Public Document Pack

Health and Social Care Scrutiny Sub (Community and Children's Services) Committee

Date: **MONDAY, 2 FEBRUARY 2015**

Time: **11.30 am**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL**

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Ann Holmes
Judith Pleasance
Emma Price
Adam Richardson
Tom Sleigh
Philip Woodhouse

Enquiries: **Philippa Sewell**
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Lunch will be served in the Guildhall Club at 1pm
NB: Part of this meeting could be the subject of audio video recording

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**
   To agree the public minutes and non-public summary of the meeting held on 25 November 2014.

   For Decision
   (Pages 1 - 6)

4. **CO-OPTED HEALTHWATCH MEMBERS**
   To review the co-option of Healthwatch representatives in line with the Sub Committee's terms of reference.

   For Decision

5. **HEALTHWATCH CITY OF LONDON UPDATE**
   Report of Healthwatch City of London.

   For Information
   (Pages 7 - 12)

6. **DEFIBRILLATORS IN PHARMACIES**
   Report of the Patients Forum of the London Ambulance Service.

   For Information
   (Pages 13 - 14)

7. **REVIEW OF HEALTH OVERVIEW AND SCRUTINY FUNCTIONS**
   Report of the Director of Community & Children's Services.

   For Decision
   (Pages 15 - 26)

8. **OVERVIEW OF THE OUT OF HOURS SERVICE IN CITY AND HACKNEY FOLLOWING ONE YEAR OF OPERATION**
   Report of the City and Hackney Clinical Commissioning Group.

   For Information
   (Pages 27 - 40)

9. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

10. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

11. **EXCLUSION OF THE PUBLIC**
    MOTION - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

    For Decision

Part 2 - Non-Public Reports

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE
Tuesday, 25 November 2014

Minutes of the meeting of the Health and Social Care Scrutiny Sub (Community and Children's Services) Committee held at Committee Rooms, West Wing, Guildhall on Tuesday, 25 November 2014 at 1.45 pm

Present

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Judith Pleasance
David Simpson (Healthwatch)

Officers:

Philippa Sewell	Town Clerk's Department
Neal Hounsell	Community & Children's Services
Nina Bhakri	Community & Children's Services

In attendance:

Jane Milligan	Tower Hamlets Clinical Commissioning Group
Paul Haigh	City & Hackney Clinical Commissioning Group
Gary Marlowe	City & Hackney Clinical Commissioning Group

1. **APOLOGIES**
The meeting was inquorate for the consideration of the item.

Apologies were received from Ann Holmes, Emma Price, Adam Richardson and Philip Woodhouse. Apologies for lateness were received from the Chairman, Wendy Mead.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
The meeting was inquorate for the consideration of the item.

Deputy Chairman Dhruv Patel declared a non-pecuniary interest in item 10 by virtue of his family's pharmacy business within the City and Hackney CCG (but not within the boundaries of the City).

3. **GOODMANS FIELD BRIEFING**
The meeting was inquorate for the consideration of the item.

The Chairman welcomed Jane Milligan from Tower Hamlets Clinical Commissioning Group and Paul Haigh and Gary Marlowe from City & Hackney Clinical Commissioning Group to the meeting.

Ms Milligan reported that the NHS in Tower Hamlets had been in discussions regarding the development of a health facility in the Aldgate area for a

considerable amount of time, and since 2010 had focused on the Goodman's Field development as the most appropriate location to provide a health facility to meet the health and wellbeing needs of the local population and reduce health inequalities. Members noted that planning permission had now been obtained and the developers were aiming for a start date in autumn 2015 with final completion anticipated for summer 2019. A business case had been submitted to NHS England to amalgamate two GP surgeries within the area, namely City Wellbeing and Whitechapel Health in the new facility.

In response to questions, Ms Milligan advised that, as the business case was still with NHS England, it was too soon to think about actively disseminating the message to local residents. She reported that more details concerning the future would be available in approximately 6 months. With regard to joined-up working, Mr Haigh reported that Tower Hamlets, City & Hackney, and Islington CCGs were working together to ensure services were aligned, and a workshop had been scheduled for January 2015.

RESOLVED – That the report be noted.

4. **CITY & HACKNEY CLINICAL COMMISSIONING GROUP - 5 YEAR PLAN**
The meeting was inquorate for the consideration of the item.

Paul Haigh and Gary Marlowe from City & Hackney Clinical Commissioning Group presented the 5 year plan, they advised Members that CCGs across England were being invited to apply to take back primary care commissioning from NHS England, and City & Hackney CCG would be submitting an expression of interest in January 2015.

In response to a query, Mr Haigh reported that the Hackney model "One Hackney" would bring providers together to ensure patients in both City and Hackney experienced linked up services. The model was divided into four quadrants; the City being part of the South Western quadrant. Mr Marlowe reported that although the quadrant did not have a City focus, City cases were always given a high priority and well-managed. The Assistant Director, Partnerships and Commissioning advised that the Corporation's Social Care team had trained Care Navigators who linked in to the quadrant system. Members noted that resources and plans were in place to address any gaps in services that might be identified, and a workshop to highlight any issues had been scheduled between the City of London Corporation, the three main hospital trusts providing for City residents, and the three CCGs. (City and Hackney, Tower Hamlets and Islington)

With regard to the recent quality concerns over Barts Health Trust, Mr Haigh reported that the City & Hackney CCG had written to the Care Quality Commission and offered financial support to the Trust for improvements to outpatient services, and Tower Hamlets CCG were looking at overall quality and ensuring action plans were in place. Ms Milligan confirmed that there were a number of concerns, but a robust system was in place to review the Trust and, generally, once people were being treated they received a good standard

of care, but there were ongoing problems with the administration and appointment systems.

RESOLVED – That the report be noted.

The Chairman thanked Ms Milligan, Mr Haigh and Mr Marlowe for attending and answering questions.

5. **HEALTHWATCH CITY OF LONDON UPDATE**
The meeting was inquorate for the consideration of the item.

The Sub Committee received a report from David Simpson from Healthwatch. Mr Simpson expanded on the items contained in the report, in particular the Healthwatch annual conference and AGM, which took place on 29 October 2014. A review of the year was presented by the Chair Samantha Mauger, followed by discussion groups which discussed various ways Healthwatch could work and engage more effectively with providers of services, young people, children and workers in the City of London.

Members had several questions regarding effective working with other Healthwatches, the level of response from surveys and focus groups, and how widely the newsletter was distributed. Mr Simpson undertook to submit a report to the next meeting regarding joined-up working practise with other Healthwatches, and to feed back details on the newsletter distribution via the Committee and Member Services Officer.

RESOLVED – That:
(a) Healthwatch submit a report to the next meeting regarding joined-up working practise with other Healthwatches, and
(b) Details on the Healthwatch newsletter distribution by circulated electronically outside the meeting.

6. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
The meeting was inquorate for the consideration of the item.

There were no questions.

7. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
The meeting was inquorate for the consideration of the item.

