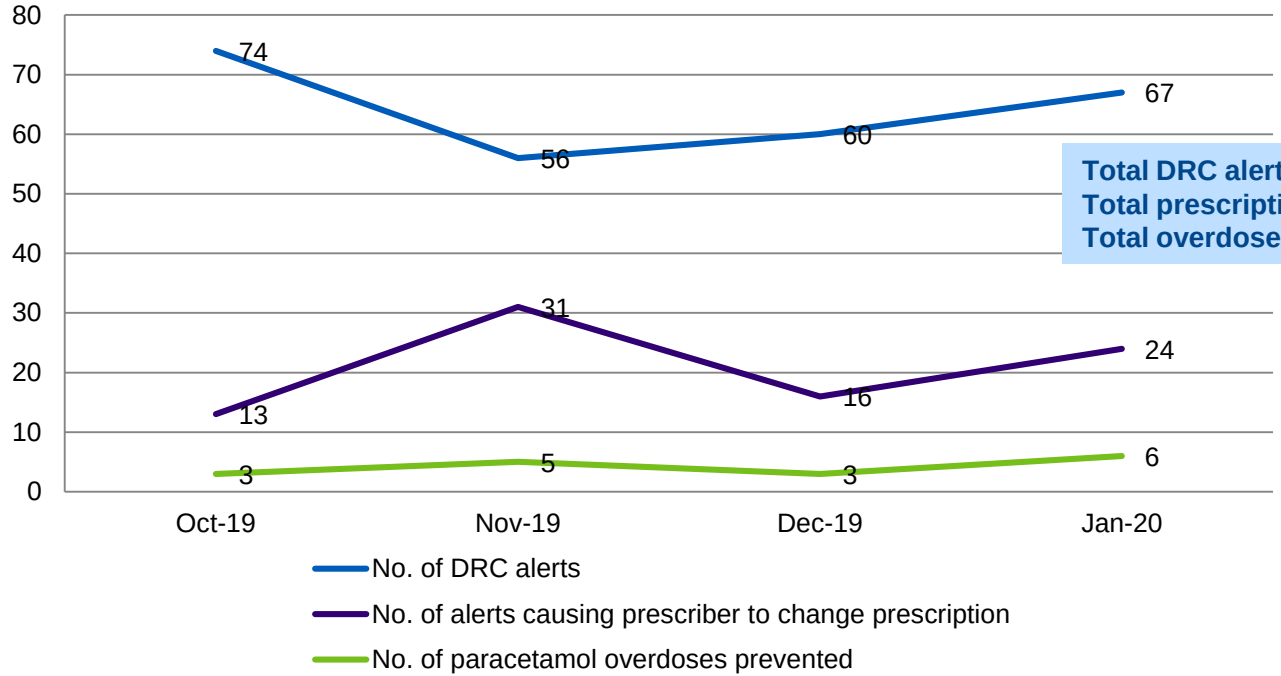
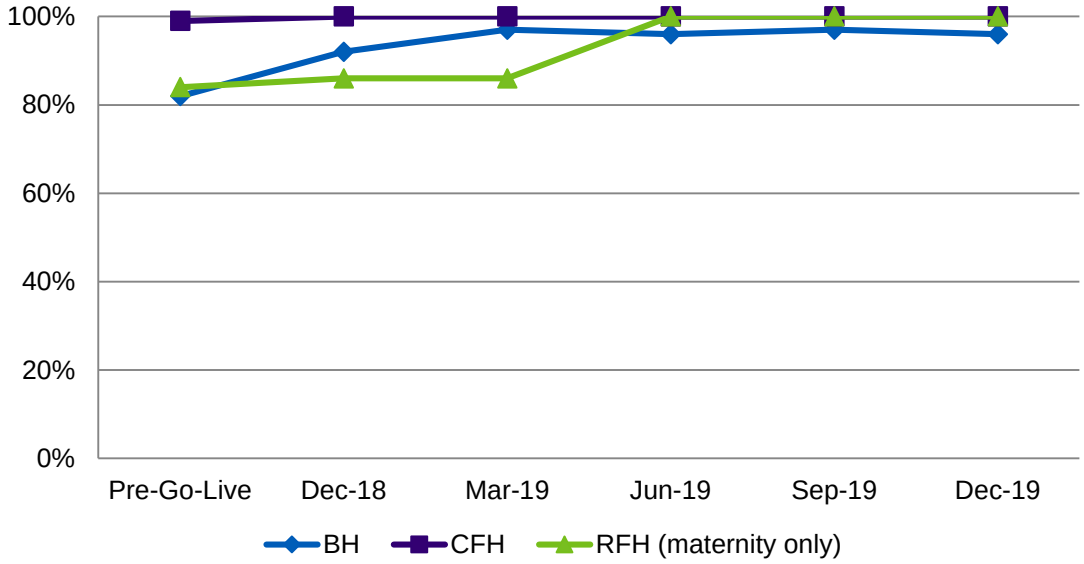
Dose Range Checking
(Paediatrics only)



