Public Document Pack

Health and Social Care Scrutiny Committee

Date: **MONDAY, 30 OCTOBER 2017**

Time: **11.30 am**

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

Members:
Chris Boden (Chairman)
Wendy Mead (Chief Commoner) (Deputy Chairman)
Emma Edhem
Alderman Alison Gowman
Michael Hudson
Vivienne Littlechild
Steve Stevenson (Co-Opted Member)

Enquiries: **Joseph Anstee**
tel. no.: 020 7332 1480
joseph.anstee@cityoflondon.gov.uk

Lunch will be served in Guildhall Club at 1PM
NB: Part of this meeting could be the subject of audio or 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 8th May 2017.

For Decision
(Pages 1 - 4)

4. **CQC INSPECTION OF ST BARTHOLOMEW'S HOSPITAL**
Includes the summary of findings following the Care Quality Commission's inspection of St Bartholomew's Hospital in May 2017. The full report including detailed findings is available on request.

For Information
(Pages 5 - 20)

5. **CITY OF LONDON HEALTH PROFILE**
Report of the Director of Community and Children's Services.

For Information
(Pages 21 - 28)

6. **HOSPITAL DISCHARGE**
Report of the Director of Community and Children's Services.

For Information
(Pages 29 - 36)

7. **PUBLIC DEFIBRILLATORS**
Report of the Director of Community and Children's Services.

For Information
(Pages 37 - 40)

8. **EMPLOYMENT FOR PEOPLE WITH A LEARNING DISABILITY**
Report of the Director of Community and Children's Services.

For Information
(Pages 41 - 44)

9. **ANNUAL WORKPLAN**
Report of the Town Clerk.

For Information
(Pages 45 - 46)

10. **INNER NORTH EAST LONDON UPDATE**
Includes minutes of the INEL JHOSC meeting on Monday 26th June 2017.

For Information
(Pages 47 - 56)

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

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

13. **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.

Part 2 - Non-Public Reports

14. **NON-PUBLIC MINUTES OF THE PREVIOUS MEETING**
To agree the non-public minutes of the meeting held on Monday 8th May 2017.

For Decision
(Pages 57 - 58)

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

16. **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 COMMITTEE

Monday, 8 May 2017

Minutes of the meeting of the Health and Social Care Scrutiny Committee held at the Guildhall EC2 at 11.30 am

Present

Members:

Chris Boden	Michael Hudson
Emma Edhem	Vivienne Littlechild
Alderman Alison Gowman	Steve Stevenson

Officers:

Philippa Sewell	-	Town Clerk's Department
Neal Hounsell	-	Community & Children's Services Department
Simon Cribbens	-	Community & Children's Services Department
Farrah Hart	-	Community & Children's Services Department

1. **APOLOGIES**
   Apologies were received from Chief Commoner Wendy Mead.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   There were no declarations.

3. **ORDER OF THE COURT OF COMMON COUNCIL**
   The Committee received an Order of the Court of Common Council of 27 April 2017 appointing the Committee and approving its Terms of Reference.

4. **ELECTION OF CHAIRMAN**
   The Committee proceeded to elect a Chairman in accordance with Standing Order No.29. The Town Clerk read a list of Members eligible to stand and Christopher Boden, being the only Member who expressed a willingness to serve, was duly elected as Chairman of the Committee for the ensuing year.

   The Chairman welcomed Emma Edhem as a new Member of the Committee, and thanked outgoing Member the Revd. Dr Martin Dudley.

5. **ELECTION OF DEPUTY CHAIRMAN**
   The Committee proceeded to elect a Deputy Chairman in accordance with Standing Order No.30. The Chief Commoner, as the immediate Past Chairman, had previously confirmed that she would take up the role of Deputy Chairman for this year as set out in Standing Order 29 (3) (a), and was duly elected as Deputy Chairman of the Committee for the ensuing year.

6. **CO-OPTION OF A HEALTHWATCH REPRESENTATIVE**
   RESOLVED – That Steve Stevenson be co-opted as the representative for Healthwatch.

7. **APPOINTMENT OF INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE REPRESENTATIVE(S)**

The Director of Community & Children's Services advised that the JHOSC was set up to consider London-wide and local NHS service developments and changes that impact the Hackney, Newham and Tower Hamlets boroughs and the City of London Corporation. The Committee noted that the City Corporation nominated one representative to the JHOSC with another acting as their substitute.

RESOLVED – That the Chairman be appointed to the Inner North East London Joint Health Overview and Scrutiny Committee with the Deputy Chairman as their substitute.

8. **MINUTES**

RESOLVED – That the public minutes of the meeting held on 16 February 2017 be agreed as a correct record.

Matters Arising

Defibrillators

The Patients' Forum for the London Ambulance Service had confirmed that John Lewis and Sainsbury's were installing defibrillators in their larger stores, but work continued to encourage Boots to do the same. Members tasked officers with checking which John Lewis and Sainsbury's stores in the square mile had installed defibrillators and to encourage the companies to install them in smaller stores.

Integrated Commissioning

Officers confirmed there was still uncertainty regarding break clauses and NHS England had advised there would be no formal response until after the general election.

9. **ANNUAL WORKPLAN**

Members received a report of the Town Clerk regarding the Committee's meetings and activities for the year and the following agenda items were suggested:

- Neaman Practice – the GP practice to reassure the Committee of arrangements after Dr Vasserman's departure.

- Sexual Health Transformation for London – an overview of the London-wide transformation of sexual health services.

- Royal London dental hospital / Barts Health – officers to look into and see if a report could be presented regarding appointments systems.

- Post-election health announcements – headline changes to be circulated electronically to the Committee after elections, and details to be presented when available.

- Employment of individuals with learning difficulties – officers to confirm figures of those employed in the Corporation and the work going on the Corporation to

encourage employment and address stigma. The Chairman of the City Bridge Trust Committee confirmed that a £3.5million commitment was being considered at the Committee's meeting later in the week for a 'Bridge To Work' programme including grants to Centre for Mental Health, Inclusion London, Muscular Dystrophy UK, National Autistic Society and Whizz-Kids.

RESOLVED – That the proposed schedule of meetings be agreed.

10. **INNER NORTH EAST LONDON UPDATE**

The Director of Community & Children's Services advised that at their last meeting the INEL JHOSC had considered the sustainability and transformation plan for North East London which sought to bring different parts of the health economy together, streamlining services and reducing costs. The INEL JHOSC had scrutinised the financials, intentions, and the inclusion of adult social care services (which were LA funded but would be impacted by the changes NHS England were proposing), and it was noted the concerns of the INEL JHOSC had not been fully assuaged.

Members requested an update on the changes to cancer services be provided at a future meeting, and agreed that INEL JOHSC minutes be circulated electronically to the Committee after meetings.

RESOLVED – That an update on cancer services be provided at a future meeting, and INEL JHOSC minutes be circulated after each meeting.

11. **SOCIAL WELLBEING**

The Committee considered a report of the Director of Community & Children's Services regarding the City of London Corporation's Social Wellbeing Panel and Strategy.

Members noted that doing more to tackle social isolation had been identified as a priority in the Department of Community & Children's Services Business Plan, in the City Corporation's Joint Health and Wellbeing Strategy, in the Mental Health Strategy and by the Adult Advisory Group. The City Corporation commissioned Dr Roger Green from Goldsmiths, University of London, to investigate the extent, causes and possible solutions to loneliness for people in the City of London. His research was presented to the
Community and Children's Services Grand Committee in July 2016 and has underpinned the City Corporation's further work on this issue. A month long public consultation was carried out on the Social Wellbeing Strategy, with face to face events, a consultation website and leaflets in libraries and other public venues. The strategy focussed on wellbeing, but this in turn would have a positive impact on health needs.

A Member queried the clarity of the strategy, which she found vague with regard to what was going to be implemented and pursued and would therefore be difficult to measure success against. Officers reassured Members that there was every intention of acting on these findings (and work had already begun in some areas) and undertook to circulate the action plan to the Committee electronically. Officers advised that the draft strategy would be considered at the Community & Children's Services Committee meeting scheduled for later this week, the Health and Wellbeing Board at their meeting in June, and had

also been submitted to the Jo Cox Commission on Loneliness. The Chairman thanked officers for the report, and proposed a follow-up report taking a quantitative approach in order to establish the cost of loneliness and/or the cost benefit of addressing loneliness. Officers agreed this would be beneficial (i.e. for seeking funding) and was the natural progression for this work.

RESOLVED – That the action plan be circulated to Members, and the report be noted.

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
There were no questions.

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There was no other business.

14. **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)
15	3
16-17	-

15. **LOCAL PROCUREMENT OF SEXUAL HEALTH SERVICES**
The Committee received a report of the Director of Community & Children's Services.

16. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
In response to a Member's question regarding accessing health services outside the square mile, officers advised that the City Corporation made no restrictions on people, it was just more difficult to identify them and link up the health provision when they used hospitals less familiar with the City Corporation.

17. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There was no other business.

The meeting closed at 12.30 pm

Chairman

Contact Officer: Philippa Sewell
tel. no.: 020 7332 1426
philippa.sewell@cityoflondon.gov.uk

Barts Health NHS Trust

St Bartholomew's Hospital

Quality Report

West Smithfield
London
EC1A 7BE
Tel: 020 3416 5000
Website: http://www.bartshealth.nhs.uk

Date of inspection visit: 9 - 11 May 2017
Date of publication: 20/09/2017

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Medical care	Good
Surgery	Good
Critical care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

St Bartholomew's Hospital is a teaching hospital in the City of London and part of Barts Health NHS Trust.

St Bartholomew's Hospital is the oldest hospital in Britain, occupying the site it was originally built on. The hospital provides a range of local and specialist services: including treatment of heart conditions, cancer, fertility problems, endocrinology and sexual health conditions. The hospital has a minor injuries unit and a specialist Heart Attack Centre, but does not offer A&E services.

The hospital has recently seen much building redevelopment, including the demolishing of parts of the site to make way for a new PFI funded building that houses the trusts specialist cancer and cardiac services. This includes the Barts Heart Centre (BHC), formed by the merger in 2015 with staff and services at the London Chest hospital and the Heart Hospital (University College Hospital).

The hospital has 365 inpatient beds and 108 day case beds, and employs 870 nursing and medical staff.

The BHC is Europe's largest specialised cardiovascular centre, covering a population of three million people across north and east London, west Essex and beyond. The facilities include: 10 theatres, 10 catheterisation labs, 250 general cardiac beds and 58 critical care beds, delivering specialist cardiac and respiratory services. The BHC aspires to perform more heart surgery, MRI and CT scans than any other centre in the world.

We inspected four core services: medical care, incorporating oncology and cardiology services; surgery, including theatre and recovery; critical care, including the specialist intensive care facilities the hospital provides; outpatients & diagnostic imaging, including radiotherapy. We did not inspect end of life care services.

We rated the well led domain in surgery and critical care as outstanding. Overall, we rated St Bartholomew's hospital as good.

Our key findings were as follows:

Safe

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff. Staff were able to tell us about improvements in practice that had occurred as a result.
- Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation.
- The surgery service had significantly reduced the number of surgical site infections in the last 12 months.
- Most clinical areas were clean, well maintained and free from clutter.
- We predominantly observed good adherence to infection control protocol.
- We observed good medicines management, including safe storage of medications and controlled drugs.
- Clinical practice was evaluated and benchmarked through an on-going programme of local and national audits, peer reviews and service development.
- There had been a sustained investment in recruitment of nursing staff.