<u>Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)</u>
The Assistant Director, Partnerships and Commissioning gave an update on the matters discussed at the INEL JHOSC meeting held on 20th November 2014, including the completion of the Cancer and Cardio review. The Committee had also discussed the recent issues raised about Barts Health Trust and concluded that, although they still had concerns, these were being addressed better and more openly than in the past. Members noted that INEL JHOSC representatives were visiting the new King George V site on 15th

December and this invitation would include a member of the Sub Committee. The Deputy Chairman indicated that he would attend on behalf of the Sub Committee and report back to the next meeting

8. **MINUTES**

RESOLVED – That the public minutes and non-public summary of the meeting held on 19 May 2014 be agreed as a correct record.

Matters Arising

Community Nursing Services

The Assistant Director, Partnerships and Commissioning advised that he had written to Dr Vaseman to ascertain whether he was happy with the changes or whether a review of the new arrangements was necessary.

Cancer and Cardio

Members noted this had been discussed at the Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC) at their meeting earlier in the month.

Healthwatch

Members noted that answers outstanding from the last meeting had been circulated electronically in May 2014.

9. **REVIEW OF HEALTH OVERVIEW AND SCRUTINY FUNCTIONS**

The Sub Committee received a report of the Director of Community and Children's Services regarding recent national developments and their impact on how local authorities exercised their health overview and scrutiny functions. The City of London Corporation was now a commissioner and provider of public health services and therefore a body which could be scrutinised, and Members considered whether the Sub Committee should examine how or if its own health scrutiny functions could be enhanced. The Chairman requested that minutes of the Board meetings of Barts Health NHS Trust and Homerton University Hospital NHS Foundation Trust be forwarded to Sub Committee wherever possible. Members agreed that, at the next meeting, Members undertake a discussion of the current position of health scrutiny processes in the City, supported by officers' research of best practice elsewhere.

RESOLVED – That:

(a) The report be noted;

(b) The Health and Social Care Scrutiny Sub Committee examine how or if its health scrutiny processes could be enhanced in line with the approach proposed in the report at its next meeting in February 2015; and

(c) The minutes of the Board meetings of Barts Health NHS Trust, East London NHS Foundation Trust and Homerton University Hospital NHS Foundation Trust be forwarded to Sub Committee wherever possible.

10. **EXCLUSION OF THE PUBLIC**

RESOLVED – That, under Section 100A of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds

that the involve the likely disclosure of exempt information as defined in Part 1 of Schedule 12A of the Local Government Act.

Item Nos.	Exempt Paragraph(s)
11	3
12-13	-

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
The meeting was inquorate for the consideration of the item.

There were no questions.

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
The meeting was inquorate for the consideration of the item.

There was no other business.

13. **NON-PUBLIC MINUTES**
RESOLVED – That the non-public minutes of the meeting held on 19 May 2014 be agreed as a correct record.

The meeting ended at 3.00 pm

Chairman

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Committee:	Date:
Health and Social Care Scrutiny Sub Committee	2 February 2015
Subject: Healthwatch City of London Update	**Public**
Report of: Healthwatch City of London	**For Information**

Summary

The following is Healthwatch City of London's update report to the Health and Social Care Scrutiny Sub Committee.

This report covers the following points:

- Joined up working practice with other local Healthwatch in relation to training and Enter and View visits
- Collaborative working with other local Healthwatch to address the concerns surrounding Barts Health NHS Trust
- Survey responses
- Summary workplan 2014-16

Recommendation(s)

Members are asked to:

- Note this report, which is for information only

Main Report

Background

At the last Health and Social Care Scrutiny Sub Committee meeting on 25 November Healthwatch was asked to submit a report to the next meeting regarding joined-up working practice with other Healthwatch organisations. This report addresses those areas.

Current Position

Joined-up working practice with other local Healthwatch organisations

A joint bid between local Healthwatch in North East and Central London was submitted to Health Education North Central East London (HENCEL) in December 2014 for funding for collaborative training. The Healthwatch organisations involved were City of London, Tower Hamlets, Hackney, Islington, Redbridge, Camden, Enfield, Newham and Waltham Forest This followed a meeting the City Healthwatch Manager had with HENCEL where the possibility of funding was discussed. The bid focussed on Enter and View training for Healthwatch volunteers with an emphasis on British Sign Language users and was emphasised as being:

- a focussed, achievable piece of work that would get results,

- a unique proposal (ground-breaking),
- a way to bring local Healthwatch together across borough boundaries,
- a pilot for future collaboration,
- responsive to London Assembly discussions on improving access for Deaf people, including involvement in Local Healthwatch.

The training sessions will take place at the beginning of 2015. The project will be managed by Healthwatch Redbridge and will enable Healthwatch City of London to access joint training with other local Healthwatch organisations.

The Healthwatch Officer carried out an Enter and View visit with Healthwatch Tower Hamlets at Peter Shore Court in Mile End in November 2014. Peter Shore Court provides residential care to older people suffering from dementia. The full report on findings from the visit will be published shortly.

Local Healthwatch working together in response to concerns over Barts NHS Trust

The continuing concerns in respect of the poor level of low level administration has been discussed jointly amongst local Healthwatch whose members use services run by Barts. There is a need for outpatient staff to be fully trained in all aspects of their work including IT and where the various waiting areas are for clinics. There are an increased number of inspections and listening events in relation to Bart's sites by the CQC which HWCoL is participating in. There is also concern that GPs have been told not to refer to Barts.

In conjunction with local Healthwatches using any of Bart's Trust services, a joint letter is being sent to Bart's with copies to CQC, NHSE and HWE to highlight the seriousness of the concerns about the Trust and its lack of improvement over the last year. Healthwatch City of London contributed examples of poor patient experience and reiterated our commitment to ensuring patient experience information can support Barts Health to improve. These concerns have been shared with Healthwatch England who are working with CQC to ensure our information informs the forthcoming inspection.

An escalation meeting to discuss the serious concerns was arranged between the CCG Chief Officers and Barts Trust and Healthwatch City of London was involved in influencing the CCGs to include a local Healthwatch representative on the agenda – this was a representative of Healthwatch Tower Hamlets. Healthwatch City of London is continuing to work with the other local Healthwatch to follow up on the outcomes of this meeting and discuss next steps. A Healthwatch City of London Board Member attended a Peer Review of Royal London on 8th January and produced a report for Tower Hamlets Healthwatch use to feed into the escalation meeting. The report focussed on cleaning not being done on time, proper cover not being provided when cleaners are off and the lack of formal method for Ward staff to do anything about the problem other than report the immediate problem to the Cleaning Contractor.

A recommendation was made in Quarter 4 of last year in conjunction with Healthwatch Newham to Newham University Hospital that a TV and stimulation activities should be available for older patients on the Elderly Care wards. Following acceptance of the proposal and successful bid to the Barts Charity in July 2014 we have been advised that the single bed television sets are due to be installed but the

larger wards require some technical adaptions that are due to take place. Contact is made every month for an update.

Newsletter distribution

Further details on the distribution of the Healthwatch City of London newsletter has been sent to the scrutiny committee via the Committee Officer.

Survey responses

Healthwatch City of London has taken the view, following discussion with other local Healthwatch organisations, that our focus should be more on community intelligence gathering and collation of anecdotal evidence rather than quantitative research. Previous surveys have generated a low response rate of approximately 5-10% and with our current working of hours of 30 hours a week in total the time required to carry out surveys is not in proportion with the results. Healthwatch City of London has coordinated and facilitated a number of focus groups over the past year and the results from these have been fed into the relevant City of London departments and providers where appropriate.

