**MEETING**

**JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**DATE AND TIME**

**FRIDAY 24TH NOVEMBER, 2017**

**AT 10.00 AM**

**VENUE**

**ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD EN1 3XA**

**TO: MEMBERS OF JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Chairman: Councillor Alison Kelly, (London Borough of Camden)
Vice Chairman: Councillor Pippa Connor London Borough of Haringey,
Martin Klute, London Borough of Islington

**Councillors**

Councillor Alison Cornelius, London Borough of Barnet
Councillor Abdul Abdullahi, London Borough of Enfield
Councillor Jean Roger Kaseki, London Borough of Islington
Councillor Samata Khatoon, London Borough of Camden
Councillor Graham Old, London Borough of Barnet
Councillor Anne-Marie Pearce, London Borough of Enfield
Councillor Charles Wright, London Borough of Haringey

Enquiries to: Vinothan Sangarapillai, Committee Services
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## ORDER OF BUSINESS

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AGENDA ITEM 1

# NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**FRIDAY, 24 NOVEMBER 2017 AT 10.00 AM**
**ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD EN1 3XA**


| | |
|---|---|
| **Enquiries to:** | **Vinothan Sangarapillai, Committee Services** |
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**MEMBERS**

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

Issued on: Thursday, 16 November 2017

# NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 24 NOVEMBER 2017

**THERE ARE NO PRIVATE REPORTS**

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

**5. MINUTES** (Pages 5 - 22)

To approve and sign the minutes of the meetings held on 19th September and 22nd September 2017.

**6. DEPUTATIONS** (Pages 23 - 28)

To consider a deputation from LUTS patients and a response from the Whittington.

**7. WORKING TOGETHER IN NORTH LONDON TO ADDRESS SOCIAL CARE CHALLENGES** (Pages 29 - 36)

To consider a presentation on collaboration in adult social care in North Central London.

**8. PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS** (Pages 37 - 66)

To consider draft principles of consultation and a consultation paper on procedures of limited clinical effectiveness.

## 9. ESTATES STRATEGY

(Pages 67 - 104)

To update members on the work underway in North Central London on the NHS estate.

## 10. WORK PROGRAMME

(Pages 105 - 110)

To consider the work programme of the Committee.

## 11. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

## 12. DATES OF FUTURE MEETINGS

The dates scheduled for future meetings are:

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

**AGENDA ENDS**

The date of the next meeting will be Friday, 26 January 2018 at 10.00 am in Committee Room 4, Town Hall, Judd Street, London WC1H 9JE.

**THE LONDON BOROUGH OF CAMDEN**

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **TUESDAY, 19TH SEPTEMBER, 2017** at 6.30 pm in Committee Room 4, Town Hall, Judd Street, London WC1H 9JE

**MEMBERS OF THE COMMITTEE PRESENT**

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Martin Klute (Vice-Chair), Jean Kaseki and Graham Old

**ALSO PRESENT**

Councillor Samata Kahtoon (LB Camden)

**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 were received from Councillors Beales, Wright, Cornelius, Abullahi and Pearce, and from Councillor Revah who was a substitute member of the Committee. It was noted that the meeting was quorate with representatives from four boroughs present.

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

Councillor Connor declared that her sister was a GP in Tottenham. Councillor Kaseki declared that he was a former governor of the Camden and Islington NHS Foundation Trust.

## 3. ANNOUNCEMENTS

There were no announcements.

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

There were no items of urgent business.

## 5. ST ANN'S HOSPITAL SITE REDEVELOPMENT

Consideration was given to a presentation by Andrew Wright, the Director of Strategic Development for the Barnet, Enfield and Haringey Mental Health Trust.

Mr Wright explained that the Trust wanted to replace their old in-patient mental health wards with new facilities. St Ann's hospital site encompassed 23 acres, much of which was underused. That size of site was not required any more and they would be putting two-thirds of the current site up for sale.

Mr Wright said the current buildings were outdated and not fit for purpose. They had been designed in the 1930s. He informed the Committee that there had been eight workshops with patients and carers to discuss the proposed new building. The aim was to modernise the site and improve the layout. The plan was affordable in capital terms.

He said that design was such that it could accommodate twice as much clinical floorspace in future if required.

Mr Wright outlined that the development fitted in with Haringey Council's plans for wider regeneration of the area. Planning consent had been obtained from the Council in 2014. The surplus land sold on the open market would have 470 housing units, 14% of which would be affordable housing. The aim was to commence building in early summer 2018 and to finish in summer 2020.

The Chair asked if the development fitted in with the estates principles the Committee had articulated previously. She asked if the estates planning had been integrated with the rest of the STP programme.

Mr Wright said that it was part of the estates workplan and there was flexibility built in for future expansion, if there was separate funding available for it. He said that the development would improve services for patients and working conditions for staff.

The Chair highlighted the Committee's view that no estates disposal should take place unless the full benefit goes to the community. She asked if this was the case.

Mr Wright said that the scheme was awaiting NHS Improvement approval. The Trust wished to retain the whole surplus to reinvest in the site. The scheme was based on this. He was asked if capital receipts would be used for revenue expenditure and he said they would not be.

Mr Wright was asked if their measures maximised the possibility of creating community hubs. He said that was not the aim of this scheme, however it was part of a broader Mental Health workstream which was focussing on reducing pressure on mental health in-patient services and providing services in the community.

Councillor Connor welcomed the new hospital building but expressed disappointment that there were no new beds. She noted that there would be 16 new

beds in another borough, but thought that the construction of a new building was a missed opportunity to provide more bedspace, particularly as occupancy sometimes exceeded 100% and so patients were being sent to East London.

Mr Wright clarified that the 16 new beds the Mental Health Trust would be providing would be in Barnet. These beds would replace the ones that were being bought in from East London. Funding more beds at St Ann's would require ongoing funding from the CCGs and was not affordable otherwise.

He said there was some flexibility in the layout and the eating disorders unit could be reprovisioned as an acute ward.

Councillor Klute queried the nature of the contract being entered into with the private firm IHP.

Mr Wright said it was a contract that was in compliance with the national procurement framework. It was a 'design and build' contract and an 'open book' approach would be taken.

In response to questions about how it differed from PFI agreements, Mr Wright said that the funding for this scheme would come from the sale of assets, not from borrowing from private investors as in PFI deals. As such, the Trust would not be borrowing money and would own the buildings, rather than lease them, when they were completed. The contractors' involvement in this contract would not cover facilities management arrangements but would be restricted to dealing with defects.

A member asked questions about education and training on site. Mr Wright clarified that students did come to the site for placements and training, but it was not a medical school.

Members asked for figures on the revenue from the sale of land. Mr Wright said it was being put on the open market and would be sold for the best offer.

Councillor Connor queried whether the government would give match funding if sales of land were conducted quickly, as she had heard information to that effect. Mr Wright said the idea of the provision of match funding had been floated as national policy, but no scheme had been agreed yet. He felt the St Ann's process was probably beyond the point at which would be eligible to apply if such a scheme was created.

Members expressed concern that 14% affordable housing on the site was too low a figure. They commented that the government's definition of affordable housing as being at 80% of market rents was not genuinely affordable for many people on low and middle incomes in London. They were also concerned about the need for housing for key workers.

Mr Wright said as part of their agreement with Haringey Council, if the Trust obtained more revenue than they needed for their scheme, 60% of that money would go towards funding affordable housing in the area up to the level needed to fund units equivalent to what the site would have had if it had 50% affordable housing.

The Chair commented that it was a shame key worker housing was not being provided, as in the past there had been health sites where staff had lived in accommodation on site.

Mr Wright said the Trust was aware of the difficulties staff had with housing, particularly as an Outer London employer which paid less London Weighting than Inner London health employers, and noted the concerns about affordable housing that members had articulated. However, he said that staff had said to health employers that they preferred not to live on the site where they worked. As such, he said he was not able to give members a commitment about the provision of staff housing.

Members queried why the full business case would not be available until November or December. Mr Wright answered that this was because it needed a final price for the new building and a contractual arrangement to be reached with a developer about buying the land.

Members were keen to see figures about the revenue from the sale of land and the amount of money the developer would be making from the deal. Mr Wright said that an open book accounting policy was being followed and these figures should become available.

**RESOLVED –**

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

(ii) THAT the full business case come to the Committee when available.

## 6. ST PANCRAS HOSPITAL SITE REDEVELOPMENT

Consideration was given to an amended presentation from the Camden and Islington Foundation Trust.

Malcolm McFrederick, the Project Director, was the lead presenter. He explained that they were not as far in the process for the St Pancras site as the Barnet, Enfield and Haringey Mental Health Trust were for St Ann's. They had submitted an outline business case to NHS Improvement and were waiting for it to be approved. They were anticipating it would be approved in October. If approval was granted, there would be a full CCG-led public consultation.

Mr McFrederick highlighted that the existing buildings were not fit for purpose and it was not viable to bring the St Pancras buildings up to date.

They wanted to see good and vibrant community facilities and mental health research taking place. A modern therapeutic environment would be good for patients and safer for staff. In-patient beds would be moved from the St Pancras site and there would be two new 'community hubs'.

Mr McFrederick said there had been consultation with service user groups, CCGs and local councils.

Members were informed that the preferred option of moving in-patient beds to the Whittington, establishing community hubs and bringing researchers and academics onto one site had been reached by considering it against 12 Quality Critical Success Factors.

There were benefits from co-locating mental and physical health services. They had also researched the travel patterns of their patients, and had wanted to find a site which was easily accessible to those who used public transport and did not have a car.

There was discussion about what would be in community hubs. There would be an office area, clinical space (for mental health services and for other health services), and a community space. The community space could include a café or gallery for service users to spend time in and for voluntary sector organisations to operate in.

The Chair mentioned that the Adult Education strategy made mention of community hubs. She asked whether the Trust were working with Camden and Islington on this. Mr McFrederick said that they had spoken to Islington about this and would also speak to Camden in future.

Trust officers said that they wished to align their plans for the surplus land in the St Pancras site with the borough's plans for housing.

Members asked how the redevelopment would fit in with wider STP matters. The Trust felt that community hubs would help with the linking of mental and physical health services.

The Chair asked where the revenue from estates disposals would go. Mr McFrederick said that the sales proceeds would be used to fund the redevelopment plans.

The Trust would be selling 80% of the St Pancras site and retaining 20%. Some of the land would be used for housing and some would be used by Moorfields Eye Hospital.

Members sought clarification that sales proceeds would not be used for revenue spending. They were assured that this would not be the case.

The Trust representatives were asked if a developer had been appointed. They said that this would take place after the outline business case was approved and would then go through the OJEU process.

Members asked about the progress Moorfields were making in terms of their business case for locating on part of the St Pancras site. The Trust representatives said that the two bodies were working together in terms of the timing of their work and submissions. However, they were two distinct schemes and not integrated.

Angela McNab, the Trust Chief Executive, confirmed that land which was surplus to Camden & Islington Foundation Trust requirements would be offered to other health bodies. Members said that there was pent-up demand for GP surgery sites in the area, and they hoped that some of the surplus land could be used for this.

Councillor Connor asked if the number of beds would increase following the move of in-patient facilities from St Pancras to the Whittington. She was informed that they would not decrease, however there had been no indication from commissioners that they would purchase enough beds to allow for the creation of a whole new ward. She expressed disappointment at this and felt it was important to ensure there were more in-patient facilities available for mental health patients, as demand for these had not fallen.

Members also wished to avoid patients having to be placed out of area. Officers said that, on average, the number of Camden and Islington patients who had to be placed outside of those boroughs was low. Ms McNab said the Trust had noted that people were being kept in beds here long than elsewhere and that they could be moved into intermediate care.

Councillor Khatoon, who was a ward councillor for the area, addressed the meeting. She wanted to see consultation with local residents and attention given to how more social housing could be provided on the site and if employment opportunities could be created for local residents. Trust officers agreed to arrange an opportunity for Councillor Khatoon to have a walkabout around the site.

Members expressed concern about the availability of key worker housing, and they felt that this was important to recruit and retain staff.

Members welcomed the proposals to move beds to the Whittington and felt that it was a suitable site. They wished the final business case to come back to the Committee at a future date.

**RESOLVED –**

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

(ii) THAT the final business case when produced be submitted to the Committee at a future date.

## 7. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There was no other business.

## 8. DATES OF FUTURE MEETINGS

Future meetings would be:

- Friday, 22nd September 2017 (Barnet)
- Friday, 24th November 2017 (Enfield)
- Friday, 26th January 2018 (Camden)
- Friday, 23rd March 2018 (Islington)

The meeting ended at 8.25pm.

**CHAIR**

**Contact Officer:** **Vinothan Sangarapillai**
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**MINUTES END**

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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, 22ND SEPTEMBER, 2017** at 10.00 am in Hendon Town Hall, The Burroughs, London NW4 4AX

**MEMBERS OF THE COMMITTEE PRESENT**

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Martin Klute (Vice-Chair), Abdul Abdullahi, Graham Old, Anne Marie Pearce and Charles Wright

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

**MINUTES**

## 1. APOLOGIES

Apologies for absence were received from Councillors Kaseki and Cornelius. Apologies for lateness were received from Councillor Klute.

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

Councillor Connor declared that she had formerly worked as a nurse and was a member of the RCN. She also declared that her sister worked as a GP in Tottenham.

## 3. ANNOUNCEMENTS

There were no announcements.

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

There were no notifications of any items of urgent business.

## 5. DEPUTATIONS (IF ANY)

A deputation was received from NCL STP Watch. Professor Sue Richards was the lead speaker, and made the following points:

- A report had been prepared by NCL STP watch which was available on their website and had been circulated to Council Leaders and MPs.

- They felt that the process of consultation had not been inclusive of disadvantaged groups of patients – such as older people, people with mental illnesses and people with disabilities.
- They feared that cuts in spending would hurt those who were most in need of health care.
- They wanted to see a pause in the STP process.

Martin Blanchard also addressed the Committee. He was concerned about the procedures of limited clinical effectiveness process which the CCGs were thinking of introducing. He felt that it took away the autonomy of GPs and would damage the doctor/patient relationship.

Professor Richards and Mr Blanchard added that they did not agree with the comments in health service documents that a move to community care would be both better for patients and save money. They said that good quality community care would not deliver savings and that an attempt to deliver savings would result in the downgrading of the skills of staff employed.

## 6. MINUTES

Consideration was given to the minutes of the meeting held on 7th July 2017.

The Chair mentioned that a special meeting had been held on 19th September. The meeting had heard from the Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust on the mental health estates developments planned for the St Ann's and St Pancras' hospitals' sites. Members had spoken of the need for land that was surplus to health needs to be used for social housing and for key worker housing.

The Chair highlighted that the July meeting had asked to hear more from the Royal Free, and she thanked officers from that Trust for attending this meeting. She also said that officers had been asked to progress the request from the Committee for a joint Health and Wellbeing Board for North-Central London.

Councillor Connor asked that the fourth paragraph down on page 5 of the minutes be amended to read "She wanted to ensure there was still the same mental health provision there […]"

A question was asked about whether a letter had been written to NHS England as noted in resolution (iii) on page 7. The meeting was informed that it had not been, as circumstances were changing and new figures were being agreed for control totals and transformation funding.

**RESOLVED –**

(i) THAT the minutes be agreed, subject to the amendment above to page 5;

(ii) THAT the comments above be noted.

## 7. ROYAL FREE LONDON NHS FOUNDATION TRUST FINANCIAL UPDATE

Consideration was given to a presentation from the Royal Free London NHS Foundation Trust on their financial position.

Caroline Clarke, the Deputy Chief Executive and Chief Financial Officer, informed members that the Trust had an underlying deficit of £123m – and, taking into account non-recurring revenue, its deficit was £28m.

She said that a number of other hospitals were in a similar position. The Trust currently had costs which were 3% lower than average, but it had built up its deficit over several years. They anticipated being able to reduce the deficit when savings once the new Chase Farm building came into operation. Ms Clarke added that a driver of the deficit was that prices paid by commissioners had reduced as they had become more cash-strapped.

David Sloman, the Chief Executive of the Trust, said that the organisation was working on consolidating back office services and, as part of this, some staff had been moved to Enfield Town Hall.

Consolidating back office services would reduce the duplication which existed at the moment. In addition, Mr Sloman said that the organisation was tackling unwarranted variation in the way tasks were carried out within different parts of the Trust.

Members asked for reassurance that the proceeds from asset sales would be spend on capital projects rather than revenue expenditure. Mr Sloman confirmed this would be the case.

Members also asked if it would be possible to have a list of assets being sold. Mr Sloman said that this information could be published on the Trust's website.

The meeting was informed that North Middlesex Hospital had joined the Royal Free as a clinical partner. They wanted to leverage benefits from co-working and economies of scale. There was no timetable for the North Middlesex to join the Royal Free London as a full member, however.

Mr Sloman said that they would be working with clinicians on the top 40 clinical pathways and doing benchmarking and gathering the relevant statistics for this.

Members welcomed joint working to learn from best practice. However, there was a concern expressed by some members that primary care needed to be improved before services could be moved off certain sites. Patients needed services to be easily accessible to them geographically.

Members asked if there would be job losses from the Trust as services were consolidated. They were informed that there would be a reduction in posts over time, and that the Trust was in discussion with the trade unions about employment matters.

Royal Free officers invited members to visit the new Chase Farm hospital site.

Mr Sloman said that the control total figures were being revised and that this was likely to improve the Royal Free's financial position. They were also likely to receive some Sustainability and Transformation Fund funding.

Members said they would like to receive an update on the situation in the Royal Free in 6 months' time.

**RESOLVED –**

(i) THAT the presentation be noted;
(ii) THAT a visit be arranged for the Committee to the Chase Farm site;
(iii) THAT a report come to a future meeting of the Committee in six months' time to update members on the financial position of the Trust.

## 8. NCL STP: STAFFING AND WORKFORCE

Consideration was given to a presentation on the STP staffing workstream.

Dr Sanjiv Ahluwalia, the Chair of the Local Workforce Action Board, addressed members and said that health partners were coming together to discuss workforce issues. They also recognised that they needed to work with the social care workforce too.

Officers said they recognised that there was a challenge in recruiting and retaining health and social care staff. Claire Johnston, the Project Director of Capital Nurse, said that London only retained 52% of its nurses after 6 years.

The largest falls in staffing were seen amongst the 25-29 age group. Ms Johnston said that they were working on projects to boost retention. One was a rotation scheme to give people a variety of experiences and show them the options for employment portability within the London nursing workforce.

Councillor Connor said that, as a former nurse, in conversation with former colleagues, she had heard concerns about not feeling supported and about poor staffing ratios – as well as concerns about pay, although that was often not the main concern. She also said that it was difficult to return to nursing after a career break, and that this needed to be addressed.

Julia Tybura, the Interim Programme Director (Workforce), informed members that an IPSOS-MORI survey would be being conducted on retention, and she could share information with members when it was available.

Members expressed concern about the cost of transport and of housing for staff in London. Additionally, the view was expressed that Brexit would have an impact on the health workforce as many health workers were from EU member states.

A question was asked about whether the work on recruitment in the nursing workforce would include practice nurses. Ms Johnstone said that it would – and that 200 extra practice nurses had been recruited who could reduce the deficit in practice nurses in North Central London.

Sue Lister from the Royal College of Nursing (RCN) was invited to comment. She said that a concern that the organisation had was that nursing students now had to pay for training. This would deter people from undertaking courses to join the profession.

Ms Johnstone said that efforts were being made to encourage people to return to nursing; however she acknowledged that more could be done. She also said that some ancillary staff in healthcare had overseas qualifications, and work was being done to encourage them to take conversion courses to take up more senior posts within the UK system. She offered to answer further questions members might have in writing.

