Public Document Pack

Health and Social Care Scrutiny Committee

Date: **TUESDAY, 13 FEBRUARY 2018**

Time: **11.00 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**
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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 30 October 2017.

For Decision
(Pages 1 - 6)

4. **GP SERVICES IN THE CITY**
Report of City and Hackney CCG

For Information
(Pages 7 - 50)

5. **UPDATE ON CHANGES TO CANCER SERVICES AND BREAST CANCER SCREENING**
Report of NHS England

For Information
(Pages 51 - 70)

6. **PROPOSAL TO MERGE CEDAR LODGE WITH THAMES HOUSE**
Report of City and Hackney CCG

For Information
(Pages 71 - 82)

7. **UPDATE ON TRANSFORMATION OF LOCAL SEXUAL HEALTH SERVICES**
Report of the Director of Community and Children's Services

For Information
(Pages 83 - 88)

8. **INNER NORTH-EAST LONDON UPDATE**
Includes the minutes of Thursday 9 November 2017 INELJHOSC meeting.

For Information
(Pages 89 - 96)

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

For Information
(Pages 97 - 98)

10. **ANNUAL REVIEW OF TERMS OF REFERENCE**
Report of the Town Clerk

For Decision
(Pages 99 - 100)

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**
To agree the non-public minutes of the meeting held on 30 October 2017.

For Decision
(Pages 101 - 102)

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, 30 October 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 (Chairman)	Vivienne Littlechild
Michael Hudson	Steve Stevenson

In Attendance:
Louise Crosby – St Bartholomew's Hospital

Officers:

Joseph Anstee	-	Town Clerk's Department
Simon Cribbens	-	Community & Children's Services Department
Farrah Hart	-	Community & Children's Services Department
Anna Grainger	-	Community & Children's Services Department

1. **APOLOGIES**
Apologies were received from Chief Commoner Wendy Mead, Alderman Alison Gowman and Emma Edhem.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
Vivienne Littlechild and Steve Stevenson declared standing interests by virtue of being residents in the City of London.

3. **MINUTES**
RESOLVED – That the public minutes of the meeting held on 8 May 2017 be agreed as a correct record.

Matters Arising

Neaman Practice
The Director of Community & Children's Services advised that a new doctor was in post following the departure of Dr Vasserman. It was suggested that the Practice Manager be invited to the next meeting in February 2018.

4. **CQC INSPECTION OF ST BARTHOLOMEW'S HOSPITAL**
The Committee received a report of the Care Quality Commission (CQC) following their inspection of St Bartholomew's Hospital in May 2017. The Committee welcomed the Director of Nursing at St Bartholomew's to the meeting and invited her to introduce the report.

Members were advised that the hospital had changed significantly since its previous inspection in 2013, having undergone a merger of cardiovascular services in April 2015, and much building redevelopment that was completed in October 2016. The hospital had around 450 beds, a respiratory ward and a specialist endocrinology unit, employing around 1200 staff including 870 nurses, following recent recruitment campaigns. This was the hospital's first inspection in their new remit as a specialist hospital for cancer and cardio services.

The Committee noted that the CQC's framework was designed for inspecting General Hospitals. Four core services of the hospital were marked against five indicators: Safe, Effective, Caring, Responsive and Well-led. Each of the core services was rated as good. The hospital was pleased with the outcomes but had taken note of the recommendations for improvement they had received, and were putting action plans in place to make the required improvements. Progress over the last 2 years was pleasing and the hospital's target was an outstanding rating in their next inspection.

In response to a question from a Member about the impact of the UK leaving the European Union on staffing, the Director told the Committee that there would not be a huge impact but it was something that would need looking at. The hospital's reputation was improving which made it easier to retain more high-quality nurses. The hospital had recruited many nurses from the Philippines over the last 18 months. Whilst this was expensive as they required training and assessment, these nurses tended to stay long-term and were of a high standard. Recruiting British nurses had become more difficult in recent years nationally, but the hospital was working on ways to combat this.

The Committee voiced their disappointment that parts of the CQC report did not comply with RNBI type standards, as the grey colour and size of the type was difficult to read, and asked officers to communicate this to the CQC.

In response to a question from Members, the Director told the Committee was generally good at treating sepsis and mortality was very low. The hospital was working hard on its implementation and monitoring of the sepsis six programme, and on improving their 'did not attend' rate.

The Committee thanked the Director for coming to the meeting and congratulated them on their positive inspection results.

RESOLVED – That the report be noted.

5. **CITY OF LONDON HEALTH PROFILE**

The Committee received a report of the Director of Community and Children's Services concerning the City of London Health Profile. The Health Profile had been produced by Public Health England. Whilst it was not completely reliable due to the small sample size of City residents, it provided a good starting point.

There were several red indicators, but the majority of these were caused by small sample sizes or the City's figures being merged with those of the London

Borough of Hackney. There was an issue around sexual health, as the figures were affected by City workers using their work postcodes to access sexual health services. The breast cancer screening figures were a possible concern, and the Committee requested that information on this be brought to the next meeting with the update on cancer services. The Committee noted that the Health Profiles were published annually and they would be able to make comparisons and see trends in future years.

RESOLVED – That the report be noted, and a report on breast cancer screening in the City be brought to the next meeting.

6. **HOSPITAL DISCHARGE**

The Committee received a report of the Director of Community and Children's Services concerning Hospital Discharge. There was a national emphasis on discharging from hospital in a timely and efficient manner and the adult social care team worked closely with the NHS to ensure a smooth admission and discharge process for all hospitals in the area. The Corporation aimed to maintain its good performance on DTOCs (Delayed Transfers of Care) and reduce numbers as far as possible. A key part of the team was the reablement service, rated as Good by the CQC, and the care navigator role in place to work between the team and the hospitals. The Reablement Plus service provided extra support including out-of-hours services.

In response to a Member's query, the Director of Community and Children's Services told the Committee that the reablement team had an occupational therapist in place to assess the needs of residents living in flats and maisonettes who would have a problem with stairs. Advance planning was key to success, and whilst there were sometimes issues, the adult social team was always looking to learn from them and improve.

RESOLVED – That the report be noted.

7. **PUBLIC DEFIBRILLATORS**

The Committee received a report of the Director of Community and Children's Services concerning public defibrillators. The report set out the provision of recorded defibrillators within the City and proposals to encourage more public access defibrillators within the City of London. The Director of Community and Children's Services circulated a map to Members demonstrating the locations of the defibrillators already in place.

The Corporation wanted to increase the availability and distribution of 24/7 publicly accessible defibrillators in the City, and had prepared a budget to grant fund parties willing to work with one of the charities working in this field. Officers planned to meet with the Community Heartbeat Trust, to explore the ability of such an organisation to support the proposals with their knowledge of the governance and security implications of increasing the provision of defibrillators. Members were supportive of the proposals, and made suggestions for promoting the scheme and increasing the awareness of currently available defibrillators.

RESOLVED – That the report be noted.

8. **EMPLOYMENT FOR PEOPLE WITH A LEARNING DISABILITY**

The Committee received a report of the Director of Community and Children's Services concerning the employment of people with a learning disability. There were 13 adults with a learning disability currently supported by the Corporation, but none were in paid employment. The adult social care team was currently doing focussed work to assess needs, with the aim of getting one or more into paid employment. Some were doing voluntary work which would not be disrupted if it was beneficial.

Members commented that mental health in employment was not given parity of esteem and discussed how the Corporation could improve in this area. Learning disabilities were very wide-ranging with regards to their impact on a person's employability, and could not always be monitored, as difficulties such as dyslexia were self-reported and were not always disclosed. Members suggested revisiting the item at the next meeting to discuss how the Corporation was supporting any employees with learning disabilities.

RESOLVED – That the report be noted.

9. **ANNUAL WORKPLAN**

The Committee received a report of the Town Clerk updating them on the annual workplan as mentioned under 'Matters Arising'. The Committee requested that the Neaman Practice be included on the agenda for the next meeting, and the Practice manager be invited to the meeting. The Committee also asked that information on the Leadenhall local service be included with the item proposed for the next meeting regarding Sexual Health Transformation for London.

RESOLVED – That the annual workplan be noted and would be updated ahead of the next meeting.

10. **INNER NORTH EAST LONDON UPDATE**

The Committee received the minutes of the last meeting of the Inner North-East London Joint Health Overview and Scrutiny Committee. The Director of Community and Children's Services informed the Committee that an Accountable Care Officer was in the process of being appointed, and the Committee could invite them to a future meeting to explain their role and where the City fit in to that. The proposal would replace the current CCG officer for East London. The Director of Community and Children's Services would continue to update the Committee on the North-East London Sustainability and Transformation Plans.

RESOLVED – That the minutes of the last INELJHOSC meeting be noted.

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

Members raised concerns about the delay to development work at Great Arthur House and its impact on the health of nearby residents. The Director of Community and Children's Services noted Members concerns and asked that any concerns about particular individuals be reported.

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

13. **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)
14	3

14. **NON-PUBLIC MINUTES OF THE PREVIOUS MEETING**
RESOLVED – That the non-public minutes of the meeting held on 8 May 2017 be agreed as a correct record.

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

16. **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 1.10 pm

Chairman

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Committee(s):	Date:
Health and Social Care Scrutiny Committee	13 February 2018
Subject: GP Services in the City	**Public**
Report of: City and Hackney CCG	**For Information**

Main Report

As part of the Committee's Annual Workplan, Members have requested information about the City of London's GP practice, the Neaman Practice, and further information on GP services in the City. At Committee we will welcome the Neaman Practice's Practice Manager, Sue Neville, and Richard Bull, Programme Director for Primary Care at the City of London and Hackney Clinical Commissioning Group (CCG) to speak with the Committee about GP services.

The Committee has been provided with a briefing paper by the City and Hackney CCG, containing questions and answers about the Neaman Practice and City of London GP services. This is supplemented by a draft outline Neaman Practice Options Appraisal scoping paper, supported by statistics and information about the practice.

Recommendation(s)

Members are asked to note the report and briefing papers provided.

Appendices

- Appendix 1 – Briefing on Primary Care Access
- Appendix 2 – Neaman Practice Data Pack
- Appendix 3 – The Neaman Practice – General Practice Profile

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Briefing on primary care access for City of London Health and Social Care Scrutiny Committee 13 Feb 2018

This briefing is made up of a compilation of relevant questions and answers posed by City Healthwatch and a local comms piece on 111/Out of Hours. It is supplemented with a draft outline Neaman Practice Options Appraisal - Scoping Paper with associated supporting information packs.

Questions from City Healthwatch (7 Dec 2017) with C&H CCG responses

Which practices serve City residents?
73% are with a C&H CCG Practice

- The Neaman Practice

16% Tower Hamlets CCG

- *Whitechapel Health (branch): TH
- *City Wellbeing: TH
- Tower Practice: transferring to TH
- *In Jan 2020 Whitechapel Health and City Wellbeing GP Practices will be moving to a new circa 1250m2 healthcare facility in the Goodman's Fields area.

6% Camden CCG

- St Philips: Camden

3% Islington CCG

- Grey's Inn MC: Islington
- Clerkenwell MP: Islington

1% Central London CCG

There is anxiety about pressure on the Neaman practice as a result of the expansion of the local population. Can you bring us up to date on any proposals to increase the size of the premises and the number of doctors?
The CCG is sharing plans with CoL planning dept. re new developments over the next 10 years.

Convening a task and finish group to look at the available options – see appended draft scoping paper.

The practice is looking at alternative ways of working/staffing mix to meet need as well as:

(1) Looking at internal systems inc. phones – have 4 receptionists on the phones at busiest times
(2) Receiving support by the local GP Confederation
(3) Introducing Doctor First (telephone triage and treat)
(4) Offering active signposting
(5) Offering online consulting
(6) Trying to widening out Practice Participation Group to reflect the patient profile
(7) Hosting a trainee practice manager
(8) Undertook a resilience self-assessment using a national tool
(9) Offering Patient On-Line (online booking, repeat prescription ordering, etc)

While the CCG monitors access to hospital services in some detail, for example waiting lists and times, what monitoring is undertaken as far as access to general practice is concerned? Does any system check the waiting time for non-urgent appointments, or indeed the performance in delivering urgent care – a requirement or request for treatment within hours or within 24 hours?
There are no national measures of demand and supply – however practices are contractually obliged to meet reasonable needs.