Summary workplan 2014-16

The summary workplan for Healthwatch City of London for 2014-16 is attached as an appendix.
Our Priorities for 2014-2016 will focus on Children and Young People and City Workers. The summary covers the areas Healthwatch will focus on under the headings of Children and Young People, City Workers and Community.

Conclusion

The Healthwatch City of London representative will provide an update on the areas raised in this report at the next meeting.

Appendices

Healthwatch City of London summary work plan 2014-16.

Healthwatch City of London

T: 020 7820 6787

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WORK PLAN 2014-2016

City of London Healthwatch works to ensure that City Workers, residents and students are able to influence the design and delivery of local services through their views and voice being heard by decision makers in all aspects of health and social care.

Our Priorities for 2014-2016 will focus on Children and Young People and City Workers.

Children and Young People

We will

- Appoint a children and Young Person Sessional Worker
- Meet and engage with young people through outreach, face to face meetings and social media such as twitter
- Engage with families through outreach, face to face meetings and social media such as twitter

City Workers

We will

- Obtain information on services required by City Workers through presentations, face to face meetings at events
- Represent the views and experiences of residents and City Workers from contacts with Healthwatch CoL (achieved through email, meetings, phone and events) at NHS national/regional committees, Barts Health Trust< Homerton and the Corporation
- Represent the views and experiences of residents and City Workers (achieved through email, meetings phone and events) at relevant City statutory committees

Community

We will

- Continue the engagement with City Residents and the homeless at meetings, events, phone email, social media
- Continue to represent the views and experiences of residents at NHS national/regional committee, Bart's Health Trust and the Corporation
- Develop and distribute the City of London Healthwatch Newsletter to contacts on our contact database
- Provide information to residents and workers and health and social care organisations, voluntary organisations and interested parties through the weekly City of London Healthwatch emails.
- Provide information through the City of London Healthwatch web site

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PATIENTS' FORUM
FOR THE LONDON AMBULANCE SERVICE

DEFIBRILLATORS IN CITY OF LONDON PHARMACIES

The Patients' Forum for the LAS is supporting the campaign to encourage every pharmacy in London to install a defibrillator and ensure that staff are trained to use them and give CPR.

When the LAS receives a call suggesting a cardiac arrest, they immediately contact the five nearest organisations holding defibrillators, asking them to go without delay to the patient. A response within minutes is essential to save the person's life.

This approach fits in well with the national aspiration to reduce deaths from cardiac arrests and specifically with the aspirations of pharmacists, to save lives by extending the training and capacity of pharmacy staff to support their local communities, by reducing the number of people who die from cardiac arrest.

Every person who is trained in the use of defibrillators and CPR will also be able to save the lives of members of their family, friends and local community. Around 28% of people survive an observed cardiac arrest but, where there is a defibrillator and someone trained to use it, the chance of survival can increase to 80 per cent.

The London Ambulance Services is a running a campaign to get 1,000 extra defibrillators in shops, businesses and gyms across the capital. The campaign is called 'Shockingly Easy'. Defibrillators cost very little and the LAS will offer guidance and support in buying, storing and using a defibrillator, which are safe and easy to use. Details of the campaign, how to get support from the London Ambulance Service, and the accreditation scheme are described in the information attached.

In this case, the LAS are offering high level support in the development of this proposals and will provide one LAS funded defib for every four pharmacies that sign up (i.e. if four pharmacies want defibs, they will pay for three between them and the LAS will contribute the fourth at no cost to the pharmacies). In addition, based on the fact that they will not need a whole training course for each pharmacy, and assuming that the pharmacies could group themselves so that four pharmacies could share a single training course, then the costs could be further reduced.

The retail price for a Physio Control LP1000 defibrillator, all accessories and training at commercial rates is £2,954 + VAT.

The starting point for the LAS proposal would be the heavily discounted LAS one-stop-shop prices (as attached) under which the usual cost for one pharmacy would be £1995 for defib, wall cabinet, location signs and training course. Defibs would include carry case, two sets of electrode pads and a first responder kit. The cost for

four pharmacies would therefore normally be £7,980. Under the proposal outlined above, the cost for four pharmacies would be £5,385, or £1,346 per pharmacy.

The LAS does not normally fund defibrillators in this way, so it should not be assumed that these costings would apply to any organisation outside of the agreed pharmacy group. The costs detailed above do not include VAT.

I do hope you, the City of London Health and Social Care Scrutiny Sub Committee, will feel able to support this campaign, which has the potential of saving many lives in the City London every year.

Very best wishes

Malcolm Alexander
Chair
Patients' Forum - London Ambulance Service

January 21 2015

Committee	Date:
Health and Social Care Scrutiny Sub Committee	02 February 2015
Subject: Review of Health Overview and Scrutiny Functions	**Public**
Report of: Director of Community and Children's Services	**For Decision**

Summary

At its meeting on 25 November 2014, the Health and Social Care Scrutiny Sub Committee received a report highlighting how recent national developments have impacted on how local authorities exercise their health overview and scrutiny function. The report recommended that although there are no concerns that the City's arrangements are flawed, the Health and Social Care Scrutiny Sub Committee should take the opportunity to examine if there are any areas where its health overview and scrutiny functions could be enhanced.

Members agreed a two phased approach for this review. This report details how the review would take place through an agenda presented in Appendix 1. To support Members benchmark against current practice, a review of key lessons from the Alexis Jay and Robert Francis QC reports is presented in Appendix 2 and overview of best practice elsewhere (Appendix 3) is also presented.

Recommendation(s)

Members are asked to:

- Note the report.
- Agree the structure and framework for the two phased review presented within this report.

Main Report

Background

1. At its meeting on 25 November 2014, the Health and Social Care Scrutiny Sub Committee received a report highlighting how recent national developments have impacted on how local authorities exercise their health overview and scrutiny function.

2. In particular, Members were alerted on how, in light of reports by Robert Francis QC and Alexis Jay into the mid Staffordshire and Rotherham enquiries, local authority health scrutiny was facing an important and challenging time and that the clear message in these reports was that these incidents should not be regarded as one off events that could not be repeated elsewhere.

3. Members agreed that although there are no concerns that the City's arrangements are flawed, the Health and Social Care Scrutiny Sub Committee

should take the opportunity to examine if there are any areas where its health overview and scrutiny functions could be enhanced. This would also be in line with earlier recommendations that the City's health scrutiny function ought to be the subject of a review no later than April 2014.

Current Position

4 At the Health and Social Care Scrutiny Sub Committee meeting on 25 November 2014, Members agreed the two phased approach proposed for this review. This would comprise firstly an initial stocktake of its current position, supported by officer's research of best practice elsewhere and then to recommend to a future meeting and, if necessary, to the Grand Committee what changes are needed to the health overview and scrutiny functions in the City as a result.

Proposals

5 This report presents a two phased approach for how the Sub Committee would undertake an assessment of its current practice and benchmark that practice against the recommendations made by Alexis Jay and Robert Francis QC, identifying any additional improvements that can be made (Appendix 1).

6 This is also supported by a review of what has been and can be learnt locally from both the Robert Francis QC and Alexis Jay reports (Appendix 2) and officers research of best practice elsewhere (Appendix 3).