However, we also found:

- Understanding and implementation of sepsis six (a procedural guideline designed to reduce the mortality of patients with sepsis) was variable among staff, and an action plan had been introduced to improve this.
- Understanding and learning from never events was not consistent across services.
- Nursing care bundles and documentation were not always completed consistently, and we found gaps in the recording of risk assessments and safety observations across medical inpatient areas.
- Nursing vacancies across some services remained above the trust target: bank and agency staff usage was high in some clinical areas, although this had had minimal impact on patient care.

Summary of findings

- Mandatory training rates across services were variable.
- Medicines fridge temperatures were not always consistently monitored in some clinical areas.
- There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisors' details.
- Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.

Effective

- Patient care was delivered in line with national clinical guidance and best practice.
- Pain was well managed across the services we inspected.
- There was effective multi-disciplinary team working in place within and across services.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was better than the national average of 90 minutes.
- The average length of stay for elective and non-elective medical inpatients, with the exception of clinical haematology patients, was shorter than national averages.
- Results from the national lung cancer audit indicated the hospital performed better than the national average in every indicator.
- Clinicians demonstrated an on-going commitment to developing pathways that improved patient outcomes.
- Consultants were participating in a multi-partner heart improvement programme to reduce late admissions and improve patient outcomes.
- A nurse education team and specialist educators were in post in each clinical area to lead on staff development and training.
- There were effective training opportunities available for clinical staff.
- A rehabilitation support team and multidisciplinary therapy team supported cardiac patients with rehabilitation goals and strategies to improve their recovery. This was part of a broad multidisciplinary approach to care and treatment that ensured patients received a holistic and individualised recovery plan.
- Surgery patients that we spoke with felt they had been well informed regarding their treatment and that consent had been well explained in pre-admission and pre-operatively

However, we also found:

- The critical care service did not fully participate in providing data to Intensive Care National Audit and Research Centre (ICNARC), which was an expectation for critical care services.
- There was not daily on-site cover from a tissue viability nurse and ward nurses told us they did not feel confident in identifying or treating pressure sores. This was reflected in the number of hospital-acquired pressure sores in the previous 12 months.
- There were gaps and inconsistencies in staff knowledge with regards to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. We found insufficient and inappropriate documentation and records of monitoring with regards to this in two medical wards.
- We found 15 policies in radiotherapy that were not up to date.

Caring

- We saw examples of staff providing compassionate care with dignity to patients across the services we inspected. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.
- Patient survey results were consistently good and there was evidence staff used narrative feedback to improve and develop services.
- We observed staff in each clinical area providing emotional support based on the needs of their patients.

However, we also found:

Summary of findings

- NHS Friends and Family Test response rate was lower than the national average in medical services. However, ward managers demonstrated how they were working to improve this.
- Results from the 2016 cancer patient experience survey indicated there was room for improvement in how patients accessed private discussions with staff and in the sensitivity of staff when communicating.

Responsive

- Flow through surgery services was well managed.
- The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.
- Recruitment of Clinical Nurse Specialists provided addition support for patients with specific clinical needs.
- The sexual health service had adapted to the needs of the local population including through the provision of a team of consultants, nurse practitioners and sexual health technicians who provided targeted support for patients with specific sexual risks.
- A new neuro-oncology rehabilitation service had been implemented to support patients with complex rehabilitation needs relating to cancer.
- A specialist team of nurses had developed an apheresis clinic in the chemotherapy day unit, which had expanded the range of specialist services available.
- Patients referred to cancer services were seen within two weeks of referral in 99% of cases and 98% of patients began their first treatment within 31 days. In addition 92% of patients were seen within 18 weeks of referral across all specialties, which met the national target.
- Clinical services had adapted access times and pathways to provide a safer and more responsive service. This included a two-week wait for angiograms and angioplasty after a cardiac inpatient stay in the heart centre.
- Specialist nurses led a 24-hour chemotherapy advice line, which patients could use during their treatment to ask questions or to access emergency admission pathways.
- The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
- The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
- Diagnostics and imaging services were meeting waiting time performance criteria.
- Medical wards had private space for patients and relatives to relax, socialise or talk privately. This included libraries, TV rooms and kitchens to make drinks and snacks. Hospital volunteers also provided daily snack and toiletry services on inpatient wards.
- A new catering contractor had improved the food service to patients and we saw an individualised service was now provided.

However, we also found:

- There were capacity issues in some outpatient clinics that meant there was insufficient number of clinics to deal with demand. Clinic rooms were booked up quickly and there was limited spare room capacity.
- Signage in some medical areas was difficult to identify and did not support easy navigation.

Well-led

- There was strong medical and nursing leadership and achievable strategies were in place to develop services.
- The senior leadership operating model allowed for good lines of governance and communication.
- Staff stated that the transition of services during the merger and formation of the Barts Heart Centre had run relatively smoothly, with minimal impact to the quality of patient care.
- Staff we spoke to across services emphasised the positive and collaborative culture following the merger.
- There was a high priority on research and senior clinical teams provided dedicated time for this.

Summary of findings

- Clinical teams used dashboards and risk registers effectively to review incident investigations and track the level of risk presented to patients, staff and services.
- Staff across services demonstrated that contingency planning worked well to minimise disruption during a prolonged IT failure.
- We saw innovation in clinical areas aimed at future service sustainability and the development of research
- Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

However, we also found:

- Staff in sexual health services said human resources or occupational health had not supported them during a period of unpredictable change.
- The risk register in outpatients and diagnostic imaging did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks

We saw several areas of outstanding practice including:

Medical Care:

- Senior teams encouraged staff to participate in research and develop innovative projects to improve care in their clinical area. For example, staff in ward 6 had been recognised as finalists for a Health Service Journal award in November 2016 for their work in redesigning a specialist service. In addition, staff teams from wards 4C, 5D and 6D had conducted falls prevention research that led to the introduction of falls champion badges for staff who had demonstrated skills development in falls prevention and who could train or coach colleagues. A research ambassador group supported staff to engage in research in line with national ethics guidance.
- Staff in the sexual health clinic were encouraged to apply to present their work at the annual British Association of Sexual Health and HIV conference as a strategy to share best practice and new learning. For example staff had attended a 2016 conference to present a reflection on their clinical practice in the management of syphilis and to present the work of a satellite screening partnership clinic with a nearby private pharmacy.
- The trust was participating in the East London Cancer Board initiative. This was collaboration between 20 organisations and 50 professionals who sought to agree priorities for improvements and drive positive change in local cancer services. In January 2017 the board announced its key areas of focus and planned work together including incorporating patient experience narratives and identifying opportunities for new care pathways such as for prostate cancer follow-up care.
- An experimental medicine cancer centre had recruited 934 patients to trials developing practice-changing medicine for four cancer types.
- An international cancer specialist organisation had selected the hospital as one of 20 global sites of excellence in immune-oncology to advance the development of cancer immune therapy.
- Staff in the chemotherapy assessment unit provided a 24-hour telephone triage and advice service for patients who were feeling unwell during their treatment and patients who had completed a course of treatment within the previous six months.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was significantly better than the national average of 90 minutes.

Surgery:

- Staff we spoke with stated they felt it had been a significant achievement by the leadership of surgery to bring three services together into one organisation, standardise processes efficiently, and continue to maintain the quality of care while doing so. Staff stated that the move into surgery services at St Bart's Hospital had been well managed and the transition was relatively smooth.

Summary of findings

- Surgery services were in the process of introducing a robotic surgical team with a fully adapted robotic surgery theatre. This would allow the surgery services to offer less invasive cardiothoracic surgery procedures, which led to faster recovery times, minimised trauma, and reduced pain. The robotic surgical programme would be the only dedicated cardiothoracic robot in the UK. The Robotic Epicentre for teaching and training in the UK will move to St Bart's Hospital in 2017.
- Surgery services had clinical research collaboration with a leading electronics company to develop visual applications for thoracic surgery. To support this, surgery services had developed a hybrid theatre, which could allow on-table visualisation of very small cancerous lesions, allowing more precise excision and reducing loss of health lung tissue.
- St Bart's Hospital was the first site in Europe to perform Electromagnetic Navigation Bronchoscopy, and was the only centre offering this in the UK as a routine service. Surgery services are also a training centre for this procedure in Europe.
- The hospital's Grown Up Congenital Heart disease (GUCH) programme had recently received national accreditation and is one of the largest in the world. The service provides supported transition from childhood to adulthood for those born with heart disease via a well-established transition programme with a leading London paediatric hospital.

Critical Care:

- The service had set up a well-governed and safe Extracorporeal Membrane Oxygenation (ECMO) service to provide both cardiac and respiratory support for patients and had put in a bid to become a national funded service.
- Since the merger of the three hospitals the service had developed a well governed critical care service with excellent medical and nursing leadership.

However, there were also areas where the trust needs to make improvements.

Medical Care:

The trust should:

- Ensure that nursing care bundles, including patient risk assessments, are completed consistently and without omissions.
- Ensure that adequate contingency plans are in place to reduce the risks of medicines management errors in the absence of pharmacy support.
- Ensure all teams meet the 90% target for completion of safeguarding training.
- Ensure all teams meet the 90% target for completion of mandatory training.
- Ensure there is adequate expertise on-site to ensure patients at risk of conditions associated with tissue breakdown or pressure sores receive appropriate care and treatment.
- Ensure further emphasis on making sure that all staff accurately and appropriately use the national early warning scores (NEWS) when assessing patients.
- Ensure staff working in laboratories have appropriate training in using personal protective equipment and protecting themselves from the risks associated with coming into contact with infectious material.
- Ensure FP10 prescription pads in the sexual health clinic are stored and managed in line with NHS Protect security of prescription forms guidance 2015.

Surgery:

The trust should:

- Ensure there are processes in place to monitor consistent recording of temperatures for medication refrigerators on surgery wards.
- Ensure NEWS scores are correctly scored and there are sufficient structures in place to frequently monitor performance in this regard.

Summary of findings

- Ensure patients who have appointments cancelled are offered an alternative.
- Ensure there is screening for patients who may have dementia, and that additional support is available for patients with dementia or other complex needs.
- Improve communication with patients regarding their discharge planning from surgery wards.
- Improve signage in the outpatients building for pre-admission appointments.
- Ensure they are meeting the trust target for appraisals of non-medical staff within surgery services.

Critical care:

The trust should:

- Ensure sepsis six pathway is fully integrated into practice and staff are educated appropriately.
- Ensure the first floor critical care units submit data to the Intensive Care National Audit and Research Centre (ICNARC) dataset to ensure patient outcomes are benchmarked against similar services nationally.
- Consider increasing the number of dieticians to meet national guidelines.

Outpatients and Diagnostic Imaging:

The trust should:

- Ensure clinics running late are reported as incidents in line with trust policy.
- Ensure clinic 5 has access to a sluice facility.
- Improve signage in the x-ray department informing patients of the dangers of radiation.
- Record ambient room temperatures are recorded in all rooms where medicines are stored.
- Ensure risk registers are fit for purpose and record actions and timescales to mitigate risks

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good	An incident reporting system was embedded into the operation of the hospital and staff at all grades told us they felt confident in escalating concerns and mistakes. We saw evidence senior staff consistently investigated incidents and learning was broadly disseminated and shared, and we saw changes in practice and policy occurred as a result. Infection prevention and control processes were effective and we saw staff consistently adhered to these. Staff adhered to good medicines management protocols that ensured patients were safe from the risks associated with improper storage and documentation. Pharmacy teams were proactive in identifying areas for improvement in medicines management and worked with clinical teams and senior leadership teams to implement safer practices. Staff at all levels demonstrated a consistently proactive approach to reporting safeguarding concerns and working within multidisciplinary teams to keep people safe. Senior clinical staff had adapted services provided to patients in response to identified risks, including the introduction of a consultant of the week model and emergency transfer care pathways. An improved recruitment strategy and the implementation of nurse development pathways had led to lower vacancy rates and consistent nurse to patient ratios. An action plan was in progress to reduce vacancy rates further through international recruitment and internal development of existing nurses. Each clinical area demonstrated improvements to patient outcomes through service developments and staff initiatives. This included a reduction in falls in the cancer wards through the introduction of a falls prevention competency framework. Multidisciplinary working with internal and external colleagues resulted in better patient care. A structured multidisciplinary education programme and the development of a junior doctor education hub had improved training and development opportunities.

