THE LONDON BOROUGH OF CAMDEN

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

MEMBERS OF THE COMMITTEE PRESENT

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

MEMBERS OF THE COMMITTEE ABSENT

Councillors Clare De Silva, Osh Gantly and Samata Khatoon

ALSO PRESENT

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

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

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillors Alison Cornelius and Clare De Silva.

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

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

3. ANNOUNCEMENTS

Webcasting

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

4. DEPUTATIONS

None.

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

There were none.

6. MINUTES

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

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

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

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

RESOLVED –

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

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

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

Jo Moss, (Director of Strategy and Business Development), Nick Strouthidis, (Consultant Ophthalmic Surgeon, Medical Director, Moorfields Eye Hospital NHS Foundation Trust), Dr Dee Hora, Portfolio GP, Moorfields Consultation Clinical Lead, North Central London Planned Care Clinical Lead, London Clinical Senate Council Member and Emily Brothers, Oriel Advisory Group Chair (patient representative) presented the item to the Committee.

The Committee was informed that:

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

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

- NHS commissioners and Moorfields consulted people on the proposals during a 16 week period from 24th May to 16th September 2019. The period of consultation had been extended from 12 to 16 weeks based on the recommendation of this Committee to allow for the holiday period.

- The consultation was unprecedented in its scale and wide ranging as the hospital touched most parts of the Country in one form or another. There were 99 events and meetings, 2 radio interviews, 84,487 direct letters to patients, 17 articles in newspapers, there were discussion workshops and field visits to explore issues concerning accessibility of the proposed location, workshops to explore the potential design of the proposed new centre and these were adapted to audience needs.

- As part of an assessment of impacts on equalities and health inequalities, over 40 meetings were conducted with people with protected characteristics and rare conditions to improve the understanding of specific needs associated with the move. Total responses received from the various methods of consultation came to about 4,600.

- The Oriel Advisory Group (OAG) (a patient and public representative group) was established in January 2019 to advise on the process and plans. The Chair of the OAG was a member of the consultation programme board and provided feedback on the consultation to the Committee.

- The Chair of OAG informed the Committee that a consistent theme came from the written and discussion feedback from the consultation. This was that Oriel supported the proposition to move Moorfields Hospital to the St Pancras site providing an opportunity to improve the patient experience.

- The key issues of importance for those consulted were getting to and from the site from a major transport hub independently which fulfilled their way of independent living, the design of the building, importance of accessibility to the site from the last half mile, the location of the hospital and how to get there from particular points including reviewing and improving links to bus, rail and other means of support such as a shuttle service drop-off and pick-up areas, creating a hazard free environment with tactile marking, a Green line similar to what was currently available at the City Road site, navigation technology linked to smart phones and good signage which was clear and accessible.

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

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

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

- One of the benefits of the move to the new site was a reduction in the Carbon footprint which would be done in a much more efficient and effective way. It had not been made clear in previous documents, however going forward the importance of a high standard of sustainability would be made much clearer in the narrative.
- In respect of the risks of increasing costs due to delays, the business case for the project would be in 2 stages to mitigate the risk of costs. It was assumed that in this case there would a 25 per cent contingency of the total cost. Then in about 18 months' time another business case would need to be submitted once there was certainty around the sale proceeds of the City Road site and confirmed proposal from a construction team on how much they would charge

to build a new building. It would only be at that point once there was certainty about these two significant financial figures would approval be given to proceed with the project. At that point the percentage of contingency allowed would be reduced to about 10 per cent of the project. It would be a real risk but there were mechanisms in place to help manage and mitigate the risk from occurring.

- The Trust partners would not be able to do anything about the business case until the Commissioners had made a decision about the public consultation but subject to that it was hoped that the trust would proceed with the business case in March.
- In relation to the public consultation process the Gypsy traveller Community and black community were fully considered within the full health and equality integrated impact assessment. The issues that came out of that report indicated that there was as much of a potential positive benefit as a negative impact. For example the City Road site had a number of inhibiting factors for patient groups with certain protected characteristics and there was an opportunity to change this when working with those groups.
- As well as all the public consultation events a lot of thought went into where those events were held and mechanisms used to reach particular population groups that could be a little more difficult to reach and those groups that might not have been so forthright in coming to events. There was also a desktop exercise at the same time, so those things were considered together in order to have a full consideration of all potential population groups that could be affected. A broader view was taken than those listed in the Equalities Act and that was why these groups were more fully considered.
- The consultation on this project required an enormous amount of planning and attendance at numerous other meetings and events. It has served as good learning point for other events and projects.
- At the outset it had not initially been thought through about the many different groups requiring consultation. However the learning from pre consultation meetings provided a fuller understanding of the many different groups affected. There was now a much fuller list of all the groups that could be potentially accessed. Having the complete fuller long list at the beginning of the process would allow more thorough engagement. There was always more that could be done in reaching out to all the communities.
- Accessibility was one of the most important issues during the consultation, as a result towards the end of the consultation two different workshops were held specifically on accessibility. Colleagues from the RNIB and Guide dogs were invited to get their expertise and input in to how to mitigate the issues highlighted. Also involved were the design team that had been appointed from the Oriel perspective, at that point nobody from TfL, the Highways Authority or local authority was included because the Trust was not able to get into the detail of that until the consultation process had concluded. Subject to the decision of the Commissioners in the next few weeks, the intention would be to rapidly start those conversations again so the Trust could get into the detail about what was feasible to come to solutions. In terms of who would fund this,