7 The two phased approach comprises:

Phase I
An initial stocktake of the Health Overview and Scrutiny Sub Committee current position benchmarked against recommendations in the Alexis Jay and Robert Francis QC reports (Appendix 2) and best practice elsewhere (Appendix 3). This initial assessment will be undertaken using the agenda presented in Appendix 1.

Phase II
A working group established, comprising two Members to work with an officer to incorporate analysis, conclusions and recommendations into a report to be presented to the Health Overview and Scrutiny Committee in May 2015.

Corporate & Strategic Implications

8. The proposals outlined within this report fit with the Community and Children's Services Departmental Business Plan priority to safeguard children and adults from abuse and neglect wherever possible and deal with it appropriately and effectively where it does occur[1].

[1] Community and Children's Services Departmental Business Plan 2014-17 Strategic Aim 1: Safety and protection for all.

Implications

9. The Regulations (2013) have implications for relevant health service providers, including local authorities carrying out the local authority health scrutiny function, health and wellbeing boards and those involved in patient and public activities. The duties in the regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties will place the City in breach of its statutory duty and render it at risk of legal challenge.

Conclusion

10. Since the publication of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, health scrutiny has faced a challenging time. Key incidents such as the mid Staffordshire hospital crisis and the abuse in Rotherham have put health scrutiny into sharp focus. This is also against the new context that local authorities are now working in – as commissioners and providers of public health they themselves can now be scrutinised.

11. A review of the Health and Social Care Scrutiny Sub Committees work programme shows that whilst the Sub Committee has been very effective in bringing to account NHS and other health bodies, hearing from its own commissioned services has not been so evident.

12. Furthermore, benchmarking against best practice in other local authorities (as presented in Appendix 3), indicates that at phase two, the City may also wish to consider whether the following steps would improve its effectiveness in undertaking its statutory duties, these could include, for example:

i) identifying a set of fundamental standards by which providers are actively measured;
ii) applying a structured approach to inviting providers to meetings;
iii) identifying how the committee could better communicate with patients/service users;
iv) doing more to reach out to those who might have comments that raise concerns to be taken up;
iv) training of members in the statutory duties of the committee so that all in the Committee can effectively contribute to the functions of the HOSC;
v) Given the role of local Healthwatch to champion patients' interests and in view of their statutory participative role in the Health and Wellbeing Board, the Sub Committee may wish to consider the benefits of co-opting Local Healthwatch to help the Sub Committee achieve points iii and iv above.

13. However, it also needs to be recognised that health services have many different aspects and a Health Overview and Scrutiny Sub Committee that meets at limited times with fixed resources needs to prioritise what it can achieve.

14. In light of these factors, this report proposes that the Health Scrutiny Sub Committee should examine how its scrutiny processes could be enhanced. The report proposes a two phase approach comprising:

Phase I

An initial stocktake of the Health Overview and Scrutiny Sub Committee current position benchmarked against recommendations in the Alexis Jay and Robert Francis QC reports (Appendix 2) and best practice elsewhere (Appendix 3). This initial assessment will be undertaken today using the agenda presented in Appendix 1.

Phase II

A working group established, comprising two Members to work with an officer to incorporate analysis, conclusions and recommendations into a report to be presented to the Health Overview and Scrutiny Committee in May 2015.

Appendices

- Appendix 1: A Proposed Structure for a Review of the City's Health Overview and Scrutiny Function (Phase 1)
- Appendix 2: A review of key lessons from the Robert Francis QC and Alexis Jay Reports
- Appendix 3: The steps being taken in other local authorities to implement the lessons of the Robert Francis QC and Alexis Jay reports – a review of best practice

Background Papers

Review of Health Overview and Scrutiny Functions, Report to Health and Social Care Scrutiny Sub (Community and Children's Services) Committee, 25 November 2014

Department of Health, Local Authority Health Scrutiny, Guidance to support Local Authorities and their partners deliver effective health scrutiny, June 2014.

Statutory Instrument No. 2013 /218 The Local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

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Appendix 1: A Proposed Structure for a Review of The City's Health Overview and Scrutiny Function (Phase 1)

(5 mins)

1. Introduction, background and outline of agenda

The Chairman of the Health Overview and Scrutiny Committee

(5 mins)

2. What have the Robert Francis QC and Alexis Jay enquiries taught us?

Verbal presentation - Nina Bhakri, Policy Officer, DCCS

(5 mins)

3. What follow up actions on Robert Francis QC / Alexis Jay are being undertaken by the Health Overview and Scrutiny committees of the local authorities where the trusts are based

Is there identified best practice in other authorities?

Verbal presentation – Nina Bhakri, Policy Officer, DCCS

(45 mins)

4. Open discussion - External Facilitator- Ben Lee, Programme Director, Shared Intelligence

The Health Overview and Scrutiny function in the City - Where do we need to be or are we where we should be?

Key questions:

- What should the scope and objectives of Health Overview and Scrutiny in the City be and what is the role of Members to that?
- How can Members be supported to be more effective in that role (training, guidance etc.?)
- Who and what should be routinely scrutinised?
- How can we gain a better understanding of user experiences?

- What information do we need?

- Do we need to agree a revised Terms of Reference to reflect a refreshed statement of the aim and objectives of Health Overview and Scrutiny and the role of Members?

(10 mins)

5. Summary and conclusion of open discussion - External Facilitator, Ben Lee, Programme Director, Shared Intelligence

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6. Next actions – The Chairman, Health Overview and Scrutiny Sub Committee

1. A working group comprising two Members to work with an officer to incorporate analysis, conclusions and recommendations into a report to be presented to the Health Overview and Scrutiny Committee in May 2015.

Biography of External Facilitator, Ben Lee, Programme Director, Shared Intelligence

Ben Lee has 20 years' experience in central and local government, and public policy consultancy. He is an experienced facilitator, project manager, and researcher with specialisms in learning and knowledge-sharing programmes, communities of practice, neighbourhood management, public libraries and the arts. He is also well experienced in capacity development for local government scrutiny and local partnerships. He led the establishment of the National Association for Neighbourhood Management and has extensive knowledge of neighbourhood initiatives and community engagement in civic decision-making. Prior to joining Si he worked for the London Borough of Camden's chief executive department responsible for the borough's community strategy. Ben spent the first part of his career working in the then DoE and DETR dealing with social housing, sustainable development, and international aviation.

http://www.sharedintelligence.net

Appendix 2: A review of key lessons from the Robert Francis QC and Alexis Jay Reports

Both the Alexis Jay and Robert Francis QC reports recommended that a fundamental change in culture was required which prioritises vulnerable and disenfranchised groups of people who are under public care.

The recommendations are framed around:

- A structure of fundamental standards and measures of compliance
- A requirement for openness, transparency and candour
- Stronger, patient centred healthcare leadership, with increased accountability
- Accurate, useful and relevant information to allow effective comparison of performance by patients and the public

Both reports point to a systematic failure by a range of national and local organisations – including the Health Overview and Scrutiny Committees of both County and District councils concerned – to respond to concerns. The reports underlined that these should not be seen as isolated incidents that could not be repeated elsewhere. On Overview and Scrutiny specifically, Robert Francis QC said:

"*The Overview and Scrutiny Committees in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement and offered ineffective challenge".*

At the annual conference held by the Centre for Public Scrutiny on 11 June 2013, at which Robert Francis QC was one of the speakers. Robert Francis QC stressed the potential value of local authority Overview and Scrutiny in safeguarding against similar failures to those in Mid Staffordshire. He drew particular attention to the need to make full use and ensure transparency of performance information, to elicit information from various sources and not to ignore the messages to be drawn from patient complaints.