Members agreed that the staffing workstream should come back to a future meeting of the Committee for further discussion. Councillor Connor agreed to lead on scoping the report.

**RESOLVED –**

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

(ii) THAT a report come to a meeting of the Committee in six months' time on the staffing workstream and progress made.

## 9. NCL STP: ENGAGEMENT UPDATE

Consideration was given to a presentation on engagement.

Gen Ileris, NCL STP Communications and Engagement Lead, addressed members. She pointed out that there had been resource constraints on the public engagement work she could carry out; however more funding had recently been made available and she was obtaining more digital support.

Members asked about the use of the term “North London Partners in Health and Social Care” and were informed that it was the branding used for co-operative work in the area. The Chair said that she preferred the use of the term “listening and learning” to engagement.

Ms Ileris said she aimed for the engagement strategy to be co-produced with local people. She was keen to have a coalition of willing participants locally who would be able to feed into this. She said she had already had meetings with the RCN and with Jewish Care.

The Chair suggested that officers liaise with Tenants and Residents’ Associations locally.

Ms Ileris said that she would come back to the January meeting with more information on the co-produced engagement strategy.

**RESOLVED –**

(i) THAT the presentation be noted;
(ii) THAT a report updating members on the engagement strategy be submitted to the 26th January 2018 meeting.

## 10. NORTH CENTRAL LONDON APPROACH TO COMMISSIONING PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS

Consideration was given to a report from the North London CCGs.

Mark Eaton, the Director of Recovery from Enfield CCG, presented the report to members. He informed the meeting that Dr Jo Sauvage was the clinical lead on the matter, but was not able to make this meeting.

He highlighted the work that had been done by Enfield CCG on this topic, including the process of public consultation that was undertaken. Enfield CCG had considered the clinical evidence for 13 procedures to determine whether, in certain circumstances, the benefits to patients did not outweigh the risk of harm and whether they could be considered as Procedures of Limited Clinical Effectiveness (PoLCE). This included investigating whether the procedures should only be authorised for treatment to go ahead if specified clinical criteria were met. Following the consultation and on reviewing additional evidence that was presented during this period, Enfield CCG decided to go ahead with implementing the revised criteria for 11 of these procedures. Enfield CCG wanted to ensure that, given the risk that existed for surgery and invasive procedures, they were only carried out where there was a high chance of the procedure proving effective for the patient.

Mr Eaton said that the work undertaken by Enfield CCG now needed to be considered as part of a North Central London (NCL) programme. He outlined that the remaining four CCGs would be engaging in a 90-day consultation on the programme

and would like it to be considered by the NCL JHOSC rather than individual borough health scrutiny committees.

Mr Eaton explained that the NCL Programme had other elements to it, including work to update the existing PoLCE Policy based on the revised evidence that had been published since the policy was first agreed. A further workstream looking at a wider range of procedures and treatments that are being considered at a London-wide level although implementation would continue to be locally driven in NCL.

Members expressed concern about the granting of authority to referral managers in this policy. They were of the view that GPs were better placed to make decisions that were best for their patient in terms of referring them for treatment. They expressed concern that financial considerations were the driver behind empowering referral managers and this might have a negative impact on patients in cases where a GP wanted a referral to go ahead but the referral manager prevented it.

Mr Eaton said that the referral management service was clinically led with decisions made by experienced local GPs and that managers did not make decisions on individual patient referrals. He also said that should a doctor consider that a patient would benefit from a treatment despite not meeting the criteria there would remain the opportunity for the GP to make an Individual Funding Request (IFR).

Members from Enfield expressed concern that Enfield CCG would be implementing the PoLCE policy first, in advance of the other four CCGs. Mr Eaton outlined that the CCG's Governing Body had agreed to implement the proposals as soon as possible after approval on the basis that the clinical evidence demonstrated that there was a need to implement them.

The Chair asked that more information come to members about the consultation that was taking place about the PoLCE policy. Members wished to receive another paper outlining the consultation process, including who would be consulted, and what information would be provided as part of that process. The Chair and Councillor Connor would work with officers on scoping this paper to ensure it met the requirements of JHOSC.

Members noted that, depending on legal advice and the views of the constituent boroughs, the PoLCE item could come to a future meeting of JHOSC or a future meeting which was made up of the 4 boroughs other than Enfield (which had gone through a consultation process first) or to the individual health scrutiny committees.

**RESOLVED –**

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

(ii) THAT officers submit an outline of the intended consultation strategy to the Committee, as detailed above.

## 11. DEMENTIA PATHWAY

Consideration was given to the reports on dementia.

Councillor Old introduced the item and highlighted the increasing demand for dementia care in an aging society. He said he saw some common threads in the work officers in the five NCL boroughs were undertaking.

Members noted that, from their experiences, there was significant variation in the care homes they had visited. There were some which were good and some which were bad. They wanted to see effective monitoring taking place. They also wanted to see good practice shared.

Officers said that boroughs did have teams that visited care homes and they were trying to make monitoring more consistent.

A member commented that early diagnosis was important for dementia and that it was concerning that the figures on rates of diagnosis varied between boroughs. It was noted that there were 'dementia navigators' who was being introduced to help people once they were diagnosed.

Councillor Connor praised Islington's work with carers. She said it was important to pay attention to the needs of carers and ensure they were supported.

Members asked that more information come to them in approximately six months' time on progress in joint working, an update on care homes, a shared service specification, interactions with GPs, on learning from each other and and on monitoring of services. Reference was also made to a previous report on GPs in care homes which had come to an earlier meeting of the Committee, and members said it would be helpful to have an update on this topic.

**RESOLVED –**

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

(ii) THAT a report be submitted to the Committee in six months' time on the progress made on the issues mentioned above.

## 12. WORK PROGRAMME

Consideration was given to the work programme of the Committee.

Members noted that they had agreed to ask for updates on the Royal Free's financial position, on the STP staffing workstream, the engagement strategy, the Procedures

of Limited Clinical Effectiveness (PoLCE) consultation strategy, a GPs in care homes update and the dementia pathway. These would be added to the workplan.

Members agreed having lead members for specific items worked well. They asked that the work programme be sent electronically for members to express interest in leading on reports.

Members asked for a further update on the NCL STP financial position as a whole, similar to that laid out on page 19 of the agenda pack, as they recognised that this was a fast-changing situation and wanted to see what the situation now was.

**RESOLVED –**

(i) THAT items on the Royal Free's financial position, the STP's staffing workstream, the NCL engagement strategy, Procedures of Limited Effectiveness consultation strategy, GPs in care homes update and dementia services be added to the work programme.

(ii) THAT the work programme be circulated to Members for expressions of interest in leading on particular items.

(iii) THAT information be circulated on the financial position of the NCL STP.

## 13. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no other items of business.

## 14. DATES OF FUTURE MEETINGS

Future meetings of NCL JHOSC would be held on:

- Friday, 24th November 2017 (Enfield)
- Friday, 26th January 2018 (Camden)
- Friday, 23rd March 2018 (Islington)

The meeting ended at 12.45pm.

**CHAIR**

**Contact Officer:** **Vinothan Sangarapillai**
**Telephone No:** **020 7974 4071**
**E-Mail:** **vinothan.sangarapillai@camden.gov.uk**

**MINUTES END**

**Deputation to the JHOSC November 2017**

Firstly we would like to thank the Committee of its ongoing support of the LUTS Clinic and its patients.

**1. Update on the LUTS service**

Following our last deputation to the JHOSC, the patient group had another meeting with the trust on 3rd Oct. At this meeting it was confirmed that the multi disciplinary team (MDT) have been meeting and have had three good meetings. We had previously been told that once this was in place a gradual reopening of the clinic could commence.

Whilst there was an indication that the Whittington were aiming to recommend that the clinic reopen in their report to the November board meeting, there has been discussion around how the CCG assure that the MDT is functioning well, and the need for a desktop review of the clinic to meet the CCGs own clinical governance processes. An extra ordinary meeting of the CCG Quality Committee is to be held in November, with input from GP representatives, depending on the outcome of the meeting the Clinic would re-open to new NHS patients. The Patient group have requested for a LUTS patient representative, residing in the local CCG to also sit on the extra ordinary meeting.

We are being assured progress is being made, and are very grateful for the hard work people are putting in, but the delays are frustrating and continue to cause a lot of anxiety in the patient group especially those whose lives are on hold as they wait to be able to be referred. Some patients feel that endless new obstacles are being presented in order to delay reopening; we are trusting that isn't the case and there is no underlying motive and appreciate that the bureaucracy just takes a long time. The clinic has now been closed to new patients for two years - a very sad anniversary.

We can only hope that the remaining issues do not have a negative impact on progress - some of the team involved have been in this stressful position now for so long waiting for confirmation that there will be a clinic in which to work, there is a worry that if things are not resolved soon this could become a very serious issue. We'd very much appreciate the committee's support in ensuring that progress continues and we do see the clinic reopened without further delays. Meanwhile there is still no care pathway for paediatric patients with the previous informal pathway with GOSH having failed.

Meanwhile there is a general groundswell of research and interest in both better diagnosis of UTIS (with a lot of research evidence now demonstrating the inadequacy of current tests and that the majority of patients with symptoms who are told at the moment they do not have infection probably do - when more accurate tests are used) and in the existence of chronic UTIs, together with the bacterial aetiology of these. I understand the clinic have several papers in the pipeline and soon to be published and other centres internationally have also been publishing relevant material to this field. Members of our campaign team are regularly being invited to contribute to discussions on these topics. It seems the clinic stands to be well timed in being at the forefront of a very interesting and groundbreaking field which I am sure will impact many lives.

**2. Paediatric admissions to the LUTS Service**

We would like to highlight the plight of child patients suffering with chronic urinary tract problems. Urinary tract symptoms in children are very common; 1 in 10 girls and 1 in 30 boys will have a urinary tract infection by the age of 16. Of those 40% of girls and 30% of boys will have a recurrence. Of those treated the majority recover with standard courses of antibiotic treatment, but a significant minority go on to have further problems.

Chronic urinary tract infections follow a typical pathway, with symptoms either failing to resolve with standard treatment, or recurring soon after treatment is stopped. An additional problem is the 'hit and miss' nature of current testing meaning that many children who remain symptomatic do not have positive cultures or dip stick tests. This means they can be refused treatment for their ongoing infection. By the time they're referred for specialist help, the infection is showing signs of resistance - either in terms of resistance to specific antibiotics, or meaning that it requires much longer term treatment in order to eradicate the bacteria.

Once referred a very difficult situation exists for children and their parents. They are typically seen by multiple specialists and offered various non-curative treatments and interventions. Failure to understand the infective ethology of their condition means that they are often diagnosed with chronic pain conditions such as bladder pain syndrome or interstitial cystitis and exposed to exploratory investigations such as cystoscopies and biopsies of the bladder or uro-dynamics, and attempts at 'treatment' which are well documented to have a very low success rate and often carry very worrying side effects and risks - these including various pain medications, urethral stretches, bladder stretches, medication for overactive bladder, and bladder relaxants. Some children are even exposed to behavioural or psychological interventions which for a child with a genuine infection are agonising and often make the condition worse. Occasionally infections become severe enough that they are prescribed further short courses of antibiotics (often up to 10 in a 12 month period), each time failing to properly treat the infection and therefore increasing the risk of resistant and complex infection developing.

The LUTS clinic started treating children in 1999 – some 18 years ago. Prior to this children were treated in a community Enuresis clinic. The team at the LUTS have therefore been treating children for over thirty years.

However, following the recent issues at the LUTS clinic, resulting in its temporary suspension in October 2015, the clinic has been unable to take child patients. This means that those children and their families now fall into two categories: those who were already receiving treatment but now have been forced into the private sector (and often are under tremendous pressure to somehow fund the ongoing treatment of the children, or to see their child's health deteriorate) and those who are currently unable to access any treatment at all.

We understand that Professor Malone Lee has been permitted by the Trust to treat as private patients *only* paediatric patients already under his care since the clinic re-opening in November 2015**.** Further pressure was placed on Professor Malone Lee within the Trust and from Trust paediatricians to stop accepting any *new* paediatric patients in the summer of 2016, which he reluctantly agreed to do. However, the Trust has neglected to re-establish a formal paediatric pathway and no Trust paediatrician has offered to help these children who have been left without appropriate care.

Parents who call the LUTS clinic for treatment for their children are currently referred to Dr Tullus, Consultant Nephrologist at Great Ormond Street Hospital. This is an informal

arrangement which sadly has so far failed to help these children. Although Dr Tullus has an interest in this field, he is only able to practice the standard treatment protocols and investigations that have already failed this patient group.

We have informed the Trust of this situation several times in patient meetings but a formal, agreed pathway for paediatrics is yet to be established. Furthermore, the RCP recommendations, following its review of the clinic in May 2016, advised that the clinic be allowed to treat current paediatric referrals with over sight being given by a consultant paediatrician. There was no restriction placed on the Clinic with regards to opening to paediatric patients once it began accepting new NHS referrals.

There are no other centres in the United Kingdom treating chronic, UTIs in children except for the LUTS Clinic. Chronic UTIs in children are currently poorly researched, understood and treated – it is an area of medicine that has been neglected by paediatricians and the wider medical community. Professor Malone Lee and the LUTS clinic are world-leading experts in chronic UTI, successfully treating children. It is a tragedy that children cannot now access care for this condition anywhere in the UK.

The effect of a chronic UTI on the quality of life for these children cannot be underestimated – they live in constant pain, unbearable discomfort and considerable anxiety, experience extreme urinary frequency and urgency, are unable to sleep at night, suffer the embarrassment of wetting themselves in front of friends, have poor attendance at school, resulting in isolation from friendships groups, poor academic achievement, are unable to take part in PE and sports or enjoy normal childhood activities. Some of these children have been in hospital for repeated IV antibiotic treatment because they are so ill and have been at risk of sepsis.

All this is even more agonising for parents who know that children who have been able to be treated have recovered fully from their infections and returned to a full and normal life.

The official waiting list for the LUTS Clinic shows no children on the list. However, parents have told us referrals are being stopped by their GP or at the central body dealing with NHS referrals. Parents are desperate.

We feel that it is unacceptable and unethical for a care pathway to be removed from children without an equal replacement being provided. Children are currently being denied access to an effective treatment, and we ask that the plan for this clinic include a pathway to treat paediatrics which enables children to access this treatment. In particular we ask that the Trust focus on finding a paediatrician who can work in the clinic on a regular basis, practicing treatment under the guidance of the LUTS Clinic to support these younger patients.

We would welcome any support the JHOSC can give in resolving these issues with the minimum delay.

Dr K Middleton, Mrs A Taylor and Ms K Dwyer
On behalf of the paediatric patients and potential patients of the LUTS clinic.

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# Update Report of the Whittington Health Lower Urinary Tract Service (LUTS)

## 1. LUTs Service

Whittington Health (WH) Lower Urinary Tract Service (LUTS) is a community based service run at Hornsey Central Health Centre. There are approximately 500 patients being treated in the clinic, from both Islington and Haringey, and from tertiary referrals from outside these boroughs.

The service is led by Prof Malone-Lee, who retired in September 2016 and since that time has been employed on a locum contract by the Trust to continue working part time to deliver the LUTS. The Trust is developing a succession plan with Professor Malone-Lee.

The clinic is not open to new patients at this time, whilst the succession plan is in development, and the concerns relating to quality and safety are fully addressed.

## 2. Succession Plan

The succession plan requires ongoing commissioner support for the service. It must also address the recommendations of the Royal College of Physicians (RCP), including the following:

- Multi-disciplinary team (MDT) meetings to consider the most complex patients
- Monitoring of prescribing for patients who are currently receiving treatments outside current national recognised guidance
- Work within an academic research framework, to provide an on-going evidence base
- Recognised by CCG Commissioners as a tertiary referral centre for the most complex patients

A third desktop review against all the RCP recommendations took place on Friday 20 October 2017, chaired by WH CEO, with senior CCG Commissioners in attendance. The current MDT working practice was well received, and the CCG now wish to engage their GP colleagues in gaining further assurance that all quality and safety concerns have been addressed.

A business plan is in development in collaboration with CCG Commissioners and UCLH, and forms the basis of the succession plan. The intended outcome is a Consultant joint appointment with UCLH, to replace Professor Malone Lee as part of the continuation of the service. Once completed the business plan will be presented for approval to the Whittington Health Trust Board part 2 meeting.

Further elements of the succession plan that require resolution are:

- Agreement with commissioners of the tertiary patient pathway
- Development of shared care protocols for out of area patient management
- Agreement with commissioners the tariff for this specialist service
- Employing a principle investigator for the academic research
- Employing the successor for Professor James Malone Lee

The plan will require approval by CCG commissioners, as part of the 2018/19 commissioning round. Subject to approval, the service could have a phased re-opened to new patients, and the Consultant Joint Appointment post could go out to advert. The service could be fully re-opened once an appointment to the post is made.

## 3. Paediatric Service

The presentation and management of medical conditions, and the way children respond to medicines, are very different from adults. It is therefore recognised as clinical best practice, and in the best interest of the child, that a paediatric trained doctor manages the treatment of children.

Whittington Health paediatric consultants are not kidney and urinary tract specialists, and do not have the specialist skills required to manage this patient group.

The commissioned pathway for this group of children is referral by their GP to the specialist paediatric centres within their areas. For those within North Central London the specialist hospital for referral is Great Ormond Street Hospital.

In developing the succession plan for LUTS, the Trust will follow the recommendations of the Royal College of Physicians to ensure the service works within an academic research framework, to provide an on-going evidence base. There will be an opportunity therefore for academic collaboration with the GOSH service in the future.

# North London Councils
# Collaboration on Adult Social Care



Joint Health Overview and Scrutiny Committee
24 November 2017

Dawn Wakeling, Director of Adult Social Services, Barnet Council
Sanjay Mackintosh, Programme Lead, North London Councils

# Contents

1. The five London Borough Councils in North London contributed to the development of the STP during 2016. However the plan was not fully reflective of the challenges facing Councils, particularly in social care, and where the opportunities were to tackle some fundamental issues in health and social care for local people. In the first half of 2017 we came together as Councils to identify shared challenges, shared solutions and begin to influence the STP locally. **This work is owned and driven by the five Councils.**

## January - February 2017

Appointed programme lead to work across five Councils to identify how we can work together with the NHS as part of the STP

**Workshops**

- Held a series of workshops with Directors of Adult Social Services, Directors of Commissioning and Operations Directors to
- Convened Directors of Children's Services to scope focus on children and young people
- Convened Directors of Finance to understand finance profile across five Councils

**STP governance**

- Ensured equitable representation of from five Councils on STP boards where there was a clear health and social care interface

## February – March 2017

Established a set of joint working principles and undertook analysis of local data to identify shared challenges in health and social care in North London

**Our Principles**

1. **Subsidiarity –** that each Council has its own democratic mandate to support and empower its local population. Any work on a sub-regional level should deliver benefits for local people within each borough. We should avoid any top-down approach to change.
2. **Local analysis** – use data on our local population needs and demands to identify shared challenges. Identify local good practice which could be shared or scaled up
3. **Local engagement** – use each borough's feedback/outcomes from resident engagement to shape our work

## April –May 2017

Presented analysis to STP colleagues, updated the STP Public Narrative to include social care, and established a small programme of work to explore the agreed areas in greater depth

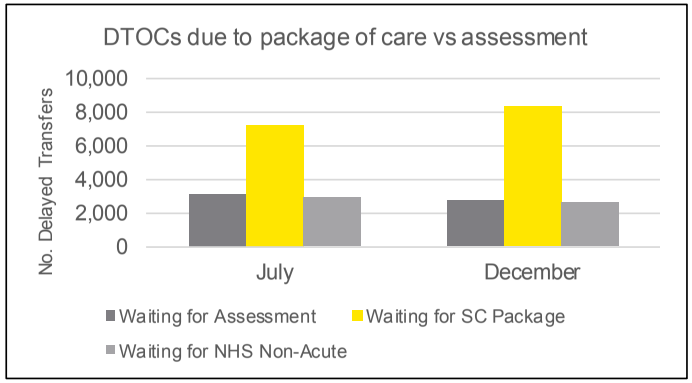
**Areas of focus from analysis**

1. **Streamlining health and social care processes** – in admission avoidance and hospital discharge and developing common principles and/or approach for both across North London
2. **Market management** – developing the residential, nursing and home care markets to have sufficient, high quality care at an affordable price
3. **Workforce** – addressing recruitment and retention issues in directly employed workforce (e.g. social workers, occupational therapists) and commissioned services (e.g. nursing, independent sector care)
4. **Learning disabilities** – looking at care models and pathways for people with learning disabilities, including transitions from children's support to adult support, low to high needs and the 'transforming care' cohort

2. Our social care analysis was able to identify some shared challenges in adult social care that interface directly with the NHS. Collectively we face a **£110m*** financial pressure between now and 2020/21, caused by demand to support more people with complex needs from a shrinking provider market that is struggling to recruit and retain staff. These challenges impact directly on local people, whether they are using NHS services, social care services or both.