it would be part of the business case so in effect it would be the joint project that would be funding this. There was provision in the contingency for this at the next stage of the project it would need to be much clearer in the contingency plan what the proposals were. At the moment there was a very long list of ideas and different solutions. In 12 to 18 months' time there would need to be clarity as to which of those proposals would be implemented. So clarity about the proposals would be better.

- There would be no costs to patients in the long run. A discussion that was required with TfL was an increase in the number of bus routes as concerns had been raised by patients coming from the Eastern part of London about increase costs of travel because the bus routes from East London to the proposed new sites were not as good and cost of travelling by tube was more expensive. These were conversations that needed to be had with TfL.
- The new centre would take over all the functionality of the hospital and would also include a research centre and an education facility. All the clinical functions taking place at City Road would be transferred to the new site. It would generate modern pathways and more methodologies for treating patients.
- The new centre would be broadly the same size as the space at City Road. The actual physical building would be a bit bigger because it would be integrated with UCL, so it would be a bit bigger than the current hospital. The language used was deliberately chosen not to call it a hospital but a centre to portray the radical different new ways of working.
- It was projected in the business case that there would a 3.1% year on year increase in the number of out-patients. It was entailed that to cover this, there would be a similar increase in the number of staff to see those patients.

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

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

In respect of ambulatory care, at the moment Moorfields had 5 hospital beds which would be retained at the new site. There was no intention to remove the in-patient

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

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

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

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

It was also suggested that the following are included in the letter:

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

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

RESOLVED –

THAT the report be noted.

8. NORTH CENTRAL LONDON HEALTH AND CARE INTEGRATION

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

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

Concerns had been expressed about the merging of Clinical Commissioning Groups (CCGs) into one. However, there had been complaints in the last few years about how the system worked with a lot of staff wrapped up in day- to- day transactional arguments and no member had requested to maintain the status quo. There had been one borough leading on behalf of the others in relationship with some of the very big providers which it was not quite equipped to do. The merger would bring together all that capacity and capability to do things once. Bringing staff together and improving the relationships both commercially, contractually with patient care quality at the heart of this would be a really good thing.

Questions had been raised about one aspect of the Governing Body. The Governing Body was a mirror of what happened within the 5 governing bodies. There was not a lot of change proposed just that it would happen once. Healthwatch representation around Governing Bodies would be there in the future.

There were some statutory rules which applied to CCG Governing Bodies that included who could and could not be voting members. Local Authorities (LA) could not be voting members. Normally portfolio holders attended current governing body meetings the proposal was that this would continue on the one seat basis. The portfolio holders had chosen to rotate this but did not have to, it could be done on a different basis. There was a Joint Committee in common which portfolio holders were invited to, their attendance was quite low. The CCG Governing Body would be meeting 4 times a year to consider the commissioning of some very important things like Mental Health Services but it would not be doing what it was doing now. This Committee will be overseeing things from a system point of view which would continue to be important.

The point of governance and governance engagement would be at borough level, Health and Wellbeing Boards would be even more important than they are now and Partnership Boards were springing up at borough level and North Central London (NCL) level and would be at the forefront in this new system. In terms of openness, transparency and accountability, it would mirror the current arrangements. The GP elected clinical representatives felt passionate about involving residents in their decisions.

One of the pieces of work led by Barnet Directorate of Public Health was to look at health inequalities borough by borough and provide an overall picture across NCL. It was known that whether looking at activity or outcomes there were pockets of the population less well served by current services than they should be. There was relative low level of investment in community services in some part of the patch than others. Consequently people were not getting quite a good service, so the ambition

was absolutely one of improvement. The ambition was to consistently deliver high quality services for everyone.

At previous NCL JHOSC meetings there had been discussion around the approach being taken around Elective Orthopaedics and it was a precursor about the approach intended for Strategic Commissioning for the future, looking right across the piece then looking with residents about what the most appropriate configuration of organisational services should be.

In relation to staffing, the restructure was still on going, it was filtering down to the lower levels. There was a requirement for cost reduction by 20% which the restructure would achieve. There was no short term ambition to be draconian, in about 18 months' time there would be a need to look again at the restructure to determine whether this was the right structure and people were in the right place. The intention was to achieve this through natural wastage.