At the same conference, Tim Kelsey, Director of NHS England, suggested that Health Overview and Scrutiny Committees needed professional support in interpretation of data and they should not rely solely on information given by NHS Trusts.

Questions for Scrutiny

The repeated service failures and tragedies uncovered at Rotherham and Mid Staffordshire suggest that scrutiny should be playing an active role in providing constructive, critical challenge to councils and their partners.

Both Robert Francis QC and Alexis Jay identify three key platforms for effective scrutiny:

1. Performance indicators measuring the right things

Are Members confident that the council and its partners will be aware of problems when they arise and can the public be confident that when problems do arise they will be acted upon?

2. Access to the right information
   Are Members confident that they have access to information that will enable them to challenge assertions about the quality of a service?

3. The role of scrutiny
   Given that Scrutiny's foremost role is in policy and service development, to effectively achieve this, evidence is needed on how things are done now and everyone at every level of an organisation needs to be acknowledged to make this happen, not just senior officers and other carefully vetted witnesses.
   So, should Members reappraise their standing practices about how and when scrutiny engages with frontline and other officers?

Summary of key messages

The Alexis Jay and Robert Francis QC reports have uncovered a number of weaknesses which can be grouped into six key areas:

1. Redefining the objectives for Health Overview and Scrutiny and specifying who should be scrutinised?
2. Members role in and improving their effectiveness
3. Prioritising issues for Overview and Scrutiny attention and getting the right information
4. User complaints – systems and overflows
5. Working with partners
6. Preparing for, conducting and recording meetings of Health Overview and Scrutiny Committees

Appendix 3: An Overview of Best Practice

Performance management

The CfPS has published a briefing intended to help those involved in scrutiny to use performance management and financial information to add value to the scrutiny process.

This briefing is based on two previous CfPS policy papers – "Green Light. How non-executives can improve people's lives by helping to manage the performance of local services", published in 2010, and "On the money: the scrutiny of local government finance", originally published in 2007 and revised in 2011.

Detailed information about the approach to performance management and financial scrutiny can be accessed through (www.cfps.org.uk).

Getting the right information

- There are many different and vast aspects to health services, an Overview and Scrutiny Committee that meets at limited times cannot hope to scrutinise more than a small part of those services. The slender resources available to O&S also means there is a need to keep the flow of information to Members of manageable size, to focus on exception reporting flagging issues of possible concern and to prioritise quite ruthlessly where O&S should focus its efforts.

Bracknell Forest Borough Council:

Members (with officer support) prioritise three or four headings to be scrutinised over a two year period and once finished then move on to another set of priorities

The Council has also adopted a tiered approach based on Members views of priority. This essentially means that a Member leads on monitoring a specific organisation. For example, One member leads on monitoring the activities of the CCG and the HOSC meet with the CCG Chairman and accountable officer at least once every two years

Dentists, opticians, pharmacists – An officer maintains watching brief on any CQC reports and brings anything of concern to a nominated Member for attention

- The CfPS has recommended that council scrutiny should consider establishing a range of triggers for action using data and information to monitor trends. This data should not come just from NHS organisations themselves but from a variety of relevant sources, in order to arrive at a well informed and balanced viewpoint.

Public Participation:

The CfPS has established four core principles to help people understand the most important activities of O&S, including that O&S "enables the voice and concerns of the public and its communities" This forms part of the CfPS "Good Scrutiny Guide".

Separately, the CfPS has recommended that Health O&S needs to monitor information about the patient experience; hearing about people's experiences of services and the public should be given an opportunity to raise issues.

The London Borough of Hackney:
"The proportion of cancer cases that present when the cancer has spread and is deemed incurable is still extremely high in Hackney and our review on Increasing cancer survival focused therefore on improving early detection rather than the wider issue of preventing cancer. We visited Barts Cancer Centre, the new Endoscopy Unit at the Homerton and met cancer survivors at Macmillan's Share Your Experience support group. Social Action for Health enabled us to meet with a large group of Turkish-Kurdish residents to discuss their experiences. We learned about the cultural and language barriers many face in engaging with health services, which is a key factor in late presentation. Our recommendations focused on reducing late presentation, addressing financial hardship for cancer patients, which is quite common, and how to reduce demand long term on the NHS by improving how people live "with and beyond cancer". London Cancer (the clinician led provider network for north and east London) supported our call for commissioners to increase support for Survivorship Programmes (exercise programmes, support groups, complementary therapies) because improving cancer survival is as much about keeping people out of hospital as it is in providing the essential medical interventions. Financial struggles and the challenges of maintaining child care continue to be too much of a burden on those who fall ill and anxieties around these will always impede a person's recovery".

Hackney Overview and Scrutiny report 2010-2014

Information on Patients Complaints
The Robert Francis QC report recommends that *"O&S committees should have access to detailed information about complaints, although respect needs to be paid to the requirement of patient confidentiality".*

There is however, a plethora of information on complaints, with complaints being dealt with in a different way in each organisation and in many cases too detailed for O&S purposes.

Bracknell Forest Borough Council:

The Council analyses the quarterly patient safety Report, published by each NHS Trust in addition to regular flows of information from Local Healthwatch,

the Panel also receives the quarterly annual report from the complaints Advocacy Service.

It appears that residents do not necessarily associate their ward members with local health issues and Members are encouraged to outreach into their respective wards to relay properly prepared and approved health information and issues to residents living in their wards.

As part of the drive to get O&S better known and closer to residents the health O&S panel has requested providers to display on their websites a postcard summarising the role of O&S and welcoming views (but not individual complaints) from patients to the O&S panel.

Partnership working:
For Health O&S to operate well, it needs to work with various organisations providing health services and related regulatory and other bodies.

Hackney O&S - Partnership working with Local Healthwatch
"Our short review on Improving GP appointment systems, partly prompted by Hackney Healthwatch, looked at the difficulties many experience in getting an appointment to see their GP. We looked at national and local research and visited 5 very different local GP practices to meet Practice Managers and GPs. We examined in detail the 'Doctor First' system, introduced locally by Nightingale Practice and spoke to its founder, a company based in Leicester. We examined how Practices can better model and manage their demand and then match that demand to capacity. We learned that GPs are dealing with increases in both volume and complexity of the health and social care needs of their patients and are doing so in the context of overall reductions in the national funding for GP services. We also looked at the burden on the NHS caused by too many patients with minor ailments presenting at A&E. This and the alarming number of "do not attends" for GP appointments represent a significant cost on the NHS and need to be tackled and we addressed all these issues in our recommendations."

Hackney Overview and Scrutiny report 2010-2014

Councillors on Trust Boards, etc.

Bracknell Forest Borough Council:

The Executive Member for Adult services, Health and Housing carries out a stocktake of all the Council's external positions on Health related bodies and works with Members to ensure that all suitable opportunities are taken up.