A proxy measure for supply is the numbers of GPs per patient ratio; we know our GPs are being productive ref our good outcomes on quality dashboard.

A proxy for demand is national patient pt survey (satisfaction measures, etc). Practices will soon be able to analyse their own demand and supply data in-house with new software.

It is understood that the CCG is making attempts to introduce additional out of hours' capacity. How is this proceeding in relationship to City residents? Is information going to be made available to patients, or only to practice reception staff?
The Neaman Practice already offers some extended hours on top of its core opening hours of 8-6.30, Mon-Fri, excluding Bank Holidays.

Three sites have been selected for C&H's South Hub: The Hoxton Surgery N1 5DR, Richmond Road Medical Centre Surgery E8 3HN and Neaman Practice EC1A 7HF. Hoxton and Richmond Road are planned to open early Feb 18 with Neaman planned to open early Apr 18. The final configuration of opening days and times is currently being determined although the initial configuration will be reviewed in light of patterns of use and patient feedback.

NHS England (London) is setting a new minimum standard for 2018/19 of thirty minutes of consultation timer per thousand population.

The CCG's 18/19 central allocation for 8-8 is yet to be confirmed but is likely to be in the region of £1.3m. This is against an 18/19 costed delivery plan of circa £1.4m. The local delivery plan will be scaled back to match the available budget but it is anticipated that the CCG will still be able to meet all minimum standards include the new 30m per 1000 population standard.

Questions about newly contracted NHS 111 system/GP Out-of-Hours

Do you have an exact date for when the new service will start?
The new service will commence by August 2018, detailed planning for this is currently underway.

When a resident is feeling unwell and calls the service out of hours, who will they speak to when they first call up?
The call will be answered initially by a call handler who has been trained to use the NHS's clinical assessment tool. If further clinical advice or assessment is needed the call handler will then transfer the call to the appropriate clinician which will include GP's, Nurses, Paramedics, Pharmacists.

Will the current local GP out-of-hours services end when the new NHS 111 service begins?
The CHUHSE contract has been extended to December 2018 and will continue until the new integrated urgent care 111 and clinical assessment goes live.

The new integrated urgent care 111 and clinical assessment service will include the telephone assessment and advice previously provided by GPOOH. Once the new integrated urgent care 111 and clinical assessment service goes live the full GPOOH service will not continue in its current form. The face to face appointments with GPs in the out of hours period will continue to be provided locally for patients that need it and the CCG is in the process of setting up this service. There is no plan for double running the GP OOH telephone service with the new integrated urgent care 111 and clinical assessment service.

In what circumstances will someone who calls 111 speak to a clinician?
The call will be answered by a call handler who has been trained to use the NHS's clinical assessment tool. If further clinical advice or assessment is needed the call handler will then transfer the call to the appropriate clinician which will include GP's, Nurses, Paramedics, Pharmacists. In addition to this calls relating to under 1's and over 75's will go directly through to a clinician.

How many GPs and healthcare professionals will be covering a single NHS111 out-of-hours shift per patient population across NEL?
Clinicians – which includes GPs, pharmacists, paramedics, nurses will be available 24 hours a day and the number of staff available will be according to predicted demand.

Does the service include home visits of any kind for specific groups of people?

As part of the new integrated 111 and clinical assessment service, if it is indicated that a home visit is required the service will be able to book an appointment for the patient to be seen at home.

Will there be locations in the local area where people can be seen in person by a GP outside of normal GP hours?
As part of the new integrated 111 and clinical assessment service, if it is indicated after a clinical assessment that a face to face appointment is required the person will be booked into the most appropriate setting according to their need

Are there plans to introduce a digital initial triage system as part of the contract?
Yes NHS 111 Online, is a national digital triage services that enables people to enter their symptoms and receive tailored advice, or receive a call back from a healthcare professionals where appropriate. We have introduced this service in part of NEL and are looking to roll this out to the rest of NEL to ensure equity of access to patients.

Richard Bull
Programme Director – Primary Care
City and Hackney CCG
26th Jan 2018

Neaman Options Appraisal - Scoping Paper DRAFT

Supporting information:

- Practice demography and trends including population expansion (attached)
- Current performance (attached)

Options to be considered to improve access (physical access and ability to get an appointment):

- Current location and scope for expansion on-site (new space to become available in 18 months' time)
- when new peace becomes available
- Other possible locations
- Branch-practice
- Neighbouring practices/catchment areas
- The Neaman Practice's current plans to improve access/new ways of consulting/practice skill mix
- Cost/affordability - premises costs are currently £471k pa which equates to £51 per patient against a CCG average of £18 per patient

Invitees to initial options appraisal meeting (6th March?):

1. Richard Bull, Primary Care Programme Director, C&G CCG
2. Mark Rickets, Primary Care Clinical lead, C&H CCG
3. Ellie Ward, Integration Programme Manager, City of London Corporation
4. Dr Chuan, GP Partner, The Neaman Practice
5. Sue Neville, Practice Manager, The Neaman Practice
6. The Neaman Practice's Patient Participation Group representative
7. City Healthwatch

Optional:

8. C&H GP Confederation
9. NHS England

Richard Bull
24th Jan 2018

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The Neaman Practice data pack

Contents

C&H CCG's Primary Care Quality Dashboard (PCQD)

The PCQD is a CCG created consolidated database of 23 indicators, the data for which have been aggregated at practice level to give an overview of the quality of primary care in City and Hackney.

The CCG rebases data for each indicator against the C&H benchmark to give an overall quality score for each practice. Neaman's overall PCQD score is 77.4, above the C&H average of 76.1. Neaman is above the National and London benchmarks when aggregated across all 23 indicators.

The table below shows Neaman's performance against each indicator.

No.	Indicator	Data Source	Interpretation	Neaman	C&H	London	England
1	Satisfaction with the quality of consultation at the GP practice (aggregate of 7 quality Q's)	GP Patient Survey (GPPS)	Higher is better	639.5	609.4	602.8	627.1
27	% patients that would recommend their GP to friends and family needing the same or similar treatment.	Friends & Family Test	Higher is better	90.8	90.2	86.4	88.4
3	Satisfaction with accessing primary care (aggregate of 3 access Q's)	GPPS	Higher is better	257.0	245.7	233.5	241.6
28	% LTC patients feeling supported to manage own condition	GPPS	Higher is better	67.8	59.6	57.6	63.1
5	% rating overall experience of GP surgery as very good or fairly good	GPPS	Higher is better	88.2	83.9	80.9	85.2
6	Mental health aggregate measure	QOF (3 Indicators)	Higher is better	271.6	269.0	263.5	267.6
7	Women receiving 6 week post-natal check, % of whom are screened for post natal depression	Clinical Effectiveness Group (CEG)	Higher is better	89.5	97.5	n/a	n/a
33	% SMI patients above threshold level (BMI ≥30; Qrisk ≥20%; alcohol use audit c score of ≥8; non-prescribed drug use; identified as a smoker at review) who have been offered a lifestyle intervention by the practice.	CEG	Higher is better	50.0	68.2	n/a	n/a
9	C&H GP referred first OP attendance (rate per 1000 registered population)	Hospital Episodes Statistics (HES)	Lower is better	292.4	248.2	375.4	393.1
10	Number of new cancer cases treated, % of which are two-week referrals	Public Health England (PHE)	Higher is better	65.4	52.9	47.7	48.4
11	% patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the past five years	QOF	Higher is better	69.8	79.3	78.5	81.4
29	% of children on the universal partnership plus (UPP) register who have an action plan	CEG	Higher is better	100.0	97.4	n/a	n/a
34	Immunisations by 24 months aggregate measure	CEG	Higher is better	367.2	303.6	n/a	n/a
15	% of patients with hypertension in whom the last BP reading (measured in the preceding 9m) is 150/90 mmHg or less	QOF	Higher is better	88.0	90.1	81.4	82.9
16	Heart failure aggregate measure	QOF (3 Indicators)	Higher is better	285.8	291.2	288.5	286.8
30	% patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the	QOF	Higher is better	100.0	98.9	96.4	94.3
18	Diabetes aggregate measure	QOF (7 Indicators)	Higher is better	878.3	891.0	1135.1	1160.2
19	% of patients attending A&E that are diverted to PUCC	SUS / CCG	Lower is better	1.0	21.8		
20	A&E attendance (rate per 1000 registered population)	HES	Lower is better	270.8	391.0	350.9	333.8
21	Unplanned admission (rate per 1000 registered population) (excluding maternity)	HES	Lower is better	60.7	77.9	81.2	99.0
31	Benzodiazepines (caps & tabs) ADQ per Benzodiazepine caps & tabs (BNF 4.1 sub-set) COST based STAR PU	CCG Medicines Management Dashboard	Lower is better	0.7	0.6	n/a	0.7
32	Co-Amoxiclav, Cephalosporins and Quinolones % of all antibacterial items	CCG Medicines Management Dashboard	Lower is better	15.8	14.3	n/a	10.2
35	% women receiving their 16w check who have smoking status recorded	CEG	Higher is better	7.7	15.9	n/a	n/a

Better than C&H AVG

Same as C&H AVG

Worse than C&H AVG

Quality Outcomes Framework (QOF)

Total QOF Achievement in the last 3 years:

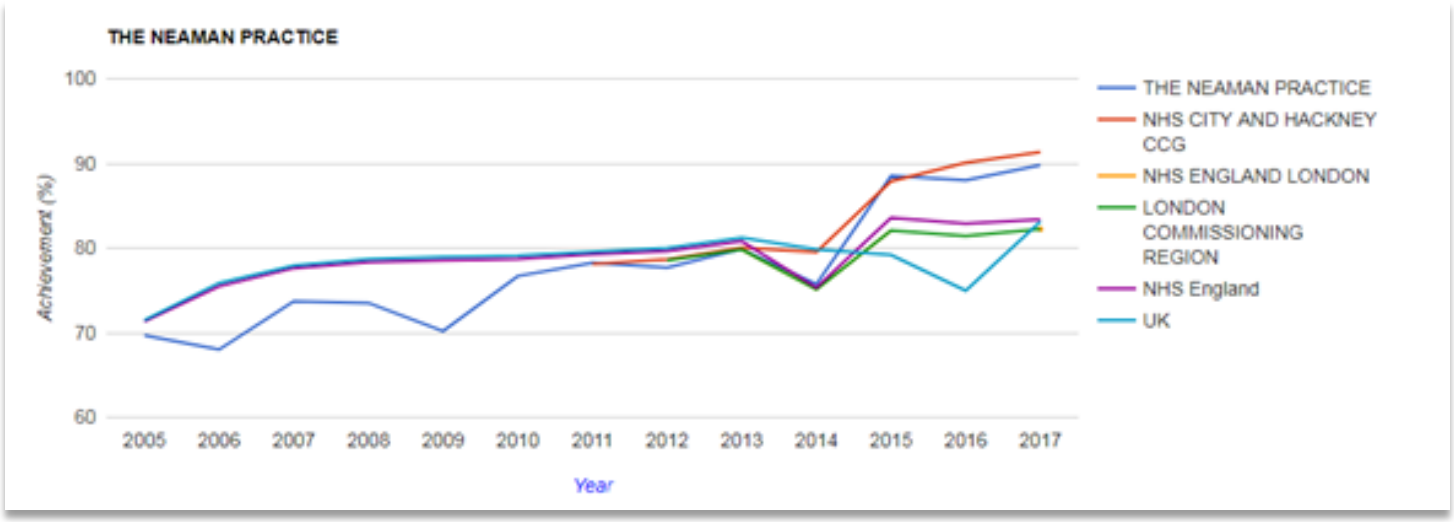
14/15 – 555.03/559 99.3% (Above England average)