Summary of findings

Clinicians had established multidisciplinary pathways and structures that meant patients treated at more than one of the trust's hospitals received coordinated, continual care.
Patients and relatives we spoke with provided consistently positive accounts of their care experiences. Good survey results and the demonstrably caring and compassionate approach of all staff we observed supported this.
Clinical processes were structured to ensure patients were included in their assessment, care and treatment. We saw evidence of this through observing ward rounds, speaking with patients, looking at patient records and looking at survey results.
Staff in each area demonstrated how they engaged patients in the service, both for improvement and to gather informal opinions and feedback.
There was evidence of innovation and a drive towards service development and sustainability in each clinical area. This included through research and the implementation of new and experimental services and treatments based on new guidance and evidence.
We also found:
Although there was consistent pharmacy support and cover in most clinical areas, there was a lack of contingency planning and elevated risks when this was not available.
Nursing care bundles and documentation were not always completed consistently and we found gaps in the recording of risk assessments and safety observations across inpatient areas.
We saw good infection control and hand hygiene practice during our inspection but this was not always supported by good long-term audit data. For example, the infection control team reported avoidable instances of hospital-acquired methicillin resistant Staphylococcus aureus (MRSA) and inconsistent hand hygiene compliance.
Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.
Completion of mandatory training was variable and no single group of staff had full compliance with the trust's minimum 90% completion rate.

Summary of findings

We found overall inconsistency in how staff assessed and recorded patient mental capacity in some inpatient areas. This included for one patient with a Deprivation of Liberty Safeguards authorisation in place.
Staff in the sexual health service described a lack of engagement or support from the trust, human resources and occupational health during a time of uncertainty.

Surgery

Good

Staff we spoke with felt there was a good attitude from managers towards reporting and learning from incidents within surgery, and they felt encouraged to report concerns or issues. Root-cause analysis of the never events resulted in review of standard operating procedures, and the introduction of Local Safety Standard for Invasive Procedures (LocSIPP) to minimise the risk of a repeat incident.
The service had significantly reduced the number of surgical site infections (SSI) in the last 12 months.
Most of the surgery wards and theatres we visited were clean and well-maintained.
There were a number of audits in place to monitor performance of medicines administration and management.
Surgical pathways were delivered in line with national clinical guidance and best practice
There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.
Staff we spoke with stated they found the appraisal process useful, and felt there were good opportunities for professional development with the trust. Surgery staff were meeting most of the mandatory training targets for the trust.
There was effective multidisciplinary team (MDT) working in place. We attended a number of ward meetings attended by medical, nursing, and MDT staff, and found communication to be effective and well managed.
Patients we spoke with gave us positive feedback on the quality of care they received. Positive interactions between staff, patients and their families was observed.
Patients and family we spoke with felt they had been well involved in their care.
Feedback from the Family and Friends Test (FFT) was consistently good across surgical wards, with an average of 98% for the period between April 2016 and February 2017.

Summary of findings

Flow through surgery services was well managed and efficient.
The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals (DGHs) in the north and east London area.
Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.
Surgery services had access to a number of Clinical Nurse Specialists who could provide additional support for patients with any additional clinical needs.
There were a number of post-discharge wound clinics available to support patients with their recovery.
There was a positive culture within surgery services at the hospital. The leadership team was well established and there were good connections throughout the service.The team were managing a very complex critical care environment in a very integrated and seamless way.
The senior leadership team within surgery had effectively overseen the joining of three separate specialist surgery services into one organisation since 2015. This included standardising process, developing a unified culture and identity for surgery services, and maintaining quality of care for patients.
Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future.
There were effective governance arrangements in place and senior staff had a good understanding of risks facing the service.
There were a number of leadership development courses available to staff who wished to have more responsibility.
Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.
We also found:
We found examples of National Early Warning Scores (NEWS) being incorrectly scored for patients on surgical wards.
There were significant vacancies in the nursing and medical teams, however this was mitigated by the use of regular bank staff. Surgery services also had a robust recruitment programme with a number of new staff due to start.
Refrigerators for medication on surgery wards did not have their temperatures checked consistently.

Summary of findings

The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results.
Some of the policies we reviewed on the trust intranet for surgery services had passed the date from review.
Surgery services were not meeting the trust target for appraisals for non-medical staff.
There was variable performance in surgery services relating to care for dementia patients.
Patients stated that communication from staff regarding discharge planning could be inconsistent.
There was limited signage in the outpatients building for pre-admission appointments.

Critical care

Good

There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.
The environment was suitable to provide effective care and treatment and equipment was available and safe for use. Required checks were completed in most cases and we observed good infection prevention and control practice.
Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation.
Care and treatment was delivered using up to date evidence based practice.
We saw examples of staff providing compassionate care to patients. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.
Patient and relative feedback was very positive about the care provided across the critical care services. Staff were described as caring and compassionate.
There was good access and flow within the critical care service. Delayed discharges on the general critical care unit were below the national average and minimal elective surgeries were cancelled due to a lack of critical care bed.
There was strong medical and nursing leadership and the service had a strategy in place to develop the service, which was achievable.

Summary of findings

		The leadership team were well established and there were good connections with all staff throughout the service. The team were managing a complex critical care environment in an integrated and seamless way The leadership team had a good oversight of local risks and risks were fully documented, discussed and we saw appropriate mitigation to reduce risks. There was an open and positive culture within the unit. Leaders were visible, supportive and approachable. We also found: We were not assured sepsis six and the new sepsis pro forma was fully integrated into practice as staff knowledge was varied. The first floor did not participate in the Intensive Care National Audit and Research Centre (ICNARC) dataset. We were told there were plans to include the first floor in the future. The service was not meeting national guidance for dietician and occupational therapy input. Visiting times were not always responsive to the needs of relatives and patients. Whilst we saw some examples of flexibility, this was not consistent.
Outpatients and diagnostic imaging	**Good**	Outpatients and diagnostic imaging staff had completed mandatory training and rates were 100% in most teams. Staff were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns in this regard. There was evidence of the WHO checklist being completed and audited. Patient protocols were in place in radiology. There was effective use of the national early warning score (NEWS) to identify a patient who might be deteriorating. Patients received care and treatment that was evidence-based and in accordance with national guidance. However, we found 15 policies in radiotherapy that were not up to date. There was compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Staff worked together in a multidisciplinary environment to meet patient's needs. There was a range of audits in place across outpatients, diagnostics and imaging to monitor patient outcomes.

Summary of findings

Consent was sought from patients prior to their receiving care or treatment. Staff received training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).
The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
Interpreters were available to enable staff to communicate with patients where English was not their first language.
Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was mostly lower than the England average.
St Barts had introduced a call reminder service to remind patients of their appointments.
Outpatients' managers told us they had not had to cancel any clinics as a result of the IT failure on 20 April 2017.
The trust had consistently performed better or similar to than the operational standard and England average for cancer waiting times.
Diagnostics and imaging services were meeting waiting time performance criteria.
Staff offered care that was kind and promoted people's dignity. We saw relationships between people who use the service and those close to them and staff were strong, caring and supportive.
Most patients and relatives we spoke with told us they were involved in decision making about their care. Patients and those close to them also understood their treatment and choices available to them.
There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff..
Interpreters were available to enable staff to communicate with patients where English was not their first language.
Staff told us there had been improvements in leadership at both an executive and local level in outpatients, diagnostics and imaging. Local leaders were visible and staff felt that concerns they raised would be addressed.

Summary of findings

Quality reports and dashboards were sent to the managers and matrons of outpatients and diagnostic imaging on a monthly basis; this included reviews of key performance indicators (KPI).
Governance systems internally within outpatient and diagnostic imaging services demonstrated information was shared and lessons were learnt about events. However, shared learning across the divisions was more limited.
Most staff knew about the trust's values and could explain what these meant to their role.
Staff told us relationships between outpatients and diagnostic imaging had improved. Staff felt that there was an open culture within services.
We also found:
Incidents in regards to clinics running late were not always reported in accordance with trust policy.
Clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.
There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisor's details.
Staff could not be assured that medicines were stored within the required temperature for the safe storage of medicines in clinic 1 as ambient room temperatures were not recorded.
There was an identified risk as a result of the age of the ultrasound machines and the potential to produce suboptimal images. Although there had been no incidents of this.
IT failures on 20 April 2017 and 30 May 2017 had led to clinicians having to leave their clinical areas to view images in the imaging department. Work was in progress on an investigation and a clinical harm review.
There was a risk to ongoing service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.
The risk register did not contain action plans to explain what actions had been take to mitigate identified risks or identify timescales for completion of actions to mitigate risks.
Between December 2015 and November 2016 the 'did not attend' (DNA) rate was mostly higher than the England.

Summary of findings

There were capacity issues in some clinics. Clinic rooms were booked up quickly and there was limited spare room capacity.
There was a risk to ongoing service development as clinic space was at a premium and as demand increased, the outpatients' model may make meeting the demand unsustainable.

Committee	**Dated:**
Health and Social Care Scrutiny Committee	30/10/2017
Subject: City of London Health Profile	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report Auther: Farrah Hart, Consultant in Public Health	

Summary

The City of London Health Profile 2017 has been published. Public Health England produces Health Profiles for local authorities which contain summary information on the health of the people in each local authority area and factors that may influence their health.

The City of London performs at or better than the national average for the following indicators: Life Expectancy, Children in Poverty, Preventable Mortality, NEETs, Fuel Poverty, Excess Weights in Adults, Smoking Prevalence and Alcohol Admissions.

There are several red indicators in the health profile. The majority of these are caused by statistical artifice due to small numbers, or where City of London figures have been merged with the London Borough of Hackney's figures.
One red indicator is directly related to underperformance in breast cancer screening.

Recommendation

Members are asked to:

- Note the City of London Health Profile and consider how they might use it to shape their forward planning process

Main Report

Background

1. Health Profiles are Official Statistics, published by Public Health England (PHE) according to Statistics Release Calendar.

2. The Health Profiles provide a snapshot overview of health for each local authority in England. They are conversation starters, highlighting issues that can affect health in each locality.

3. Health Profiles aim to:
    - provide a consistent, concise, comparable and balanced overview of the population's health
    - inform local needs assessment, policy, planning, performance management, surveillance and practice

- be primarily of use to joint efforts between local government and the health service to improve health and reduce health inequalities
- empower the wider community

4. Traditionally the Health Profiles have been a 4 page pdf report. These reports have been produced annually since 2006 for most local authorities, but not the City of London.

5. In 2016, we requested that Public Health England (PHE) produced a Health Profile for the City of London's population. PHE produced one, but it was mutually agreed that the City of London's report is never published on the national website, as the data contained within it cannot be compared with other areas, for reasons explained below.