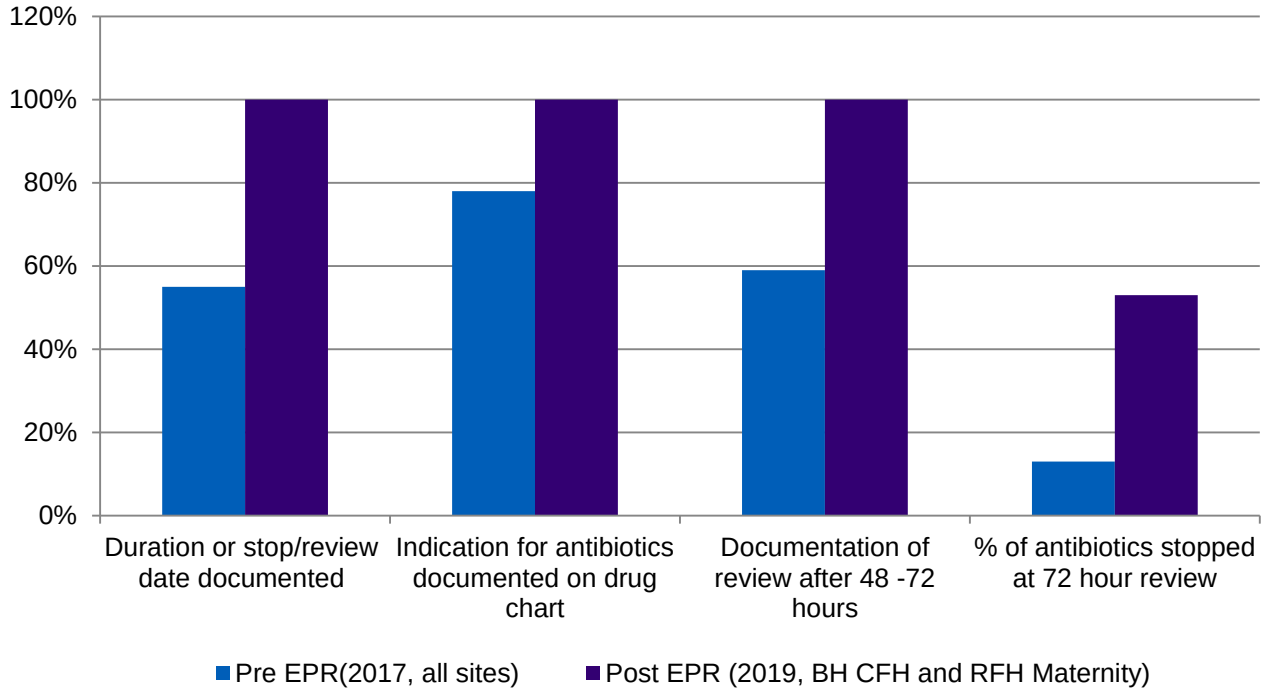
Total DRC alerts = 257
Total prescription changes = 24 (9%)
Total overdoses prevented = 17

VTE Risk Assessment



National Target
95%

Antimicrobial Stewardship

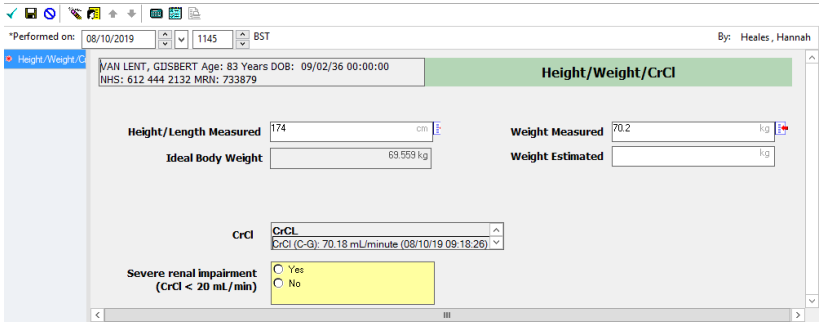


Gentamicin Dose Prescribing Errors

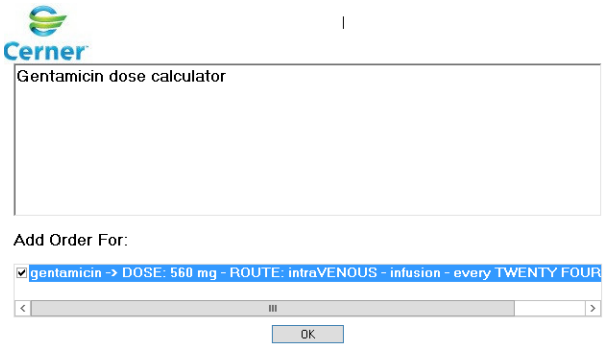
Problem: Gentamicin is an extremely effective antibiotic and is life saving is acutely septic patients. However, the complex prescribing regime and narrow therapeutic index means gentamicin prescribing accounts for **one of the most common medication related incidences.**

Solution: A gentamicin prescribing plan was designed in the EPR which automatically calculates the gentamicin dose based on the patient's height, weight (either ABW or CDW) and renal function.

1. Prescriber orders gentamicin plan. They are prompted to enter patient measurements. These auto populate if available within system.