The O&S Panel maintains regular contact with those councillors on Trust Boards / Governing bodies, with the aim of working in concert with them to best represent resident interests. This includes asking each councillor

representative to report to the Panel at least once annually, subject to confidentiality rules.

Local Healthwatch:

Bracknell Forest Borough Council formally recognises in its terms of reference, that the Local Healthwatch is a formal observer in its Health Overview and Scrutiny Panel and the Panel obtains regular feedback on complaints processes, trends and feedback.

NHS

City and Hackney
Clinical Commissioning Group

An overview of the Out of Hours service in City and Hackney following one year of operation

Joint briefing paper between City and Hackney CCG and City and Hackney Urgent Healthcare Social Enterprise for London Borough of Hackney Scrutiny Committee 21 January 2015

1. Introduction and context

The City and Hackney Urgent Healthcare Social Enterprise (CHUHSE) was launched in December 2013. The service launched following a procurement process that commenced in April 2013 with a decision to award the contract made by the CCG board in September 2013.

Following a lengthy and robust consultation and engagement exercise which commenced in March 2013 and concluded in June 2013 the CCG developed a service specification which set out the following requirements:

- a local out of hour's service provided by local GPs with good knowledge of local health services,
- close links to in-hours primary care,
- robust clinical assessment and management, and,
- the provision of a safe service with high quality patient experience and satisfaction for City and Hackney patients
- value for money

Given the national uncertainty about the fit with the new 111 service to replace NHS Direct, the provider opted to sub-contract their call handling element to Tower Hamlets Doc (THDOC), which is based in the Royal London Hospital.

2. Early reflections and learning lessons

Historical data about the number of calls received by the previous out-of-hours (OOH) provider was lower than the actual numbers of calls received which meant CHUHSE experienced capacity issues early on. This presented the provider with significant challenges and meant that meeting the OOH National Quality Requirements (NQRs) for telephoning 95% of patients back within one hour or within 20 minutes if deemed Urgent by the call handlers was initially very challenging.

The provider responded by developing a system of Home Working GPs utilising a secure IT system and making phone calls to provide safe clinical management and treatment to patients via the telephone. In addition more doctors were added to the rota at peak times.

Call handling has been the only area where CHUHSE has had difficulty in meeting the requirements set out in the service specification. This report demonstrates how this was addressed in the section below on Performance and Quality data.

The provider has been consistently performing well in all other areas, which include, telephone consultations, face-to-face appointments, home visits and partnership working.

CHUHSE continues to recruit new GPs, both those working and/or trained locally and those from outside the area with appropriate experience. This is because of the need to continue to replenish the pool of doctors, a key lesson learned from historical OOH experience. More than half of the doctors who form the CHUHSE GP pool have a local connection in terms of having trained in, worked in a daytime role in or living in City and Hackney either now or in the past. They therefore have some knowledge of local services which helps to provide an element of continuity of care and increases the chances of avoiding unnecessary admissions. Of our more recent recruits the majority have been GPs with daytime jobs in City and Hackney.

3. Service review framework and an overview of performance from Jan 14 to Nov 14

Service review framework

In April 2013 as part of the stepping down of the previous OOH agreement which was delivered as part of a consortia with Camden, Islington and Haringey CCGs, the CCG made wholesale changes to how the service would be monitored, how information would be cascaded and how performance was reported. It was decided that the CCG would adopt a more robust approach to contract monitoring mirroring the type of rigour normally associated with reviewing an acute service. In practice this meant meeting and liaising with the provider on the following fronts:

1) A monthly meeting exploring:

- Performance against standards
- Action plans and recovery trajectory for below par performance
- Recommendations for breach audits for underperforming slips,
- Patient perceptions formal and anecdotal feedback
- Use of local GP feedback to inform areas of interest at the monthly meetings
- Opportunities for integration and improved care – Hospitals, community services, GP practices (also winter/pressure surge planning)
- Future direction (and formal review/feed-back) – commissioner to lead

2) A quarterly quality review meeting to explore:

- outcomes/dispositions/number referred/trends
- outstanding breaches and effect on quality
- feedback from GPs
- significant incidents
- review of complaints, learning lessons and making changes to address trends
- feedback from audits
- Providers own staff surveys
- Clinical and non-clinical development plans
- Review of policies and procedures
- This meeting also involves members of the CCG's PPI committee, independent clinical/GP members, CCG's quality lead and a member of the LMC

In addition to the two formal meetings the CCG and provider agreed that there would be certain scenarios that would warrant immediate reporting and feedback, these are described as but not limited to:

- Significant staff shortfall that may affect performance
- Potential for closing a face-to-face centre as a result of staff shortfall
- Any Serious Untoward Incident (or possible)
- Details of each contact and the care provided to every patient that is known to have died after an initial call to the OOH service
- Any complaint suggesting significant harm or failure
- Any potential professional/financial/legal/patient care issue

The relationship between commissioner and provider is such that there is a no surprises standard way of working where both parties are kept informed of any material issues as early as possible.

The CCG takes the quarterly OOH reports to the full CCG board meeting on a quarterly basis. This means performance, quality and standards are all in the public domain as well as being scrutinised by the board. It should be noted that this level of open and robust performance monitoring was not in place under the previous provider or commissioner.

An overview of the data

NQR 8 – Call answering

	Nov	Oct	Sep	Aug	Jul	Jun	May	April	Mar	Feb	Jan
Calls not engaged	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Calls not abandoned	96.3 %	94.6 %	93.2 %	82.8 %	84.8 %	86.7 %	84%	77%	76%	76%	80%
Answered within 60 secs	90.3 %	91.5 %	90.9 %	80.2 %	84%	80.6 %	80%	72%	78%	77%	84%

Source: Monthly performance reporting as set out in the contract

NQR 9 – Telephone Clinical Assessment

- ILTCs (Immediate and Life Threatening calls) – these must be passed to the ambulance service within 3 minutes
- Urgent – start definitive clinical assessment within 20 minutes
- Routine – start definitive clinical assessment within 60 minutes

	Nov	Oct	Sep	Aug	Jul	Jun	May	April	Mar	Feb	Jan
ILTCs	78.6 %	50%	50%	90%	100%	100%	100%	0%	43%	57%	0%
Urgent	90.2 %	92.2 %	95%	95.2 %	95.6 %	95.9 %	90.5 %	89%	89%	79%	79%
Routine	96%	96.4 %	97.6 %	96%	96.8 %	96.6 %	94%	92%	90.5 %	81%	86%

Source: Monthly performance reporting as set out in the contract

Key messages

The data demonstrates that call answering and telephone clinical assessment are the areas where the provider faced the greatest performance challenge.

Due to the poor performance issues CHUHSE agreed to bring the service in house. The Call Handling service directly managed in CHUHSE commenced at the beginning of Sept 2014. CHUHSE recruited and trained new Call Handling staff for the service based at the Homerton Site. The data shows an immediate impact through improved performance. Both commissioner and provider are working to ensure the performance improves and is regularly reviewed.