Current Position

6. The most recent Health Profiles pdf reports were published in July 2017 and contained 30 indicators. Indicators are reviewed regularly to ensure that they reflect important public health topics.

7. The City of London performs at, or better than, the national average for the following indicators:
    - Life Expectancy,
    - Children in Poverty,
    - Preventable Mortality,
    - Young people not in employment, education or training (NEETs),
    - Fuel Poverty,
    - Excess Weights in Adults,
    - Smoking Prevalence and
    - Alcohol Admissions.

8. The Health Profile highlights several red indicators, as follows:

<u>Indicator 8. Violent crime</u>
Violent crime (including sexual violence) – hospital admissions for violence, directly standardised rate – per 100,000 2013/14 – 15/16

9. This value is for the City and Hackney combined so does not reflect the figure in the City

<u>Indicator 9. Statutory homelessness</u>
Households in temporary accommodation per 1,000 households, 2015/16

10. Looking at the figures in isolation, we had 24 households in temporary accommodation on 31 March 2016. Their connection with the City was as follows:

Work = 10
Residence = 5

Family = 0
Other/none = 9

11. 42% of our caseload had a connection to the City through work. This information is not recorded by DCLG so a direct comparison cannot be made, but anecdote suggests other councils have approximately 10% local connection rate through work. The unique imbalance in the City for working versus resident population distorts our figures in comparison to any other local authority in England.

12. If we only had 10% of our caseload having a connection through work, this would only be 2 households, giving total number in temporary accommodation as 16. This would result in 3.3 households per thousand in temporary accommodation, much closer to the national average

Indicator 20. Breast cancer screening
% eligible women screened adequately within previous three years on 31st March 2015

13. This indicator is likely to relate to underperformance within this service, as breast cancer screening is provided to a whole population group within the City. NHS England provides this service.

Indicator 22. Health checks (offered)
Cumulative % eligible population aged 40-74 offered NHS health check in the five year period 2013/14 – 2017/18

14. The City of London only has one GP surgery, the Neaman Practice. Health check data is only collected for residents who are registered at the Neaman Practice. Many of our residents are registered at GPs in Tower Hamlets or Islington so may be offered health checks but aren't included in the figure provided.

15. The City of London has recently commissioned Reed Momenta to deliver a new Integrated NHS Health Checks, Lifestyle Weight Management and Physical Activity Service (HWMPA), which was mobilised in October 2016. This included a community Health Check service available for residents and workers so will increase offers and uptake in the City of London. Data will take a while to reflect this change

Indicator 23. Air pollution mortality
Fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter PM2.5), 2013

16. Public Health England states that this indicator may not be accurate data for the City due to its small population. Air pollution is likely to contribute a small amount to the deaths of a large number of people rather than being solely responsible for the 8.4% - which complicates the relationship between pollution and mortality even more.

Indicator 24. New STI diagnoses (exc. Chlamydia in <25's)

All new sexually transmitted infections diagnoses (excluding Chlamydia in under 25 year olds) per 100,000 population aged 15-64.

17. New STI diagnoses in the City of London are significantly higher than the national value due to workers in the City of London accessing sexual health services using their work postcode. Additionally, attendees at St Bartholomew's Hospital who refuse to give a postcode or who are from overseas may also be allocated to the City of London.

Indicator 26. TB incidence:
Rate of reported new cases of TB per year per 100,000 population, 2013-15

18. This equates to 2 new cases of TB in the City of London. This is marked as red but given our small resident population is not comparable to England/other local authorities. A small change in numbers can give a very big change in rate.

Indicator 27. Infant mortality:
Rate of deaths in infants aged <1 year per 1,000 live births, 2012-14

19. This value is for the City and Hackney combined. Infant mortality in the City is 0.0 and therefore the value does not reflect infant mortality in the City.

Conclusion

20. Whilst the Health Profile for the City of London provides a useful starting point for looking at performance, the small numbers must be treated with caution, as they can cause statistical artefacts.

21. The Health Profile highlights some underperformance with regards to NHS cancer screening, as this is a whole population intervention.

22. Members are asked to note the Health Profile and consider how they might use it to shape their forward planning process

Appendices

- Appendix 1 – City of London Health Profile 2017

Farrah Hart
Consultant in Public Health
T: 020 7332 1907
E: farrah.hart@cityoflondon.gov.uk

Public Health England

Protecting and improving the nation's health

City of London

This profile was produced in July 2017

Health profile 2017

About this profile
This profile has been developed by PHE at the request of the City of London. This is a bespoke profile based on a limited number of indicators available. Due to the small population, indicators have a large margin of error and should be used with caution.

Health in summary
The health of people in City of London is varied compared with the England average. As with other parts of the country, health outcomes are closely linked with levels of deprivation, which vary across the local authority.

Local priorities
Priorities in the City of London include mental health and wellbeing, the health and wellbeing of rough sleepers, workplace health, air quality and integration of health and social care.

Life Expectancy
Life expectancy is better than both the London and England average. Male life expectancy at birth is 86.1 years, which is 6.8 years higher than the England average. Female life expectancy at birth is 89.0 years which is 6.0 years higher than England.

Child Health
In 2014, only 12.8% of children under 20 were living in poverty, this compares with 23.9% across London and 19.9% in England.

78.6% of children leaving reception in City of London in 2015/16 were school ready compared with 71.2% in London and 69.3% in England.

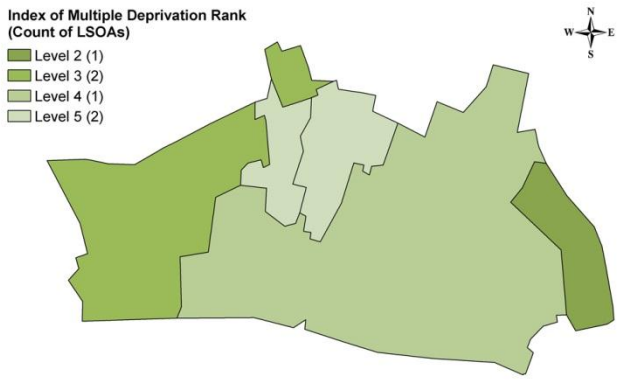
Population: 9,401 (Mid-2016 population estimate: ONS)
In addition, over 400,000 people work in the City of London and there is a significant population of rough sleepers (street count of 50 in Autumn 2016).

Adult health
47.9% of adults in the City of London have excess weight as estimated in 2013-15. This is lower than both the London average (58.8%) and the England average (64.8%). Only 45.8% of residents are considered active in the City of London compared with 57.8% of all Londoners and 57.0% across England. 36.5% of the adult population eat the recommended '5-a-day' portions of fruit and vegetables. There are significantly fewer hospital admissions for alcohol-related conditions in the City of London compared with England (585 vs. 647 per 100,000 population) but significantly more new STI diagnoses (2,516 vs. 795 per 100,000 population).

City of London had the highest proportion of mortality attributable to particulate air pollution at 7.0%, higher than both London (5.6%) and England (4.7%).

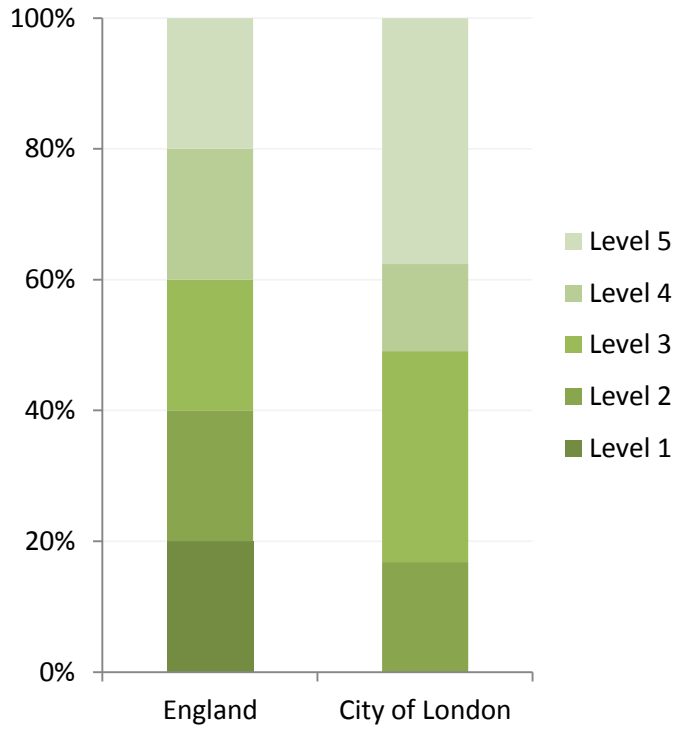
Deprivation: a national view

City of London is the third least deprived borough in London and the 96th least deprived local authority in England. In London, only Kingston upon Thames and Richmond Upon Thames are less deprived.



There are no areas within City of London that are in the most deprived 20% of residents in England. 38% of the population live in areas that are within the top 20% least deprived areas in England.

This chart shows the percentage of the population who live in areas of each level of deprivation.



Level 1 = Most deprived, Level 5 = Least deprived

Demographics: population

According to the 2016 ONS Mid-Year Estimates, there are 9,401 people living in the City of London, representing just over 0.1% of the total London population.

13.6% of the population in the City of London (1,276 people) are under the age of 20. In London 24.7% of the population are under 20 years.

The City of London has a higher proportion of its population in older age groups.

Age Group	City of London (%)	London (%)
0-19	13.6 (1,276)	24.7
20-44	45.0 (4,232)	41.6
45-64	26.1 (2,449)	22.1
65+	15.4 (1,444)	11.6

Health outcomes: life expectancy

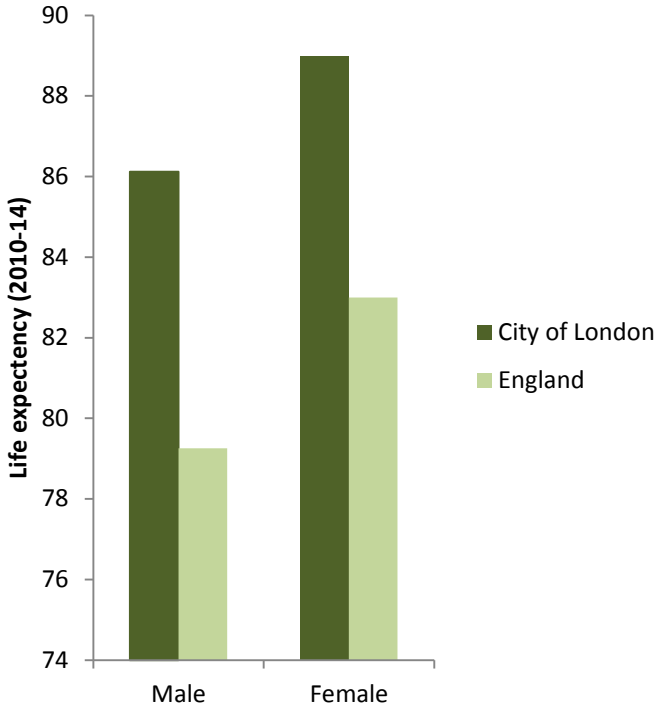
Life expectancy is closely linked to levels of deprivation, particularly in men, and this is reflected in life expectancy levels in City of London.

Life expectancy in City of London at birth in 2010-14 was 86.1 years for men and 89.0 years for women. This suggests that life expectancy in both males and females is considerably higher than both the London and England averages.

Life expectancy* at birth for males has steadily increased in England from 76.2 in 2001-03 to 79.4 in 2012-14. A similar improvement had been seen in London, where life expectancy increased from 76.0 in 2001-03 to 80.2 in 2012-14.