## 1. Social care and hospital discharge

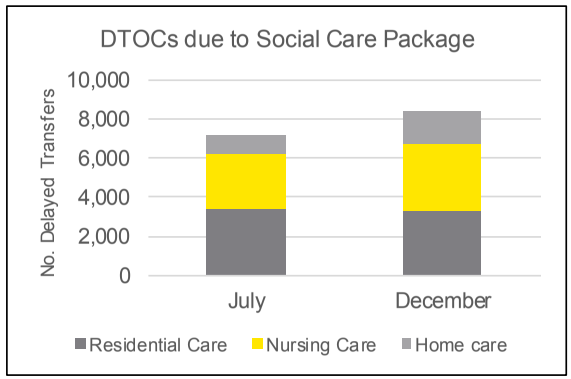
**When delayed transfers of care (DTOC) in North London are attributable to social care, the biggest challenge is arranging a suitable package of care**




Source: NHS Digital (March 2017)

## 2. The social care market

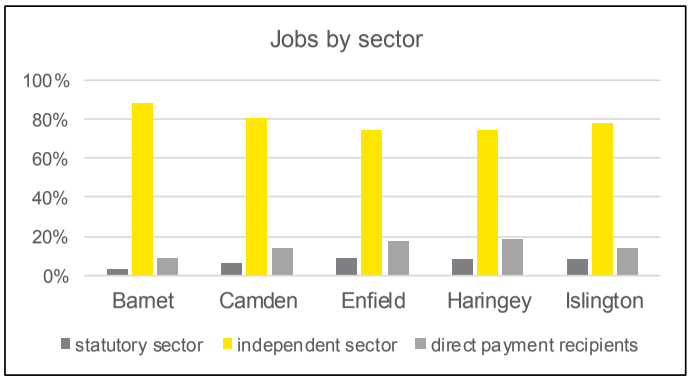
**We have seen a 40% reduction in care homes since 2010, which in part is causing a large proportion of DTOCs**




Source: NHS Digital (March 2017)

## 3. The social care workforce

**Most of our workforce are not employed directly by us, meaning we have no direct control over the workforce dynamic. Average turnover is 21%.**




Sources: www.skillsforcare.org.uk/regionalreports

Lack of care package availability drives DTOCs, meaning people stay in hospital for longer

Difficulty in recruitment and retention affects quality, which in turn can lead to embargoes and/or home closures

* Figure sourced from data provided by each Council in March 2017 on current and projected budget for adult social care to 2020/21

3. As five Councils we have set out to look deeper at our local data and systems, understand where we share challenges in adult social care, define where we feel a shared response is required, then explore what we will do differently together as Councils and with partners (e.g. the NHS, VCS, providers of social care etc).

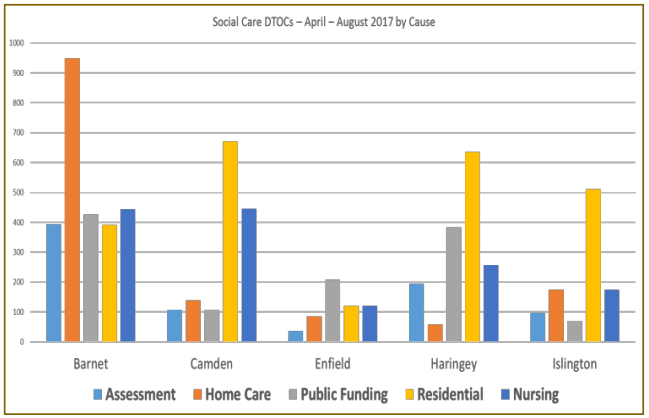

| Social care analysis report recommendations (Apr '17) | Shortlist of specific actions (Oct '17) | Areas for further exploration (Nov '17 onwards) |
|---|---|---|
| 1. Streamline health and social care processes around the hospital | 1. Increase direct payment take up<br>2. Align reablement processes<br>3. Provide intensive care home support<br>4. Streamline hospital discharge processes | 1. Improve consistency in the social care element of the hospital discharge process |
| 2. Develop a sustainable social care market | 1. Share pricing strategy for purchasing care<br>2. Align/share brokerage activity<br>3. Develop more O65 nursing home capacity | 2. Build more capacity in the nursing home sector looking at options for joint-capital investment to build more homes;<br>3. Joint brokerage of health and social care packages of care, looking at options to combine the existing operations run by Councils and CCGs; and |
| 3. Develop a sustainable social care workforce | 1. Focus on nursing recruitment and retention<br>2. Focus on independent sector workforce recruitment and retention<br>3. Develop shared practitioner training and development across health and social care<br>4. Focus on occupational therapist recruitment and retention | 4. Develop a joint approach to recruitment and retention of staff in health and social care, focusing on nursing and the independent sector; |
| 4. Look at specific support to people with learning disabilities | 1. Establish NCL-wide operational forum for case management<br>2. Ensure annual health checks are taken up across GP practices<br>3. Establish LD provider forum jointly with CCGs<br>4. Review complex needs provision, focusing on young people transitions and/or working age adult complex needs<br>5. Develop LD/autism/challenging behaviour accommodation/support capacity | 5. Develop a stronger provider market to support people with LD and challenging behaviour, focusing on prevention of needs escalating into the 'transforming care' cohort and those transitioning from children to adulthood. |

3. Having narrowed our focus to **five specific areas**, we have conducted further research and analysis to test the evidence for collaboration on a five-borough basis. We do not believe bringing consistency to **social care hospital discharge processes** nor sharing **brokerage functions** will deliver much value for the sub-region, but we do believe we need to enable building of more **bedded care provision** and look to **rationalise the purchasing of nursing beds** between CCGs and Councils.

## 1. Hospital discharge processes

Social care DTOC data suggests that timely social care assessments are not the biggest challenge in discharging people from hospital. Rather we lack sufficient high quality residential and nursing bed provision in order to aid hospital discharge (see 2).

We have agreed to share good practice on hospital discharge work and bring this into the STP Urgent and Emergency Care workstream.

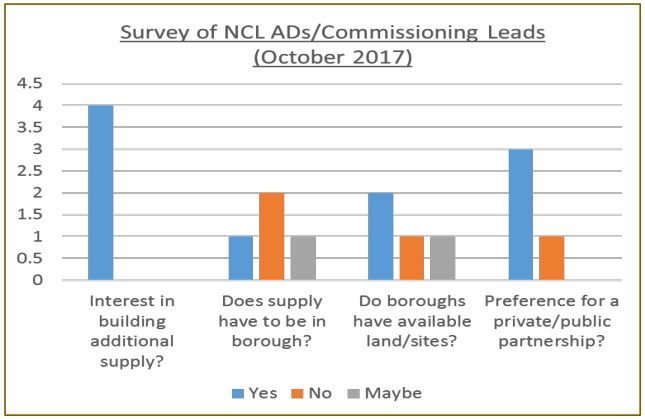



**Note:** DTOC data is sourced from NHS Digital. There are known inaccuracies in local recording (e.g. Barnet) which is being rectified

## 2. Over 65s nursing care market

North London Council social care commissioners agree on the need for more provision, with some flexibility over where in North London this is. Research suggests a specific need for residential and nursing dementia provision and psychiatric provision.

With NHS CCG colleagues we will scope where opportunities lie to work with existing high quality providers to increase this capacity across North London.




## 3. Brokering packages of care

Only 10% of the 8000+ beds available in North London are purchased by all five local authorities. This suggests that all five boroughs are not competing over the majority of their beds, but they may be doing so on a two/three borough basis. This means there is little immediate value in rationalising brokerage activity on a five-borough basis, but there might be on a two/three borough basis.

However, there is a mismatch in the way the 5 Councils and 5 CCGs purchase nursing care beds and we want to focus on rationalising this to remove this disingenuous competition.

| Borough | CCG average (p/w) | Council average (p/w) |
|---|---|---|
| Barnet | £950 | - |
| Camden | £1,050 | £800 |
| Enfield | - | £775 |
| Haringey | £1,225 | £950 |
| Islington | £1,115 | £925 |

**Note:** each Council has a pricing strategy which enables market sustainability. Barnet Council and Enfield CCG pricing is being updated.

3. One of our biggest opportunities is to develop joint approaches to **workforce challenges** across health and social care. Good work is happening across the country and the STP Workforce Workstream is keen to expand its focus into social care. For people with **learning disabilities**, we want to look at what support is needed for those with complex needs and plan now for what they will need. Over the next two months we will be testing our commitment as five Councils to each of these areas, using our principles to guide us. This includes engagement with local people, via Healthwatch, VCS etc.

## 4. Workforce

**We are keen to develop a model akin to the South West's 'Proud to Care' approach, which brings together health and social care organisations:**

- Started small in 2014 with ASC & Commissioning - now funded through Health Education England transformation fund & 16 local authorities in the South West of England
- Delivering career pathways, apprenticeships; work experience, nurse associate schemes, shared recruitment and marketing using Proud to Care Ambassadors across health and social care. Recruitment portal allows health and social care providers to advertise jobs in one place.

**We have been working well with the STP workforce workstream to broaden the focus to social care and health. Some examples include:**

- With Middlesex University, a bid has been successful to fund approx. 25 nursing home workers with oversees nursing qualifications to train with the NMC – focus on removing barriers to access in the profession
- Via the Capital Nurse programme, jointly ran a care home nursing event in October 2017 to develop approaches to attracting nurses into the care home sector and retaining them as part of a structured rotation approach
- Claire Johnston (Capital Nurse Project Director, HEE) is appearing at Health Select Committee feeding in social care nursing workforce challenges and good work taking place in NCL.
- Draft proposals going into HEE in November 2017 on projects for joint recruitment of homecare staff, expanding apprenticeship schemes to health and social care roles, employment models/rotations/cross-sector/use of facilities and international connectivity with overseas universities

## 5. Learning disabilities

**All five Councils agree with a need for:**

- More sufficient high quality providers of accommodation and/or support for people with LD, autism and challenging behaviours. This ranges from small bedded units to support complex needs to community based provision promoting independence, e.g. 'positive behaviour support' providers
- The need for joint protocols on purchasing care, which are causing similar challenges to the older people's bedded care market issues

We are looking at whether to use the infrastructure created in health and social care by the Transforming Care Programme to develop these suggestions further, and will be focusing our efforts on planning support for those with complex needs who are not part of the existing Transforming Care Programme.

4. We feel we have made significant progress in 2017, both in coming together as five Councils and influencing our NHS colleagues to involve us in the STP. But we can go further as a health and social care system and should continue to build on our progress. There are two things we want to see happen in the STP in 2018 and beyond:

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1. A real shift in the focus from the NHS to the NHS and social care, listening to the needs of residents and users of local services to plan transformational change across the health and social care system. We are making progress but this needs to be quicker.

2. Greater focus on delivering strategic, long-term transformation rather than avoiding short-term crises, specifically:
   a. Better analysis and understanding of the root cause of pressure in the NHS and social care in North London sourced from local data, and action focused on tackling the cause (e.g. why people are readmitted to hospital, who they are, where they live etc) rather than the symptom (e.g. focusing on the speed at which people are discharged from hospital)
   b. More strategic planning about how we best use our resources jointly as a health and social care system. For example, our work looking at increasing nursing home capacity in North London is an opportunity for NHS/Council joint working given the pressure it could alleviate on both the NHS and Councils

| Report title: | Draft principles of consultation and draft consultation paper on Procedures of Limited Clinical Effectiveness |
|---|---|
| Report to: | Joint Health Overview & Scrutiny Committee |
| Paper number: | |
| Date of meeting: | 24 November 2017 |
| Report author: | Will Huxter, Director of Strategy, North Central London CCGs; and<br>Dr Jo Sauvage, Co-Clinical Lead, North London Partners in Health & Care and Chair of Islington Clinical Commissioning Group |
| FOIA status: | No exemption |

## Executive summary

Following discussion at the last meeting of the JHOSC of the proposed consultation on extending the range of the policy on procedures of limited clinical effectiveness across Barnet, Camden, Haringey and Islington, we have produced two draft papers for discussion:

1. Draft principles of consultation – this paper sets out a proposed set of principles to be applied when considering consultation on changes in policy or service provision and how we will go about consultation/engagement

2. An early draft of the consultation paper on proposals on extending procedures covered by existing policy on procedures of limited clinical effectiveness, taking account of comments at the last JHOSC meeting. We recognise that this draft needs further work and we will work on refining the draft with HealthWatch and other partners to finalise by early January. It is proposed that the public consultation will commence before the end of January 2018 and will run for 12 weeks.

We would welcome comments from JHOSC on both these draft documents.

## Key recommendation(s)

The Joint Overview & Scrutiny Committee is requested to:

- Review and comment on the draft principles of consultation paper and the draft consultation paper on extending the procedures of limited clinical effectiveness.

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Presentation to JHOSC
24 November 2017

## A commitment to listen and learn from local people

We want to find the best way to involve local people in the health and care decision making process. To do this we are working together with the Joint Health Overview & Scrutiny Committee to develop a set of principles based on best practice so we know when we should formally consult, who to involve and how best to share information to assist people in being able to fully participate in the process.

Not every change needs formal consultation. However, it is best practice to share information widely, and to listen and learn from the people who use services now, or may have in the past, to understand their needs, their experience and how a service might be improved. We want to involve carers, families and other people who are interested in participating to give their views and insights from their experiences of a health or care service.

North London is a culturally diverse community. The richness of this diversity must be recognised in our programme. It is important when we listen to people that our community is appropriately represented. To do this we must recognise and facilitate inclusivity by making our documents easy to read and when requested in a variety of formats. Our events must be accessible for people and located near good transport links.

Working together we would like to propose the following criteria are considered whenever there is a proposed change in relation to policy or service provision (i.e. the way services are delivered) to determine if we require formal consultation or can we involve people via listen and learn (engagement) events or activities and consider their views when making a decisions.

To do this we will consider:

1. The evidence of improved health outcomes if there is a change to a policy or service provision.
2. Demonstration of savings/elimination of waste/duplication and where the resources will be used to achieve better outcomes
3. Risk to public reputation if there is a change to a policy or service provision
4. The number of residents impacted if the proposal was agreed
5. Impact on consistency of provision of service to residents across the five boroughs

We will work together to identify:

a) What local groups we need to work with
b) What work is being done by other CCGs in London/nationally that demonstrates good practice
c) How to monitor the outcomes post consultation and reporting back to JHOSC and to local communities

## Consultation Principles

The purpose of consultation is to listen to the views of local people about what is important to them, to learn from their experiences, and ask what they think could be done better. We can use these insights to inform the decision making process.

We will use the following principles to guide our work:

### 1. Consultations should be clear and concise

We will use plain English and avoid acronyms. We will be clear what questions need answering and why. We will limit the number of questions to those that are absolutely necessary. We will ensure every question is easy to understand and easy to answer.

We will avoid lengthy documents and we will when appropriate consider merging those on related topics.

At times consultation documents will require that the correct medical terminology is used. When this is the case consultation documents will be supported by a plain English version.

### 2. Consultations should have a purpose

We will not consult for the sake of it. We will always check whether there is a legal duty to consult about policies or implementation plans when the development of the policies or plans is at a formative stage. We will not consult about issues on which we already have a final view.

### 3. Consultations should be informative

We will provide enough information to ensure that those consulted understand the issues, including the financial and legal context, so they can give informed responses. We will include validated assessments of the costs and benefits of the options being considered when possible;

All documentation and engagement activity will provide information to support greater understanding of the issues and the rationale for change. We will be transparent about savings and focus on how we will be spending money more wisely.

**4. Consultations are only part of a process of engagement**
We will consider whether informal engagement is appropriate, before or during any formal consultation process. We will seek to use new digital tools and open, collaborative approaches, where possible. We acknowledge consultation is not just about formal documents and responses. It should be an on-going dialogue and process with local people.

**5. Consultations should be targeted at the right people and groups**
We will consider the full range of people, business and voluntary bodies affected by the suggested change to policy or service provision, and whether representative groups exist and consider targeting specific groups if appropriate. We will ensure they are aware of the consultation and can contribute, and consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

We will explore and identify ways to reach people who may be difficult to access or have language needs. We will work with others to successfully reach people in our communities.

**6. Consultations should take account of the groups being consulted**
We will consult stakeholders in a way that suits them. We acknowledge some stakeholders may need more time to respond than others. When the consultation spans all or part of a holiday period, we will consider how this may affect consultation and take appropriate mitigating action.

We will take into account any cultural or religious dates to consider, as well as any significant events that may impact on the effectiveness of the consultation.

**7. Consultations should be agreed before publication**
We agree to share the draft documents before publishing a written consultation, particularly when consulting proposals on changes to policy or service provision.

We will publish on CCG and other partner websites, prior to the commencement of the consultation period. We will work with local community and voluntary sector groups to publish the consultation documents and /or use link to the CCGs.

**8. Consultation should facilitate scrutiny**
We will clearly state how many responses have been received, in what format and outline from which groups/people. We will ensure it is clear when and how the CCG has responded.

We will publish any response by the CCG on the same page as the original consultation and we will explain how responses have informed and changed the proposed changes to policy or service provision or not. We will work with JHOSC in the lead up period, during and post consultation to ensure all documents and activity is inclusive, accessible and meaningful and the process meets the legal requirements of consultation.

**9. Consultations should last for a proportionate amount of time**

We will judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long may cause unnecessary delays. Consulting too quickly will not give enough time to inform and listen to residents and will reduce the quality of responses.

Twelve (12) weeks is the standard maximum period required for formal consultation. There may be times where a shorter period is appropriate and this can be considered on a case by case basis and we will bring all issues that may require consultation to JHOSC as proposals for consideration and advice.

**10. Responses to consultations should be published in a timely fashion**

We will publish responses within 12 weeks of the end of the consultation or we will explain why this is not possible. We will allow appropriate time between closing the consultation and implementing policy or legislation.

**11. Consultation exercises should not generally be launched during local or national election periods or during holiday periods.**

We would launch consultations at these times only if and when exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health).

