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

PRESENT:

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

ALSO ATTENDING:

Sarah Mansuralli (Chief Strategy & Population Health Officer)

Duncan Jenner (Head of Communications ICB)

Clare Dollery (Acting CEO – Whittington Health)

David Probert (CEO – University College London Hospitals)

David Cheesman (Programme Director – Whittington/UCLH)

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

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

Richard Dale (Executive Director of Performance- NCL ICB)

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

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

Dominic O'Brien (Principal Scrutiny Officer)

Serena Shani (Interim Principal Committee Co-ordinator)

38. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

39. APOLOGIES FOR ABSENCE

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

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

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

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

In the circumstances, the meeting continued as a briefing for the Members present. This meant that discussions on the agenda items could continue but any formal decisions made could not be ratified.

40. URGENT BUSINESS

None.

41. DECLARATIONS OF INTEREST

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

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

42. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

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

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

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

43. MINUTES

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

44. ACTION TRACKER

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

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

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

45. WHITTINGTON/UCLH COLLABORATION

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

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

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

The floor was then open to questions.

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

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

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

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

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

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

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

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

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

46. NCL ICS FINANCIAL REVIEW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47. WINTER PLANNING

The Director of Finance for Strategic Commissioning introduced the report.

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

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

The floor was open to questions.

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

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

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

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

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

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

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

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

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

The Chair requested:

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

48. WORK PROGRAMME

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

i- 3rd February 2025.

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

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

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

ii- 7th April 2025.

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

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

49. DATES OF FUTURE MEETINGS

- Mon 3rd Feb
- Mon 7th Apr

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

This page is intentionally left blank