Life expectancy* at birth for females has also increased in both England and London between 2001-03 and 2012-14, but the increase has been smaller than among males. In England the figure rose from 80.7 to 83.1, and in London from 80.8 to 84.0.

*England and London figures presented here have been updated for a new methodology for 2012-14, they are available elsewhere for 2013-15, but have not been presented here for consistency with City of London.



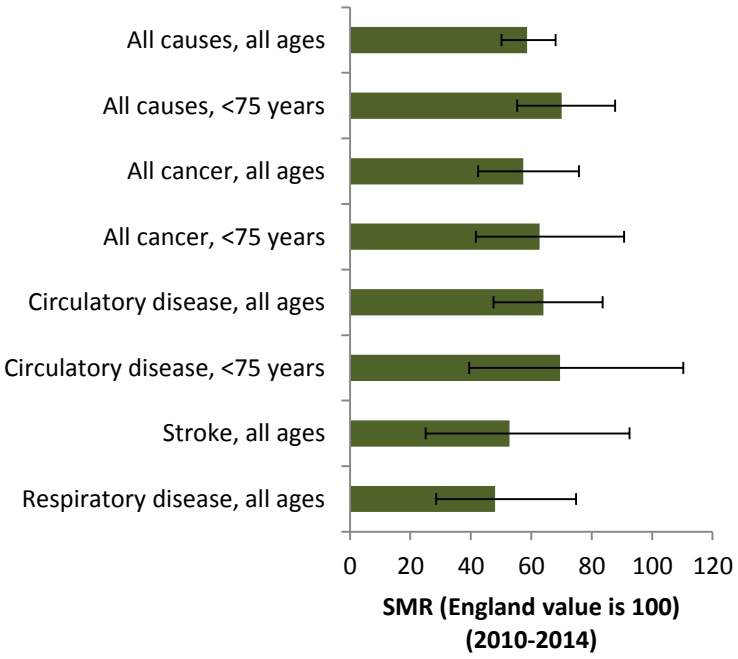
Source: ONS

Health outcomes: causes of death

The mortality rate in the City of London is significantly lower for all causes and for the specific disease groups displayed in the graph, apart from circulatory disease for the population under 75 years of age.

Overall in London for the past 10 years, the standardised mortality ratios have been consistently lower than the England average.

During the five year period 2010-14, there were around 170 deaths among City of London residents. Almost a third of these were from cancers, with a similar proportion from circulatory disease and one in 10 were from respiratory disease.



Source: localhealth.org.uk

Health summary for City of London

	Indicator	Local value	England Value	England Worst	England Best	Statistical significance
1	Life expectancy (males)[a,b]	86.1	79.3	74.3	86.1	
2	Life expectancy (females)[a,b]	89.0	83.0	79.7	89.0	
3	Children in poverty (under 20)	12.8	19.9	41.9	6.8	
4	Children in poverty (under 16)	12.0	20.1	39.2	7.0	
5	School readiness	78.6	69.3	59.7	78.7	
6	Pupil absence	4.2	4.6	5.8	3.4	
7	NEETs (16-18 year olds) [b]	0.0	4.2	7.9	1.5	
8	Violent crime[c]	52.6	44.8	133.4	9.1	
9	Statutory homelessness (temporary accom)	5.0	3.1	35.0	0.0	
10	Fuel poverty[b]	5.7	10.6	15.1	5.8	
11	Social care users content with social contact[d]	42.5	44.8	34.6	54.8	
12	Smoking Prevalence in adults	8.4	16.4	24.1	9.8	
13	Smoking during pregnancy[c]	5.2	10.6	26.0	1.8	
14	Proportion eating '5-a-day'[b]	36.5	52.3	36.5	62.8	
15	Excess weight in adults	47.9	64.8	76.2	46.5	
16	Active adults	45.8	57.0	44.8	69.8	
17	Inactive adults	21.0	28.7	43.7	17.5	
18	Recorded diabetes[b]	2.8	6.4	3.7	8.9	
19	Alcohol admissions (persons)[c]	585	647	1,163	390	
20	Breast cancer screening	71.8	75.5	57.2	84.0	
21	Abdominal Aortic Aneurysm screening	87.2	79.9	57.5	87.2	
22	Health checks (offered)	33.1	56.4	17.0	100.0	
23	Air pollution mortality[b]	7.0	4.7	7.0	3.2	
24	New STI diagnoses (exc. Chlamydia in <25's)	2,516	795	3,288	344	
25	Late presentation HIV	35.7	40.1	75.0	12.5	
26	TB incidence	8.2	12.0	85.6	1.2	
27	Infant mortality[c]	5.4	3.9	7.9	2.0	
28	Preventable mortality	114.0	184.5	320.5	114.0	
29	Emergency readmissions	10.7	11.8	14.5	8.8	

a. England figures updated for new methodology
b. Although City of London has the highest/lowest figure, it is not recorded as such in the Public Health Outcomes Framework due to its small population
c. Value for City of London and Hackney combined
d. Most recent data (2015/16) is missing. Data is from 2014/15.

Sources: all data in the above table sourced from the Public Health Outcomes Framework except 1 and 2 (source: Local Health, PHE), 10 (source: ONS) and 30 (source: Sexual and Reproductive Health Profiles, PHE)

Statistical significance colour code (City of London values compared to England)

Better than average/target	Worse than average/target	Similar to average/target	Lower than average/target	Not compared

1. Life expectancy at birth (males), 2010-14 **2.** Life expectancy at birth (females), 2010-14 **3.** % all dependent children <20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs), 2014 **4.** % children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only, 2014 **5.** All children achieving a good level of development at end of reception as % of all eligible children, 2015/16 **6.** % half days missed by pupils due to overall absence (incl. authorised and unauthorised absence), 2014/15 **7.** % of 16-18 year olds not in education, employment or training (NEET), 2015 **8.** Violent crime (including sexual violence) – hospital admissions for violence, directly standaridsed rate – per 100,000 2013/14 – 15/16 **9.** Households in temporary accommodation per 1,000 households, 2015/16 **10.** % of households that experience fuel poverty based on the "Low income, high cost" methodology, 2014 **11.** % of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey, 2014/15 **12.** % of the population who classify themselves as either occasional or regular smokers according to the GP Patient Survey (GPPS), 2015/16 **13.** % women who smoke at time of delivery, 2015/16 **14.** % of the adult population meeting the recommended '5-a-day', 2015 **15.** % adults classified as overweight or obese, 2013-15 **16.** % adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines on physical activity, 2015 **17.** % adults classified as "inactive", 2015 **18.** % QOF-recorded cases of diabetes registered with GP practices aged 17+, 2014/15 **19.** Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population, 2015/16 **20.** % eligible women screened adequately within previous 3 years on 31st March, 2016 **21.** % of men eligible for abdominal aortic aneurysm screening who are conclusively tested, 2014/15 **22.** Cumulative % eligible population aged 40-74 offered NHS Health Check in the 5 year period 2013/14 – 2017/18, for 2013/14 – 2015/16 **23.** Fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, $PM_{2.5}$), 2015 **24.** All new sexually transmitted infection diagnoses (excluding Chlamydia in under 25 year olds) per 100,000 population aged 15 to 64, 2016 **25.** % adults (aged 15 or above) newly diagnosed with HIV with a CD4 count < 350 cells per mm^3 2013-15 **26.** Rate of reported new cases of TB per year per 100,000 population, 2013-15 **27.** Rate of deaths in infants aged < 1 year per 1,000 live births, 2012-14 **28.** Age-standardised rate of mortality from causes considered preventable per 100,000 population, 2013-15 **29.** Indirectly standardised % of emergency admissions to any hospital within 30 days of the previous discharge from hospital, 2011/12.

Committee(s)	Dated:
Health and Social Care Scrutiny – For information	30/10/2017
Subject: Hospital Discharge	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Information**
Report author: Anna Grainger, Department of Community and Children's Services	

Summary

There is a national focus on ensuring that people are prevented from being admitted to hospital needlessly and on making sure that discharge from hospital is timely and efficient. A number of measures are in place between adult social care and NHS colleagues to tackle this issue. The report and presentation illustrate the measures being taken. In addition the unplanned and planned care workstreams of integrated commissioning are developing action plans together. This report includes a presentation on the hospital discharge pathway.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The emphasis nationally for the NHS and social care is on self-care and preventing the need for hospital admission. The adult social care team will assess people at home to help prevent falls and to provide equipment, adaptations, reablement (home care focussed on building people's independence) and longer term support. The adult team works closely with NHS colleagues in Hackney and neighbouring boroughs to ensure a smooth admission and discharge process. Homerton is the main hospital for Hackney residents although many City residents use the Royal London Hospital and UCLH – so liaison meetings are held with all of these hospitals.

Current Position

2. Measures are in place to ensure that a smooth and timely hospital discharges can occur. These are included in the presentation at Appendix One and are as follows:

    - City of London Corporation adult social care employs a care navigator – a role that works between the team and the hospitals used by City residents. The

navigator is notified of admissions and impending discharges and can arrange the support needed.

- The duty social worker can also arrange support packages for people returning home.
- The reablement team can provide a tailored programme of support for people returning home after a period of illness as well as equipment to assist them getting around the home.
- The City's domiciliary care provider can provide additional home care as needed.
- If there is a need for urgent discharge over the weekend we have services that can provide support as per the pathway for "Reablement plus".
- A "placement without prejudice" protocol is being developed to avoid people staying in hospital while health and social care decide who should be assessing and paying for long term support. This will mean that social care will provide and fund support in the interim but should the person be found eligible for nhs funded support, the payment would be re-imbursed to social care.

3. Through Better Care Fund funded projects and other services, the City of London Corporation aims to maintain its good performance on Delayed Transfers of Care (DTOCs) and contributes to a system wide approach to minimising the number of DTOCs. The City of London has a number of schemes which are key in helping people at the point of discharge, it has also developed a High Impact Change Model (HICM) Action plan based on national best practice.

Implications

4. The actions in the High Impact Change Model action plan are being developed.

5. People will receive a timely and effective discharge from hospital.

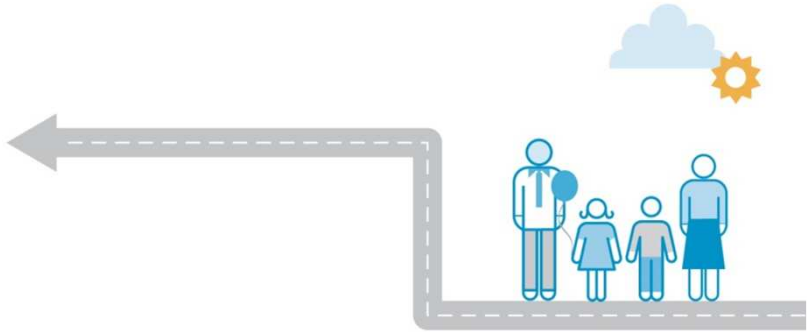
Appendices

- Appendix 1 – Presentation on high impact change model and hospital to home

Anna Grainger
Service Manager, Adult Social Care

T: 020 7332 1216
E: anna.grainger@cityoflondon.gov.uk

High Impact Change Model

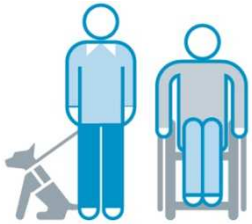


Developed in partnership – NHS and Local Government

8 changes:

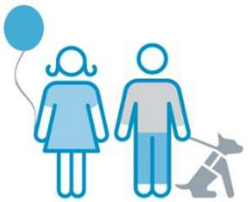
- Early discharge planning
- system change (incl. voluntary sector)
- multi- disciplinary teams
- trusted assessors
- discharge to assess
- 7 day working
- improved choice
- improved health in care homes

Self assessment nationally



What is already in place?