NORTH LONDON PARTNERS in health and care

# Spending NHS money wisely

## We are proposing to make changes to some of the procedures available for the following conditions and we need your views:

| *Procedure/Condition* | *Summary* |
|---|---|
| Bunions | A bony deformity of the joint at the base of the big toe. |
| Hernia | A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. |
| Vasectomy | Vasectomy is a surgical procedure for male sterilisation or permanent contraception. |
| Uterovaginal Prolapse | Utero-vaginal prolapse is a downward movement of the uterus and/or vagina. |
| Penile procedures | Treatment for erectile dysfunction |
| Cholecystectomy for Gallstones | Removal of gallbladder. |
| Chalazions | A firm round lump in the upper or lower eyelid caused by a chronic inflammation/blockage of the meibomian gland. |
| Homeopathy | Homeopathy is a treatment based on the use of highly diluted substances, which practitioners claim can cause the body to heal itself. |

This is a summary of where some procedures are under review. More details about the proposed changes are contained in the document.

# Contents

# Message from local clinicians

As GPs working in surgeries across Barnet, Camden, Haringey and Islington we know only too well the pressures that the NHS faces both here and across the country at the moment.

There is considerable evidence that some procedures offered routinely by the NHS have limited or no benefits for patients. In some circumstances this can draw funding away from services that do provide benefit to patients whilst also exposing patients to risks such as those associated with surgery for little or no gain. These procedures are termed 'Procedures of Limited Clinical Effectiveness' (PoLCE) in North Central London.

The North Central London PoLCE policy is a list of treatments that are only offered on the NHS when a patient meets certain clinical criteria. This helps ensure our patients are only put forward for procedures that have a high chance of being successful and of making a measurable improvement to their health and quality of life. The care and treatment that we provide to our patients is funded by taxpayers' money – your money. That's why we have a responsibility to spend it wisely and to make sure we get the best value for every pound we spend.

That's why we need to make some decisions about how to spend our money more wisely if we are to protect our most essential health services – like cancer care, emergency care, and to treat life threatening conditions and improve our mental health services in the years ahead.

In this document, we talk about some of the things we think we can save money on and why. We want to know what you think. We haven't made any decisions yet and we won't until we have heard from you, our patients. Unfortunately, doing nothing is not an option. We are family doctors, not politicians, but it's up to us – with your help – to get the local NHS onto a secure and sustainable footing to ensure that we can maintain vital local services for you and your families, both now and in the future.

We would welcome your comments (please read our questionnaire) and any suggestions you may have.

| **Dr Jo Sauvage** | **Dr Peter Christian** | **Dr Debbie Frost** | **Dr Neel Gupta** |
|---|---|---|---|
| Chair | Chair | Chair | Chair |
| Islington CCG | Haringey CCG | Barnet CCG | Camden CCG |

# Introduction

This document is about how we might change some of the things we spend NHS money on in Barnet, Camden, Haringey and Enfield.

Barnet, Camden, Haringey and Islington Clinical Commissioning Groups (CCGs) are four of the NHS organisations that plan, design and buy (commission) local health services across North Central London. Enfield CCG, which is also part of North Central London, has already consulted with its residents on extending their policy on procedures of limited clinical effectiveness (PoLCE) and we now want to review the policy across the remaining four CCGs.

Due to the growing needs of an ageing population, increased demand for healthcare and other factors, including the costs of drugs and technology, the NHS is facing increased and severe financial pressures. Barnet, Camden, Haringey and Islington CCGs, along with all other NHS organisations, must make the most effective use of our budgets and we want to work with you to make the right choices and sometimes difficult decisions.

We recognise that as evidence about how to get the best outcomes for patients improves, we may have to change the ways we commission services. The cost of referrals for hospital care, increasing demand, and pressures to meet targets, means that the thresholds for a referral for planned (elective) surgery need to be as based on evidence that they are effective. Certain procedures are now considered to have limited clinical value but are still known to be taking place, such as tonsillectomies.

As a result of the pressures on our services we are required to make approximately £70 million of savings next year across Barnet, Camden, Haringey and Islington CCGs to be able to continue buying all the services in the way we do now. We want to make sure that services for local residents offer the best possible care, in the right place, at the right time. It is our responsibility to prioritise services for those most in need and make sure that we spend every pound available in the most responsible way.

We believe that this approach will mean we can protect the most important services so they are available when people need them, whilst at the same time continuing to live within our financial means.

We want to know what you think and if there is anything else you want us to consider before we make any decisions. We would like to hear from as many local people in Barnet, Camden, Haringey and Islington as possible. So please tell your friends and family, and encourage them to respond and comment on our proposal. Your ideas and opinions matter to us, and we want your feedback on our ideas. You can fill in the online questionnaire on our websites or print off the questionnaire at the back of this document, fill it in and send it back to **FREEPOST xxx CCGs**, free of charge.

The consultation runs for a period of 12 weeks from xxxx to xxxx.

**For more information visit our websites:**

www.barnetccg.nhs.uk/public consultation

www.camden ccg.nhs.uk/public consultation

www.haringeyccg.nhs.uk/public consultation

www.islingtonccg.nhs.uk/public consultation

# What are we consulting on?

The North Central London PoLCE (Procedures of Limited Clinical Effectiveness) policy is a list of treatments that are only offered on the NHS when a patient meets certain clinical criteria. This helps ensure that patients are only put forward for procedures that have a high chance of being successful and of making a measurable improvement to their health and quality of life.

We want to ensure we do our best to spend our allocated resources with care. This includes taking sensible steps to make sure treatments are undertaken when there is evidence of improving health outcomes and people are encouraged and helped to personally take part in their programme of care.

Collectively the Barnet, Camden, Haringey and Islington Clinical Commissioning Groups (CCGs), along with our provider partners at University College London Hospitals, Whittington Health, Royal Free London and North Middlesex University Hospital are seeking to undertake a wide-ranging review to ensure that there is a consistency of approach.

We keep our existing policy on PoLCE up to date in light of any changes in NICE guidance or other clinical evidence. However we will not extend the policy to new procedures without being open and transparent about our plans. We are committed to discuss any proposed changes with the Joint Health Overview & Scrutiny Committee in advance to agree what form of public engagement or consultation should be undertaken in advance of finalising decisions to make changes.

Enfield CCG has recently agreed to extend their PoLCE policy following a public consultation. As part of our commitment to quality and better outcomes for patients, Barnet, Camden, Haringey and Islington CCGs are continuing to review their clinical policies in the light of current clinical (medical) evidence and the experience from other CCGs.

As a result of this work we are now consulting on extending the PoLCE policy for Barnet, Camden, Haringey and Islington CCGs. After careful review of our financial expenditure and NICE guidance, we are proposing that certain procedures are only funded by the NHS in exceptional circumstances. However, we want to hear from local people to inform our decisions and make the right choices on behalf of the people living in North Central London.

We are undertaking a public consultation to shape the way forward regarding proposed changes to our policy for access to some procedures. The following

section of the document sets out the specific clinical criteria we propose to introduce. The language is technical as we need to very clear with our clinical teams. However we have added a glossary at the end of the document to help explain the terms we are using.

**Bunions (hallux valgus)**
A bunion is a bony deformity of the joint at the base of the big toe.

**Proposed Revised Criteria**
Bunion surgery is justified and appropriate when:

- the patient experiences persistent pain and functional impairment that is interfering with the activities of daily living.

AND

- all appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: up to 12 weeks of evidence based non-surgical treatments, i.e. analgesics/painkillers, bunion pads, footwear modifications

AND

- the patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car)

OR

- there is a higher risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment. A patient should not be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

**Hernia**
A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. A hernia usually develops between your chest and hips. In many cases, it causes no or

very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin.

There are many different types of hernia and some present a greater or lesser risk to your health from twisting or getting stuck. The decision around whether an operation is required depends on the symptoms you are getting and how risky the hernia is.
http://www.nhs.uk/conditions/Hernia/Pages/Introduction.aspx

**Some of the more common types of hernia and the proposed revised criteria are described below:**

**Femoral Hernia**
Surgery will be funded.

**Inguinal Hernia**
Patients with asymptomatic or mildly symptomatic inguinal hernias should not be referred. Surgery will not be funded unless there is:

- difficulty in reducing the hernia

OR

- an inguino-scrotal hernia

OR

- pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living.

**Abdominal (including incisional and umbilical) hernia**
Surgery will not be funded unless:

- there is pain/discomfort significantly interfering with activities of daily living.

AND

- for patients with BMI≥45kg/m2, there have been attempts at weight reduction and these have not resolved the pain/discomfort.

**Divarication of Recti**
Surgery will not be funded.

**Groin pain with clinical suspicion of hernia (obscure pain or swelling)**
These patients should not have diagnostic testing in primary care, but be referred for specialist assessment. Funding criteria for surgery are then applied as laid out in this policy.

**Recurrent and bilateral hernia**
These are considered in the same way as primary hernias and funding criteria for surgery will be applied as described in this policy. Referral should be made to appropriate specialists with expertise in open and laparoscopic surgery.

**Vasectomy**
http://www.nhs.uk/Conditions/contraception-guide/Pages/vasectomy-male-sterilisation.aspx

Vasectomy is a surgical procedure for male sterilisation or permanent contraception.

**Proposed Revised Criteria**
Vasectomies will only be routinely commissioned under local anaesthetic.

**Uterovaginal Prolapse**

This occurs when one of the pelvic organs can bulge into the vagina. A Prolapse is a medical condition where an organ or tissue falls down or slips from its normal position.

This is a very common problem and often gives no symptoms at all. Symptoms can be improved through muscle strengthening exercises and are to be recommended. Operations may have complications or not reliably improve symptoms in all cases
http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx

**Proposed Revised Criteria**
The CCGs will only fund surgical interventions for Uterovaginal Prolapse when conservative management has failed and when one of the following criteria has been met:

1) In cases of mild to moderate symptomatic prolapse where a comprehensive, documented course of pelvic muscle exercises has been unsuccessful and a trial of pessary has either failed or is inappropriate for long term management.

2) Moderate or severe symptomatic prolapse (including those combined with urethral sphincter incompetence or urinary/faecal incontinence).

**Note:** Patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

**Penile Procedures (Penile Implants)**
http://www.nhs.uk/Conditions/Erectile-dysfunction/Pages/Treatment.aspx

**Proposed Revised Criteria**
The CCGs will not fund penile implants as first or second-line treatment for erectile dysfunction (Grade C recommendation).

Exceptions to this policy are patients with severe structural disease, where first and second line treatments may not be effective, are conditions such as:

- Peyronie's disease
- post-priapism
- complex penile malformations

**Cholecystectomy for Gallstones**
http://www.nhs.uk/conditions/Laparoscopiccholecystectomy/Pages/Introduction.aspx

A cholecystectomy is a surgical procedure to remove the gallbladder- a pear-shaped organ that sits just below the liver on the upper right side of the abdomen. The gallbladder collects and stores bile - a digestive fluid produced in the liver. A cholecystectomy may be necessary if a patient experiences pain from gallstones that block the flow of bile.

A cholecystectomy is most commonly performed by inserting a tiny video camera and special surgical tools through four small incisions to see inside the abdomen and remove the gallbladder. Doctors call this a laparoscopic cholecystectomy.

**Proposed Revised Criteria**
CCGs will not fund cholecystectomy for asymptomatic gallstones.

Funding will be available if one of the following criteria is met:

- Confirmed episode of gall stone induced pancreatitis.

- Confirmed recurrent episodes of abdominal pain typical of biliary colic.
- Confirmed episode of obstructive jaundice in the presence of gallstones where the gallstones are thought to be the cause.
- Confirmed acute Cholecystoitis.
- Where there is clear evidence from an ultrasound scan that the patient is at risk of Gallbladder Carcinoma.
- Patient has Diabetes Mellitus, is a transplant recipient or has Cirrhosis, and has been managed conservatively within Primary Care but subsequently develops symptoms which cause significant functional impairment.

The preferred procedure is laparoscopically unless clinical indications suggest otherwise.

**Chalazions (Internal Stye or Meibonian Cyst)**

Chalazion www.moorfields.nhs.uk/content/chalazion-meibomian-cyst

A chalazion is a firm round lump in the upper or lower eyelid caused by a chronic inflammation/blockage of the meibomian gland. It can sometimes be mistaken for a stye. Unless acutely infected, it is harmless and nearly all resolve if given enough time. In the majority of cases, a chalazion does not cause any problems. Good hygiene, especially eye and hand hygiene can reduce the risk of them recurring.

**Proposed Revised Criteria**
The CCGs will fund excision of chalazia when the patient presents with two or more of the following:

- Present for more than six months
- Recurrent infection
- Interferes with vision
- Conservative management has been tried & failed and there is no appropriate alternative to surgical intervention.
- The site of the lesion or lashes renders the condition as requiring specialist intervention.

**Homeopathy**

**Proposed Revised Criteria**
The CCGs will no longer fund homeopathic treatments and services will be decommissioned.

# Impact of proposed changes

We believe that these proposed changes will benefit patients by ensuring that they are not exposed to risks such as those associated with surgery (e.g. use of general anesthetic) and other procedures for little or no gain.

In addition we believe there will be a financial benefit through not funding procedures of limited clinical effectiveness. Savings have been estimated as follows:

| | Projected savings |
|---|---|
| **Barnet CCG** | £180,000 |
| **Camden CCG** | £425,000 |
| **Haringey CCG** | £310,000 |
| **Islington CCG** | £515,000 |
| **TOTAL** | **£1,430,000** |

Releasing savings of this scale will help us to ensure that we can continue to fund other important NHS services across Barnet, Enfield, Haringey and Islington.

# How to respond

**No decisions have been made.** We want to hear from as many people as possible about what they think about our proposals. You can give us your feedback in a variety of ways:

### Complete the online form

www.barnetccg.nhs.uk/Public consultation

www.camdenccg.nhs.uk/Public consultation

www.haringeyccg.nhs.uk/Public consultation

www.islingtonccg.nhs.uk/Public consultation

### Come to a 'drop in' session on the Public Consultation road show (details below tbc)

| Dates | Time | Venue |
|---|---|---|
| Feb | | |

| | | |
|---|---|---|
| Feb | | |
| Feb | | |
| Feb | | |
| March | | |
| March | | |

We are also working with GPs, patient groups, local HealthWatch organisations and community and voluntary organisations to make sure we reach as many local people as possible. All responses will help form a proposal which will go to our governing bodies to consider and make a decision.

## Equality impact assessment

An equality impact assessment (EIA) is a process to make sure that a policy, project or proposal does not discriminate or disadvantage against the following characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

As part of this work we will carry out an initial EIA and publish this on our websites. We will take into account people's responses to our proposals and this will inform a more detailed EIA, which will go to our governing bodies to consider before any decisions are reached.

## Tell us about you

We want to see what sorts of people are responding to our proposals. This helps us to understand if our proposals might have more of an impact on some groups of people than others. **These questions are optional – you don't have to answer them if you don't want to.**

# Please tick as appropriate

**1. Are you?**

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

**2. How old are you?**

- ☐ Under 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years or older
- ☐ Prefer not to say

**3. Do you consider yourself to have a disability?**

- ☐ Yes – a physical/ mobility issue
- ☐ Yes – learning disability/mental health issue
- ☐ Yes – a visual impairment
- ☐ Yes – a hearing problems
- ☐ Yes - another issue
- ☐ No

**4. Which borough do you live in?**

- Barnet
- Camden
- Haringey
- Islington

Other (please tell us which borough)

**5. What is your ethnicity?**

This is not about place of birth or citizenship. It is about the group you think you belong to in terms of culture, nationality or race.

- ☐ Any white background
- ☐ Any mixed ethnic background
- ☐ Any Asian background
- ☐ Any black background
- ☐ Any other ethnic group (please tell us what it is)
- ☐ Prefer not to say

**6. Are you an employee of the NHS?**

☐ Yes ☐ No

**7. Are you responding as...?**

- ☐ An individual
- ☐ A representative of an organisation or group (please tell us which)

## What do you think about our proposals?

We want to understand your views about what we're proposing.

**You don't have to answer the whole questionnaire if you don't want to – only answer the sections you're interested in.**

## Bunions

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop paying for bunions | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

## Hernia

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop paying for hernia | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

## Vasectomy

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for Vasectomy | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

## Uterovaginal Prolapse

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for uterovaginal prolapse | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

## Penile procedures

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for penile procedures | | | | | |

2. Do you have any other comments about our proposals that you'd like to make?

| |
|---|
| |

## Cholecystectomy for Gallstones (Gallbladder removal)

1. Please tell us what you think by ticking the statement that best matches your views:

| | **I strongly support this proposal** | **I support this proposal** | **I am neutral about this proposal** | **I am against this proposal** | **I am strongly against this proposal** |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for gallbladder removal | | | | | |

2. Do you have any other comments about our proposals that you'd like to make?

| |
|---|
| |

## Chalazions *(nodule inside the upper or lower eyelid)*

1. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for chalazions | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

## Homeopathy

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should tighten the eligibility criteria for homeopathy | | | | | |

.

2. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

| |
|---|
| |

# We want to hear from everyone

This document is about changes we want to make to some health services in Barnet, Camden, Haringey and Islington. We want to know what you think about this. If you require a hard copy of this public consultation document or a copy in an alternative format, please email NCLPublicconsultation@nhs.net or telephone 020 xxxx and tell us what help you need.

Let us know if you need this in large print, easy read or a different format or language.

# Glossary

| Term | Meaning |
|---|---|
| **Acute** | Severe or intense |
| **Anisometropia** | A condition in which the two eyes have unequal refractive power. |
| **Aural microsuction** | Procedure to remove excess wax from the ear |
| **Bunion** | A bunion is a bony deformity of the joint at the base of the big toe. |
| **CCG** | Clinical Commissioning Group |
| **Chalazions** | A chalazion is a firm round lump in the upper or lower eyelid caused by a chronic inflammation/blockage of the meibomian gland. |
| **Cholecystectomy for Gallstones** | Removal of Gall bladder |
| **Commission** | Buying of health services |
| **Cortical cataract** | Type of cataract that occurs in the eye |
| **Corticosteroid** | A type of steroid that can help reduce inflammation |
| **Department of Health** | Department responsible for government policy on health and adult social care |
| **Diabetes** | A long-term condition that causes a person's blood sugar level to become too high |
| **Disc** | Circular pads of connective tissue between the vertebrae of the spine |
| **Eligible** | Whether someone qualifies. In this case, the minimum criteria to access a procedure |
| **Epidural** | An injection into the back |
| **Equality impact assessment (EIA)** | A process to make sure that a policy, project or proposal does not discriminate or disadvantage against people with certain characteristics |

| | |
|---|---|
| **Facet joint** | Small joints located between and behind the vertebrae of the spine |
| **Glaucoma** | Eye condition where the optic nerve, which connects the eye to the brain, becomes damaged |
| **GP** | General practitioner |
| **Hernia** | A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue |
| **Intra ocular pressure** | The eye's fluid pressure |
| **Musculoskeletal** | The nerves, tendons, muscles and supporting structures, such as the discs in your back |
| **NHS England** | National organisation that leads the NHS in England |
| **Optometrist** | Specialist eye doctor |
| **Osteopathy** | A way of detecting, treating and preventing health problems by moving, stretching and massaging a person's muscles and joints |
| **Pharmacist dispensing fee** | Pharmacists receive a professional fee for every item dispensed. |
| **Podiatry** | A branch of medicine devoted to the treatment of feet, ankles and lower legs |
| **POLCE** | Procedures of Limited Clinical Effectiveness |
| **Pollen** | A fine powder produced by flowers |
| **Posterior subcapsular cataract** | Type of cataract that occurs in the eye |
| **Probiotics** | Products containing live bacteria and yeasts |
| **Recurrent** | Occurring often or repeatedly |
| **Refractive correction** | Surgery to correct your eyesight |

| | |
|---|---|
| **Retina** | Thin lining at the back of the eye |
| **Rheumatoid arthritis** | A long-term condition that causes pain, swelling and stiffness in the joints |
| **Spinal claudication** | Walking difficulties or pain, discomfort, numbness, or tiredness in the legs that occurs during walking and/or standing |
| **Uterovaginal Prolapse** | This occurs when one of the pelvic organs can bulge into the vagina. A Prolapse is a medical condition where an organ or tissue falls down or slips from its normal position. |
| **Vasectomy** | Vasectomy is a surgical procedure for male sterilisation or permanent contraception. |
| **Visual acuity** | How clearly you see |
| **Vitamin D** | A vitamin that is essential for strong bones |

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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: NCL ESTATES UPDATE** | |
| **For submission to: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE** | **Date: 14/11/2017** |
| **Summary of report:**<br>**This report gives an update on the work underway across the NCL NHS Estate**<br>**Contact Officer:**<br>**Simon Goodwin (simon.goodwin1@nhs.net)** | |
| **Recommendations:**<br>**The JHOSC is asked to NOTE the report** | |

**INTRODUCTION**

With the advent of the STP, and the changes in commissioning arrangements (with the five CCGs appointing a single overarching management team), estates issues across NCL are beginning to be considered in a more strategic manner than was the case previously.