15/16 – 549.04/559 98.2% (Above CCG and England average)

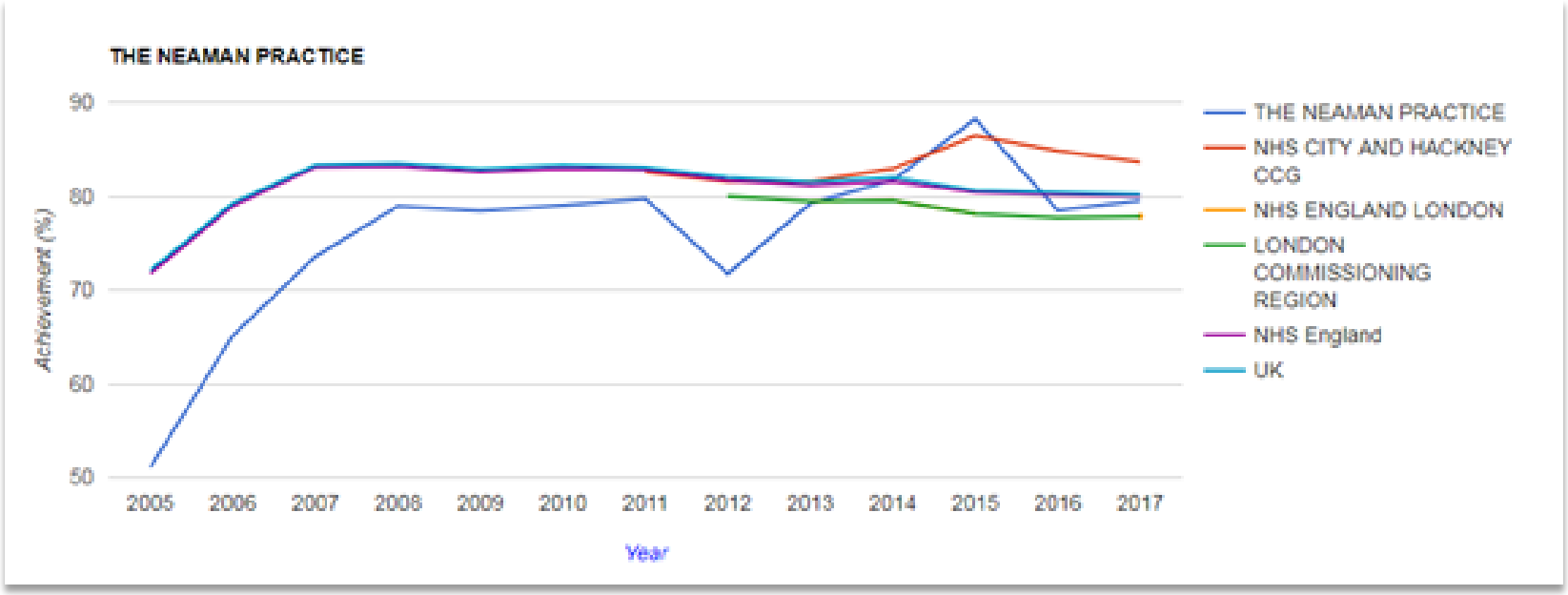
16/17 – 552.84/559 98.9% (Above CCG and England average)

*http://qof.digital.nhs.uk/search/index.asp

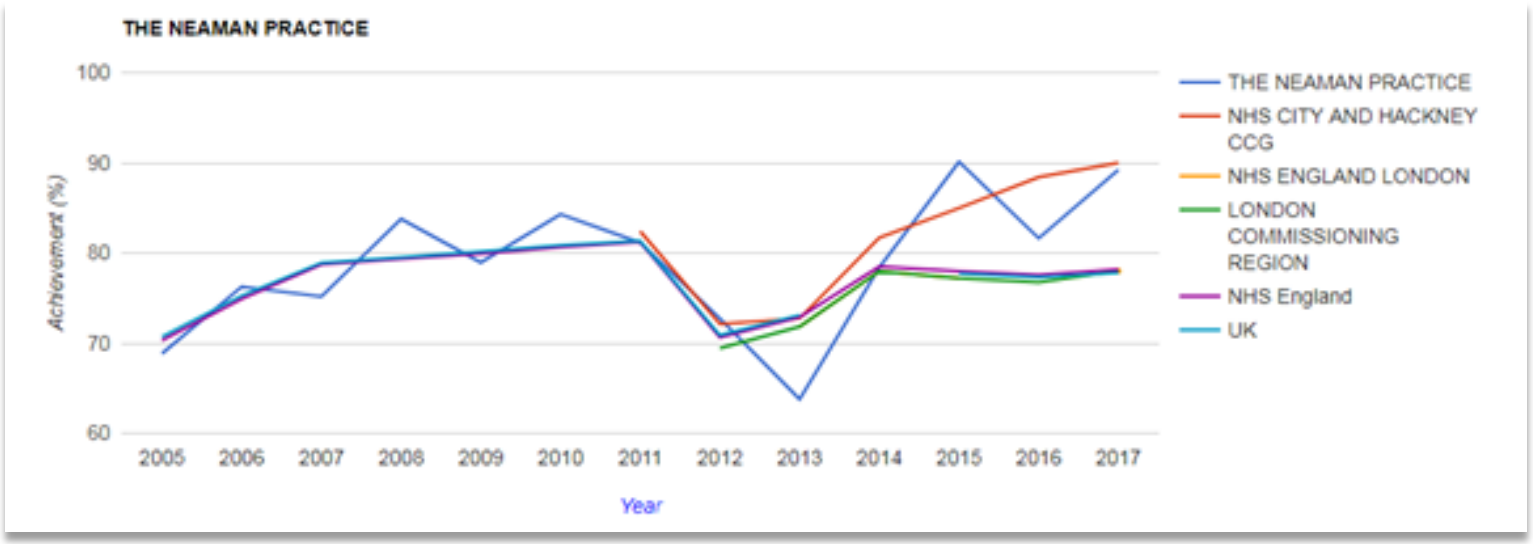
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.



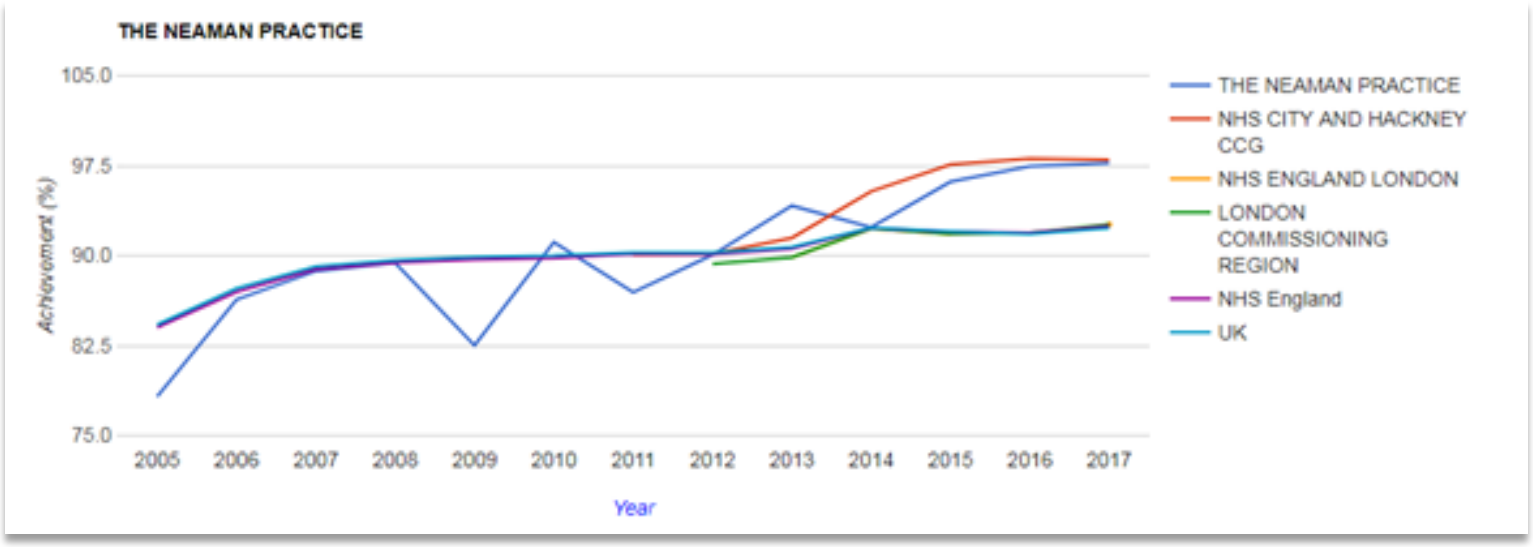
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less



The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.



The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less



Vaccinations

Flu Performance in the last 3 years:

Summary of Flu Vaccine Uptake (%)				
Year	**Target**	**65 and over**	**Under 65 (at-risk only)**	**All Pregnant Women**
Jan-17	75	65.4	44.2	38.8
Jan-16	75	63.4	41.1	39.6
Jan-15	75	67.3	44.7	44.8

Pneumococcal Performance 15/16 and 16/17:

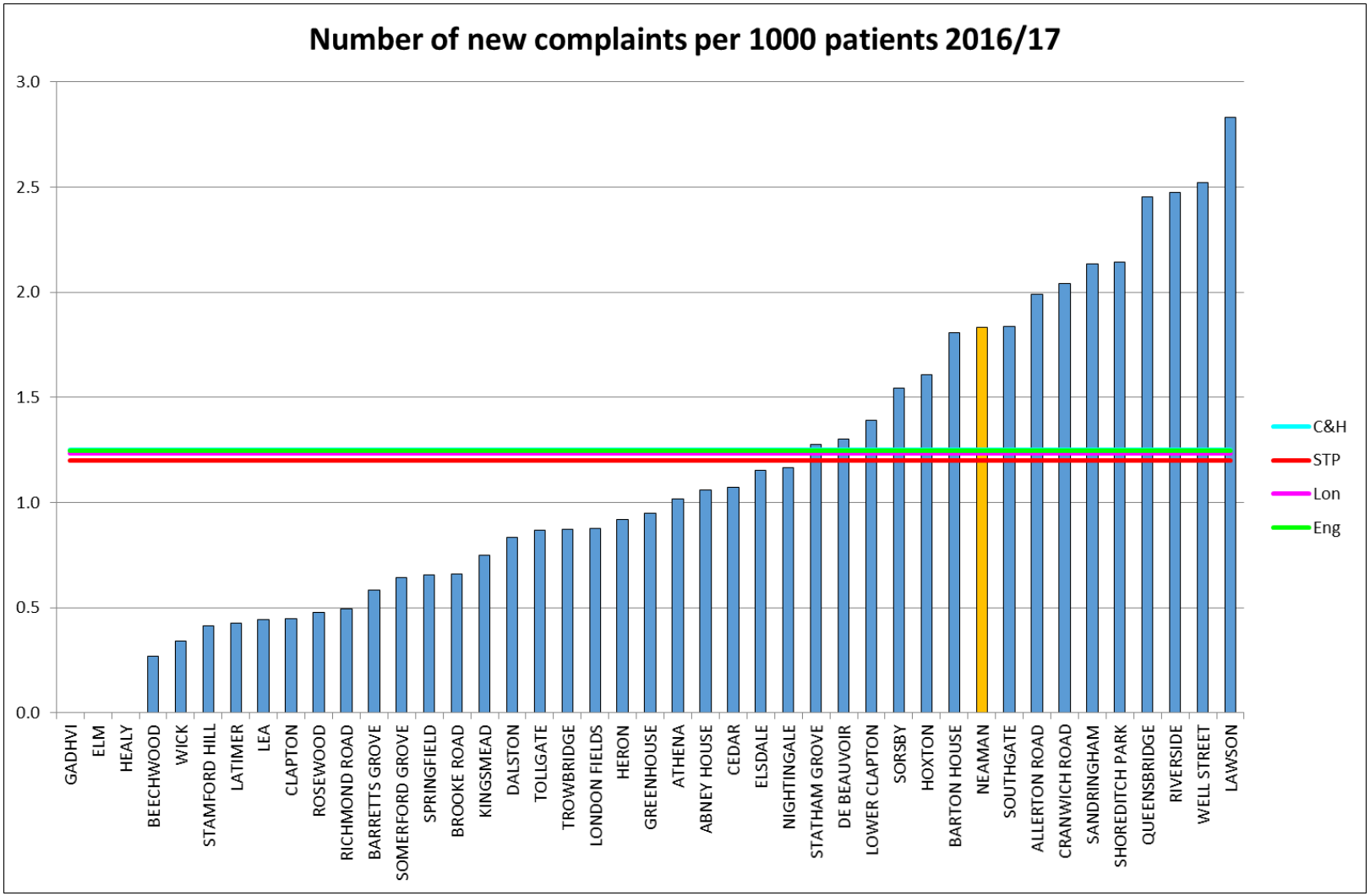
Received the Pneumococcal (PPV) vaccine at any time aged 65 and over (%)			
Year	**Target**	**No of patients**	**% of patients**
2016/17	75	702	63.0
2015/16	75	726	63.4