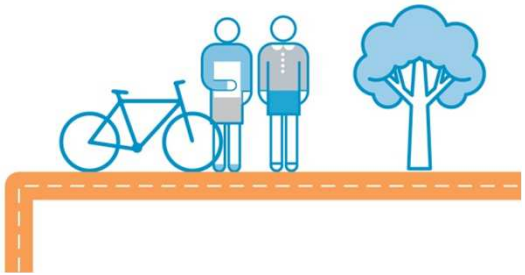
- Re-ablement service with “Good” CQC rating
- Good relationships with hospitals, GP practice, housing and other agencies
- Low delays attributed to social care
- Responsive adult social care team
- Single provider in place
- New hospital to home model



Hospital to Home (H2H)

STAFF :Two full time Reablement Coordinators (cover 7 am -7pm weekdays) backed up by commissioned domiciliary care agency (Blue Bird Care) who take on all hospital discharge referrals
Reablement service is led by Senior Occupational Therapist.
Care navigator role - liaison with wards and G.Ps.

Reablement Service offers:
Telecare /Assistive technology assessments including Fire Safety Risk assessment.
Take Home and Settle Service. This is to be taken on whilst person is an inpatient where level of complexity warrants (to be decided by Senior practitioner)
Baseline assessment with person and their family ready for transition to Social Work allocation.
Urgent Duty Home Visits as requested by Duty Senior Practitioner.
Full Reablement service in conjunction with OT.
Reablement plus – out of hours hospital avoidance – up to 72 hours support from Explora Haven – can be 24 hours a day and include adaptations and equipment

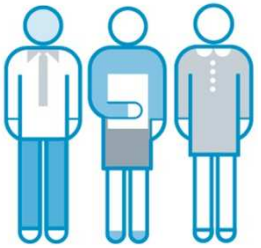


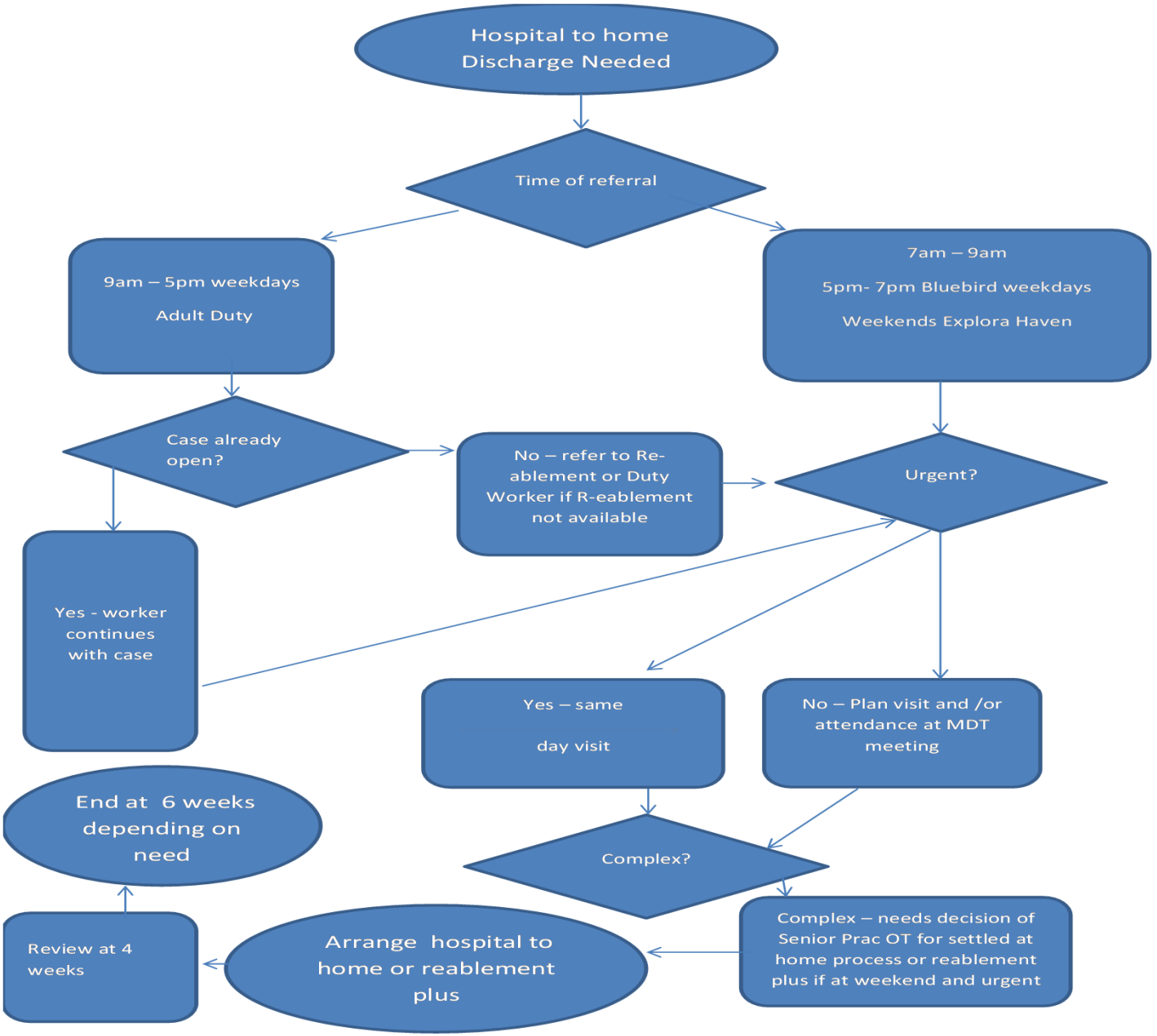
Duration:

Work continues for up to 6 weeks and is not chargeable to the service user. At week 4 any case that requires ongoing support is allocated to a social worker and assessment is completed prior to end of Reablement service (ideally conducted jointly with a Reablement Coordinator). Financial assessment is commenced at 4 week stage for anyone assessed as needing an Individual Budget.

Weekly meetings take place between Duty Senior Practitioner OT Reablement coordinator and Bluebird Care to ensure support plans are being followed effectively and outcomes measured.

CITY OF LONDON




Hospital to home Discharge Needed
Time of referral
9am – 5pm weekdays
Adult Duty
7am – 9am
5pm- 7pm Bluebird weekdays
Weekends Explora Haven
Case already open?
No – refer to Re-ablement or Duty Worker if R-eablement not available
Urgent?
Yes - worker continues with case
Yes – same day visit
No – Plan visit and /or attendance at MDT meeting
End at 6 weeks depending on need
Complex?
Review at 4 weeks
Arrange hospital to home or reablement plus
Complex – needs decision of Senior Prac OT for settled at home process or reablement plus if at weekend and urgent

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Committee(s)	Dated:
Health and Social Care Scrutiny Committee	30 October 2017
Subject: Public Defibrillators	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report author: Simon Cribbens, Head of Strategy & Performance	

Summary

This report sets out proposals to encourage more public access defibrillators within the City of London, and seeks Members comments.

Recommendation(s)

Members are asked to:

- comment on the proposed scheme.

Main Report

Background

1. Members of the Health & Social Care Scrutiny Committee have sought to clarify the current availability of defibrillators within the City and explore the opportunity to increase the number of public access defibrillators in key sites around the City.

2. Every year in the UK, around 30,000 people suffer out of hospital sudden cardiac arrest, making it one of the UK's biggest killers. There were 146 estimated cases within the City & Hackney during 2015/6 (City of London level data is not available).

3. Areas of high population density are identified as key risk areas. The City has a working population of 450,000 and an estimated 10 million visitors a year.

Current Position

4. The table appended lists the provision of recorded defibrillators within the City of London. This information is provided by the Heartsafe Charity, TFL and the Helicopter Emergency Services Equipment and may not be a complete picture. The information demonstrates that the majority of defibrillators in the City of London have limited access in that they are available during certain hours. However, it should be noted that these hours map to the peak in working population footfall. There are also a few 24/7 publicly accessible defibrillators.

5. Initial desktop research shows that no major urban local authority is directly funding publicly sited and available defibrillators. Most schemes supporting this provision are offered through charities. This approach can help address some of the issues of governance, insurance, maintenance, electricity supply, safety compliance and public liability that need to be considered and met.

6. Community and charitable schemes include the conversion of phone boxes for this purpose. Such conversion occurs through local adoption of a phone box by a community group or organisation, and tends to be community funded. There are none in the City.

7. Some retailers have schemes to make this equipment available, but these are limited in number and linked to opening hours.

Proposals

8. It is proposed that the City Corporation develop a scheme to increase the availability and distribution of 24/7 publicly accessible defibrillators in the City.

9. The pilot will be funded by £6,000 in 2017/18 from the Corporation's Public Health budget. It is proposed that the scheme will grant fund parties willing to partner with one of the charities working in this field, to ensure plans are fully considered and sustainable. It will support proposals that will provide devices that can be accessed around the clock, and will prioritise areas with limited provision and/or high footfall.

10. It is envisaged that the funding will be a contributory donation which will meet the initial capital costs (in the region of £1,500). Bidders will need to consider the sustainability of their plans as there will be some small ongoing revenue costs and maintenance needs.

11. The funding provides for a limited pilot through which the Corporation can test out the interest in this approach, and its efficacy in encouraging greater availability of defibrillators. Its outcome will used to inform future plans.

12. Members are asked to comment on these proposals.

Corporate & Strategic Implications

13. The provision of defibrillators within the City aligns with the Community and Children's Services Departmental Business Plan and the priorities of the Health and Wellbeing Board.

Conclusion

14. Publicly available defibrillators provide a vital contribution to saving lives. The proposed scheme will test out the opportunity to ensure greater coverage and availability of this essential equipment.