This report gives an update on the strategic content, explains progress to date, and what the next steps are. The last section gives an update on progress with NHS England Estate and Technology Transformation Fund (ETTF) funded schemes.

**CONTEXT**

A number of documents have been produced setting out the detail of the NHS estate across NCL (encompassing the five CCGs, 3 mental health Trusts, four acute trusts, two NHS community providers', several specialist trusts, and numerous GP practices), and this report will not seek to replicate any of the background material.

The NCL Estate Strategy is however attached for information.

The NCL NHS estate is extensive, of varied quality, with varied utilisation rates, and owned by a large number of separate statutory bodies.

The STP, and the changed commissioning arrangements, do not in any way alter the ownership arrangements, or the roles, responsibilities or power of these separate bodies with regard to the NHS estate.

The new arrangements are intended to facilitate greater cooperation and coordination, and in respect of the NHS estate to therefore achieve a collective NHS estate that is more closely aligned with what is needed to provide the required clinical services.

At London and national level, the two big-ticket items are London devolution and the Naylor review. Although not yet impacting on the ground, either or both of these have the potential to impact in the future on how estates issues are transacted in NCL.

**NCL ESTATES STRATEGY**

The Estates Strategy was produced in June 2016. Though most of the broad principles and themes remain relevant, some of the detail is in need of a refresh. (For example, the section on Moorfields / St Pancras / St Ann's as CIFT are no longer considering St Ann's as a potential location for the reprovision of services currently provided at St Pancras, and the section on Marie Foster which has now been declared surplus by Barnet CCG, and is now being sold by NHS Property Services who hold the freehold).

The key principles stated in this Strategy are:

- Better health and care outcomes, based in a fit-for-purpose estate
- Partnership working to align incentives for estate release
- Optimising the use and costs of the NHS estate

These broad principles remain the core principles determining the work that is being progressed, which can be summarised into three broad headings:

- Working with providers to identify surplus estate that can be disposed of;
- Producing an NCL wide estate database so that we have one version of the truth to help future decision making;
- Within each of the CCGs, working to reduce the void costs currently being incurred by the CCG.

The work underway in each of these, and the next steps are as follows:

**Working with providers' to identify surplus estate that can be disposed of**

To date there have been meetings with Estates Directors and CFOs to understand their individual estate plans, to gain transparency of their current assumptions, seeking to join up discussions across the system, and to give commissioning support to decisions to reduce estate. (Such support did not always exist prior to the current arrangements).

The key projects in this area include Moorfields, St Pancras, and St Ann's, with discussions also underway with the Royal Free in respect of their large estate.

All of these schemes are currently in progress, so the next steps involve continuing to work to bring them to fruition.

**Producing an NCL wide database**

There are a number of different databases of NHS NCL Estates, or sub sets thereof. The data held within each varies in terms of the datasets held, their completeness, and how up to date they are. Given the scale and complexity of the NCL NHS estate, this work is progressing more slowly than is ideal.

The next steps are to complete this work, which is now likely to be in the New Year.

**Working to reduce void costs**

Across the five CCGs, void costs (essentially rental costs for empty NHS space, which under the NHS rules CCGs have to pay for when the landlord is either NHS Property Services (NHSPS) or Community Health Partnerships (CHP)) total £5m per annum. These voids are not evenly distributed, with about half of the total cost being incurred by Barnet CCG.

The work to date has involved understanding what providers intentions are respect of NHSPS and CHP owned estate, and in light of those working with NHSPS and CHP, to either bring in new clinical services, or helping them to bring surplus estate to the market.

The earliest results of this included releasing Marie Foster for disposal and working with CHP to better use space in Finchley Memorial Hospital (both in Barnet). Other projects underway include planning to reduce Edgware hospital void costs, and in Enfield freeing up vacant or nearly vacant health centres for disposal. Future work will also include looking at how to better utilise underused space in LIFT new buildings in both Haringey and Camden.

**ETTF**

The ETTF is a programme to improve NHS commissioned primary care estate, and to build IT projects that better join up primary care and hospital services to improve both the patient experience and efficiency.

To date, nine bids have been successful across NCL, with Haringey being the most successful with 3 schemes and Camden being the least successful with no schemes.

These schemes are a mix of small expansion to existing premises and now building to accommodate practices collocating.

Confidential

North Central London Sustainability and Transformation Plan



# North Central London STP: Estates Addendum

**30 June 2016**

# Introduction

North Central London Sustainability and Transformation Plan

As clinical requirements are developed through the STP, the health and care estate is recognised to be a key enabler. The importance of estates to the STP has been demonstrated by NCL's role as an estates devolution pilot and our success in moving forward to the next stage of bidding for One Public Estate (OPE) resources.

This addendum to the STP focuses on the emerging estates changes and sets out:

- Vision and priorities;
- Context (an overview of the NCL health and care landscape);
- The state of the current estate;
- Drivers of change – clinical requirements, population change and efficiency;
- The potential scale of estates change;
- Barriers to achieving change;
- A summary of devolution asks – drawing from our emerging devolution case for change which is being prepared to a slower timescale and will include options analysis;
- Timeline;
- Governance; and
- Risks and dependencies

# Executive Summary

North Central London Sustainability and Transformation Plan

This document provides additional information on the estate in NCL and the potential for estates devolution. Whilst our work is at an early stage, the analysis to date has demonstrated that we will only get best value from our estate if all commissioners and providers of health and social care in a locality work together. A strong partnership is being established around the STP estates and devolution workstream to lay the foundations for the future.

Our vision for the NCL estate is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for local residents. As clinical requirements are developed through the STP, estates has been recognised as a key enabler to transformation. The importance of estates to the STP has been demonstrated by NCL's role as an estates devolution pilot and our success in moving forward to the next stage of bidding for One Public Estate (OPE) resources.

This document and the case for estates devolution is work in progress, but provides a useful foundation to inform development of a devolution business case and OPE plan, to be delivered by the end of July. Whilst we mainly consider the health estate in this addendum, our future plans include the review of opportunities in the wider care and public sector estate through our devolution business case and OPE plan. Workstream risks and dependencies will also be included in these documents.

The principles underpinning our emerging strategy are:

- Better health and care outcomes through the transformation of health and social care delivery, based in a fit for purpose estate;
- Partnership between commissioners, providers, other public sector organisations and the London Land Commission to align incentives for estate release and support the delivery of new models of care; and
- Optimising the utilisation and costs of the health and care estate.

The priorities for development of our estates strategy are:

- To respond to clinical requirements and other changes in demand to put in place a fit for purpose estate;
- To increase the operational efficiency of the estate;
- To enhance capability to deliver; and
- To enable delivery of a portfolio of estates transformation projects.

A number of barriers to moving towards a fit-for-purpose estate have been identified through discussions within NCL, with London partners through the case for devolution and from other estates rationalisation projects within the NHS. The main barriers include:

- Complexity of the estates system, including the number of organisations and the differences in governance, objectives and incentives between each organisation-type, which often results in organisations working in silos;
- Misaligned incentives, which do not encourage optimal behaviour;
- Affordability: retention of receipts, budget "annuality" and access to capital investment for re-provision;
- Complexity of business cases: getting the right balance of speed and rigour and the different approvals processes facing different organisation types, for example, different capital approval regimes operating across the NHS and local government

# Executive Summary

North Central London Sustainability and Transformation Plan

The London Health and Care Devolution Estates sub-group is developing a 'menu' of devolution asks around estates, informed by the devolution pilots, including NCL. We will draw upon these 'asks' from the London menu, so that the barriers identified can be overcome, and to assist in delivery of NCL estates transformation. In summary, the devolution asks are:

- Delegation of business case approval, coupled with the retention of capital receipts within the London systems and the ability to make local decisions relating to the reinvestment of capital receipts;
- Adoption of a capital control total (including provision for greater flexibility within London between revenue and capital allocations) and gain-share agreement with all relevant partners to govern the redistribution of capital receipts;
- Joint NHS-I/NHSE route for business case approvals that fall within the £50m-£100m range and above;
- Ability to agree London variations to:
    - National business case approval criteria to enable a broader assessment of value for money;
    - NHSPS / CHP operating framework to mandate compliance with London-specific requirements; and
    - Estate assessment and use methodology (Carter).
- Ability to agree and adopt solutions to address rent-reimbursement and service charge issues where these present a significant barrier to relocation to more appropriate premises and/or improved utilisation of existing estates;
- Using the newly established estates governance system within London, agree the relevant development and delivery vehicle option(s) that will be used; and
- Ability to pay off PFIs using money raised from capital sales and / or a commitment by national partners to renegotiate such agreements where they have been identified as a significant barrier to financial sustainability and / or the facility is less than 50% utilised and no other utilisation solution will address the issue.

The benefits we anticipate through our STP partnership and devolution include:

- Better local health economy planning including establishing estates requirements;
- Contribution to affordability of estates change across NCL;
- Greater certainty on treatment of capital receipts in project development;
- Greater incentives to dispose of surplus property for organisations which do not currently retain receipts;
- Potential to retain all or a share of NHSPS receipts from disposal to contribute to improvements in the out of hospital estate;
- A whole system approach to estates development across NCL, with different partners, currently subject to different governance processes, working together on projects and developing a shared view of the required investment and development to support clinical change;
- Focused action on the development of the out of hospital estate, to deliver clinical strategies and better outcomes for patients;
- Contribution to affordability of estates across NCL;
- A shared endeavour approach to business case development, which should allow an integrated approach to identifying and meeting requirements and allow early identification of issues to facilitate the process;
- Greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co location, to deliver financial benefits
- Increased capital receipts, achieved through the incentives of devolution.
- Release of land for housing, resulting from improved utilisation and disposals.

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North Central London Sustainability and Transformation Plan

# Vision

NCL want estates to be an enabler to the vision for health and social care being set out in the Sustainability and Transformation Plan (STP). It also responds to a number of external objectives focused on efficiency, capital receipts and housing.

North Central London Sustainability and Transformation Plan

## STP

- The vision for the NCL estate is aligned to the vision for the North Central London STP as a whole
- The STP vision for NCL is to be a place with the best possible health and wellbeing, where no-one gets left behind. It will be supported by a world class, integrated health and social care system designed around our residents
- Further information on the STP vision can be found in the STP document

## Efficiency

- The Five Year Forward View aims to address the projected £1bn NHS budget deficit
- Lord Carter's review of productivity identified a number of areas where improved efficiency in estates could lead to savings: running costs and improved utilisation of space

## Housing

- The NCL boroughs have a collective new homes target to deliver 47,614 units by 2025 in the London Plan. 8,000 new units have been built by the five boroughs over the last four years. Major regeneration schemes in NCL will create new communities for health and care to serve.
- The Mayor's Housing Strategy recognises the importance of affordable housing for essential workers
- Department of Health has a target to release land across England with capacity for 26,000 homes by 2020

## Capital receipts

- Investment will be needed to deliver a fit for purpose estate, and capital receipts from estates disposal are an important funding source for investment
- Department of Health has a target to generate c. £2bn of receipts by 2020

## Estates vision

**Our vision for the NCL estate is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for local residents.**

The principles underpinning our emerging strategy are:

- **Better health and care outcomes** through the transformation of health and social care delivery, based in a **fit for purpose estate;**
- **Partnership working** between commissioners and providers to **align incentives** for **estate release** and support the delivery of new models of care; and
- **Optimising the use and costs** of the health and care estate

The priorities for development of our estates strategy are:

- to respond to **clinical requirements** and other changes in **demand** to put in place a fit for purpose estate;
- to increase **efficiency** of the operation of the estate;
- to enhance **capability** to deliver; and
- to enable **delivery of a portfolio of estates transformation projects**.

Whilst our work is at an early stage, we understand that we will only get best value from our estate if all commissioners and providers of health and social care in a locality work together. A strong partnership is being established around the STP estates and devolution workstream to lay the foundations for the future.

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North Central London Sustainability and Transformation Plan

# Overview of the NCL health and care landscape

North Central London Sustainability and Transformation Plan

The population of NCL is approximately 1.44 million. GLA population estimates show that the population is expected to increase by 9.7% by 2025, with key growth areas in parts of Barnet, Camden, Haringey and Enfield. People are living longer, but in poor health, whilst there is widespread deprivation and stark inequalities in life expectancy. For example, men living in the most deprived areas of Camden are living on average 10 years fewer than those in the least deprived locations. The number of children in poverty is high, particularly in Islington, whilst childhood obesity is also high. The prevalence of mental illness is high in Enfield, Haringey and Islington and many mental health conditions go undiagnosed. There is high use of health and social care by individuals with long term conditions, severe mental illness, learning disabilities and severe physical disabilities, dementia and cancer.

NCL CCGs have a budget of £1.8bn per annum, with an adult social care budget of c. £400m. The majority of NHS commissioner spend is on acute care.

The health and care challenges facing NCL are summarised below. They are reflected by the STP workstreams.

| Primary care | Integrated support for those with long term conditions | Mental health | Urgent and emergency care |
|---|---|---|---|
| Low numbers of GPs per head, few registered practice nurses and low satisfaction levels. High levels of outpatient attendance suggest gaps in primary care provision. High levels of undiagnosed long term conditions. | High levels of hospitalisation for those with chronic conditions suggests patients do not feel supported to manage long term conditions. Lack of available social care services. | The prevalence of mental health problems is in the national top quartile. There are high rates of premature mortality. Other challenges include wide differences in spending, lack of access to liaison psychiatry and long waiting times at weekends/overnight. | Hospitals face challenges in providing specialist care, particularly at the weekend. Within A&E, there are shortages of middle grade doctors. Infection rates are high and patient satisfaction is low. |
| **Care at home** | **Cancer** | **Workforce** | **Estates** |
| High numbers of patients in hospital beds are used by people who could be cared for closer to home, with older people taking up a large proportion of emergency day beds. Delayed discharges are high. | There may be issues with identification of cancer in primary care. There are long waits for cancer referrals and treatment in acute providers. | More than half the GP workforce is aged over 50 and there is significant concern over the sustainability of GP provision.<br><br>Many key workers find it difficult to source affordable accommodation from the private market. | Services delivered from a large number of properties of variable condition with potential for greater utilisation of parts of the estate. |

STP workstreams: primary care, urgent and emergency care, mental health, cancer, workforce, productivity, estates, population health, new models of care, digital enablers

# Contents

North Central London Sustainability and Transformation Plan

# State of the estate - scale

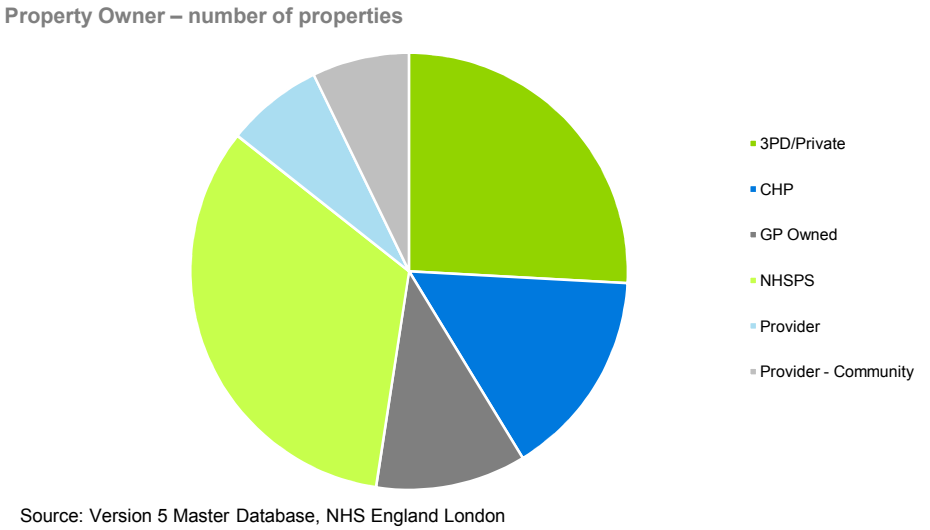
North Central London Sustainability and Transformation Plan

The estate is highly fragmented, in terms of number of properties and their ownership.

The version 5 Master database, NHS England London, shows health services are delivered from 557 property records across NCL (the data includes multiple property records for some sites and some small sites are amalgamated). This is outlined by property owner / landlord below.

| | No. property records | Net internal area (sq m) | No. records without area |
|---|---|---|---|
| Provider | 40 | 995,917 | - |
| Provider-community | 40 | - | 40 |
| CHP | 86 | 17,187 | 22 |
| NHSPS | 185 | 59,770 | 91 |
| GP owned | 62 | 14,204 | - |
| Third party developer (3PD) / private | 144 | 23,955 | 57 |
| Total | **557** | **1,111,033** | **210** |

Source: Version 5 Master database, NHS England London




Source: Version 5 Master Database, NHS England London

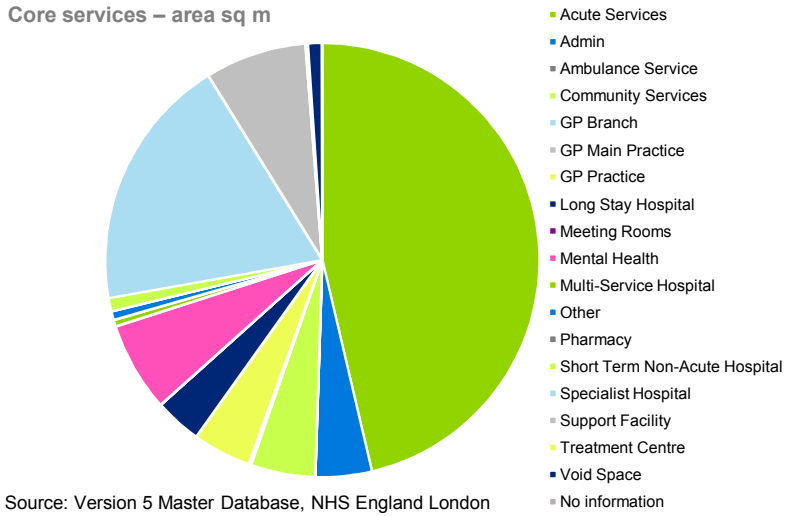
By number:

- 15% are owned by providers or provider-community
- 15% are owned by CHP
- 33% are owned by NHSPS
- 11% are GP owned
- 26% are 3PD / private

# State of the estate – core services provided

North Central London Sustainability and Transformation Plan

Whilst dominated by acute services and specialist hospitals, a wide ranges of services are provided from the estate. The chart and table below show how the NCL estate is split across the core services provided.