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

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

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

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

ACTION BY: Independent Chair

RESOLVED –

THAT the report be noted.

9. GENERAL PRACTICE STRATEGY FOR NORTH CENTRAL LONDON

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

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

- In relation to the Primary Care Network the main concern related to money, the service was being asked to do a lot more with no money.
- The situation relating to the service was that the new contract had been centrally negotiated with NHS England and the General Practioners Committee and was directed down into general practice and the Primary Care Network as such there was limited influence with these negotiations. The responsibility of NCL was to look at the opportunities and understand how they could be enhanced and work with general practice to work through some of the complexities.
- Recently NHS England conducted a period of engagement around the requirements for Primary Care Networks around 2020/21 asking for feedback, this feedback was collated from NCL and fedback nationally what practices and clinicians had said.
- In relation to finance and funding and the concerns around no additional resources, the contract that was negotiated in January 2019 and implemented in July 2019 came with a significant amount of additional funding which was attached to additional staff. Over the course of the 5 years additional staff would be supported to be employed into general practice in order to address capacity issues and to start to deliver on the specification that were linked to this new enhanced service. The aspiration was 70% of those additional staff would be centrally funded through the new enhanced service and the new contract and 30% would be funded at a practice level. The risks and concerns that had been identified was that when the new specifications came out, there was an expectation of additional funding which did not materialise so any additional resources would be linked to these additional people. These people needed to be employed and in place before the funds were released. These significant concerns were picked up in the feedback to the consultation.
- There were additional concerns in London relating to London weighting which had not been accounted for in the additional funding and the expectation that funding would be the same across the Country placed significant additional risk to General Practice in London.

- The additional aspect was that many of the outcomes expected to be delivered with this enhanced service were system led outcomes. They were not solely reliant on General Practice they could only be delivered by systems working together. So to expect Primary Care General Practice to bear the risk on their own, carry the cost of the additional 30% was not in the best interest of the system. There was a need therefore to look collectively across all the providers to determine how the risk could be shared and work as a system. This had been relayed to NHS England.
- The additional concerns highlighted were that when you looked at London, Physio's, Pharmacists and other providers they were often paid at a higher rate than what had been identified in the specification, it has not really been determined how the system could support and address these issues. This was something that needed to be done across NCL in conjunction with all the partners.
- There was significant reduction in GP Partners across London and the country and the concerns were how to encourage young GPs to stay in NCL and to continue to deliver care to NCL. Fellowship programmes, peer support and mentoring programmes to encourage people to stay in London had started to take place.
- Providing direct funds and collaborative support to failing practices to raise the bar and improve care to local residents.
- Increasing visits to Care Homes to increase the care and support of people in Care Homes.
- Anticipatory care and personalised care, Identify what was important to people, strengthen what they have and what they do in their local communities.
- Even though there were significant risks, there was a real strong offer in NCL.

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

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

RESOLVED –

THAT the report be noted.

10. ROYAL FREE LONDON FOUNDATION TRUST FINANCIAL UPDATE

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

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

The Director of Financial Performance informed the Committee that the organisation was in a system which had financial challenges. Royal Free Hospital (RFH) was a large provider in the sector which had its own financial challenges. A significant change this financial year compared to last year was that it was able to accept a plan from a regulatory perspective. From an overall sector perspective RFH was on plan to meet its savings target of £61m. If this was achieved £31.8m of additional funding would be made available. For this financial year it remained at and slightly above the internal trajectory, there was no particular cause or risk associated with the rest of the year. At the end of this financial year it would have hit 4 consecutive years of recovery back to a position which would achieve long term financial sustainability. This was highlighted on page 116 of the agenda.

The following responses were provided to Committee members questions:

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

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

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

- In terms of savings and quality, a very well embedded quality impact assessment process was expected which was very sensible to have. The monthly savings proposals which had worked its way up through the divisions, were reviewed by senior officers in the organisation. It was only as and when senior colleagues from the Clinical perspective were comfortable with the

proposals would the savings plan proceed. The savings plan could not proceed until it was signed off by a director.

- Alongside that there was an independent view provided by a Clinical Advisory Group which was made up of senior clinical staff from across the organisation that did not have any managerial responsibility, so it was felt they were not conflicted in any way. They carried out regular reviews of all the schemes as they went forward to give an independent view on whether they thought there might be any clinical quality impact. The chair of the group reported on a quarterly basis to the Group Executive of the Committee. There had been instances of where schemes had been put forward and turned down through either of these processes because of concerns about impact on quality.

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

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

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

RESOLVED –

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

11. WORK PROGRAMME AND ACTION TRACKER

Consideration was given to the work programme and action tracker.

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

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

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

RESOLVED –

THAT the work programme be amended, as detailed above.

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

None.

The meeting ended at 12.14 pm.

CHAIR

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MINUTES END