The area of telephone clinical assessment is an area that is closely monitored by the CCG's contract monitoring group. The group acknowledged that in the earlier months, as the organisation bedded in and staff learned new systems and protocols that it would take some time for the new ways of working to become familiar. Particularly in managing cases out of hours which is very different to working in-hours. The data demonstrates an upward shift towards improved performance. There is clearly more room for improvement, however the CCG is satisfied that

performance has shifted in the right direction. It should be noted that for ILTCs, given the low number of calls received and the small window for transferring the calls to LAS, that breaches can occur, there are also occasions where individual calls can take longer for good reason, e.g. the call handler needing to clearly understanding a patients symptom or condition or where there is a language barrier.

Face-to-face consultations (whether in a centre or in the patient's place of residence)

These must be started within the following timescales, after the definitive clinical assessment has been completed:

- Urgent: within 2 hours.
- Less urgent: within 6 hours (routine).

Seen at the centre

	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
Urgent	98%	100%	100%	98%	100%	100%	97%	93%	90%	94%	100%
Routine	99.6 %	99.7 %	99.7 %	99.6 %	100%	99.7 %	99.5 %	99%	100%	100%	99%

Source: Monthly performance reporting as set out in the contract

Home Visits

	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
Urgent	90%	98%	92.9 %	100%	100%	95.7 %	91%	84%	100%	93%	96%
Routine	92.3 %	99.6 %	100%	1005	100%	95.2 %	99%	97%	100%	99%	100%

Source: Monthly performance reporting as set out in the contract

Key messages

The provider has consistently achieved the target for this performance measure. The provider should be congratulated for achieving these results in the short time frame since it was established.

Rota Fill data

	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan
% filled by GP pool	75.1	92.5	89	80	89.5	89.5	91	95	98	100	100
% filled by locum	14.9	7.5	11	20	10.5	10.5	9	5	2	0	0

Source: Monthly performance reporting as set out in the contract

Key messages

An important lesson learned from the previous OOH experience was for the commissioner to capture data around rota fill and capacity management to ensure there are enough trained staff in place to cope with demand. There is therefore a requirement for CHUHSE to provide monthly reporting on its rota of GPs working OOH shifts. The previous provider in 12/13 achieved a best rate of 4% agency/locum fill, and at worse, a rate of 19%. There is an improvement in this area for CHUHSE as it consistently fills it OOH shifts with local GPs, with the exception of the school holiday period. The introduction of homeworking GPs has also added capacity meaning there is less reliance on locum GPs to fill vacant shifts.

Attendance data

The table below demonstrates the clinical outcomes/dispositions made by the OOH provider following a clinical assessment of the patient – the options open are for the patients query to be closed on the phone (advice calls), the patient to attend the OOH centre (PCC attendance) or for the patient to be visited by a GP at their home.

CHUHSE data												
	Nov	**Oct**	**Sep**	**Aug**	**Jul**	**Jun**	**May**	**Apr**	**Mar**	**Feb**	**Jan**	**%**
Advice calls	1267	1115	894	988	1079	1137	1398	1390	1300	1193	1229	**56**
PCC attendances	879	738	707	817	719	814	988	862	861	758	779	**38**
Home visits	104	76	102	113	90	88	125	225	126	122	122	**6**
Total contacts	**2250**	**1929**	**1703**	**1918**	**1888**	**2039**	**2511**	**2477**	**2287**	**2078**	**2138**	

Source: Monthly performance reporting as set out in the contract

Harmoni data for the same period in 12/13 and 13/14												
	Nov	**Oct**	**Sep**	**Aug**	**Jul**	**Jun**	**May**	**Apr**	**Mar**	**Feb**	**Jan**	**%**
Advice calls	557	556	476	455	490	517	565	436	870	774	935	**39**
PCC attendances	846	748	700	641	643	740	790	651	952	760	950	**50**
Home visits	190	160	159	171	163	187	176	138	223	153	180	**11**
Total contacts	**1593**	**1464**	**1335**	**1267**	**1296**	**1444**	**1531**	**1225**	**2045**	**1687**	**2065**	

Source: Monthly performance reporting

Key messages

When compared to the activity levels under the previous provider, it is worth noting actual activity (which is higher for the same period) and the difference in disposition outcome.

The differences in activity has caused some capacity issues and these were addressed as indicated through the implementation of homeworking doctors and increasing funding through the Winter Planning process.

In terms of the activity profile, it can be seen that CHUHSE is completing more calls on the phone, visiting fewer patients and recommending fewer visits to the urgent care centre. This ensures patients are not unnecessarily having to attend the hospital during the OOH period. Indicating a much more efficient service as a majority of calls to the OOH service are dealt with by phone and only those patients requiring urgent treatment are visited or asked to attend the centre. This way of managing conditions also provides a better patient experience.

Early anecdotal feedback from both patients and GP practices has indicated a high level of user and stakeholder satisfaction with the service. The CCG at its last contract review meeting signed off a newly designed patient feedback survey which will be posted to all patients and feedback collated for an end of year patient feedback report. The survey will also seek patients' views about whether additional OOH centres would be useful. The CCG is awaiting the results of this patient experience survey which is expected to report by the end of the year.

4. Clinical audits and lessons learned

There has been a collaborative approach to designing the audit programme for CHUHSE. A key feature of the programme is that all GPs working the OOH shifts are audited for quality and clinical outcomes. At least 5% of all case records are audited for each GP every month. This is in line with the service specification and was a key feature of lessons learned from the previous provider. The additional programme of audits also includes:

- Prescribing outcomes (in particular the use of antibiotics)
- Referrals from 111
- Referrals – general
- Special Patient Notes – these are for patients with complex health and social care needs and or who may be at risk to themselves or others; may be at risk from others and / or cannot manage their own care. It is therefore important that this information is kept up-to-date and shared amongst health care services so that health professionals may effectively meet the needs of these patients.

The result from the latest records-audit are that all CHUHSE GPs have been audited by end of Q2. Outcomes/actions arising from the audit process are progressed immediately, for example in 2 cases cause for concerns were identified and as a result those GPs no longer work for CHUHSE.

The level of feedback given to GPs is welcomed and the process provides a real opportunity for development and improvement. These outcomes are reported to the CCG through the monitoring framework on a quarterly basis.

CHUHSE has been performing satisfactorily since the service went live on Dec 2013. Following the initial teething issues the service has continued to develop and improve. At this stage the provider has not undertaken a formal patient satisfaction survey, however, initial feedback from patients has been positive, with 2 patients sending emails directly to the CCG to reflect on their positive experiences. Patient complaints are being reported at the monthly monitoring meetings and there have been 5 complaints reported so far, the majority of these have now been closed with one complaint being investigated.

There has been no negative feedback received from GP practices in The City or Hackney.

5. Quality developments 2014/15

Organisational development

- The provider has set up its board and committee meetings which have commenced since September 2014.

- Set up of CHUHSE bi-monthly Clinical Governance meeting to oversee all clinical governance e.g. procedures, policies, incidents, performance and audit.

- Monthly clinical audits of GP records have been undertaken since January 2014, with 5-15% of each doctors' records being reviewed anonymously using an IT tool, Clinical Guardian. All doctors have received feedback about their work.

- The provider has set up a Clinical and Quality Performance Committee, with responsibility for clinical quality and compliance.

- Set up of CHUHSE Financial Governance meetings e.g. Finance and performance committee, Audit Committee, Remuneration Committee.