2. Gentamicin dose is calculated based on the patient's measurements and renal function.



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Gentamicin Dose Prescribing Errors

Target Number of Errors	Pre-Go-Live Number of Errors (FY17/18)
0	51

Gentamicin Dose Prescribing errors (using EPR, FY19/20)	Gentamicin Dose Prescribing errors (using paper, FY19/20)
0%	40%

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1. Introduction

2. Benefits Realisation

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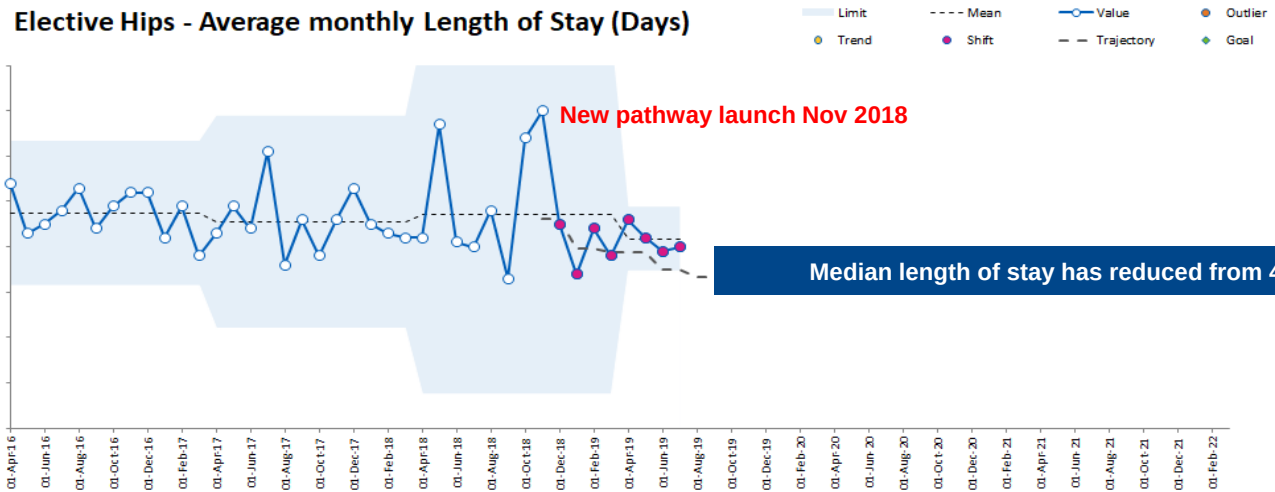
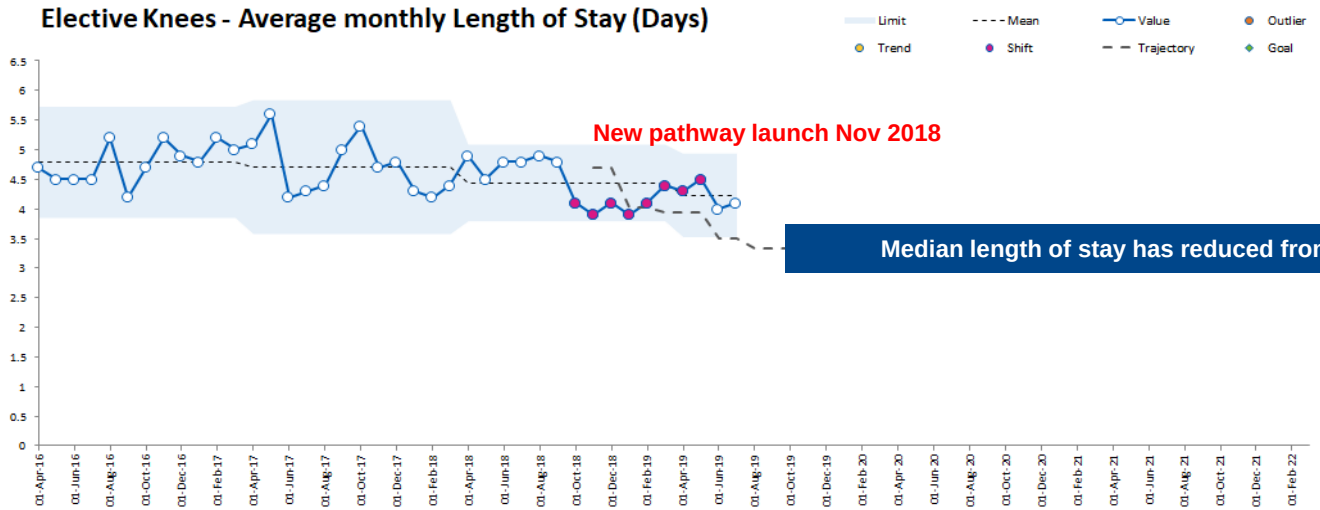
Elective Hip Replacement CPG



Period	Mean Average	Upper limit	Lower limit
1	4.7	6.3377	3.1457
2	4.6	6.8956	2.2044
3	4.7	8.6825	0.7508
4	4.2	4.8843	3.4657