*Data Extracted from Immfom

Patient Feedback & Complaints

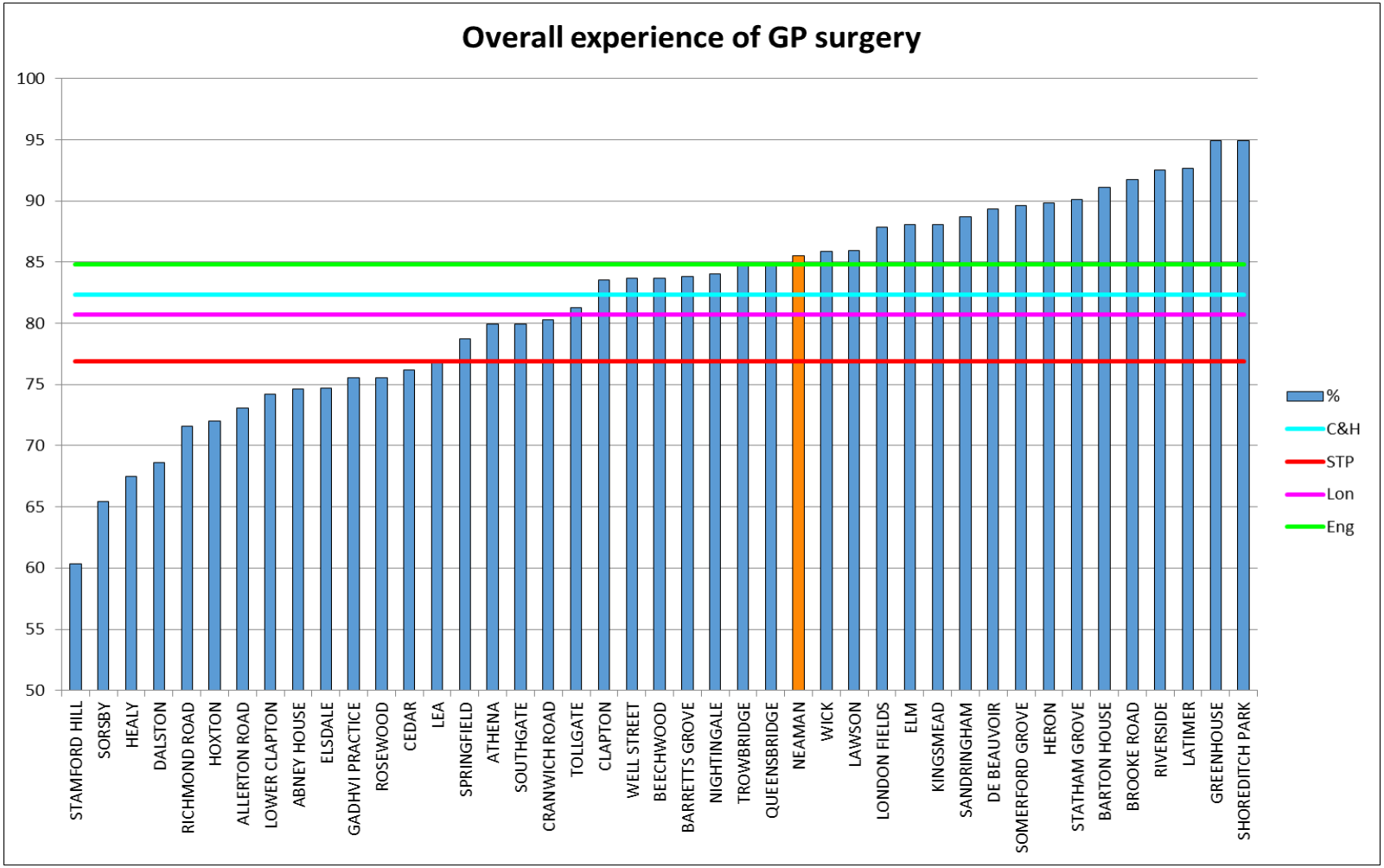
The table below shows the practice's return to NHS Digital outlining the number of complaints received by the practice in 2016/17 and whether they were upheld.

2016/17	
Upheld	9
Partially upheld	3
Not upheld	5
Total	**17**

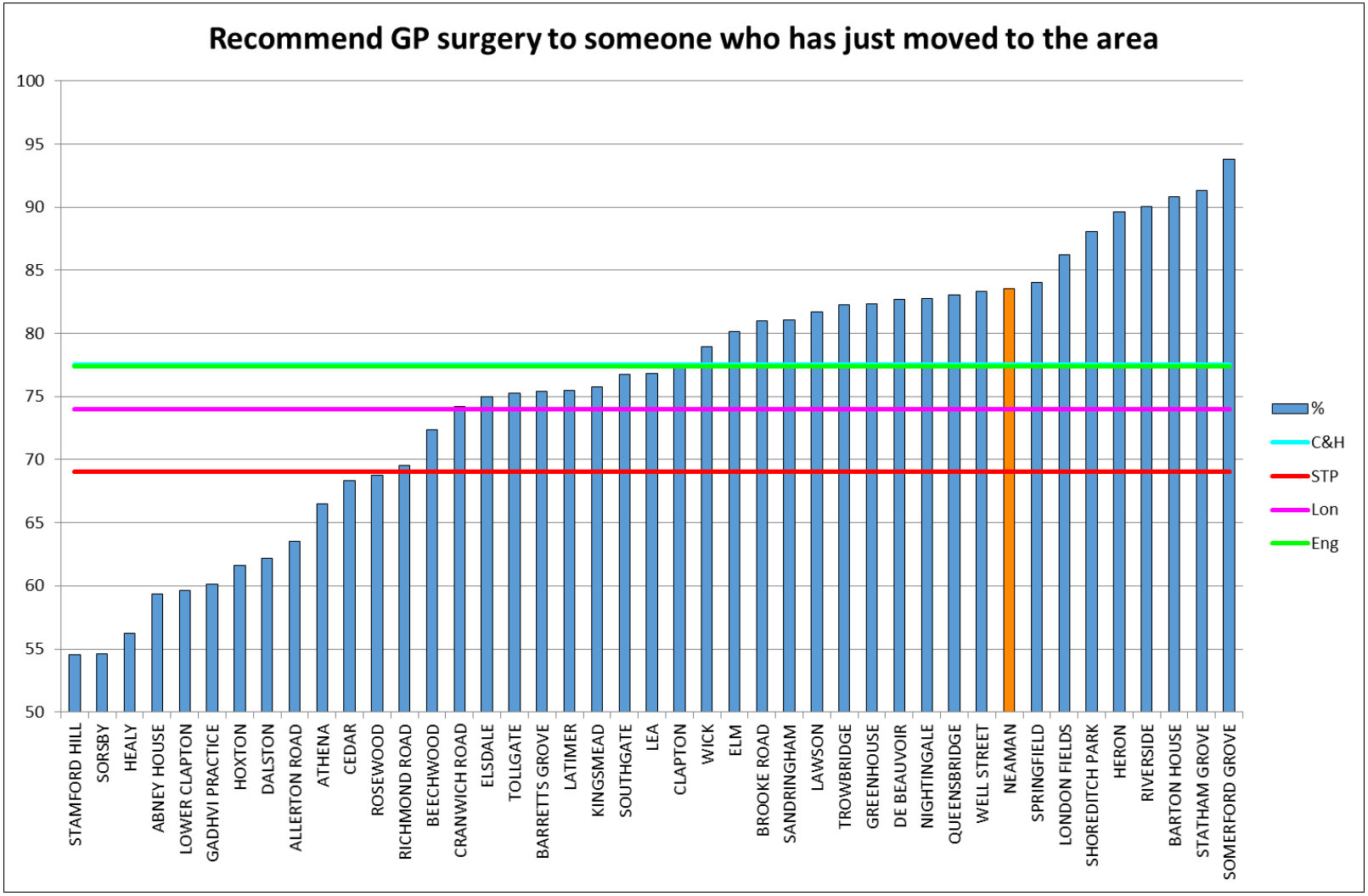


The Neaman Practice 1.83 new complaints per 1000 patients in 2016/17 – higher than the CCG, STP, London, and England.

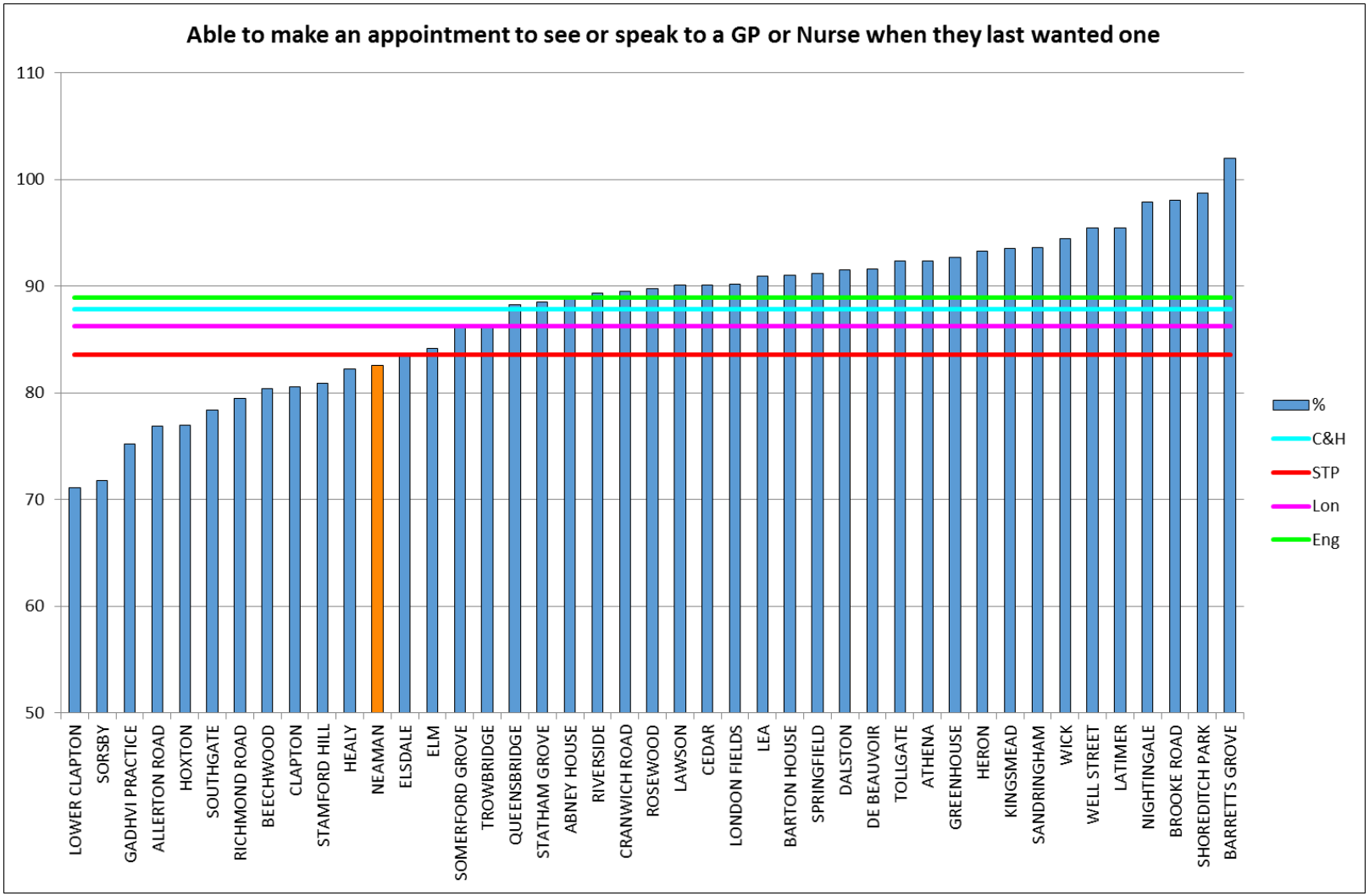
The main source of patient feedback in primary care is the national GP Patient Survey (GPPS). The graphs below show The Neaman Practice results for several key GPPP questions taken from the July 2017 publication. The number of weighted responses for the practice was