Appendices

Appendix 1 – Defibrillators in the City

Simon Cribbens
Head of Strategy and Performance
Community and Children's Services
T: 020 7332 1210
E: simon.cribbens@cityoflondon.gov.uk

Appendix 1 Defibrillators in the City

Occupier	Street Name/Number	Postcode	Accessibility	Number
Ardmore Construction Limited	10 Trinity Square	EC3N 4AL	24/7 unlimited access	1
Brookfield Bishopsgate	99 Bishopsgate	EC2M 3XD	24/7 unlimited access	1
Ardmore Construction Project	27-35 Poultry	EC2R 8AJ	24/7 unlimited access	1
Aberdeen Asset Management	1 Bread Street	EC4M 9HH	24/7 unlimited access	1
Broadwalk House	5 Appold Street	EC2A 2DA	24/7 unlimited access	1
Fenchurch Street Station	Fenchurch Place	EC3M 4AJ	24/7 unlimited access	1
Cannon Street Station	Cannon Street	EC4N 6AP	24/7 unlimited access	1
Liverpool Street Station	Liverpool Street	EC2M 7QH	24/7 unlimited access	1
Moorgate Station	Moorgate	EC2Y 9AE	24/7 unlimited access	1
Blackfriars Station	179 Queen Victoria Street	EC4V 4EG	24/7 unlimited access	1
ISG (side entrance)	35 Seething Lane	EC3N 4AH	Limited Access	1
Everest Reinsurance Group	40 Lime Street	EC3M 5BS	Limited Access	1
Lendlease Project Office	1 Cousin Lane	EC4R 3XX	Limited Access	1
Park House	16-18 Finsbury Circus	EC2M 7EB	Limited Access	1
Callcredit Information Group	Red Lion Buildings, Cock Lane	EC1A 9BU	Limited Access	1
NESTA	1 Plough Place	EC4A 1DE	Limited Access	1
Redrow Homes London	53 – 64 Chancery Lane	WC2A 1QS	Limited Access	1
Tesco Metro	80B Cheapside	EC2V 6EE	Limited Access	1
Mansion House Station	38 Cannon Street	EC4N 6JD	Limited Access	1
Moorgate/Liverpool Street	Moorfields London	EC2Y 9AE	Limited Access	1
St Paul Station	Cheapside, London	EC2V6AA	Limited Access	1
Aldgate Station	Aldgate High Street	EC3N 1AH	Limited Access	1
Bank/Monument Station	Princes Street	EC3V 3LA	Limited Access	8
Barbican Station	Farringdon	EC1A 4JA	Limited Access	1
Cannon Street, Mansion House	Cannon Street	EC4N 6AP	Limited Access	1
Chancery Lane, St Pauls	High Holborn	WC1V 6DR	Limited Access	1
Farringdon	Cowcross Street	EC1M 6BY	Limited Access	1
Holborn	Kingsway	WC2B 6AA	Limited Access	2

Committee(s)	**Dated:**
Community and Children's Services – For Health and Social Care Scrutiny – For information	30/10/2017
Subject: Employment for people with a learning disability	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Information**
Report author: Anna Grainger, Department of Community and Children's Services	

Summary

There are two national targets for people with learning disabilities – one for the number of people in settled accommodation and the other for the number of people with a learning disability in paid employment. Being in paid work gives a person an income and helps the economy in general. People with a disability have a right to expect the same opportunities as others. The performance for people in City of London stands at 0% out of a total of 13 people who are supported by the City. The report illustrates the measures that are being taken to assist people into employment.

Recommendation

The report is for information.

Main Report

Background

1.1 There are a total of 13 adults with a learning disability supported currently by the City of London. 6 of are in a residential or nursing placement and employment seems to be a challenge due to their complex needs. Of the remainder most are in a supported living environment (a flat with support provided) and have a varying level of needs. The adult social care team are taking a focussed approach to reviewing the possibility of each of the 13 gaining voluntary or paid employment. The report summarises the position to date.

Current Position

2.1 Each of the 13 people has been allocated a social worker to get to know their wishes – some may not want to be in employment whilst others clearly do, the positive benefits of employment will be explored with everyone. The age distribution is from age 26 to 55 with most being in their 30's.
Each worker will visit the person and speak to them and their family/care team, as appropriate, with a view to establishing a focus on employment rather than a more general care review. See Appendix One for the assessment being used.

- Contact has been made with the Tower project who have an employment and training team. They work closely with employers and Jobcentreplus so can give specialist advice and support.
- An action plan is in place to follow up the actions from the initial assessments with an aim of finding paid employment for those who want this and are work ready. Specialist support and training will be given on a spot purchased basis (i.e. support will be bought according to each individual's need to secure training to help them get work ready).
- The Tower employment project has a good record of finding employment, however they caution that for people out of the job market for a long time and with profound needs it may take up to a year or so to get them onto the first rung of the employment ladder. It is positive that around half the people of the current list mentioned above are in some form of voluntary work and therefore it is a logical next step to look for employment.
- The Special Educational Needs action plan includes actions for people coming up to adulthood to be assisted to find employment so that there continues to be a focus on this area in future.
- Two suggested apprenticeship posts within adult and children social care are being explored as a way to assist people with a disability into employment.

Implications

3.1 The action plan is being developed.

3.2 The focussed approach will determine a realistic timeline to follow to ensure that those who wish to be in employment are assisted to do so.

Appendices

- Appendix 1 – Assessment form

Anna Grainger
Service Manager, Adult Social Care

T: 020 7332 1216
E: anna.grainger@cityoflondon.gov.uk

Employment Project Initial assessment Form

Name:

Local Area:

Strengths brief pen picture of strengths and abilities
What do they like or enjoy doing?
Are they currently involved in any work, voluntary work or employment?
List previous work experience, college course qualifications
Current Support
Current Support Networks
Are there other available support networks they can tap into?
What support could the current provider give? Is there scope for changing support plans
What else is there in the local area that they could tap into? E.g. places they would like to work, schemes, social enterprises, job centres etc.

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Health & Social Care Scrutiny Committee – Annual Workplan

Members are reminded of the agenda items suggested at the 8th May meeting and the scheduled dates for future meetings of the Committee. Future agendas can be discussed at each meeting to raise any issues and to determine which topics or services should be considered at the next meeting.

Subject List Brought Forward	Date Proposed	Information	To be considered by the Committee
Employment of Individuals with Learning Difficulties	8th May 2017	Officers to confirm figures of those employed in the Corporation and the work going on the Corporation to encourage employment and address stigma.	30th October 2017
Neaman Practice	8th May 2017	The GP practice to reassure the Committee of arrangements after Dr Vasserman's departure	Proposed for February 2018 meeting
Sexual Health Transformation for London	8th May 2017	An overview of the London-wide transformation of sexual health services	Proposed for February 2018 meeting
Royal London Dental Hospital/Barts Health	8th May 2017	Officers to look into and see if a report could be presented regarding appointments systems.	TBC
Update on Changes to Cancer Services	8th May 2017	Members requested an update on the changes to cancer services be provided at a future meeting	TBC
Post-election Health Announcements	8th May 2017	Headline changes to be circulated electronically to the Committee after elections, and details to be presented when available.	Ongoing

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

HELD AT 6.30 P.M. ON MONDAY, 26 JUNE 2017

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)	INEL JHOSC Representative for Tower Hamlets Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representive for London Borough of Hackney
Councillor Sabina Akhtar	INEL JHOSC Representative for Tower Hamlets Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Susan Masters	INEL JHOSC Representative for Newham Council

Others Present:

Paul Binfield	(Personal and Public Involvement representative)
Selina Douglas	(Deputy Chief Officer, Clinical Commissioning Group for Newham)
Rhiannon England	(Mental Health Clinical Lead, Clinical Commissioning Group for City and Hackney)
Richard Fradgley	(Director of Integrated Care, East London NHS Foundation Trust)
Steve Gilvin	(Chief Officer, Clinical Commissioning Group for Newham)
Paul Haigh	(Chief Officer, Clinical Commissioning Group for City of London and Hackney)
David Maher	(Deputy Chief Executive & Programme Director)
James McMahon	(Programme Manager, East London Health and Care Partnership)

Jane Milligan	(Executive Lead, East London Health and Care Partnership)
Ian Tompkins	(Director of Communications and Engagement, East London Health and Care Partnership)

Officers Present:

Daniel Kerr	–	Strategy, Policy & Performance Officer
Denise Radley	–	(Corporate Director, Health, Adults & Community)
Joseph Lacey-Holland	–	Senior Strategy Policy & Performance Officer
Anthony Jackson	–	(Committee Services Officer)

1. APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Chair welcomed everyone to the Committee and asked for introductions.

2. DECLARATIONS OF INTEREST

Councillor Ben Hayhurst, from Hackney Council, declared a pecuniary interest as he sat on the Council of Governors at Homerton Hospital.

3. MINUTES

The Committee agreed the minutes of the meeting, held on 19 April 2017, subject to the following amendment:

On page 2, Denise Radley – Corporate Director of Health, Adults and Community being added to the list of officers present.

4. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; ACCOUNTABLE CARE SYSTEM

Jane Milligan, Executive Lead for the North East London Sustainability and Transformation Plan (NEL STP) introduced this item. She pointed out that there had been minor updates to the item which had been circulated. She confirmed that, nationally, there had been a significant amount of discussion on the subject of accountable care and that a lot of work had been done, some under the banner of devolution. She confirmed that, at some point soon, there would be a clear taxonomy, whilst pointing out that the population base was important when considering how to deliver the plan.

Paul Haigh, Chief Officer of the Clinical Commissioning Group for the City of London and London Borough of Hackney, stated that there were four work

streams that brought together commissioners and providers. Mr Haigh confirmed that the work streams would look at the totality of funds and would identify exactly what they were trying to achieve.

Selina Douglas, Deputy Chief Officer of the Clinical Commissioning Group for the London Borough of Newham, confirmed that the building blocks for integrated care were in place and that they needed to consider how it would be taken forward. She referred to the fact that the CCG in Newham was hoping to streamline their services and pointed out that it was important that all concerned were working towards the same goal. Ms Douglas explained that they were hoping to significantly transform the service in July 2017.

Steve Gilvin, Chief Officer of the Clinical Commissioning Group for the London Borough of Newham, referred to the challenging position they were in and stated that it was important to step away from the system of financial incentives.

Councillor Munn referred to page 17 of the revised slides, specifically no.5 in the list of questions that the WEL ACS had asked themselves – "how should we go about the move to an ACO/ACS (assuming we agree that we want to)?" Councillor Munn asked why they would not want to move to an ACO/ACS. She also referred to no.14 and enquired whether they had come up with any solutions. Ms Douglas stated that it was important to adopt a different approach however she conceded that they were not sure what that approach might look like. She confirmed that the focus would be on integrated care and that a system framework needed to be developed on accountability. She stated that they would want the system framework to be as borough-based as possible.

Councillor Masters referred to the circulated revised document and asked how the London Borough of Newham felt about the prospect of capitalised budgets. Mr Gilvin stated that the London Borough of Newham already had capitalised budgets and gave the view that this was an opportunity to look at how they worked with providers. He stated that the funds were for the public and therefore needed to be spent in the appropriate way to potentially achieve financial viability. Mr Gilvin confirmed that an in-principle view had been given on how the money would be spent, but stated that a lot more detail was required before there was confirmation.

Councillor Masters asked for an explanation of Primary Care at home. Ms Douglas responded that there were a number of budgets nationally for Primary Care at home and that work was underway with care practitioners to decide the best way forward. She gave data as an example, stating that it needed to be decided how it would work, what systems would be used and how to make the information that becomes available meaningful for the ACS. Ms Douglas then referred to the importance of having a system that provided the desired outcomes and that each area was organised around the needs of the population.

Ms Milligan confirmed there were similar models in Tower Hamlets around supporting integrated care – including mental and physical health. She pointed out that it was important to ensure there was a learning platform in not just inner London, but also Outer London. Ms Milligan explained that there was a big focus on prevention and that they were moving forward in terms of implementation.

Denise Radley, Director of Adult Services, explained that Tower Hamlets Council was very much focussed on Tower Hamlets Together as a core partnership. She also confirmed that there had been significant investment in developing a new framework, however they were not yet in the position where a detailed model could be agreed.

Councillor Hayhurst asked if it was planned to take funding allocated to the CCG and redistribute that sum around the three ACS. Mr Gilvin confirmed that there was a borough based partnership with the aim to deliver that approach. He stated that the London Borough of Newham would prefer a borough based arrangement as the Council was trying to move away from compartmentalisation.

The Chair agreed that compartmentalisation was one of the risks when three such models were developing. She then asked for some detail on the London Borough of Hackney's approach. Mr Haigh explained that the London Borough of Hackney's model had emerged from devolution and was similar to the models of the other boroughs represented at this meeting. He stated that the Council preferred a borough based model around a set of outcomes.