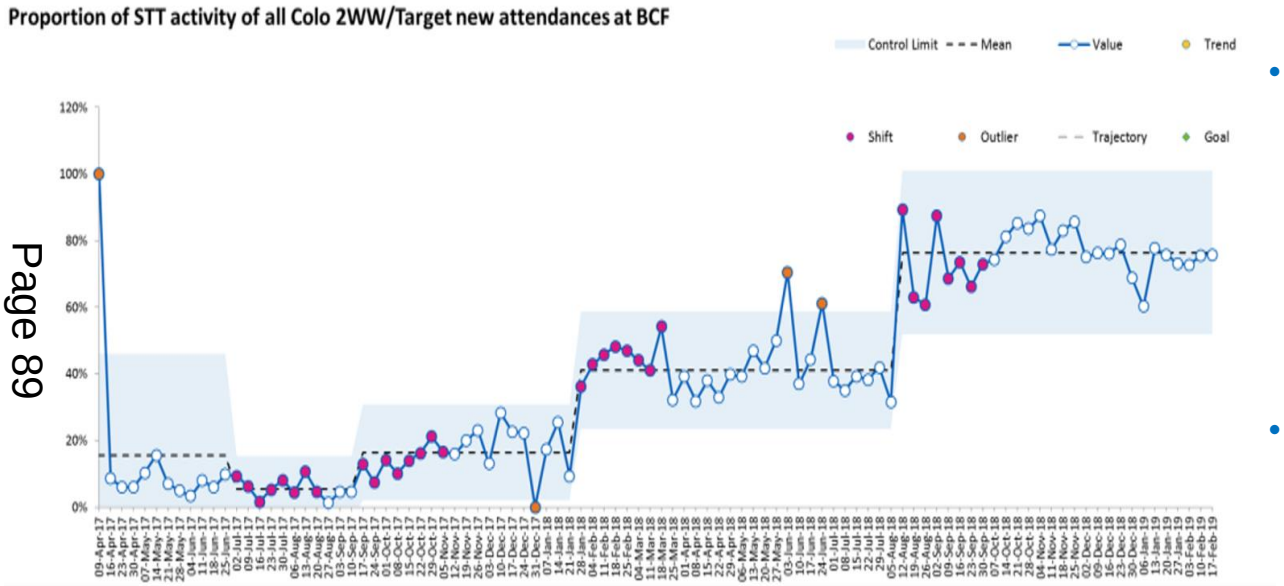
Median length of stay has reduced from 4.6 to 3.4 days

Elective Knee Replacement CPG



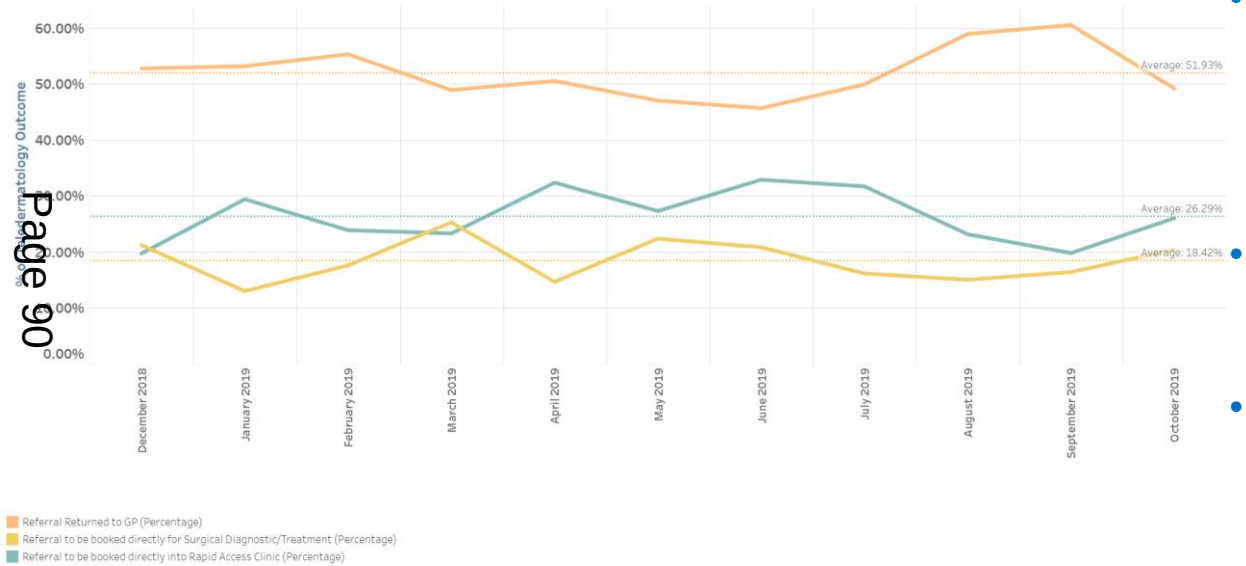
Period	Mean Average	Upper limit	Lower limit
1	4.8	5.7264	3.8402
2	4.7	5.8365	3.5635
3	4.4	5.0862	3.7804
4	4.2	4.9343	3.5157

Lower GI CPG



- **2211** patients **(54%)** of patients referred to the straight-to-test telephone clinic were able to continue straight to diagnostic testing without a face-to-face outpatient appointment
- **60%** increase in two-week-wait (2WW) target performance

Tele-dermatology CPG



- **2,128** telederm. patients **(52%)** were referred back to the GP with no outpatient appointment needed
- **£269,100** annual savings for the wider healthcare system
- Virtual outpatients allows means that **double the number of patients** are either seen or reviewed

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1. Introduction

2. Benefits Realisation

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Acute Kidney Injury (AKI) is common and expensive