Source: Version 5 Master Database, NHS England London

| Core services provided | Number of properties | Net internal area (sq m) |
|---|---|---|
| Acute Services | 30 | 514,779 |
| Admin | 25 | 46,638 |
| Ambulance Service | 1 | 13 |
| Community Services | 27 | 53,341 |
| GP Branch | 11 | 907 |
| GP Main Practice | 11 | 1,318 |
| GP Practice | 222 | 48,245 |
| Long Stay Hospital | 4 | 38,881 |
| Meeting Rooms | 1 | |
| Mental Health | 22 | 74,210 |
| Multi-Service Hospital | 1 | 5,511 |
| Other | 37 | 7,186 |
| Pharmacy | 4 | 176 |
| Short Term Non-Acute Hospital | 3 | 10,904 |
| Specialist Hospital | 7 | 210,942 |
| Support Facility | 3 | 84,023 |
| Treatment Centre | 1 | 2,001 |
| Void Space | 35 | 11,507 |
| No information | 112 | 450 |
| **Total** | **557** | **1,111,033** |

Source: Version 5 Master database, NHS England London

- The majority of the estate by footprint (sq m) consists of acute services and specialist hospitals.
- The GP estate shown accounts for less than 5% of space by footprint but this is likely to be under-reported.
- Information on the core service provided at a particular property is not available for 21% of properties.
- Information on net internal area is not provided for 38% of properties. As these are concentrated in the community-provider, CHP, NHSPS and 3PD / private estate, it is likely that the community and primary care footprint is under-represented in the analysis above.

# State of the estate – the acute provider estate

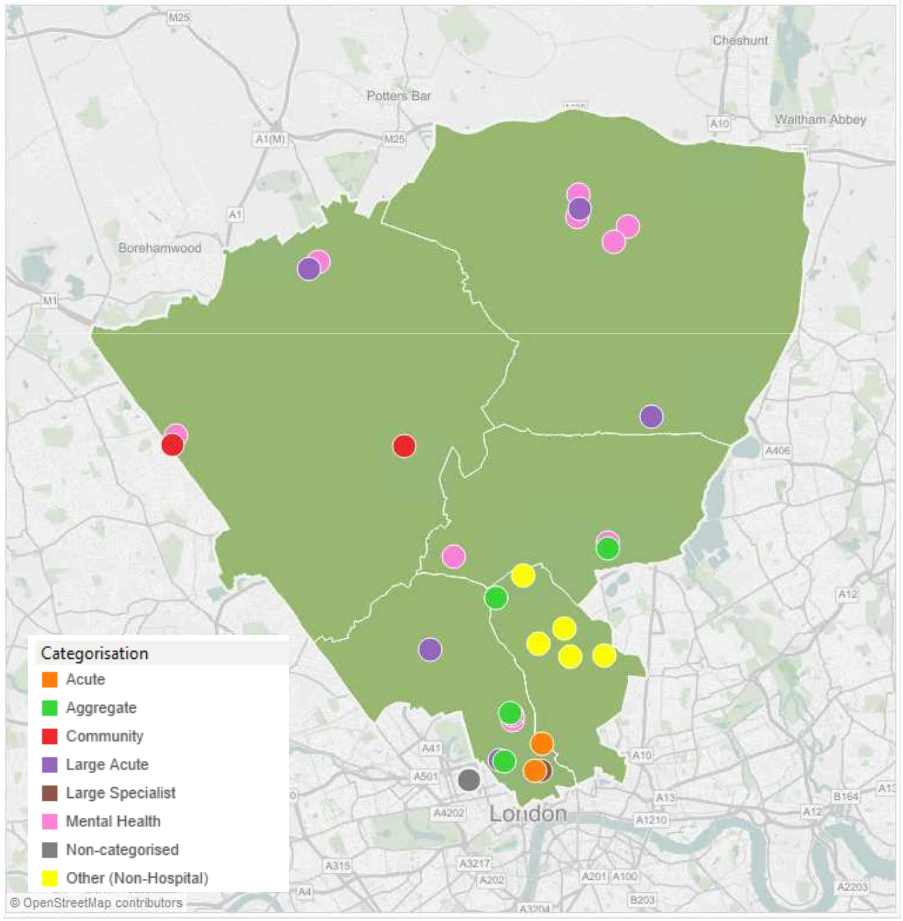
North Central London Sustainability and Transformation Plan

**Acute provider estate**

The condition of the hospital estate in NCL is variable. It is of mixed age, quality and fitness for purpose. It ranges from recently built state of the art facilities at University College London Hospital, to facilities where significant investment is currently underway, for example, North Middlesex University Hospital and Chase Farm Hospital, to outdated mental health facilities at St Pancras and St Ann's.

**The acute provider estate in summary:**

- **Age:** 23% of estate by footprint was built before 1948, whilst a further 32% was built between 1948 and 1984. 37% of the acute estate footprint is less than 21 years old (built after 1995).
- **Backlog maintenance:** Addressing the costs of significant, high and moderate risk backlog maintenance across the acute estate would cost £658m.
- **Utilisation:** 25% of the provider estate (by number of properties) does not meet the Carter benchmark that health and care locations should operate with a maximum of 2.5% of unoccupied or unutilised space. Over half (by number of properties) of the provider estate does not meet the Carter benchmark that health and care locations should operate with a maximum of 35% of non-clinical floor space.
- This analysis provides an insight into the gap between the current estate and the Carter benchmarks. We hope to embed the recommendations of the Carter Review on utilisation through joint working, home-working and improvements in IT, in addition to using devolution as an enabler to facilitate improvements.
- **Running costs:** The total running cost of the provider estate is £384m. According to 2014/15 trust ERIC returns, just under half of the properties cost more to run than the Carter benchmark on estates and facilities running costs.



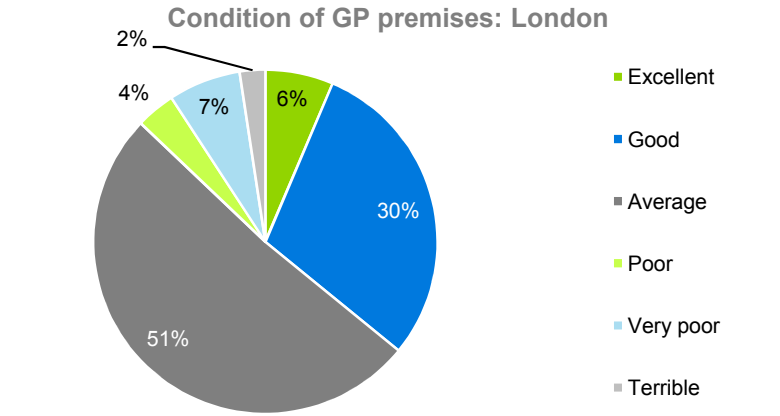

Provider estate in NCL
Source: Eric 2014/15

# State of the estate – the primary care estate

North Central London Sustainability and Transformation Plan

**Primary care estate**

GP services operate out of 244 property records in the NCL footprint – 44% of the total number of properties (this is likely to be understated).




Source: NHS North West London Shaping a Healthier Future, from Better Health for London: the report of the London Health Commission, November 2014

The table below shows primary care business types and property ownership in NCL.

**NCL GP Business Types and Ownership**

| Business type | 3PD/Private | CHP | GP Owned | NHSPS | Total |
|---|---|---|---|---|---|
| Corporation | 4 | | | | **4** |
| GP Branch | 5 | | 2 | 1 | **8** |
| Not Known | 1 | | | | **1** |
| Partnership | 90 | 9 | 41 | 15 | **155** |
| Single Handed | 44 | 6 | 19 | 6 | **75** |
| No information | | | | 1 | **1** |
| **Total** | **144** | **15** | **62** | **23** | **244** |

Source: Version 5 Master database, NHS England London

Across London, the quality of premises occupied by GPs is known to be poor. Whilst 36% of GP premises are rated in excellent or good condition, 51% are rated only average whilst the remaining 13% are rated poor, very poor or terrible.

The source report for this data suggests that those GP premises rated as average require refurbishment, whilst those GP premises rated poor, very poor or terrible require rebuild.

The Estates and Technology Transformation Fund bids, due to be submitted by 30 June 2016, will offer further insights into the state of the primary care estate.

Of the 244 GP properties:

- 75 are occupied by a single handed GP and 155 by a partnership;
- The majority of GPs are owned by the private sector and leased to GPs;
- The distribution across ownership types is similar for both Partnerships and Single Handed GPs; and
- Only 15% of GP properties are owned by either NHSPS or CHP.

# State of the estate – the community estate

North Central London Sustainability and Transformation Plan

**Community estate**

Of the 557 property records in NCL, 272 are not within the following core service types:

- Acute services
- Multi-service hospital
- Short term non-acute hospital
- Specialist hospital
- GP branch
- GP main practice
- GP practice

These 272 properties are described in this addendum as the "community estate". Of the community estate 56% of properties are owned by NHSPS, with a further 22% owned by CHP.

Within the 272 records, there is no information on core service for 112 records.

For the remaining records, the most dominant types of community space are administration space, community services and mental health. These make up 27% of all community property records.

A further 26% of the community estate (by number) consists of void or "other" space.

The remaining community locations include ambulance services, meeting rooms, pharmacies, support facilities etc.

NCL Core Services by Owner

| Core Service | CHP | NHSPS | Provider | Provider – Community | Total |
|---|---|---|---|---|---|
| Administration | 9 | 15 | 1 | | 25 |
| Ambulance Service | 1 | | | | 1 |
| Community Services | 12 | 12 | 3 | | 27 |
| Long Stay Hospital | | | 4 | | 4 |
| Meeting Rooms | 1 | | | | 1 |
| Mental Health | 3 | 11 | 8 | | 22 |
| Other | 20 | 17 | | | 37 |
| Pharmacy | 4 | | | | 4 |
| Support Facility | | | 3 | | 3 |
| Treatment Centre | | | 1 | | 1 |
| Void Space | 8 | 27 | | | 35 |
| No information | 2 | 70 | | 40 | 112 |
| **Total** | **60** | **152** | **20** | **40** | **272** |

Source: Version 5 Master database, NHS England London

**CHP estate**

Across all core services (ie not just those defined as community estate), CHP own 15% of properties in NCL (86 property records) with a total floor area of 17,187 sq m and an average property size of 200 sq m. These are relatively modern buildings and typically in good condition.

# State of the estate – data improvements

North Central London Sustainability and Transformation Plan

We want to develop a more comprehensive analysis of the NCL estate to help us identify opportunities for greater integration of services, development of out of hospital care and to drive rationalisation & efficiency. We will work together with partners to incorporate the estate of other public sector occupiers. This will enable the identification of further opportunities. Work is also underway to improve the quality of the data on the out of hospital estate, which together with the clinical requirements, will support development of out of hospital change and investment requirements.

**Condition of the primary and community care estates**

Across London, work is underway on utilisation and condition studies to be completed by 30 June. This work is being led by CHP. These should provide greater insight into the quality and use of the estate in NCL.

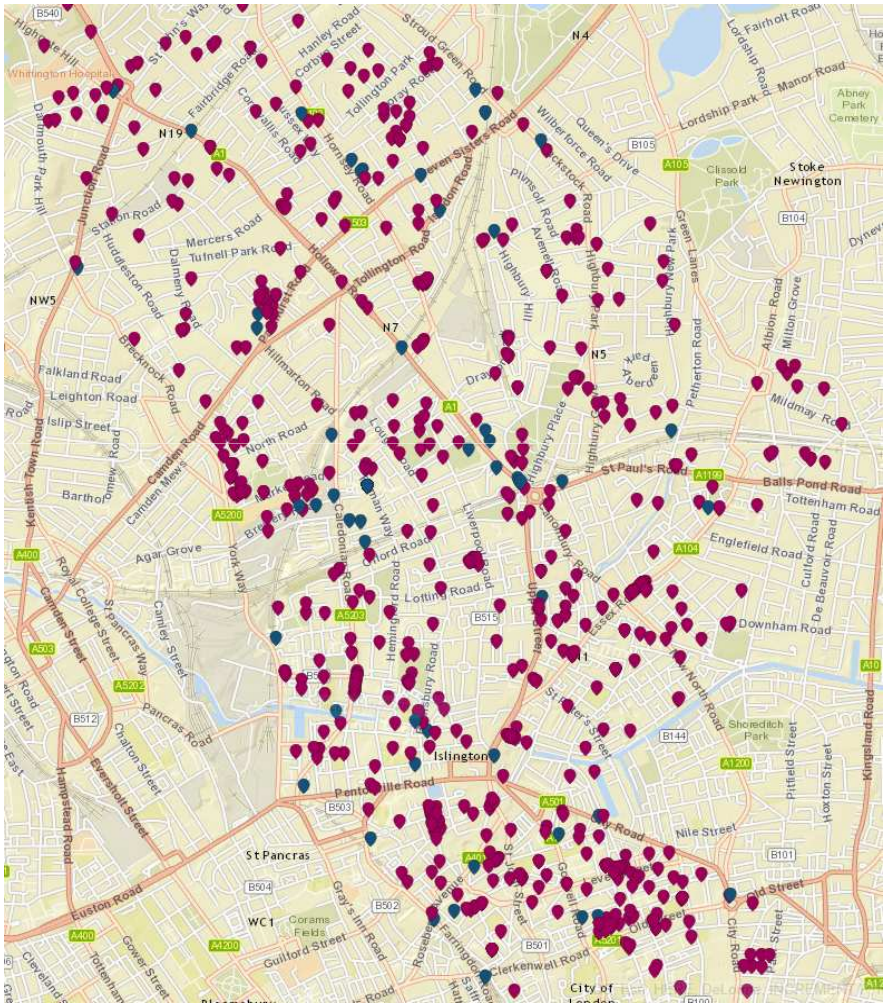
This intelligence will be supported by the 30 June ETTF bids which should provide further information on the scale of improvement required in the primary care estate.

We will continue to work with London partners including HLPP to improve the quality of information available.

**One Public Estate**

Alongside the estate currently used for health service delivery, there are significant opportunities for out of hospital services to be delivered using the local authority estate, such as children's centres and libraries . Islington Council and CCG have mapped the health estate against the wider local authority estate, including social care, leisure and libraries and are using this to develop local opportunities. Across NCL we want to undertake similar mapping to facilitate the delivery of our strategic aims for the health and care estate.

NCL now has three complementary One Public Estate programmes underway: NCL, Barnet and Haringey & Islington. These will provide the means to consistently capture local information which can be overlaid with public land ownership to gain a view of the entire opportunity.




Public sector land in Islington
Source: London Land Commission

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North Central London Sustainability and Transformation Plan

# Drivers of change – clinical requirements

North Central London Sustainability and Transformation Plan

Changes to models of care and the way in which services are delivered arising from the **clinical (and other STP) workstreams** suggest a greater focus on out of hospital delivery. This is likely to have consequences for the estate, including:

- **Population health**: Greater focus on population health and prevention to allow people to live well in their communities and avoid illness, reducing the burden on health and care estates.

- **Primary care:** Development of primary care hubs (scope still to be designed) that will provide for greater access and a range of services in the community, reducing activity in acute sector estates but requiring investment to build or redevelop sites. In parallel, GP practices will require estates investment to achieve DDA compliance and provide suitable premises for focus on patients that require continuity of care (for example people with long-term conditions, frail elderly, children, etc).

- **Urgent and emergency care:** over the first two years of the STP the main focus will be on reducing variability of service across NCL. As the plan develops, specific areas of focus will impact the estate. These include ensuring services meet required criteria and standards; co-location of emergency departments and primary care; transforming urgent care services (111, GP out of hours and urgent care centres) through Integrated Urgent Care; access to community-based mental health close to home; and better use of technology.

- **Mental health:** This workstream includes developing outreach and community based resources and growing out of hospital mental health locality teams. This will impact on estates requirements with a close link to primary care. Activity for 2016/17 is likely to be within the existing estate, with greater estate change consequences coming into play in later years. Projects at St Ann's and St Pancras (see pilot case study section) also contribute to this workstream.

- **Cancer:** Currently scoping the case for change in service delivery. Once service requirements are identified there are likely to be estates implications (greater clarity on estates implications anticipated Q3/Q4 2016/17).

- **Workforce:** An enabling workstream, like estates, also responding to increasing out of hospital delivery and allowing staff to work across NCL. Key initiatives around recruitment, retention, skills and knowledge. IT changes which enable new ways of working are likely to also have estates consequences. Whilst there are individual IT projects in 2016/17, significant estates consequences from IT change are more likely in the later years of the STP. Potential for greater focus on affordable housing for staff across the workforce and estates from 2017/18.

- **Productivity:** As organisations consider how they can work together to provide services differently this could have further consequences for the estate, including how corporate functions are delivered, which could potentially lead to estates savings (with links also to the wider Public Estate); supporting opportunities for pharmacy and food management consolidation; plus workforce and digital change .

# Drivers of change – population change

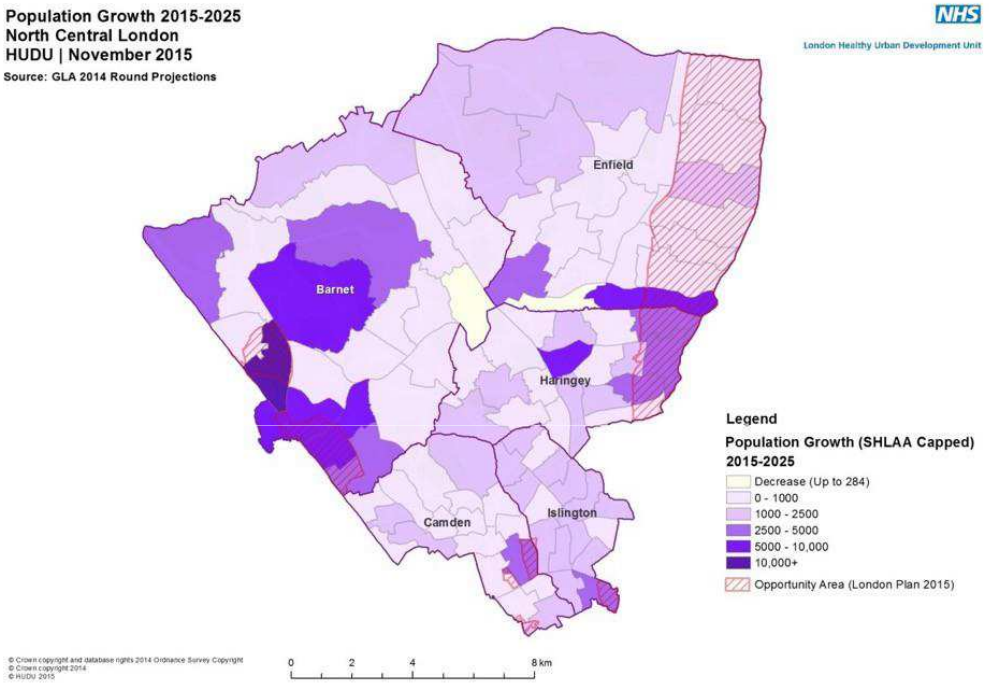
North Central London Sustainability and Transformation Plan

Alongside changes to the way in which services are delivered, provision needs to be capable of responding to changes in the population.