Ms Milligan stated that payment per item did not support a partnership approach. She said that it was important to identify a number of key thresholds as this would add extra benefit. She also explained that it was important to find a way to develop whilst ensuring that, for example, urgent primary care was available without the need to attend Accident and Emergency. Ms Milligan stated that the biggest challenge was the fact that they do not know what the outcomes will look like. Mr Gilvin added that, with this approach, there was a risk that it would not incentivise clinicians to do right by their patients. He also said that providers needed to be financially viable going forward. The Chair enquired as to whether he was referring to care providers only and Mr Gilvin responded that a comprehensive piece of work was required on this subject.

Ms Radley referred to discussions that had been had at Tower Hamlets Council on the broader social care market. She stated that, should accountable care be integrated, then it would need to focus on the broader social care market.

Councillor Hayhurst stated that he was concerned that the local authority and CCG would lose control as things progressed and asked for clarification on timescales in relation to the budget. Ms Milligan explained that CCG had statutory decision making powers and that the timescales were being

developed. She said that by December 2017 it was important to have reached an understanding of what the timescales would be as the plan was to test the proposals by 2018/19.

Councillor Hayhurst asked for thoughts on Hackney Council's proposal to pool all relevant budgets. Ms Milligan confirmed that there was a commitment to integrated budgets. She stated that it was important to consider where resources should be allocated to be most effective. She pointed out that providers might need support in order to get the best outcomes.

Councillor Hayhurst referred to the fact that there was a budget shortfall and expressed concerns at the proposal to re-evaluate and come up with a new system when the money to fund that system was not available. Ms Milligan explained that previous experiences had yielded positive outcomes and said that there was evidence that such approaches had a positive impact. She gave dementia as an example.

Councillor Masters asked what proportion of local budgets would be included in the ACS for Newham and Tower Hamlets Councils. Mr Gilvin explained that the proportion would depend on the range of acute services that would be provided. He confirmed that further discussions were needed on this subject.

Councillor Masters referred to a task and finish group that had been set up and asked whether it had completed its work and for clarification on who was on the group. Mr Gilvin confirmed that the group ensured structured collaboration. He explained that it was the intention to liaise with all community providers within the London Borough of Newham. He said that work had commenced, however, there was some further work required on establishing the sub-groups which would sit beneath the task and finish group.

Councillor Masters then asked whether a strategy had been developed for ACS proposals. Mr Gilvin stated that, as a test, a number of events had been organised in Stratford in order to develop a strategy. He said the next stage was how the ACS would deliver the strategy.

Action: Councillor Masters asked that a list of all the working groups be provided to Members of the Committee.

5. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; MENTAL HEALTH

Ms Milligan introduced this item, together with Mr Fradgley, and explained that the report would provide Members with an overview of the work being undertaken to develop mental health services as part of the North East London Sustainability and Transformation Plan.

Mr Fradgley referred to the fact that there was now significant drive to make mental health a national priority. He stated that investment in that area was needed as much as it was in acute illnesses. Mr Fradgley then explained that

inner North East London had the highest level of mental illness in the country and that there was significant increasing demand for mental health services. He also stated that there had been a 10% increase in those with mental health issues requiring primary care and that it was expected that that growth would continue. Mr Fradgley highlighted the fact that good mental health services were provided in inner North East London and that they were leading the way in terms of innovation.

Mr Fradgley pointed out that they were focussing on mental health inequality and the fact that mental health issues were often a problem for those with complex needs. He confirmed that 51% of those with complex needs had a mental health problem. He also pointed out that East London NHS were focussing on improving access to talking therapies for those from BME communities.

Mr Fradgley then referred to the following key priorities for East London NHS around mental health:

- Improving the number of mental health sufferers in the inner North East London area
- Suicide prevention
- Helping those with mental illnesses to find employment
- Improving access and parity in relation to mental health services (whilst keeping the waiting list to two weeks)
- Considering how mental health would fit into the ACS system

Mr Fradgley went on to explain that approximately 50% of those individuals who were known to mental health services were under 65 years old. He stressed the importance of ensuring mental health services were not placed at risk and the need to give due consideration to how the above priorities would be delivered.

Rhiannon England, Mental Health Clinical Lead for the City of London Corporation and the London Borough of Hackney, referred to the innovative models that they had developed. She pointed out how important such services were as there was a high need for mental health services due to the high levels of deprivation in the borough concerned. Ms England stated that there was a very strong level of primary care in her boroughs and that a particular area of interest and focus was frequent users of primary care services. She pointed out that many frequent users had a mental health problem.

Ms England also referred to the difficulty in balancing good patient care with a lack of funding. She confirmed that inner North East London could learn from the outer North East London boroughs in relation to crisis care. She explained that the number of children and young people requiring crisis care was small and thus, it was difficult to provide a good service. She stated that a 24 hour crisis phone line was a consideration and could potentially make the service more efficient and effective.

Paul Binfield, Personal and Public Involvement (PPI) representative, referred to a set of priorities set by PPI, including the fact that there was a significant amount of work needed to challenge an existing stigma around mental health which he described as a big barrier. He referred to a project currently being implemented involving a mental health worker engaging with the public on the Docklands Light Railway. He also explained that there was work being undertaken to raise awareness of mental health issues. Mr Binfield pointed out that clinical work was only one aspect and that it was also important to consider social and health education.

Mr Binfield stated that considering practical options was also a priority, such as assisting users of the service to find employment. He gave an example of certain individuals using the PPI service and being trained to become fitness instructors.

Mr Binfield confirmed that PPI had a wealth of experience and expertise on how to engage people on the subject of mental health. He offered that expertise to other organisations represented at the meeting to assist in delivering positive outcomes and explained the importance of a community approach to mental health issues.

David Maher, Deputy Chief Executive & Programme Director for the City and Hackney, explained the importance of allowing people with mental health issues to live normal and independent lives. He referred to the issue of substance abuse, giving the view that the issue should sit with public health and pointed out that relevant organisations had an opportunity to undertake joint work on this issue. He stated that everyone involved should be proud of the work that has been done by this committee.

The Chair agreed that linking up relevant systems was important, especially in relation to individuals with mental health problems having access to housing and employment. She referred to the fact that there were many undiagnosed people with mental health problems and pointed out that finding new methods of accessing relevant services was paramount.

Councillor Maxwell referred to page 2 of the report which stated “The Development of additional psychological therapies so that at least 19% of people with anxiety and depression access treatment…” She asked how that 19% was prioritised and what would happen to the remaining 81%. Mr Maher explained that they work closely with providers to prioritise and explained the importance of ensuring there was a system in place for people to rise through the system should their mental health needs escalate.

Ms England suggested that that the system be prescribed and evidence-based as many people might show recovery from mental health symptoms in ways that are unseen by relevant professionals, for example, faring better in relationships or gaining employment. She also pointed out that housing was a big problem for many suffering from mental health and stated that the solution

for many might not be prescribed medication, but a more practical solution such as access to housing.

Councillor Masters asked how mental health was being integrated into GP services. Mr Gilvin confirmed that there were additional mental health services from General Practitioners and that practices were being consolidated which was helping to improve quality.

Councillor Hayhurst asked whether they were a victim of their own success. Mr Fradgley explained that they had experienced success in reducing the length of patients' stay, however, given the financial situation with regard to the NHS, it was important to consider how beds would be managed in the future. Councillor Hayhusrt asked whether there was a possibility of consolidating sites and Mr Fradgley responded that there were no plans for consolidation and that they were looking at available options.

Councillor McAlmont referred to highest spend per head, saying that the trend seemed to be upwards for the London Boroughs of Newham and Tower Hamlets especially. He asked what was being done and how much was being spent on prevention. In response, Mr Binfield explained that part of a nurse's role was to provide support to whoever came in to them. He also said that challenging the stigma associated with mental health would go a long way to raising awareness and encourage people to seek help earlier.

Councillor McAlmont asked for a breakdown of the number of mental health sufferers who were in employment. Mr Binfield confirmed that approximately 5% of mental health sufferers were in employment, compared with 8% nationally. He stated that there was a need to look at the strategic priority. Mr Binfield added that Job Centre staff in the London Boroughs of Hackney, Newham and Tower Hamlets were being trained to identify mental health issues.

The Chair stated that BME communities were a hard to reach group in terms of mental health and asked why there was such a low take up on talking therapies. Councillor Beckles agreed and pointed out that some communities had their own stigmas. He asked what was being done to alleviate the issue. Mr McMahon explained that there was a work-stream being developed around prevention and workplace prevention. He said that he hoped that this issue would be looked at as part of the work-stream and that they were considering their approach. He added that the plan was to look at establishing a work place health charter for smaller organisations. Ms England confirmed that there was a lot of work being undertaken on the BME community. She expressed the importance of looking at recovery rates as those of the Turkish and Kurdish communities very low. Mr Maher said that recovery rates were very low for the Turkish community when IAPT talking therapies were used, however he pointed out that when local engagement methods were used, such as gardening, recovery rates were excellent.

Mr Binfield explained that they were working closely with the Metropolitan Police, whilst explaining that some boroughs were more receptive than others. He stated that the national Police did not receive adequate training on mental health however he said that the situation was improving. Mr Maher referred to a pilot that was currently running on street triage. Councillor Beckles asked if those participating in the pilot were trained. Ms England confirmed that those involved were mental health professionals who were receiving training by observing on the job.

6. URGENT BUSINESS

Accountable Care Officers

The Committee was informed by the NHS that they were recruiting a single Accountable Care officer for Inner North East London and Members requested a discussion on the subject, as the appointment could potentially represent challenges to local accountability of health services.

Councillor Munn expressed concerns about the removal of accountable care officers from individual CCGs. She explained that if there was just one Accountable Officer, this would change the way the NHS operated with little transparency or legal basis for the change.

Councillor Hayhurst pointed out that the loss of Accountable Care officers could potentially result in a lack of local control and leadership.

Councillor Masters concurred with Councillors Munn and Hayhurst. She added that she was concerned that there was not a clear breakdown of what issues would be dealt with at the Accountable Care officer level.

Ms Milligan explained that the removal of Accountable Care officers had not yet been agreed by CCG Boards as it was still at the design stage. Mr Haigh added that they were still in the early stages of discussion and confirmed that firm proposals would be put to each of the CCG bodies in July 2017. He added that the change of the management process was complicated and how the ACS would be regulated needed to be considered. He stated that the relevant budget would stay with the CCGs and that the only way the budget could move would be via risk share. He stressed the importance of transparency around how the money would be spent.

Ms Milligan explained that it was intended to work closely to try and free up resources and time to support borough developments. She added that the proposed singleAccountable Care Officer would benefit Londoners. She referred to the fact that there were challenges concerning the addresses of patients with larger providers. She said that local arrangements were not necessarily being moved.

The Chair gave the view that local authorities needed to be involved in relevant discussions and should be considered a key partner.

Councillor Munn asked for an explanation on the duties undertaken by an Accountable Care officer. Mr Gilvin explained that the role was set out in their constitution, however, he confirmed that the officer's powers were those delegated to them by the CCG. He added that clarity was needed around the arrangement of functions and stated that a strong commissioning team would be required.

Councillor Hayhurst stated that a formal case for the proposals should be put before this committee and asked for a commitment that this would happen as, otherwise, the committee would be signing off a model which had not been subject to scrutiny. Ms Milligan explained that timelines were still being worked out. Mr Gilvin confirmed that he would take councillors' comments back to relevant officers for discussion.

The meeting ended at 8.45 p.m.

Chair, Councillor Clare Harrisson
Inner North East London Joint Health Overview & Scrutiny Committee

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