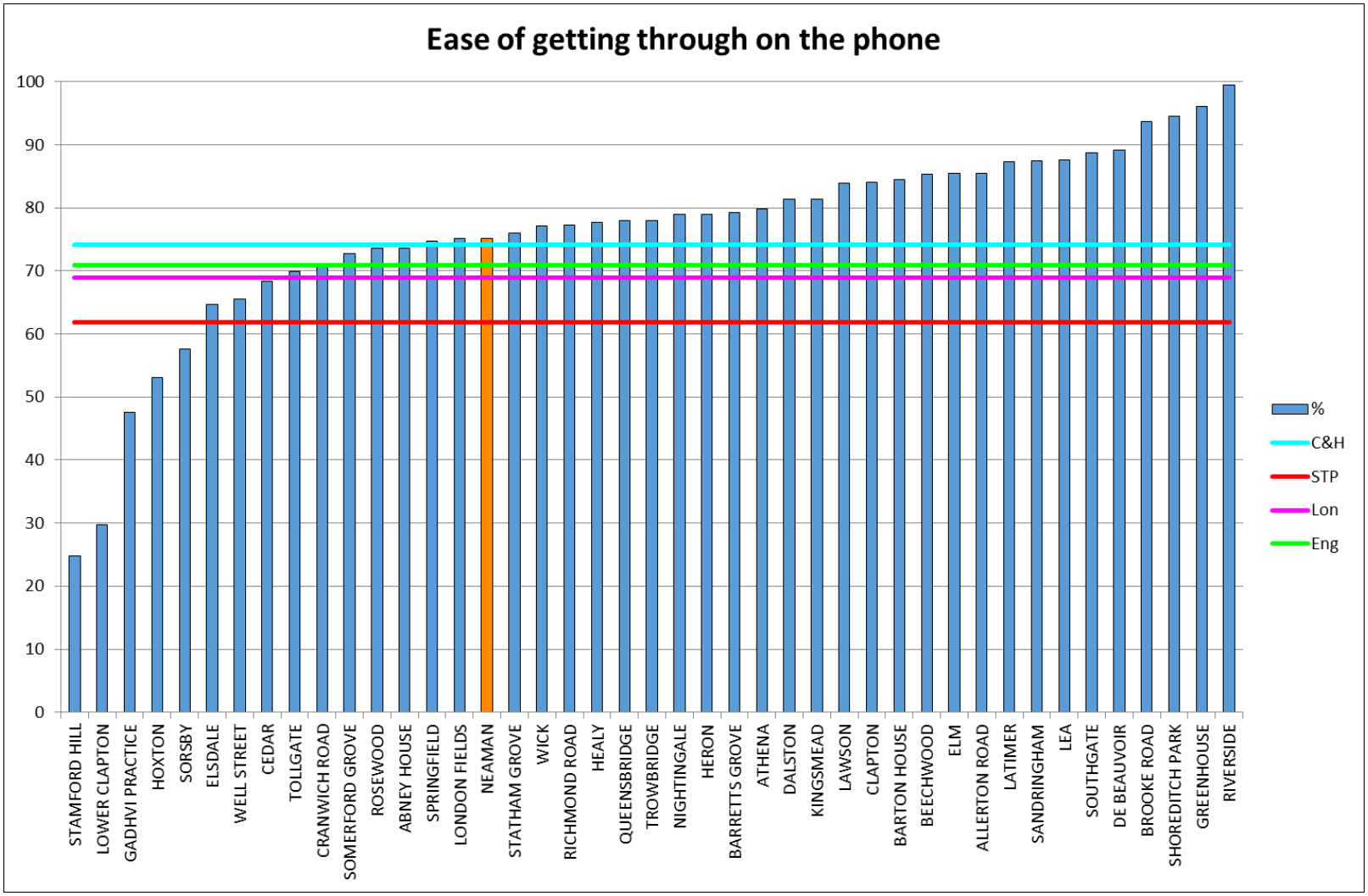
85.5% of registered patients responding to the GPPS described their overall experience of the practice as very good or fairly good. This is higher than the CCG (82.3%), STP (76.9%), London (80.7%) and National (84.8%) averages.



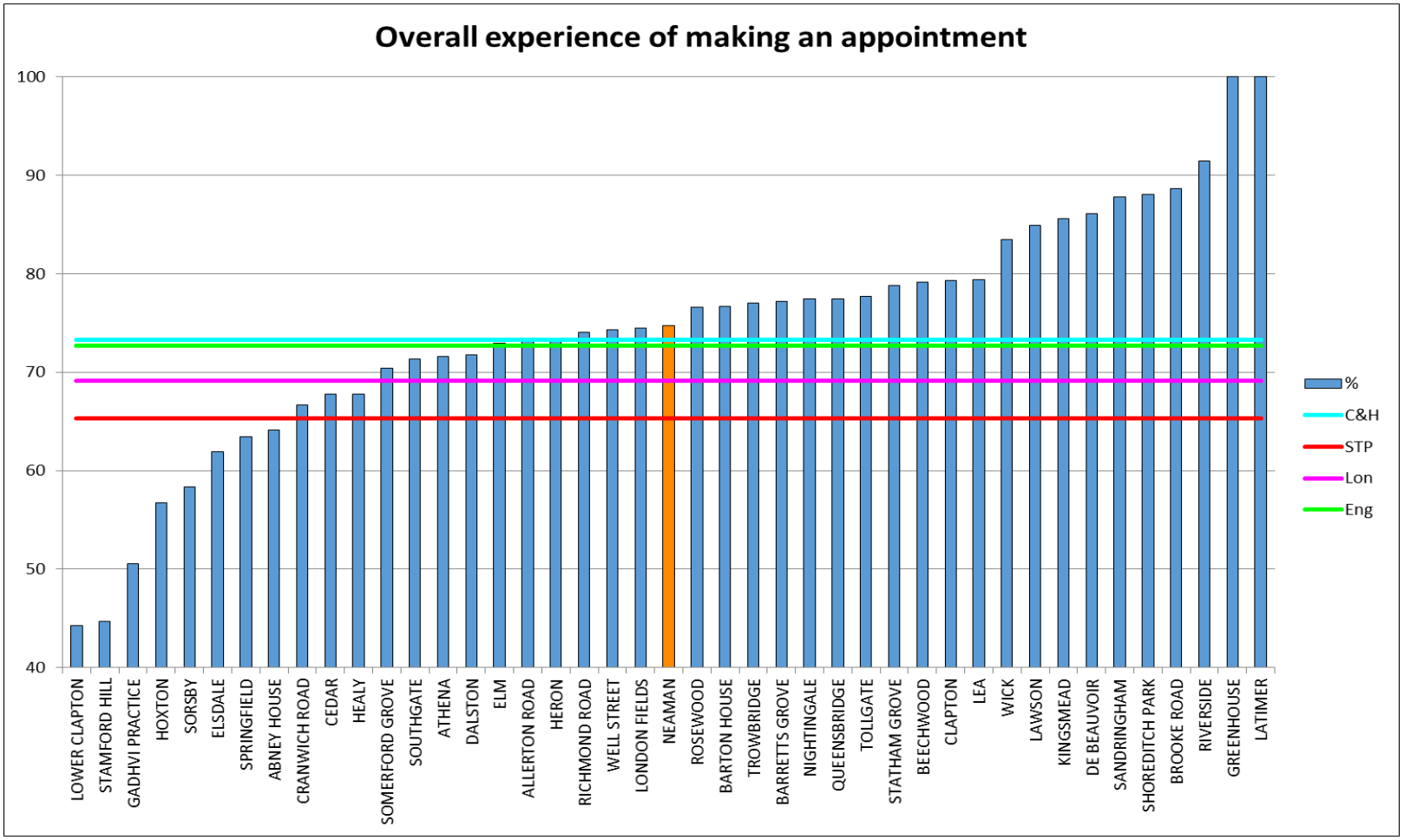
83.5% of registered patients responding to the GPPS would recommend The Neaman Practice to someone who has just moved to the area – Higher than the CCG (77.6%), the STP (69%), London (74%), and England (77.4%).



82.5% of registered patients responding to the GPPS were able to get an appointment to see a GP or Nurse when they last wanted one – Lower than the CCG (87.8%), STP (83.6%), London (86.2%), and England (88.9%).



75.2% of respondents felt that it was easy to get through on the phone – Higher than the CCG (74.2%), STP (61.9%), London (68.9%), and England (70.9%)



74.7% of respondents described their overall experience of making an appointment as good – Higher than the CCG (73.3%), STP (65.3%), London (69.1%), and England (72.7%).

In 2017, the CCG also asked practices to carry out a local patient survey including questions which corresponded to key GPPS questions. The table below shows selected results from that survey.

Describe their overall experience of GP surgery as good	94.9%
Would recommend GP surgery	91.0%
Responded that it was easy to get through on the phone	73.1%
Had a positive experience of making an appointment	91.0%

CQC

Table below shows ratings for each domain of the practices most recent CQC report

The Neaman Practice	
CQC overall rating	Good
Date published	23/01/2017
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Older people	Good
LTC	Good
Families, children and young people	Good
Working age	Good
Vulnerable	Good
Mental health	Good