The NCL boroughs are expected to see significant housing growth, drivers of which include major regeneration and new communities. The total population of NCL is projected to grow from 1,445,100 to 1,584,800 between 2015 and 2025, an increase of 9.7%. Growth is concentrated in key areas, for example over half the forecasted population growth comes from within 15 wards in the sub-region.

**London Plan 2016 Refresh: Minimum Net New Housing Targets**

| Borough | Annual |
|---|---|
| Barnet | 2,349 |
| Haringey | 1,502 |
| Islington | 1,264 |
| Camden | 889 |
| Enfield | 798 |
| **NCL Total** | **6,802** |




The total new homes target to 2024/25 is 47,614 units. This is a minimum target. Most boroughs need to deliver more to meet their own assessment of need.

The NCL area includes seven of the Mayor of London's opportunity zones for housing growth. The map on this page shows areas of greatest forecasted housing growth (darker colour, higher growth) and opportunity areas (red crosshatch shading).

Areas of housing growth such as the new development at Meridian Water in Enfield, regeneration at Kings Cross in Camden & Islington, Colindale in Barnet and White Hart Lane in Haringey, bring in new population demands and the opportunity to use new development as a location for service delivery.

# Drivers of change – efficiency

North Central London Sustainability and Transformation Plan

Three main opportunities to increase efficiency have been identified:

1. Reviewing opportunities for cost reduction in the current estate – building on FM cost benchmarks from the Carter review;
2. Reviewing ways to make better use of the current estate – building on utilisation benchmarks from the Carter review;
3. Working with other public sector property owners to make best use of the wider public estate in the area – One Public Estate.

## FM costs*

- ERIC returns show the annual FM costs of 31 provider sites in NCL as £384m
- Eleven sites have FM costs at least 10% more than the Carter benchmark (£319 p sq m), with a further three sites within 10% of the benchmark
- If the FM costs of these eleven sites were reduced to the Carter benchmark the total FM cost would be £123m lower
- The five sites performing the poorest with respect to the FM costs account for 80% of the potential opportunity. These sites are:
  - New University College Hospital
  - North Middlesex Hospital
  - St Pancras Hospital (MHALD)
  - Seacole Centre Department
  - Great Ormond Street Hospital
- Three of the eleven sites identified are PFI sites (New University College Hospital, North Middlesex Hospital and Barnet General Hospital)

## Utilisation

- Eight sites, including Seacole Centre Department, Chase Farm Hospital, St Michael's Hospital, and St Pancras Hospital have a higher proportion of un-utilised space than the 2.5% benchmark contained within the Carter report
- Over half of the sites analysed (16/31 sites) were found to have a higher proportion of non-clinical space than the Carter benchmark (35%)
- The non-clinical benchmark needs to be treated with care on sites with a non-typical mix of activities, eg research and teaching

## One Public Estate

- One Public Estate (OPE) describes an approach where public sector bodies work together and take a strategic approach to asset management. This includes:
  - Identification of opportunities for shared use of accommodation – which could include office and back office functions, public facing space (eg leisure centres and libraries)
  - Improving utilisation of buildings
  - New ways of working, eg shared booking systems
- NCL has been successful in submitting an Expression of Interest for OPE status and has been invited to bid to become a new OPE partnership, which could unlock revenue of up to £500k to support delivery of projects.

*Work on FM costs will be taken forward by the productivity workstream factoring in existing CIPs

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North Central London Sustainability and Transformation Plan

# Current estates plans

North Central London Sustainability and Transformation Plan

**"Do nothing" case**
Under the "Do Nothing" case, the trusts have provided their assumptions for capital spend and funding sources over the five year STP period. The total capital requirement equates to £1.1bn. It is assumed that this will be funded by c.£450m of internally generated funds; c.£163m of disposals; and c.£531m of externally agreed funding (predominantly IFTT loans and PDC). Within the do nothing capital position, the largest capital requirements are:

- **Royal Free:** £351m capital requirement. This is funded by £161m of disposals (majority relating to Chase Farm site, with some other smaller disposals), £95m of internal funds and £95m of external funds (PDC and loans); and
- **UCLH:** £590m capital requirement relating to Phase 4 (Clinical Haem-oncology facility) and Phase 5 (ENT Clinical facility). This is funded by £155m of internally generated funds and £435m of external funds, including loans and PDC.

**"Do something" case**
The "Do Something" capital will continue to be assessed as the STP clinical strategy develops. Once developed further, it is expected that "Do Something" capital requirements will include:

- **Acute (Estates) – MEH, BEH and C&I** – Further detail is currently being developed on the Moorfield, St Pancras, St Ann's case studies.

- **Primary and community care –** NCL will develop a fully worked up clinical and estates strategy for the out of hospital estate. Whilst the changes required are not yet defined sufficiently to be costed, one indicator of the potential cost of change associated with a move to greater out of hospital care is by reference to Better Health for London work, published in 2014. The estimated capital cost to transform primary care in London is c.£1bn. This estimate is due to be updated in July 2016. Based on experience elsewhere, there will potentially be a requirement for significant investment in the out of hospital and primary care estate to support the transformation of primary care and facilitate the clinical strategy. An initial high level estimate of the investment required is of the order of £100m-200m.

  Initial proposals for investing in the primary care estate are summarised in the ETTF bids (June 30 submission date), which include some developments to support primary care hubs. The bids submitted are for a three year period, do not cover all project requirements and often only cover a proportion of funding for some projects, rather than the full funding required. Across the five CCGs, c.£63m is expected to be bid for through the ETTFs. Projects include new build premises at White Lodge Medical Practice (Enfield), the transformation and expansion of Andover Medical Centre (Islington) and provision of better primary care services at Colindale & West Hendon (Barnet).

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North Central London Sustainability and Transformation Plan

# Barriers

North Central London Sustainability and Transformation Plan

A number of barriers to estates rationalisation have been identified through discussions within NCL, with London partners through the case for devolution and from other estates rationalisation projects within the NHS. These are summarised below and incentives, retention of receipts and approvals are considered further on the next pages. More information on the barriers is contained in – Developing London's Devolution Proposal on Estates (report to London Devolution Programme Board, 2016). The issues are then explored further through a series of case studies.

| Barriers |
| --- |
| **Complexity** of the estates system, including the number of organisations and the differences in governance, objectives and incentives between each organisation-type: organisations often work in silos |
| **Misaligned incentives**, which do not encourage optimal behaviour |
| Historically limited **joining up** of estates strategy at the local and sub-regional level within health and limited read across to other local public bodies |
| **Affordability: retention of receipts**, budget "annuality" and **access to capital investment** for re-provision |
| **Town planning**: achieving a shared vision on the optimal use of sites, the perspectives of the health economy, the Local Plan and development viability / affordability |
| **Approvals: complexity** of **business cases:** getting the right balance of speed and rigour and the different approvals processes facing different organisation types, for example, different capital approval regimes operating across the NHS and local government |
| **Community consultation:** if the benefits case is not compelling or where it has differential impacts on different parts of the community that need to be mitigated this can cause delays |
| **Length of existing contracts:** long term contracts, for example PFI and LIFT can constrain ability to realise opportunities to exit from some sites |
| **Offering surplus opportunities** to health sector and other public sector |
| **Wheel re-invention** (e.g. multiple trusts getting legal advice on similar issues) |
| Missing **marriage value** opportunities across health and other public bodies |
| **Development timescales** (often 5-10 years). Selling **the "right site"** – what was surplus becomes necessary for delivery in later years. When to bring in a private partner. |
| Mismatch of **skills** and **requirements** |
| Data **quality** and **completeness** is poor |

# Incentives to rationalise estate, affordability and approvals – FTs and Trusts

North Central London Sustainability and Transformation Plan

The financial incentives against the desired behaviour to rationalise the estate and approvals processes differ for Foundation Trusts and NHS Trusts and are summarised below. More detail is set out in the documents on Developing London's Devolution Proposition on estates.

| | Foundation Trusts | Trusts |
|---|---|---|
| **Financial incentives to rationalise estate** | • Benefits from running cost savings if surplus property is sold<br>• Benefits from Public Dividend Charge (PDC) saving if surplus property is sold (if old property is being replaced by new, PDC may increase representing a dis-incentive to re-provide) | • Benefits from running cost savings if surplus property is sold<br>• Benefits from Public Dividend Charge (PDC) saving if surplus property is sold (if old property is being replaced by new, PDC may increase representing a dis-incentive to re-provide) |
| **Affordability** | • FT retains receipt for FT-related use, as per Constitution. | • Trust retains receipt up to delegated limit (see below). Balance goes to Department of Health. Trust can seek consent to retain for investment in project. |
| **Approvals** | • Risk framework for material or significant transactions. NHS-I approval required for transactions that reach specified threshold. Threshold is whether the ratio of the gross assets, income or consideration attributable to the transaction exceeds 10% of the FT's gross assets, income or total capital respectively. | • Delegated approval limits – various levels of TDA approval required for property transactions of between £5 million, or 3% of turnover whichever is the lower, and those up to £50 million. |
| **Other factors influencing behaviour (relating to complexity of the system)** | • Estate code states that surplus property "should be sold as soon as possible and not be retained in the expectation that the market might improve"<br>• Potential competitive advantage in future service commissioning due to ability to deliver from a specific location | • As per FT |

The difference in treatment of capital receipts and the differences in approval processes mean that incentives to dispose are greater for FTs than for trusts.

# Incentives to rationalise estate– community and primary estate

North Central London Sustainability and Transformation Plan

Financial incentives relating to rationalisation of the estate are more complex in the community and primary estate, as outlined below:

| Occupier | Owner | CCG (and NHS-E) |
|---|---|---|
| **Trust / FT**<br>• Costs of occupation covered by tariff (or where not in tariff covered in block pass through) – funded by CCG<br><br>**GPs**<br>• Rent reimbursed by NHS-E (moving to CCGs with delegated commissioning)<br>• NHS-E do not cover service charge | **Property companies (NHSPS or CHP)**<br>• Receives income for let space from occupier<br>• Receives income for void space from CCG (or NHS-E for specialised in a small number of cases)<br>• NHSPS receives receipt if property sold<br>• CHP (LIFT) assets in long contracts so unlikely to be disposed of<br>• Responsible for centre management<br>**GP owner occupier**<br>• Receives notional rent (or cost rent) from NHS-E<br>• Benefits from capital appreciation of asset<br>**Private sector third party**<br>• Receives rental income from occupier for occupied space<br>**Trust Property Owners**<br>• Trusts own some community health properties inherited from the PCTs (if they were 50+% occupiers)<br>• If they lose the contract they lose the building (back to Sec of State)<br>• If they are FTs they can sell and keep capital receipt | • Funds costs of occupation<br>• Funds costs of void space in NHSPS and CHP buildings<br>• Funds under-utilisation through lost opportunity<br>• Responsible for coming up with commissioning plans to fill void space<br>• Can give notice (6-12) on void space in NHSPS buildings but not CHP<br>• CCG approval prior to declaration of property as surplus (required prior to disposal by NHSPS and FTs) |

*Funding flows do not reflect roles and responsibilities or create incentives for desired behaviours:*

- Other things being equal, GPs are not financially incentivised to move into NHSPS / CHP buildings where the service charge may be higher than in the private sector as service charge will not be reimbursed. GPs in owner occupied properties in areas of capital value growth have an incentive to retain those properties because of capital appreciation.
- The property companies are responsible for centre management but have a mixed track record in this area. They receive income whether space is let or void so are not financially incentivised to maximise use of the space.
- Conversely CCGs pay for the space, whether used or not and do not have responsibility for centre management.
- CCGs cover the cost of empty space and NHSPS receives the receipt when a property is sold.
- There are many situations where the costs of a GP occupying space in the private sector are being funded by the NHS and the costs of nearby void space are also being funded – a double cost to the NHS.
- The total CCG void cost in NCL is £4.8m per annum (including voids and meeting room charges, sourced from Master Estates Database V5, NHS England London).

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North Central London Sustainability and Transformation Plan

# Summary of NCL devolution 'asks'

North Central London Sustainability and Transformation Plan

The London Health and Care Devolution Estates sub-group is developing a 'menu' of devolution asks around estates, informed by the devolution pilots, including NCL. The estates subgroup currently includes representation from national partners including NHS-I, NHS-E and Department of Health and London partners, including London Councils, the GLA, the London Land Commission, the Office of London CCGs, and the NCL devolution pilot.
We set out below the 'asks' from the London menu that NCL would seek to draw on initially, the barriers these could help to overcome and how they could assist in delivery of NCL estates transformation. The emerging approach to governance is described in a later section.

| Devolution ask | Barriers addressed | How this can help delivery in NCL |
|---|---|---|
| Delegation of business case approval, coupled with the retention of capital receipts within the London systems and the ability to make local decisions relating to the reinvestment of capital receipts | Complexity<br><br>Financial incentives<br><br>Lack of joined up strategy<br><br>Affordability<br><br>Approvals<br><br>Wheel re-invention | • Support to the STP process of local health economy planning including establishing estates requirements<br>• Contribution to affordability of estates change across NCL<br>• Greater certainty on treatment of capital receipts in project development<br>• Greater incentives to dispose of surplus property for organisations which do not currently retain receipts<br>• Potential to retain all or a share of NHSPS receipts from disposal to contribute to improvements in the out of hospital estate<br>• A whole system approach to business cases including a single process for business case approvals for different partners, currently subject to different governance processes, working together on projects<br>• A shared endeavour approach to business case development, which should allow an integrated approach to identifying and meeting requirements and allow early identification of issues to facilitate the process<br>• Greater consistency between health and local government on value for money assessment on jointly promoted OPE projects<br>• Greater financial flexibility in managing the delivery of complex projects |
| Adopt a capital control total (including provision for greater flexibility within London between revenue and capital allocations) and gain-share agreement with all relevant partners to govern the redistribution of capital receipts | | |
| Joint NHS-I/NHSE route for business case approvals that fall within the £50m-£100m range and above | | |
| Ability to agree London variations to:<br>• National business case approval criteria to enable a broader assessment of value for money<br>• NHSPS / CHP operating framework to mandate compliance with London-specific requirements<br>• Estate assessment and use methodology (Carter) | | |
| Ability to agree and adopt solutions to address rent-reimbursement and service charge issues where these present a significant barrier to relocation to more appropriate premises and/or improved utilisation of existing estates | Financial incentives | • Flexibilities to incentivise use of void and under-utilised space<br>• Reduce the net cost of void space to the NHS |
| Using the newly established estates governance system within London, agree the relevant development and delivery vehicle option(s) that will be used | Marriage values<br>Development timescales | • Flexibility to transfer assets to delivery vehicles or the local public sector organisation best placed to deliver a project to support OPE delivery<br>• Allow share of returns over time where offers better VfM than upfront disposal |
| Ability to pay off PFIs using money raised from capital sales and / or a commitment by national partners to renegotiation of such agreements where they have been identified as a significant barrier to financial sustainability and / or the facility is less than 50% utilised and no other utilisation solution will address the issue | Length of contract | • Reduce under-utilised space<br>• Greater flexibility to identify solutions for sites with highest running costs |

# Summary of NCL devolution 'offers'

North Central London Sustainability and Transformation Plan

NCL partners also recognise that alongside the technical devolution 'asks', new ways of working locally can also help to overcome barriers. The table below summarises the NCL 'offer', ie how the NCL partners intend to work differently to help tackle barriers.

| Barrier | How NCL partners are seeking to address the barrier |
|---|---|
| **Town planning** | • The STP partnership working should allow senior local authority officials greater line of sight into projects, their benefits and their interdependencies so that each local planning authority will be aware at strategic level how a planning application on one site in one borough has implications across NCL for local residents.<br>• Collaborative working between planning teams in NCL will facilitate faster decision making and a shared view of the wider community, health and wellbeing benefits for their local populations. |
| **Skills** | • By working together in partnership there is greater potential to draw on the combined estates capacity and expertise across partners.<br>• NHS organisations have a wide variety of estates capability. There is an opportunity to work alongside local authority estates teams, making use of their powers for capital borrowing, land assembly and development. Local authorities in NCL and the NHS have a range of procurement frameworks and strategic partnership arrangements which could be drawn on.<br>• If successful in the OPE bid, NCL should be able to access revenue funding to allow resourced workstreams to be set up deliver initiatives and provide a portfolio management resource across projects and will also look to partner organisations to dedicate resources.<br>• NCL would seek to draw on London-wide capacity proposed for the London Delivery Unit around business case expertise and expertise in site disposals |
| **Lack of joined up working across health and the wider public sector** | • By taking an OPE approach to identification of opportunities as to where and how the estate is best used, this should drive efficiency.<br>• Whilst reviews of opportunities and individual projects are managed at a local level the NCL partnership provides a way to establish consistent approaches, economies of scale (eg booking systems) and to bring attention to high profile / difficult issues. |

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North Central London Sustainability and Transformation Plan