100,000

Deaths per year in the UK

NHS England 2014

>£1.2 billion

Cost to the English health service per year

Kerr (2014)

20%

Contributes to a fifth of all emergency admissions

Wang 2012

Up to

50%

of acute kidney injuries are associated with sepsis

Poston 2019

Detection and management of AKI is *relatively* simple

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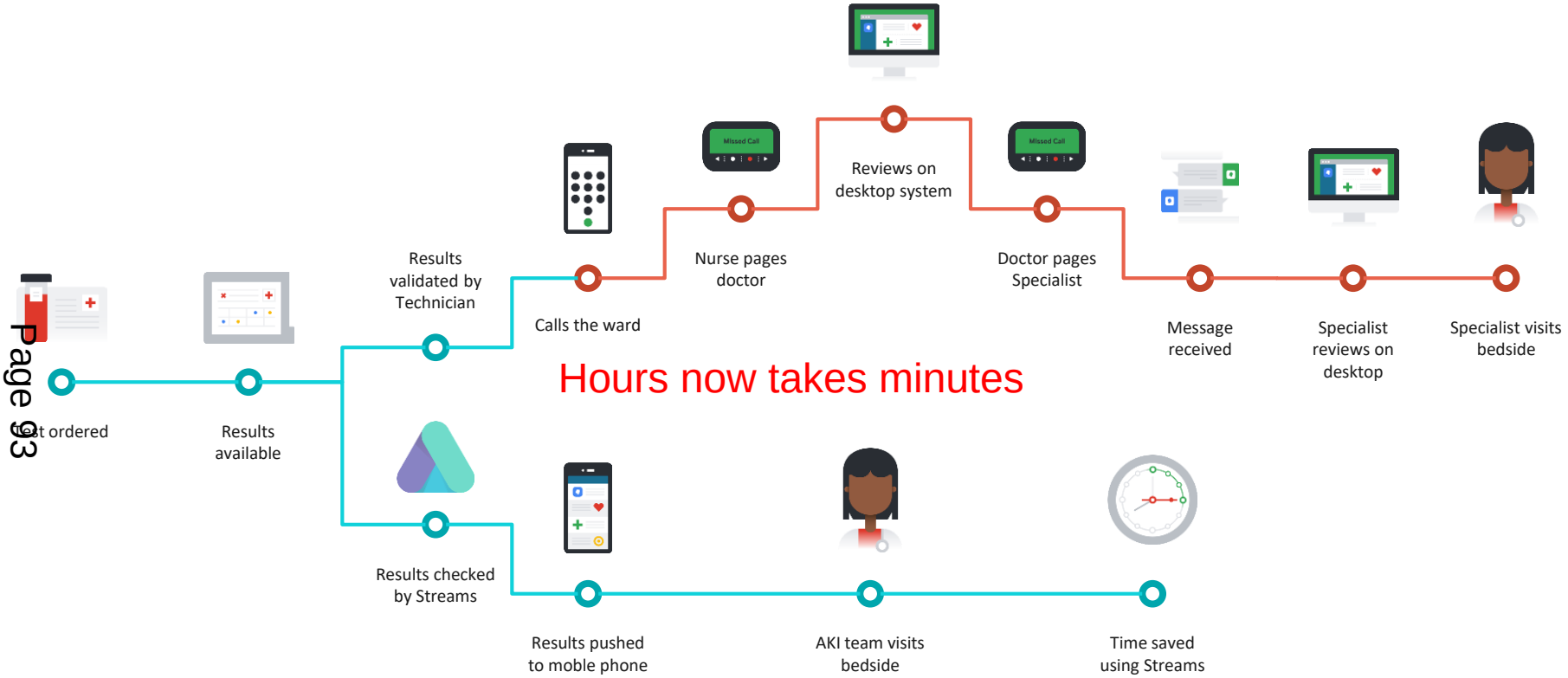
Current pathway of getting an expert review