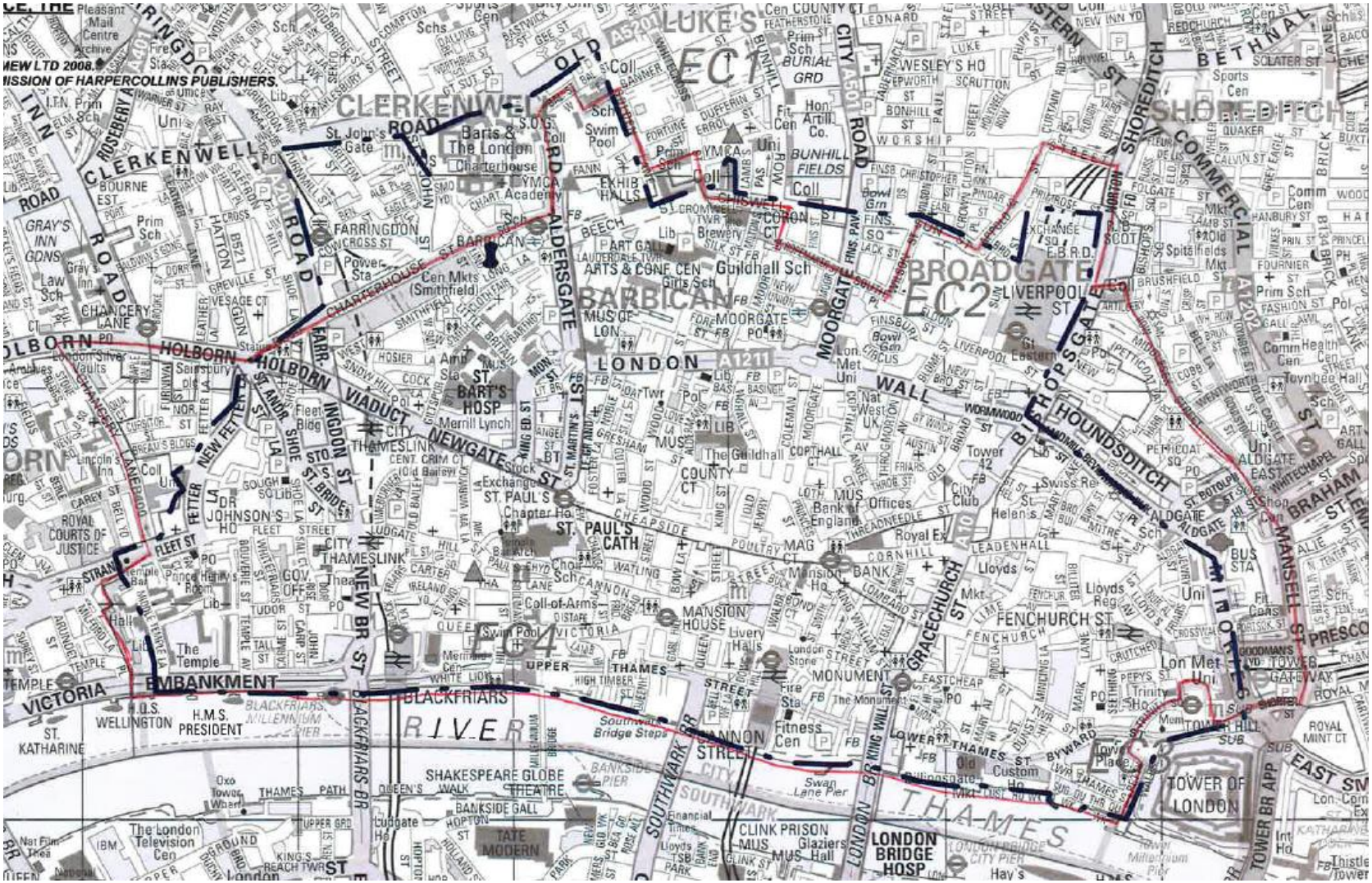
Workforce

Data taken from NHS Digital - General and Personal Medical Services England Sept 2017

	Neaman	C&H	London	England
Total Patients	9431	315528	9737168	58674676
Total GPs - Full Time Equivalents	3.8	190	5923.1	33301.7
GPs per 1000 patients	0.4	0.6	0.6	0.6

Catchment Area

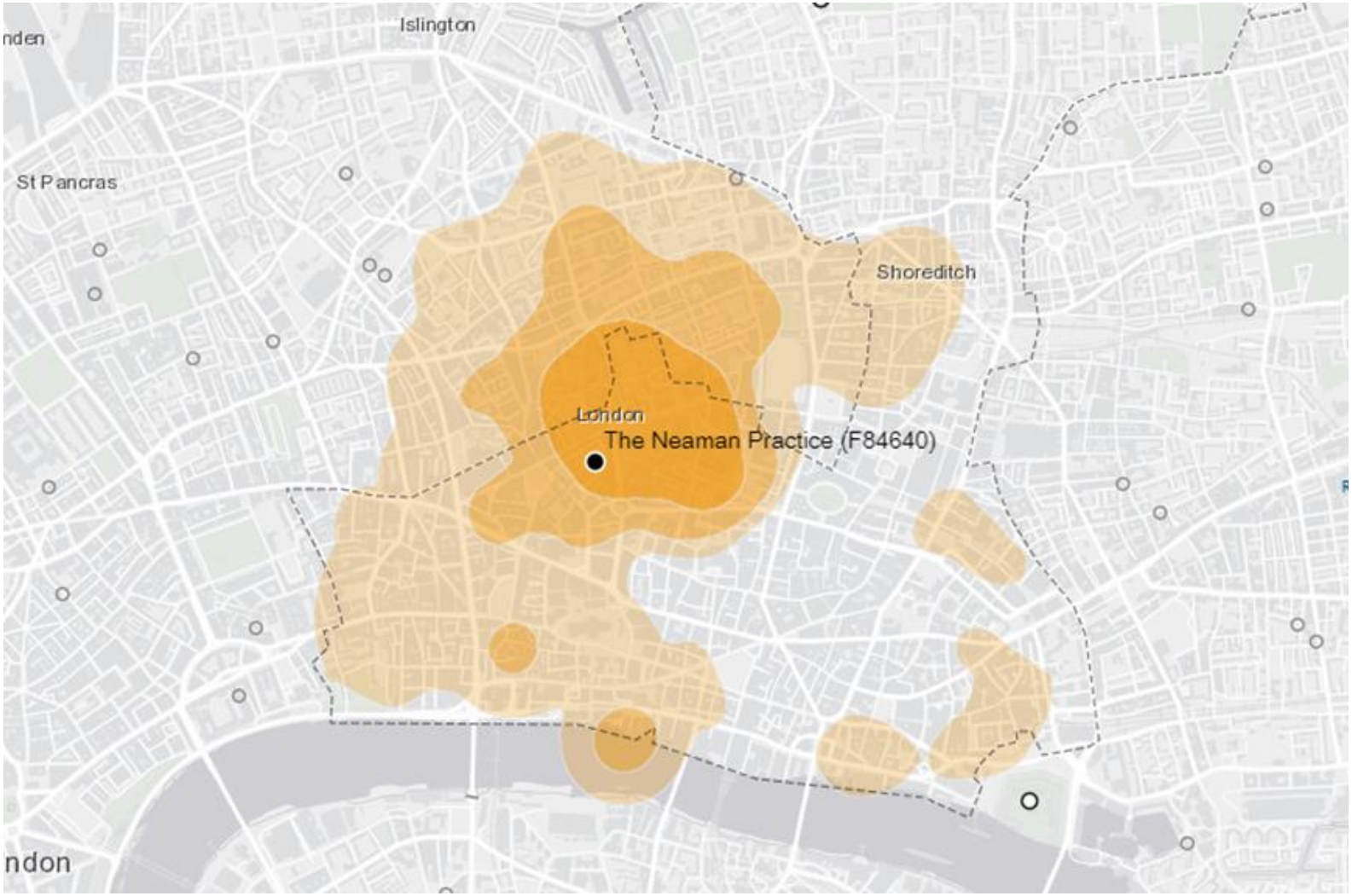
The map below shows the contractual catchment area for The Neaman Practice (marked in blue). The red line shows City of London boundary.



Map 1

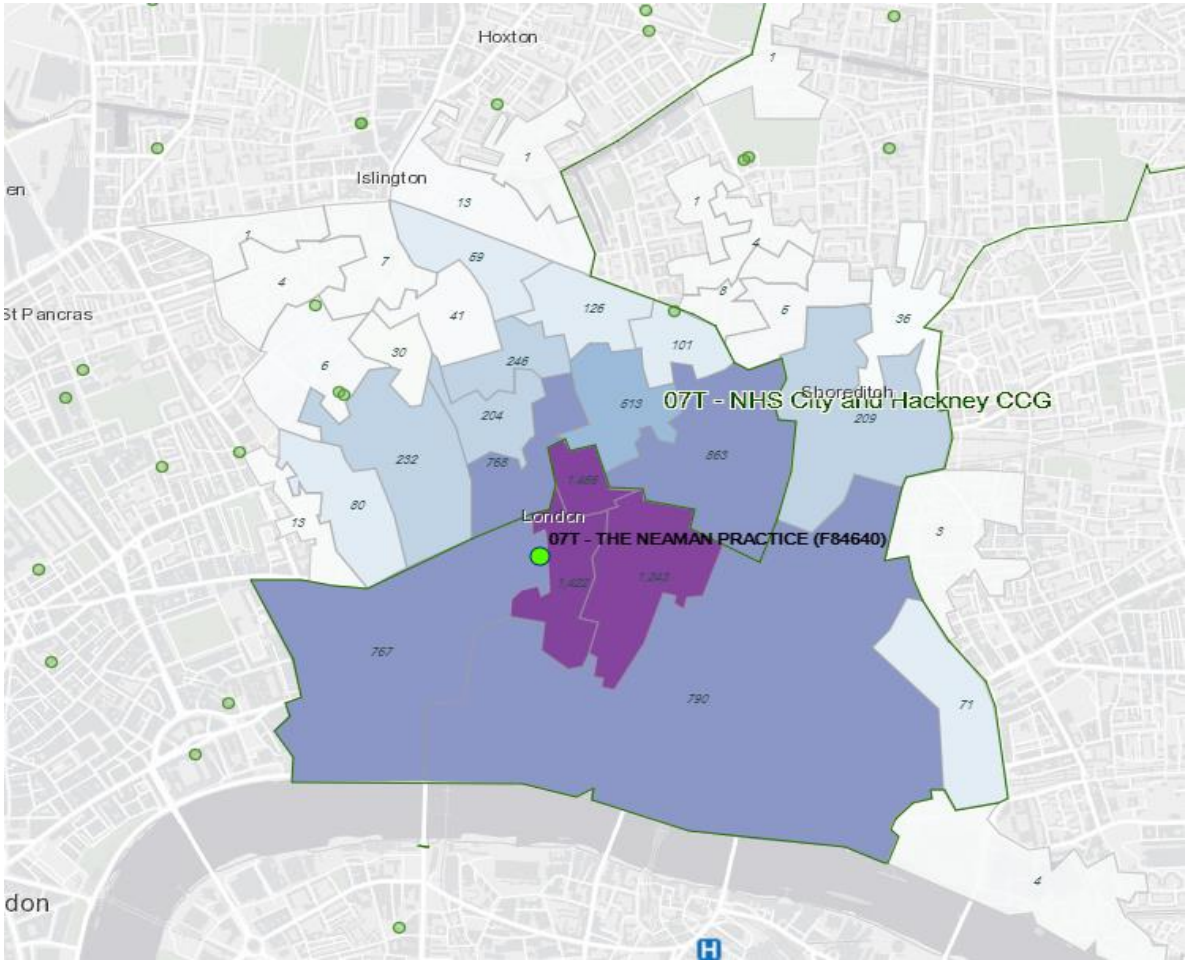
The two maps below shows the distribution of patients at The Neaman Practice by postcode. It is clear from the *Map 1* that quite a reasonable proportion of the patient list are Islington residents. The small circles mark the location of GP practices in neighbouring CCG areas.