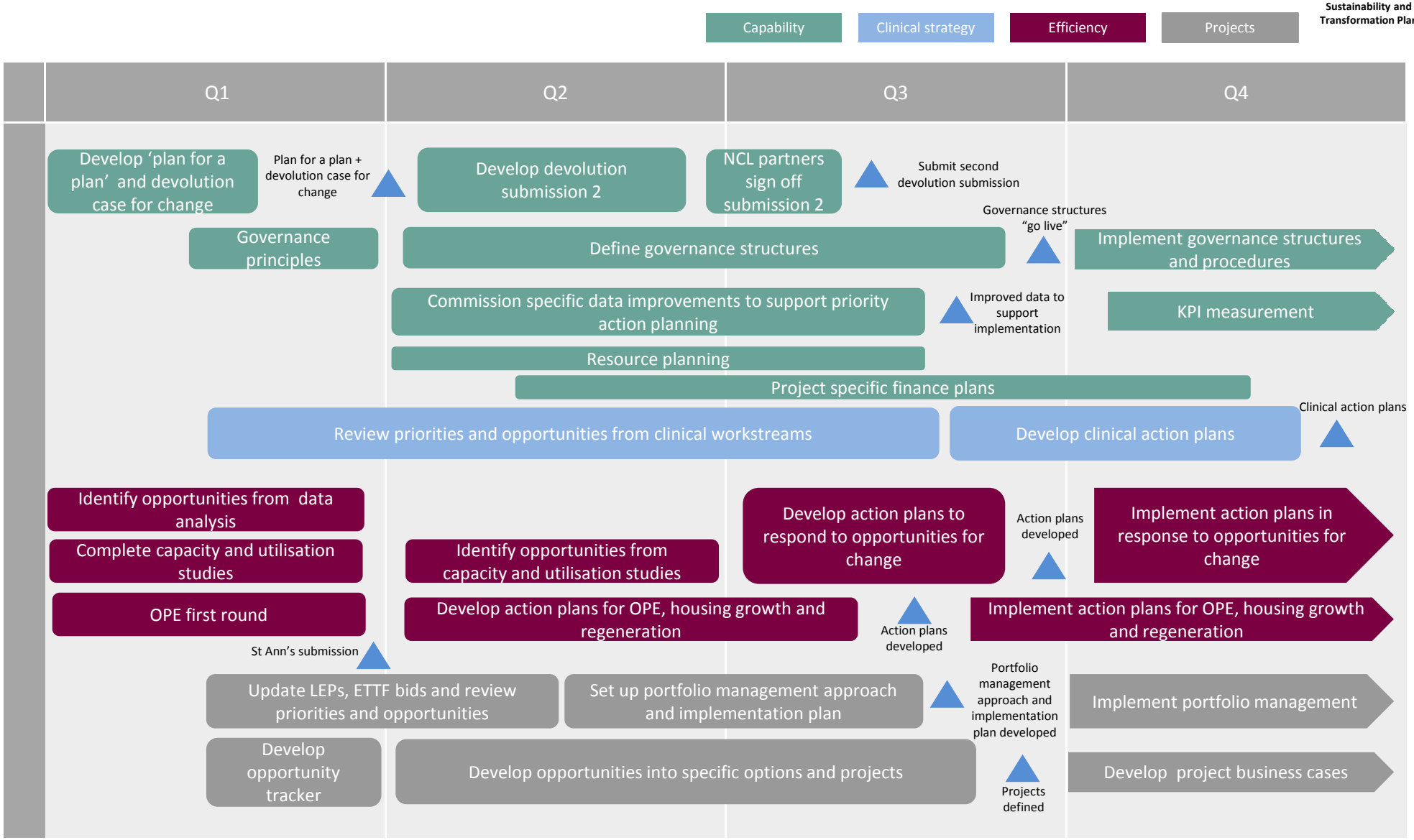
# High level milestones

North Central London Sustainability and Transformation Plan

| | Design phase | Detailed planning phase | Implementation phase |
|---|---|---|---|
| Capability | • Devolved freedoms and flexibilities<br>  • Case for change - Q1 2016<br>  • Devolution submission 2 - Q2/Q3 2016<br>  • Decision on devolution – TBC<br>• Identify resource and funding to deliver workstream. Links to development of action plans – Q2/Q3 2016 | • Governance arrangements set up, including approach to One Public Estate - Q4 2016<br>• Project specific financing plans - 2016/17<br>• Capital financing need and plan for investment, disinvestment, reinvestment and disposal – 2017/18 | • Capability and mechanisms in place to manage changing estate – TBC |
| Clinical strategy | • Clinical strategy which articulates estates requirements (mental health, primary care, urgent & emergency care, cancer, workforce) – Q3/4 2016 | • Thematic action plans to respond to clinical workstreams – 2017/18 | • Implement clinical workstream related action plans from 2017/18 (ongoing) |
| Efficiency | • Complete data analysis (including comparisions to Carter benchmarks), capacity and utilisation studies (led by CHP) Q1 2016<br>• OPE first round | • Action plans to respond to opportunities for change resulting from data analysis , Carter benchmarks and utilisation and condition surveys - Q2/Q3 2016<br>• Respond to changes in ways of working arising from STP productivity workstream – TBC<br>• Develop action plans around OPE (eg back office, leisure), housing growth and regeneration etc - 2016/17 | • Implement opportunity for change related action plans from Q4 2016 (ongoing)<br>• Implement OPE, housing growth and regeneration action plans from Q4 2016 (ongoing)<br>• Introduce operational changes to ways of working e.g. shared bookings from Q4 2016 (ongoing) |
| Projects | • Update Local Estate Plans (LEPs) - Q1 2016<br>• Review updated LEPs and Provider Estate Strategies to test scale of opportunities - Q2 2016<br>• Develop a project opportunity tracker - Q1 2016 | • Set up projects portfolio management approach including implementation plan Q3/Q4 2016 | • Whittington Strategic Estates Partnership – 2016/17<br>• FBC for St Ann's, St Pancras and Moorfields plan – 2019<br>• Requirements associated with early phases of Meridian Water by 2020<br>• Islington / Haringey admin function – 2016/17<br>• Edgware Community Hospital – to be retained but potential to identify some disposals<br>• Marie Foster House – disposal of vacant site which is surplus to requirements<br>• Additional sites shown on pages 32-33 |
| Approach to monitoring and evaluation | • *Approach to estates governance is being established, which will include assigning responsibilities and tracking milestone delivery*<br>• *As action plans are developed, KPIs will be set and monitored on an ongoing basis* | | |

# Workplan for 16/17

North Central London Sustainability and Transformation Plan



# Emerging project list

North Central London Sustainability and Transformation Plan

As NCL partners have come together they have started to develop a shared "bottom up" list of potential estates projects for the first time. The status and maturity of projects on the first draft of this list is mixed and includes some which have been approved, many not yet funded and others which are at the initial concept stage. This first draft of the list does not represent STP priorities or proposals, rather it is a building block to support local partners coming together around a portfolio of projects and to explore the potential to develop a co-ordinated approach. The first draft project list as at 27 June 2016 is summarised below and overleaf. This is a 'live' document and a work in progress.

| Theme | LA/CCG | Site | Site Ownership | Prospective project | Likelihood (Low, Medium or High) | Stage | To complete | Clinical activity |
|---|---|---|---|---|---|---|---|---|
| Community estate development | Barnet | Edgware Community | NHSPS | General redevelopment | High | Masterplan/ Delivery Plan (to inform SOC) | 01/11/2016 | Secondary |
| | Barnet | Finchley Memorial Hospital | LIFT | Reconfiguration of first floor | High | Review the legal and planning issues in respect of unlocking a specific site (open land to the south of the new hospital buildings) for development (pre-SOC).. | 01/08/2016 | Primary/Community |
| | Camden | CNWL community estate | Central & North West London | Various rationalisation | High | TBD | ? | Community |
| | Camden | CLCH community estate | Central London Community Healthcare | Various rationalisation e.g. Trust relocation to Parsons Green | High | TBD | ? | Community |
| | Islington | The Whittington hospital | Whittington Health | Maternity block and staff accommodation block | Medium | Partnership arrangements being explored | ?2021 | Secondary |
| | Islington | The Whittington community estate (9 freehold sites + occupancy in a further 30+ sites) | WH + Various | General rationalisation and redevelopment | Medium | Partnership arrangements being explored | ?2021 | Community |
| Disposals | Barnet | Marie Foster | NHSPS | Redevelopment or disposal | High | Next steps TBA | ? | None |
| | Islington | Moorfields Eye Hospital | Moorfields Eye Hospital | Disposal | High | OBC complete | ?2021 | Specialist |
| Housing and regeneration | Enfield | Meridian Water, Upper Lee Valley Corridor | LB Enfield | 10,000 housing units and health hub | High | 20 year programme; health hub at options stage | 2036 | housing plus primary/community |
| | Enfield | Upper Park Road/Ladderswood Way/Station Road New Southgate | 517 housing units | being developed with Mulalley and One Housing | | completed July 2015 | | |
| | Enfield | Fore Street, Upper Edmonton, N18. | 118 housing units | formerly known as Silverpoint | | Construction start in 2016, completed in 2026 | | |
| | Enfield | South Street, Napier Road & Alma Road, Ponders End EN3 | 993 housing units | medical centre proposed | | autumn 2016 | | |
| | Enfield | South Street Ponders End EN3 | 38 | formerly known as Academy Street | | start Spring 2017 | | |
| | Enfield | Avenue Road/ Cowper Gardens Southgate, N14 | 400+housing units | | | 20 year programme | | |
| | Enfield | Upper Lee Valley Corridor | 10000 housing units | Barratt & Segro development partners | | | | |
| | Enfield | New Southgate | 150 beds | | | | | |
| | Enfield | Enfield Highway EN3 | | | | | | |
| Mental health | Camden | St. Pancras | Camden & Islington NHS Trust | General redevelopment | High | OBC | ?2021 | Mental Health & relocated Moorfields Eye &? |
| | Haringey | St. Ann's | Barnet, Enfield & Haringey NHS Trust | Major redevelopment (1/3) and disposal for housing (2/3) | High | SOC submitted 30 June 2016, OBC target April 2017, FBC target Sept 2017 | 2019 | Mental health |
| Out of hospital care | Haringey | Welbourne site, Monument Way, Tottenham | LB Haringey | Health centre on ground/first floor of 3PD residential development | High | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Haringey | Haringey Heartland (Iceland site, Noel Park) | LB Haringey | Health centre on ground/first floor of 3PD residential development | High | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Haringey | Hawes & Curtis site, Green Lanes | 3PD | Health centre on ground/first floor of 3PD residential development | High | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Haringey | Muswell Hill | Site unconfirmed but likely option - LB Haringey | Co-location of primary care and LB Haringey services | Medium | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Islington | Archway | TBD | new hub due to population growth | Medium | Pending ETTF 2016 bid | TBD | Primary/Community |
| | Islington | Finsbury Park | private | new hub due to population growth | Medium | Pending ETTF 2016 bid | 2018 | Primary/Community |
| | Islington | Bunhill | private | new hub due to population growth | Medium | led by local authority, procurement underway | 2020 | Primary/Community |

# Emerging project list

North Central London Sustainability and Transformation Plan

| Theme | LA/CCG | Site | Site Ownership | Prospective project | Likelihood (Low, Medium or High) | Stage | To complete | Clinical activity |
|---|---|---|---|---|---|---|---|---|
| Primary care development | Barnet | New Graham Park | LB Barnet | 3PD new build | High | In design | ?2019 | Primary/Community |
| | Barnet | Colindale Centre (new facility on "Peel" land) | 3PD (NHSPS prospective head tenant) | 3PD new build | High | Negotiation with 3PD | ?2019 | Primary/Community |
| | Barnet | Colindale temporary practice | 3PD (NHSPS prospective head tenant) | 3PD new build (as retail premises) | High | Negotiation with 3PD | ?2020 | Primary |
| | Camden | Hampstead Group Practice | Royal Free | Expansion and rationalisation of GP back office across premises | High | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Camden | Belsize Priory | 3PD (LB Camden propective head tenant) | General redevelopment | High | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Enfield | Moorfield Rd/Durant practice | NHSPS/private | Rationalisation of primary care estate | High | Concept TBA | ?2019 | Primary |
| | Haringey | Northumberland Park/White Hart Lane | Somerset Gdns practice | Extension of current health centre building at 4 Creighton Rd N17 | Medium | Pending ETTF 2016 bid | ?2017 | Primary/Community |
| | Haringey | Waltheof Gdns/Westbury | LB Haringey | Westbury medical centre to relocate to LB Haringey depot site | Medium | Pending ETTF 2016 bid | ?2018 | Primary/Community |
| | Haringey | Highgate Group Practice | Owned by a private company | Extension of current health centre building at 44 North Hill N6 4QA | Low | Pending ETTF 2016 bid | ?2017 | Primary/Community |
| | Haringey | Morum House Group Practice | Owned by a private company | Increased use of current health centre 3-5 Bounds Green Road N22 8HE | Low | Pending ETTF 2016 bid | ?2017 | Primary/Community |
| | Haringey | Morris House Group Practice | Prop Co | Increased use of current HC 239 Lordship Lane Tottenham, N17 6AA | Low | Pending ETTF 2016 bid | ?2017 | Primary |
| Primary care hubs | Barnet | Cricklewood | TBD | New hub due to population growth/GP rationalisation (2018) | Medium | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Barnet | Hendon | TBD | New hub due to population growth/GP rationalisation (2018) | Medium | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Barnet | East Finchley | TBD | New hub due to population growth/GP rationalisation (2018) | Medium | Pending ETTF 2016 bid | ?2019 | Primary/Community |
| | Enfield | Durant Park site - new build health hub | GP freehold and GP led (ETTF support TBC) | Relocation of McLean and East Enfield practices in new GP freehold | High | Pending ETTF 2016 bid | ?2019 | Primary |
| | Enfield | Cockfosters South Gate (Holbrook House site) | 3PD | New hub including CCG accommodation | High | Concept TBA | ?2019 | Primary/CCG |
| Trust development | Barnet | Barnet Hospital | Royal Free | General redevelopment | High | Feasibility | TBD | Secondary |
| | Camden | Royal Free - various projects in Hampstead | Royal Free | Various rationalisation | High | Feasibility | ?2020 | |
| | Camden | UCLH Eastman Dental Hospital and Institute | UCLH | UCLH Eastman Dental Hospital and Institute | High | ? | ? | Secondary |
| | Camden | UCLH Heart Hospital | UCLH | UCLH Heart Hospital | High | ? | ? | Secondary |
| | Camden | Great Ormond Street Hospital | Great Ormond Street Hospital | Various on main GOSH site and local to it | High | Underway | 2020 | Specialist/private & charity (interest in acquiring new sites) |
| | Enfield | Chase Farm | Royal Free | Major redevelopment and disposal for housing and a new school | High | Underway | 2018 | Secondary |
| | Enfield | North Middlesex University Hospital - various | North Middlesex University Hospital - various | Various | Medium | ? | ? | Secondary |
| | Haringey | Stuart Crescent | Whittington Health | Extension and intentisification of use of Whittington Health site | Medium | Pending ETTF 2016 bid | ?2018 | Primary/Community |

# Contents

North Central London Sustainability and Transformation Plan

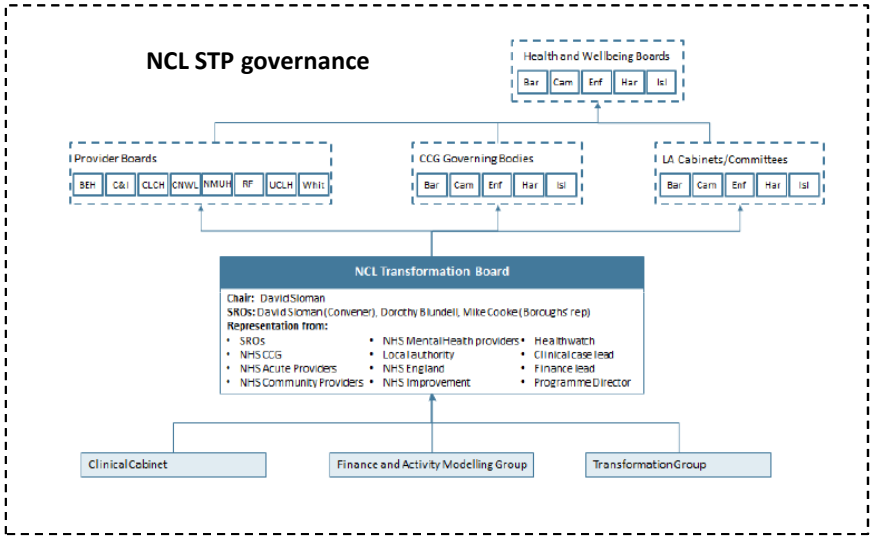
# Governance - current

North Central London Sustainability and Transformation Plan

NCL devolution proposals have, to date, been developed within the NCL STP programme, governed by the NCL transformation programme board. Three SROs for each of the partner groups oversee the programme: David Sloman (Royal Free Foundation Trust), Mike Cooke (Camden Council) and Dorothy Blundell (Camden CCG).

**NCL STP estates**

The NCL STP has established an Estates & Devolution Pilot Working Group (NCLEWG), a working group within the governance of the wider NCL STP process. This group is working on the following:




Strategic Objectives

- Develop the estates element of the STP by involving all key stakeholders and supporting organisations
- Ensure that the estates workstream is fully integrated with clinical and service workstreams
- Enable full integration of the CCG, provider and local authority estates plans
- Support themes and devolution learning as part of the London Devolution Programme
- Develop an approach to the adoption of One Public Estate in NCL

Operational Objectives

- To produce the estates element (chapter) of the STP
- Develop the business case for the Estates Devolution Pilot
- Develop proposals for new estates flexibilities under the Estates Devolution Pilot
- Develop one or more pilot projects to be progressed through the Estates Devolution Pilot
- Produce detailed plans for One Public Estate in NCL, linking with existing Barnet initiatives

The NCLEWG will comprise representatives from each of the following core stakeholders:

- Each NCL CCG, local authority and provider organisation
- Office of the London CCGs
- Community Health Partnerships & NHS Property Services
- NCL Programme Management Office
- London Health Commission
- Healthy London Partnership
- GLA

NCLEWG is not a decision-making body but it will make recommendations to the NCL STP Programme for official approval/adoption. All NCLEWG members will be responsible for taking issues and matters requiring agreement/decisions back to their own organisations.

The case for devolution of freedoms and flexibilities relating to the estate in NCL also feeds into the London devolution programme, which is governed by the London Devolution Programme Board, following the signing of the London devolution agreement at the end of 2015. A dedicated estates sub-group of this board has been established, alongside a sub-group for all 5 devolution pilots in London.

# Governance - future

North Central London Sustainability and Transformation Plan

The process of developing the STP, devolution proposals and One Public Estate continues to strengthen and develop the NCL partnerships around estates. A workstream group is already in place comprising senior staff from all CCGs, councils and NHS provider organisations in the STP. This group has been jointly developing the NCL devolution proposals and STP workstream objectives and plans. This group will continue to work together to develop the longer term governance, strategy and delivery plan for the STP and devolution programme.

At this stage, the NCL STP is a "plan for a plan". As we develop our detailed plans between now and October, we will further develop our governance, respecting the principles of subsidiarity agreed within the STP, taking account of the constitutions of providers, CCGs and LAs. As we move into the delivery phase of the NCL programme, we will ensure our governance reflects:

- work being undertaken at the London level to define governance to support devolution;
- next steps for development of the STP in the period up to full plans by September 2016; and
- the guidance and requirements of One Public Estate which includes having an effective board.

As arrangements develop, they are expected to include an NCL estates board or equivalent, working alongside local estate forums to ensure adherence with the principles of subsidiarity. A board could potentially have a number of functions:

- **Bringing partners together** – to provide greater co-ordination and easier escalation to tackle barriers which can be addressed through improved local joint working;
- **Strategic** – in relation to oversight of the STP strategy for estates. A statement of principles is being developed setting out what activities should be considered at what level; and
- **One Public Estate** – further discussions are underway as part of developing the OPE submission to Government Property Unit on the appropriate role of NCL in co-ordination.

Specific governance arrangements will need to be put in place in relation to devolved activities, to ensure appropriate, transparent and robust decision-making authority within the NCL context (including taking account of the constitutions of providers and links through to finance). The arrangements currently being developed at the London level to ensure that the relevant stakeholders and London and national partners as necessary are appropriately involved in decision making relating to devolved freedoms and flexibilities. Any governance structure for devolution would need to be agreed with constituent partners and with London and national partners.

For all the current case study examples provided in this pack, governance of the current and immediate capital development rests with those organisations, for example, Moorfields, BEH and Camden & Islington; plus Barnet CCG and CHP/LIFT for Edgware Community Hospital and Finchley Memorial. Organisations in NCL at the local level will continue to lead and control these estates projects.

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

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

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

| **FOR SUBMISSION TO:**<br>NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE | **DATE**<br>24th November 2017 |
|---|---|

**SUMMARY OF REPORT**

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

**Local Government Act 1972 – Access to Information**

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

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

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**RECOMMENDATIONS**

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

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

## 1. Introduction

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

## 2. Terms of Reference

2.1. The Committee has been set up with the following terms of reference:

- To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;
- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;
- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the area of Barnet, Camden, Enfield, Haringey and Islington;
- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities,
- although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;
- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and
- The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

## 3. Meeting dates for 2017-18

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

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

**Appendix A: Committee agenda**

**Friday, 7th July 2017 (Haringey)**

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

**Tuesday, 19th September 2017 (Camden)**

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

**Friday, 22nd September 2017 (Barnet)**

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

**Friday, 24th November 2017 (Enfield)**

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

**Friday, 26th January 2018 (Camden)**

| Item | Lead Organisation |
|---|---|
| NCL Sustainability and Transformation Plan: Devolution and Implications for North Central London<br><br>Lead - Councillor Alison Kelly | North London partners |
| NCL Sustainability and Transformation Plan: Strategic Risk Management<br><br>Lead - Councillor Alison Kelly | North London partners |
| NCL Sustainability and Transformation Plan: Engagement Plan | North London partners |

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

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