Streams pathway delivering an accelerated alert

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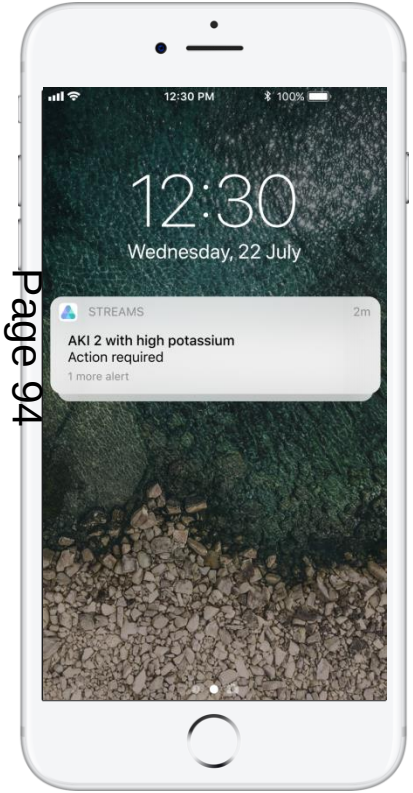
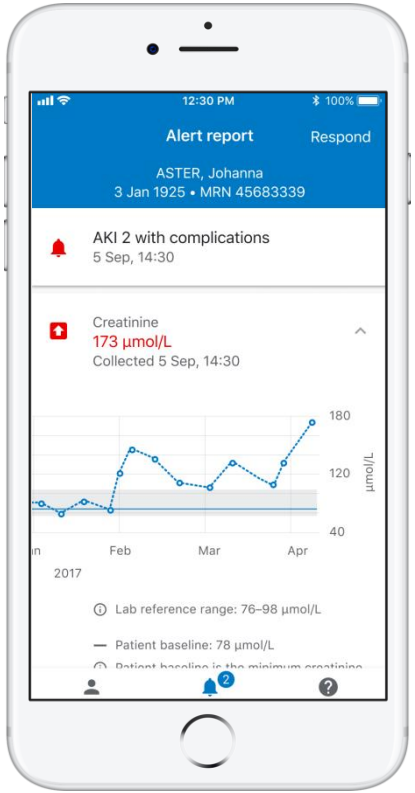
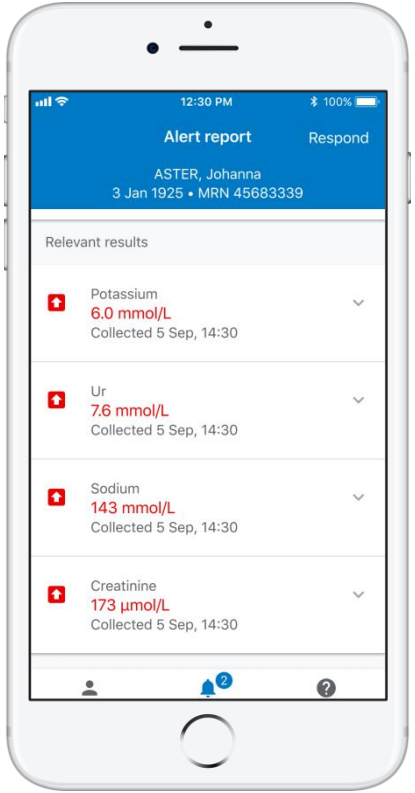
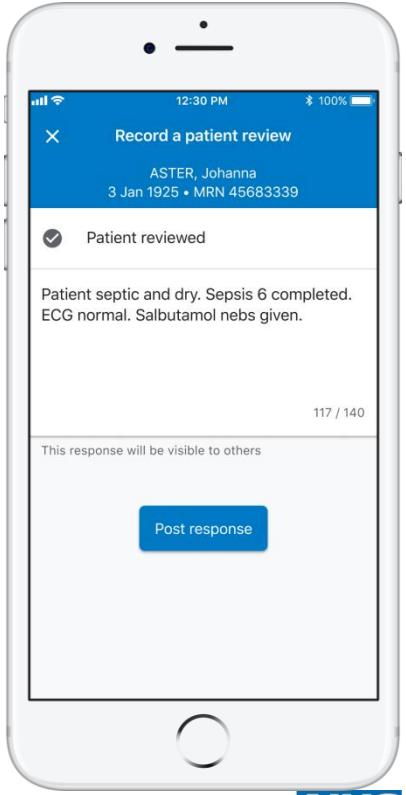
Streams provides push alerts alongside relevant context









We set out to see whether Streams could support triple aim

1. Better clinical outcomes
2. Reduce costs
3. Enhance patient and clinician experience

Check for updates

STUDY PROTOCOL

REVISED **Service evaluation of the implementation of a digitally-enabled care pathway for the recognition and management of acute kidney injury [version 2; peer review: 2 approved]**

Alistair Connell[1,2], Hugh Montgomery[1,2], Stephen Morris[3], Claire Nightingale[3,4], Sarah Stanley[5], Mary Emerson[5], Gareth Jones[5], Omid Sadeghi-Alavijeh[5], Charles Merrick[5], Dominic King[6], Alan Karthikesalingam[6], Cian Hughes[6], Joseph Ledsam[6], Trevor Back[6], Geraint Rees[7], Rosalind Raine[3], Christopher Laing[5]

Author details

This article is included in the University College London collection.

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Abstract

Acute Kidney Injury (AKI), an abrupt deterioration in kidney function, is defined by changes in urine output or serum creatinine. AKI is common (affecting up to 20% of acute hospital admissions in the United Kingdom), associated with significant morbidity and mortality, and expensive (excess costs to the National Health Service in England alone may exceed £1 billion per year). NHS England has mandated the implementation of an automated algorithm to detect AKI based on changes in serum creatinine, and to alert clinicians. It is uncertain, however, whether 'alerting' alone improves care quality.

We have thus developed a digitally-enabled care pathway as a clinical service to inpatients in the Royal Free Hospital (RFH), a large London hospital. This pathway incorporates a mobile software application - the "Streams-AKI" app, developed by DeepMind Health - that applies the NHS AKI algorithm to routinely collected serum creatinine data in hospital inpatients. Streams-AKI alerts clinicians to potential AKI cases, furnishing them with a trend view of kidney function alongside other relevant data, in real-time, on a mobile device. A clinical response team comprising nephrologists and critical care nurses responds to these AKI alerts by reviewing individual patients and administering interventions according to existing clinical practice guidelines.