Map 1


Islington
St Pancras
Shoreditch
London
The Neaman Practice (F84640)

Map 2 shows the distribution of patients by Lower Layer Super Output Area (LSOA), meaning a geographical area with a minimum population of 1000. The Neaman Practice have a number of registered patients living in LSOAs that are completely or partially outside of their catchment area. 16.1% of CoL residents are registered with Tower Hamlets GPs. On this map, other GP practices are marked green circles

Map 2



Thomas Clark 01/12/2017

Crossing borders

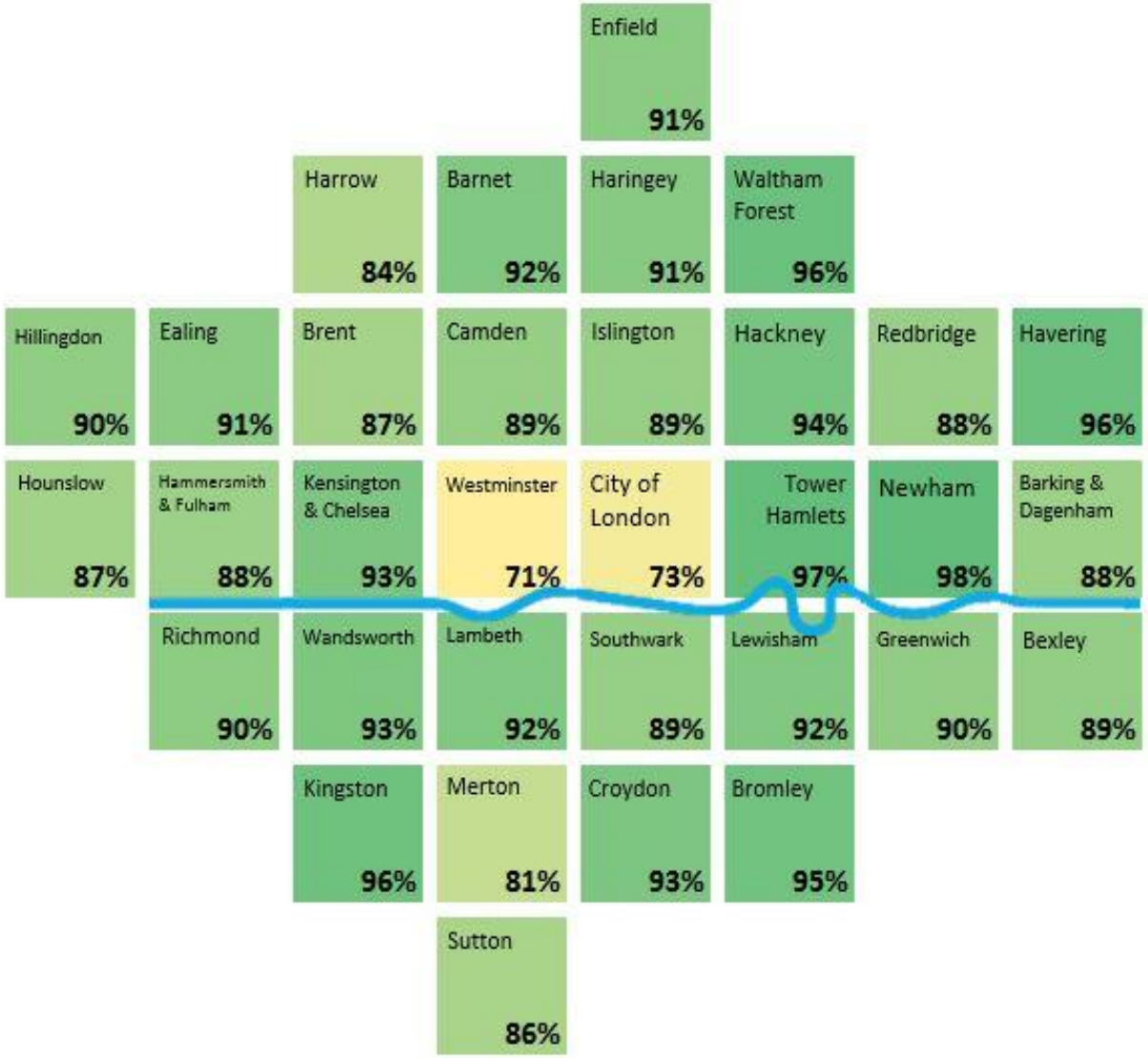
Most Londoners register with a GP in the borough where they live. However, many also travel to a neighbouring borough to access services, especially where they live close to a border. It is important when planning services to be aware of these populations.

This table shows the percentage of residents of each local authority by the NHS area where they register. This ranges from 71% of Westminster residents who are registered with a GP in the borough, to 98% of Newham residents who are registered with a Newham GP.

According to these figures, 94.2% of Hackney residents are registered with a GP in the NHS City & Hackney CCG area, 3.6% with a GP in NHS Islington CCG area, and 0.5-1% in Camden, Haringey and Tower Hamlets. There are smaller numbers of residents registered outside these areas.

Of City of London residents, 73.0% are registered with a GP in NHS City & Hackney CCG area, 16.1% in Tower Hamlets, 6.2% in Camden, 3.0% in Islington and 1.2% in NHS Central London CCG area. There are also small numbers registered outside these areas.

Of people who register with a GP in City & Hackney, 90.3% are Hackney residents, 3.3% live in Islington, 3.0% in Haringey, 1.8% in the City of London, and 0.9% in Tower Hamlets. There are smaller numbers who live outside these areas.


Enfield 91%
Harrow 84%
Barnet 92%
Haringey 91%
Waltham Forest 96%
Hillingdon 90%
Ealing 91%
Brent 87%
Camden 89%
Islington 89%
Hackney 94%
Redbridge 88%
Havering 96%
Hounslow 87%
Hammersmith & Fulham 88%
Kensington & Chelsea 93%
Westminster 71%
City of London 73%
Tower Hamlets 97%
Newham 98%
Barking & Dagenham 88%
Richmond 90%
Wandsworth 93%
Lambeth 92%
Southwark 89%
Lewisham 92%
Greenwich 90%
Bexley 89%
Kingston 96%
Merton 81%
Croydon 93%
Bromley 95%
Sutton 86%

GENERAL PRACTICE PROFILE

POPULATION, OBESITY & SMOKING

2015

THE NEAMAN PRACTICE

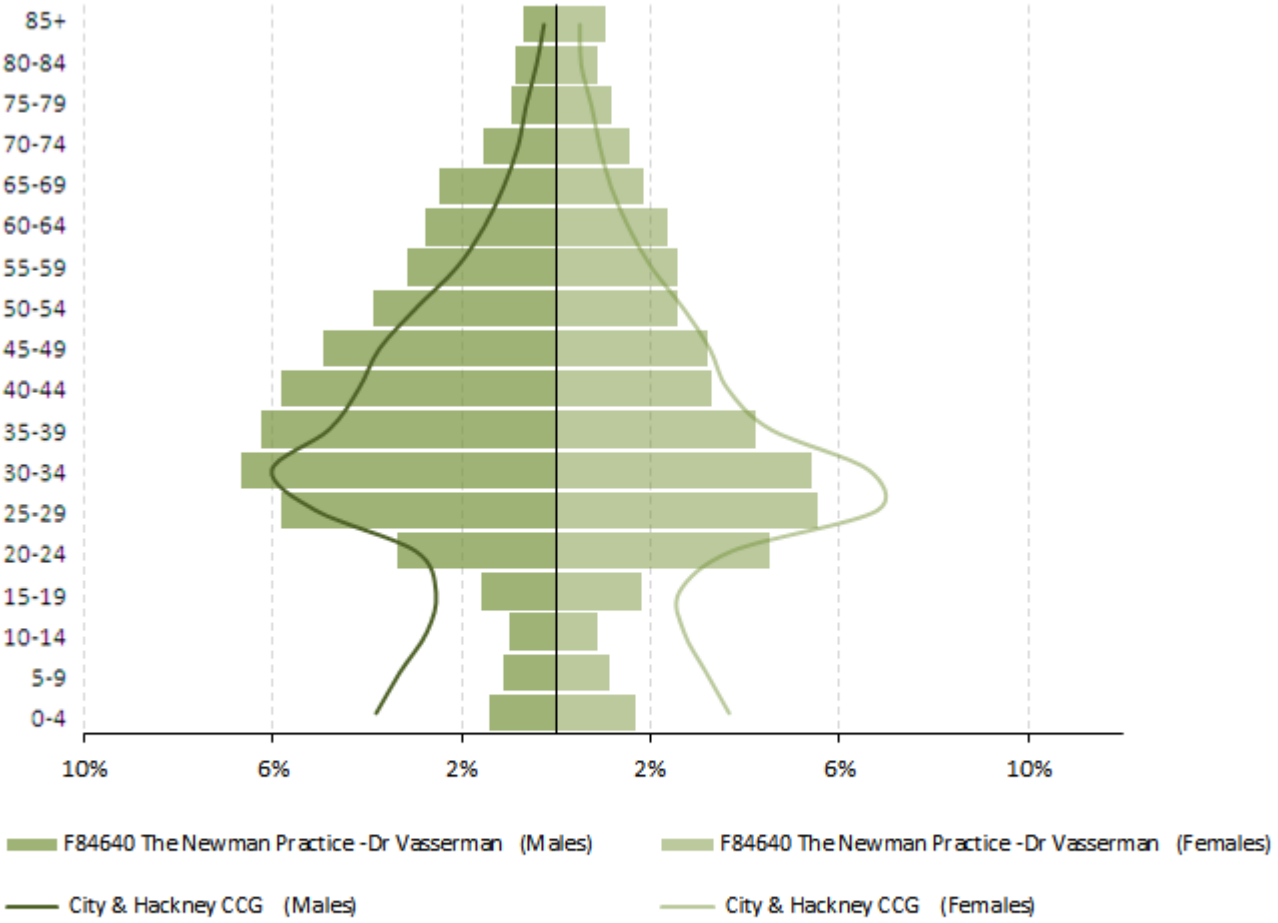
(Practice Ref: F84640)

1. Introduction

This profile describes the population of the practice in the context of the wider local population, including age, gender, ethnicity, deprivation, and population change. It also includes data on smoking and obesity – two other leading risk factors for poor health.

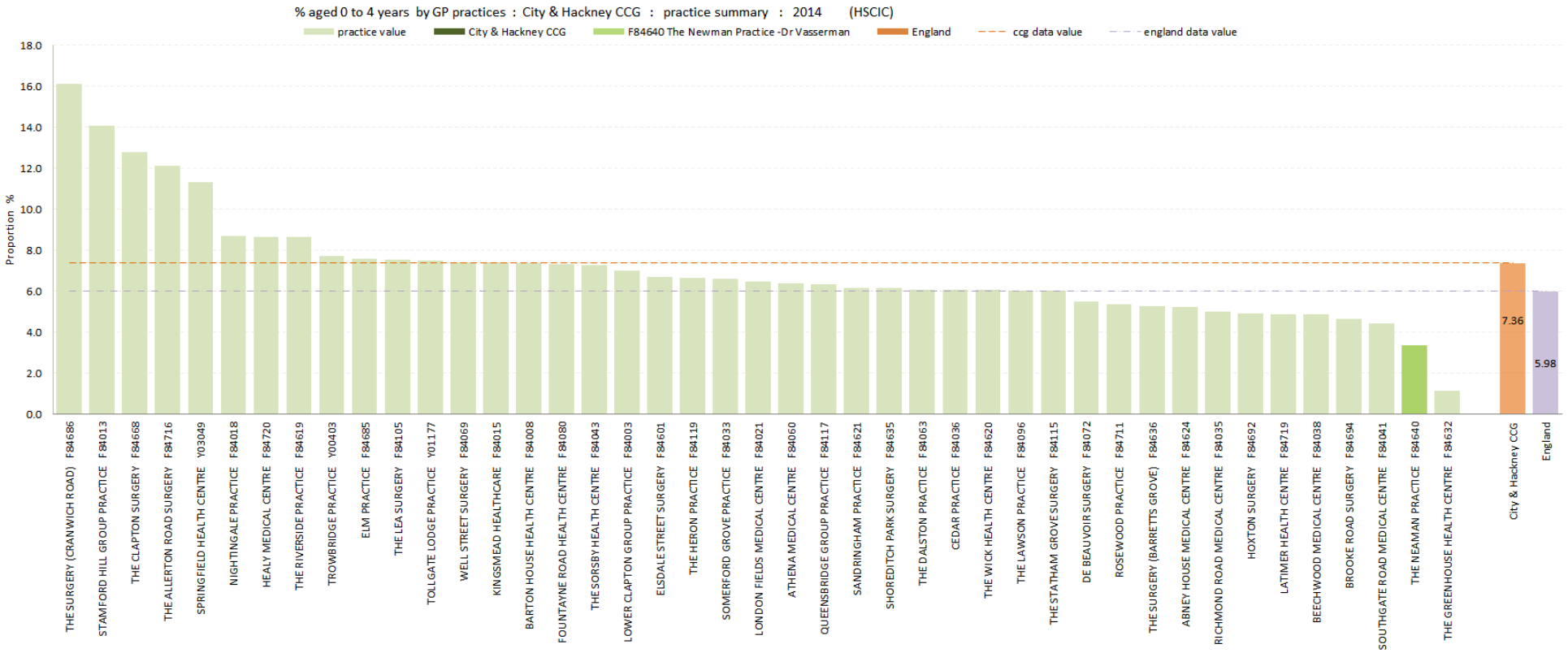
1.1 Population profile by age

Figure 1: Population structure of the practice and the CCG (CEG 2013)