- The staffing structure and professional training and development plan is being reviewed in line with business requirements.

OOH nursing pilot

An OOH nursing scheme commenced on the night of 5th September. The scheme is intended to add capacity to the service, enhance delivery of the admission avoidance objectives and offer a greater skill mix for patients needing out of hours care. It is designed so that nurses can assist GPs as appropriate by attending to care needs such as dressings, catheter replacements or other conditions suitable for a nurse to

treat. The service model will remain as GPs conducting the primary clinical assessments and nurse supporting as required.

The scheme is being delivered in partnership with the Homerton who are supplying nurses via the bank rota. It is being rolled out in a phased approach with shifts being offered during weekends only until the service is bedded in.

The CCG awaits feedback on the progress of the pilot which if successful will be part of the core business of the OOH service.

Working with stakeholders to integrated and improve services

The provider has a very good relationship with the wider urgent care system. The UC board receives the routine reports about OOH performance and the clinical lead has a place on the full CCG board. Service developments about potential integration with other services are debated at the programme board.

The local links with primary care are also very strong. Practices are able to give instant feedback to either the commissioner or the provider if they feel there are any clinical matters they wish to raise. GP practices can communicate directly with either the clinical lead for Urgent Care, the clinical lead for monitoring the OOH service or the OOH contract manager should they need to.

The CCG also has several *fora* where any clinical or service matters can be raised about OOH, these are the Clinical Executive Committee (CEC), where the lead for Urgent Care has a seat on the committee as does the clinical lead for monitoring OOH, the Clinical Commissioning Forum (CCF) where the OOH clinical lead is a member and through quarterly GP practice forum meetings, where the feedback can be passed directly to the OOH contract manager.

CHUHSE has been involved with the One Hackney Board from the outset helping to shape the exciting collaboration across health, social care and voluntary service in Hackney to reduce admissions and improve the quality of care to the most vulnerable patients in the local area. Two additional schemes have been piloted to support admission avoidance, these are:

- **Overnight on call doctor**. Currently there is only one doctor working for CHUHSE through the night and this is normally adequate for the workload. However, there have been occasions when the service has been stretched by the one doctor being involved in a lengthy admission avoidance type visit. Having an additional overnight on call doctor will mean that when the night doctor is on a visit to a complex patient there will be capacity for other patients to receive telephone advice calls within the appropriate time frames as set out in the service requirements.

- **Overnight care co-ordinator**. This pilot sees an enhanced level of input from the overnight call handler who as well as taking calls will make onwards referrals to other services (e.g. palliative care, First Response) to ensure that patients not admitted are picked up by appropriate services the following

morning. In addition they will be transferring information from Care Plans onto Special Patient Notes within Adastra.

6. Financial performance

The contract awarded to the provider was for a sum of £6,037,201 broken down by the following annual split:

- Year 1 – Dec 13 – Mar 14 £ 397,600
- Year 2 £ 1,460,460
- Year 3 £ 1,511,580
- Year 4 £ 1,501,773
- Year 5 Apr 17 – Dec 17 £1,165,788

Unit prices were agreed as follows:

- Home visits £144
- Consultation at base £69
- Phone consultation £45

This cost was based on the activity baselines calculated by the data from the previous provider and compared to other PCTs at the time. The contract also included a cap and collar agreement whereby the CCG would pay a minimum of 95% of the annual sum if activity fell below 95% of the anticipated activity plan and up to a maximum of 105% of the annual sum if activity went above the plan.

It became apparent early on that the actual activity levels were greater than anticipated and that the provider would receive less funding for under activity in home visits and GP consultations at the centre and would over perform, well above the 105% cap for telephone consultations.

Rather than re-negotiate the activity profile and unit costs the CCG and provider agreed to a risk share whereby the block amount of the contract would be honoured for years 1 and 2 and that any material changes to the contract would be considered in March 2015. This has meant that the provider has performed within the financial thresholds and has also not had any difficulty with its cash-flow despite being a new start-up organisation.

The over performance for telephone consultations and additional capacity requirements were supported through Winter Planning in both 13/14 and 14/15. In 13/14 the provider made a successful bid for additional Winter capacity for £100k and in 14/15 £150k was allocated to the provider to address additional winter pressures.

Managing conflicts

As a result of increased public interest in clinical commissioning in light of the developing landscape it is important that the CCG has rigorous, transparent and open processes for managing potential conflicts of interest. This was first tested when the CCG procured the current OOH service, which of course had a successful outcome.

For 2015/16 the CCG has established a new committee of the CCG Board called the Primary Care Contracts Committee which has delegated responsibility from the CCG Board for ensuring the delivery of the CCGs clinical strategy through robust contractual arrangements with general practices, the GP Confederation and the GP OOH provider, ensuring this is transacted in a robust way to manage conflicts of interests.

The committee is made up of the CCG's non-GP Board members which includes two lay members, Nurse member, Consultant member, CCG Chief Officer and the CCG Chief Finance Officer. In addition Healthwatch from the City of London (CoL) and the London Borough of Hackney (LBH) also have voting membership. In attendance with no voting rights are the Health and Wellbeing Board Chairs for LBH and CoI, the local Director of Public Health and an independent GP Advisor co-opted from outside the area.

All members and anyone attending CCG committees, sub-committees or Programme Boards, will be asked to register their interests and this will include CHUHSE memberships. This will mean that where there are discussions about payments, contract variations or other financial matters concerning CHUHSE there will not be any clinicians with a CHUHSE interest/conflict present. However as a clinically lead organisation, clinicians with a CHUHSE interest declared, are able to take part in meetings and discussion related to service developments or reviews as these will not involve them in making commissioning decisions..

7. Summary

The City and Hackney Urgent Care Board reviews all of its services in terms of their support to the overall Urgent Care system. In its first year of development, it has become clear that the new CHUHSE out of hours service is supporting the overall system through effective clinical telephone triage. In terms of onward referral to A&E and London Ambulance Service, the service compares favourably to the 111 system, which is run by non-clinical call handlers. While the two services are not directly comparable, the CCG supports the clinical triage model given the low onward referral rates to LAS or A&E.

The introduction of the new CHUHSE service is arguably one of a number of factors across the local system, which has supported the Homerton's continued achievement of the four hour A&E target, one of the few Trusts in London and across the country which is currently meeting the target during the winter period.

The service did suffer some early teething problems both technical system issues and developmental issues with staff learning new ways of working. Despite these early challenges the provider did manage to recover and started to achieve the performance standards quite early into their first year of operating.

The collaborative approach that the provider adopted with stakeholders and partner organisations has helped with service delivery and quality of service. CHUHSE has a place on the Urgent Care Programme Board, is an active participant in the One Hackney Programme and has very close links with both primary and secondary care. This has helped to deliver the service outcomes as described in the service specification.

The provider has also been able to take on board new innovations such as the OOH nursing pilot, the overnight on call doctor, overnight care-coordinator and has brought handling in-house within a short space of time. The good relationship between the commissioner and provider has meant that problems are identified early and solutions are implemented quickly and efficiently.

Overall the CCG is satisfied with the service following a robust procurement process, speedy mobilisation and 1 year of service delivery. The CCG would welcome views from Hackney's scrutiny committee about where the service might be developed further and improved.

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