We propose a mixed methods service evaluation of the implementation of this care pathway. This evaluation will assess how the care pathway meets the health and care needs of service users (RFH inpatients), in terms of clinical outcome, processes of care, and NHS costs. It will also seek to assess acceptance of the pathway by members of the response team and wider hospital community. All analyses will be undertaken by the service evaluation team from UCL (Department of Applied Health Research) and St George's, University of London (Population Health Research Institute).

2017 Protocol (peer reviewed)

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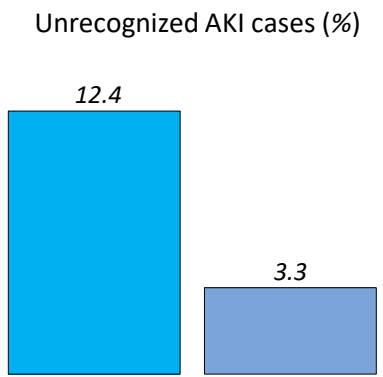
NHS Royal Free London NHS Foundation Trust

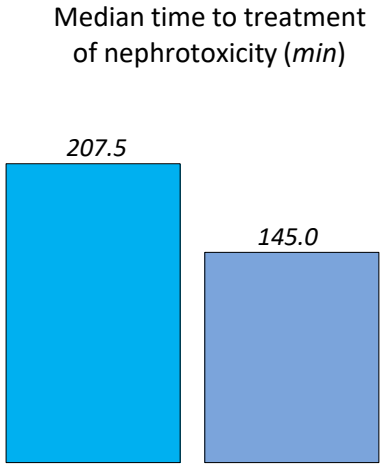
Improved outcomes and reduced cost

Median alert triage time = 14 min

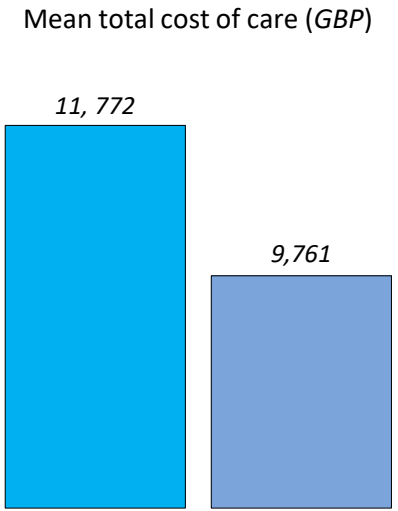
Cardiac arrests reduced by 30%



- 9.1%



- 62.5min



- 17%

Connell A, Martin P et al. Evaluation of a digitally-enabled care pathway for the management of acute kidney injury in patients admitted to hospital as an emergency. Manuscript in press,, Nature DIgital Medicine (2018).
Connell A,, Black G et al. Qualitative evaluation of the implementation of a digitally-enabled care pathway in secondary care. Manuscript in press, JMIR (2018).
Connell A, , Martin P et al. Implementation of a digitally-enabled intervention to detect and treat acute kidney injury arising in hospitalised patients: an evaluation of impact on clinical outcomes and associated healthcare costs. Manuscript in press, JMIR (2018).

Enhance clinician experience

" With the app, we are able to detect pretty much all kidney disease across the hospital. We are getting to intervene on patients we wouldn't normally be able to. The results viewing platform is **saving us LOTS of time**"

"I have noticed patients who have flagged up on the app that the clinical management has been poor up to that point. When we get involved, or the renal team get involved, that management changes. **I think It has definitely saved lives."**

"Being able to look up results for anyone in the hospital wherever you are is unparalleled. **It must save at least a couple of hours in a day."**

Connell A,, Black G et al. Qualitative evaluation of the implementation of a digitally-enabled care pathway in secondary care. Manuscript in press, JMIR (2018).

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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 and Action Tracker 2019-20	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 13 March 2020

SUMMARY OF REPORT

This paper provides an initial outline for the 2020/21 work programme for the North Central London Joint Health Overview & Scrutiny Committee.

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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London N1C 4AG

02079743219
henry.langford@camden.gov.uk

RECOMMENDATIONS

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

a) Note the contents of the report; and
b) Consider the work programme for the remainder of 2020/21.

1. Purpose of Report

1.1. This paper provides an outline of the proposed areas of focus for the Committee for 2019-20. This has been informed by topics highlighted by the previous Committee and a review of key health and care strategic documents that impact on North Central London. Throughout the municipal year, as the Committee considers other areas of interest, these will also be added to the work programme, either for discussion in the current municipal year or in subsequent years.

1.2. The report also includes an action tracker for the Committee, Appendix B. This will be populated with actions from each Committee meeting. It is intended to help the Committee effectively track progress against recommendations and requests for further information.

1.3. The agreed NCL JHOSC Governance Principles are attached at Appendix C for reference.

2. Terms of Reference

2.1. In considering topics for 2019-20, 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 – 2019/20 Work Programme
Appendix B – Action tracker
Appendix C – NCL JHOSC Governance Principles

REPORT ENDS

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Appendix 1 – NCL JHOSC Work Programme 2019/20

13th March 2020, Islington

Item	Purpose	Lead organisation
Electronic Patient Records	An updated report on Electronic Patient Records to identify the benefits of the scheme from the perspective of patients and health staff, and including insight from officers and clinical practitioners. Also to include measures taken to ensure data security. Following report in January 2019.	Royal Free London FT
Estates Strategy Follow Up Report	In July the committee requested a substantive item return to committee following the release of the revised estate offer in September 2019. To include disposal of assets and where the money has gone for each of the providers.	NCL Partners
Working to improve lives for residents in NCL Care Homes	Report to provide further information regarding plans for the workforce in the care home settings, the focus on prevention and the financial strategy as part of the implementation of the NHS Long Term Plan.	NCL Partners
NCL Mental Health: Reducing A&E attendance	Report covering the cross organisational working of NHS, local providers and councils to reduce attendance at A&E. To include discussion on A&E and Place of Safety following Mental Health Programme item in January 2019.	NCL Partners
Work Programme and Action Tracker	Work Programme, action tracker and follow up of any ad hoc requests.	Policy Officer

26 June 2020, Barnet

Item	Purpose	Lead organisation
Orthopaedic Services Review	Report to review findings from the Orthopaedic Service Review consultation process (January to April 2020).	NCL Partners
NCL Digital Programme		NCL Partners
Children's and paediatric services in		NCL Partners

Appendix 1 – NCL JHOSC Work Programme 2019/20

Item	Purpose	Lead organisation
NCL		
Integration follow up	Follow up from integration seminar, hosted by Mike Cooke, for JHOSC and HASC members from across NCL.	NCL Partners
Work Programme and Action Tracker	Work Programme, action tracker and follow up of any ad hoc requests.	Policy Officer

25 September 2020, Camden

Item	Purpose	Lead organisation
General Practice as the foundation of the NHS: A strategy for NCL	Update of new roles of GPs and general practice in NCL.	NCL Partners
Tackling inequalities through prevention and early intervention	Including cross-NCL comparison on preventable health issues.	NCL Partners
Integration of health and care		NCL Partners
Work Programme and Action Tracker	Work Programme, action tracker and follow up of any ad hoc requests.	Policy Officer

Appendix 2 – NCL JHOSC Action Tracker January 2020

Meeting	Item	Action	Action by	Progress
Jan-20	Health and Care Integration	Informal private seminar to be set up, hosted by Mike Cooke with invites to HASC members from across NCL. To discuss what outcomes we want to achieve.	Mike Cooke, Henry Langford	A date has been set with invites distributed to JHOSC members. Individual HASC members also to be invited.
Sep-19	Deputation - Patient Transport	Pan London JHOSC meeting to be arranged with representatives from NHS England, Department for Health and Kings Fund on patient experience of transport.	Policy Officer	Officers continue to work alongside the Chair to arrange a Pan London JHOSC meeting on patient transport. Awaiting confirmation from NHS colleagues. A successful Pan London JHOSC meeting was held on 16 January 2020 discussing the Mayor's '6 Tests' framework for major hospital service reconfigurations.
Sep-19	Deputation - Proposed Merger North Central London CCGs	The Committee requested further information about the amalgamation of the CCGs from the North London Partners in Health and Care. It was suggested that the Committee hold a special meeting to consider the information when it became available and to understand the financial and resident impact on each Borough.	Policy Officer	Where possible, items for consideration by JHOSC are incorporated into the work programme and planned schedule of meetings for 2019/20. Having met with the Chair, it was agreed a specific response to the comments made by JHOSC would be included in the Health and Care Integration item at the January 2020 meeting. The committee can choose to allocate further time to the issue during the work programme item.
Jun-19	ESTATES STRATEGY UPDATE	Report on the Estates Strategy to come back to the Committee in November 2019. To include information on the disposal of assets and where the money had been	North London Partners	Deferred following request from the committee in September. To be considered in March 2020.

		allocated for all the providers.		

North Central London Joint Health Overview Scrutiny Committee

OUR GOOD GOVERNANCE PRINCIPLES

Members believes that effective public scrutiny helps local providers to reduce inequalities, to improve people's lives, to improve people's experiences, to deliver better health and services and to achieve greater value from the public's money.

Effective public scrutiny uses democratic accountability, openness, transparency, searching questions and focused recommendations to deliver public good.

1. **Putting patients and residents at the centre of all we do**
   Our priorities are to reduce health and wellbeing inequalities, to improve health and wellbeing outcomes, to improve the experience of patients and residents, to prevent ill health and to make the best use of public money.

2. **Establishing our common ground, focusing at all times on our common purpose, setting objectives, planning**
   Our priorities are clear and focused. We are clear who is responsible for what, what will be different, and for whom. We are not distracted from our real business.

3. **Working collaboratively**
   We listen and learn from experts – patients, residents, clinicians, colleagues, partners, the voluntary and community sector, local businesses, elected members, council officers, NHS officials, and from each other - before we take decisions and before we act.

4. **Evidence based**
   We will actively seek evidence and relevant information from a range of sources and witnesses so that we are able to provide challenge and recommendations that are based on evidence.

5. **Acting in an open and transparent way**
   We always us inclusive language that is understandable to all.

6. **Publically accountable**
   We demonstrate consistently that we are publicly accountable for what we do and how we conduct business. Including for how and when we make decisions and take actions - in everything we do.

7. **Integrity**
   We consistently demonstrate an understanding that health sectors, local councils and the voluntary and community sectors have different cultures and priorities. We always act, individually and collectively, with the highest standards of integrity and behaviour

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