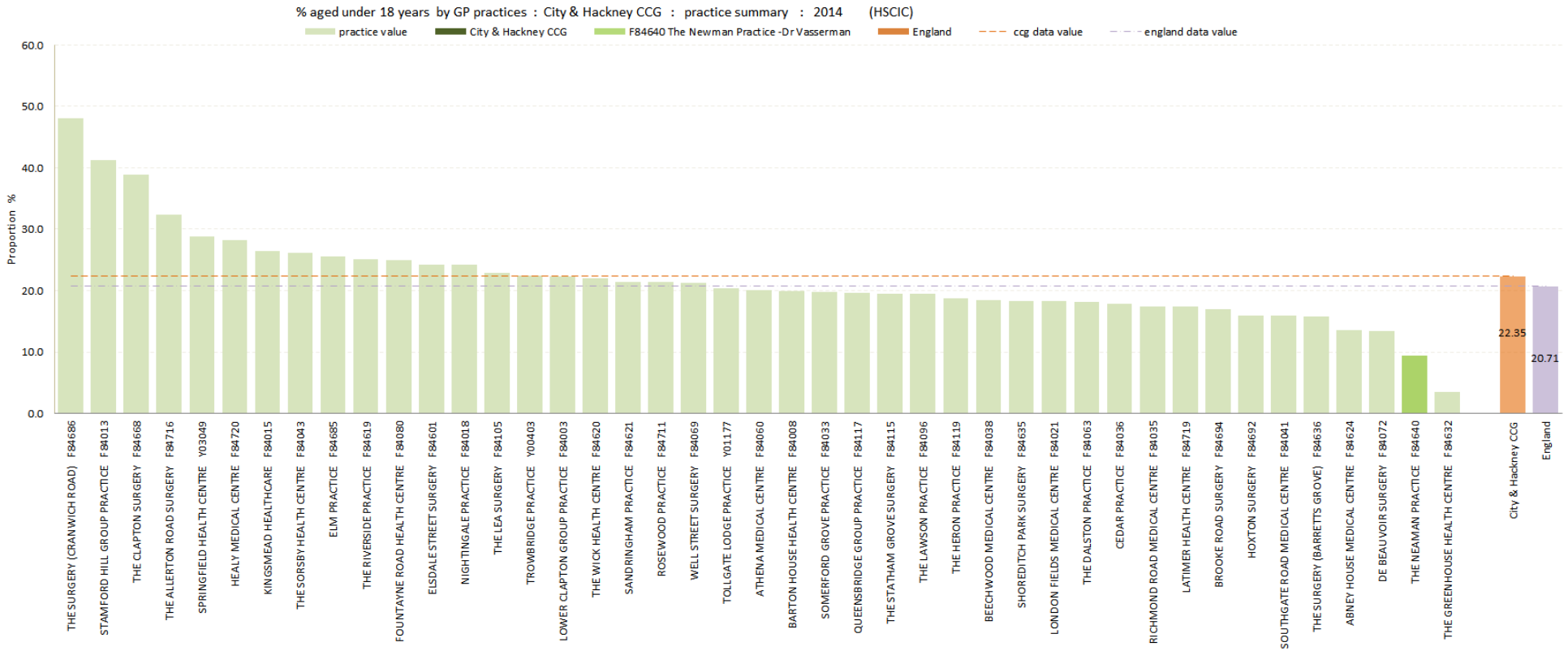
Compared to the rest of England, City & Hackney has a relatively young population, with high numbers of working age people. The population profile of this GP practice has fewer children, more older people, and more working age males.

Figure 2: Registered population by age group, by GP practices: City & Hackney CCG 2014 (age group 0-4 years)



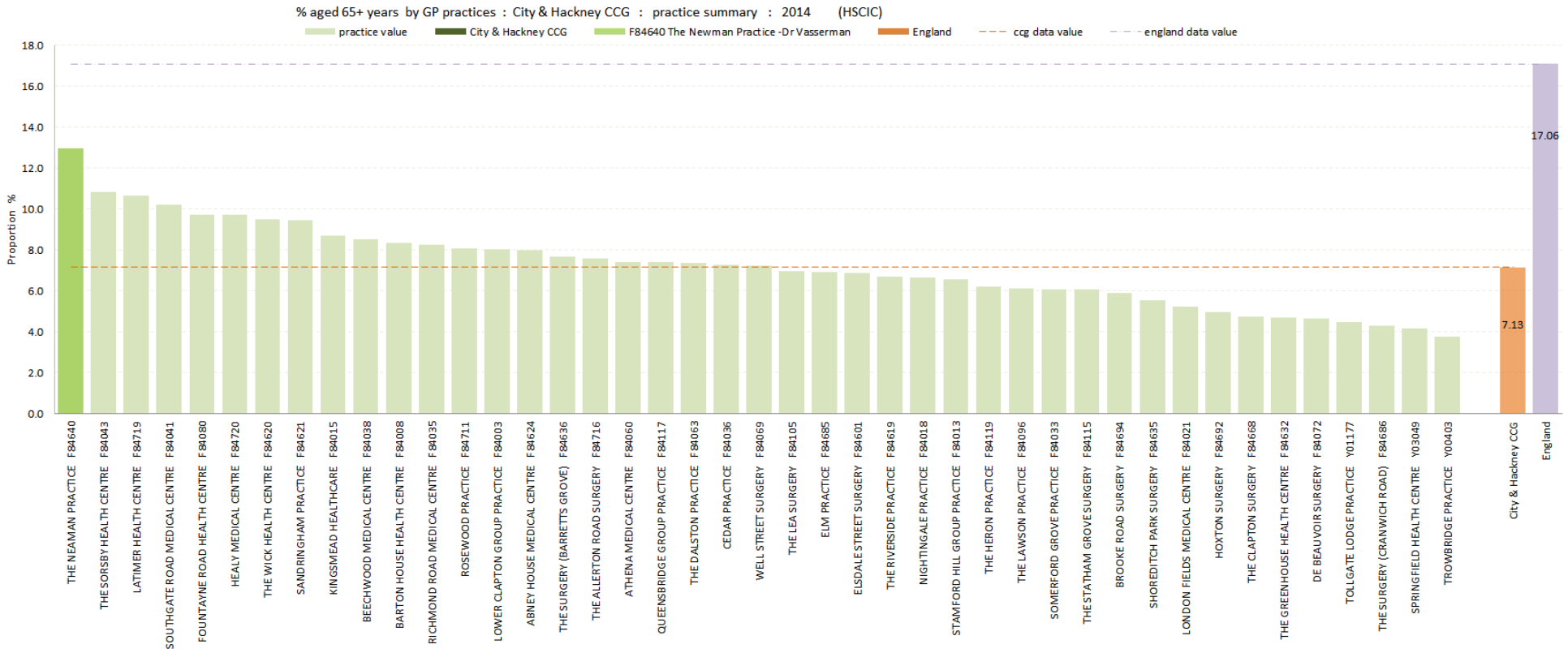
The practice level variation for % aged 0 to 4 years ranges from 1.1 to 16.1%. The Neaman Practice (3.4%) is below the CCG value of 7.4% and statistically significantly lower than the CCG average.

Figure 3: Registered population by age group, by GP practices: City & Hackney CCG 2014 (age group under 18 years)



The practice level variation for % aged under 18 years ranges from 3.5 to 48.0%. The Neaman Practice (9.4%) is below the CCG value of 22.3% and is statistically significantly lower than the CCG average.

Figure 4: Registered population by age group, by GP practices: City & Hackney CCG 2014 (age group >=65 years)

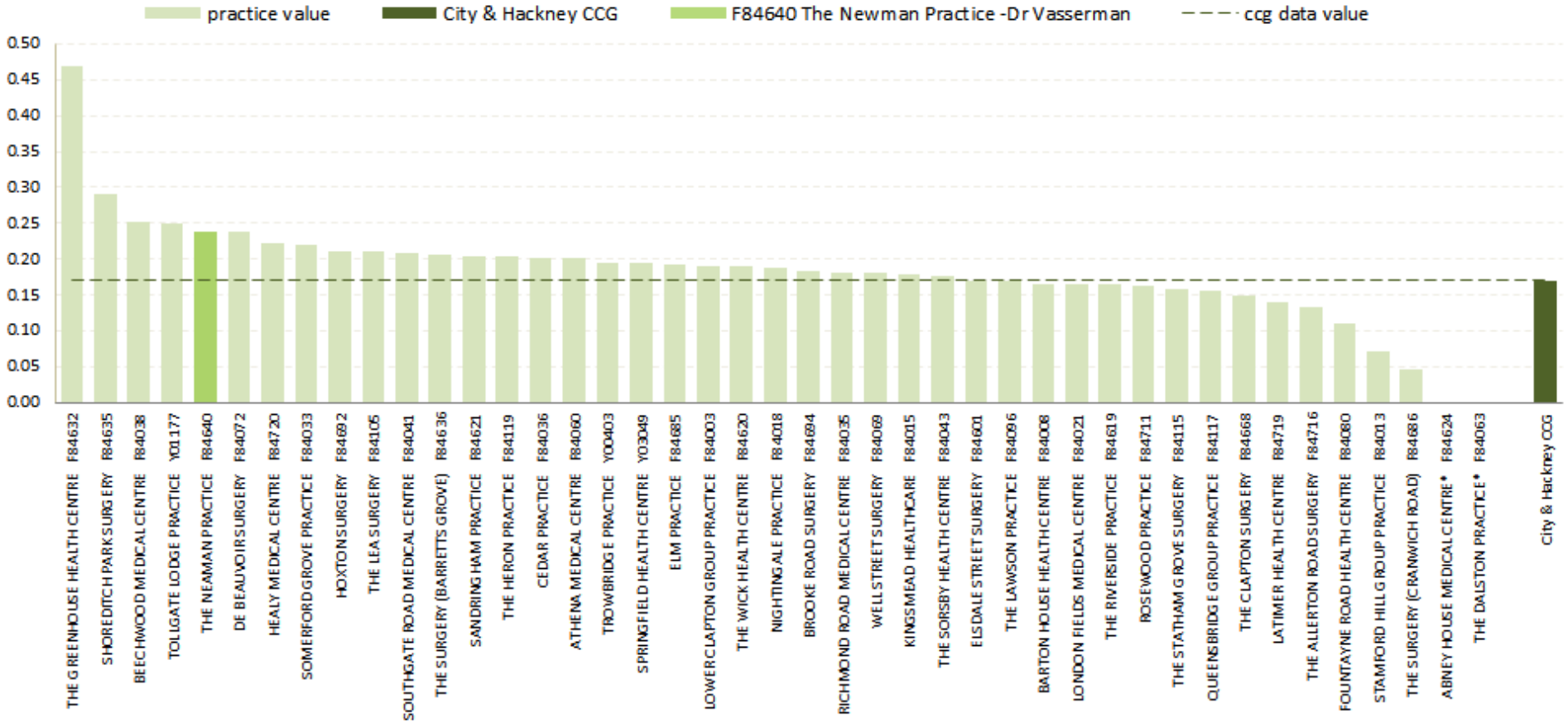


The practice level variation for % aged 65+ years ranges from 3.8 to 13.0%. The Neaman Practice (13.0%) is above the CCG value of 7.1% and statistically significantly higher than the CCG average.

1.2 Practice turnover

Practice turnover is defined as the registered list for Year A plus new registrations for Year B, minus registered list for Year B – divided by the registered list for Year A. National figures are not available.

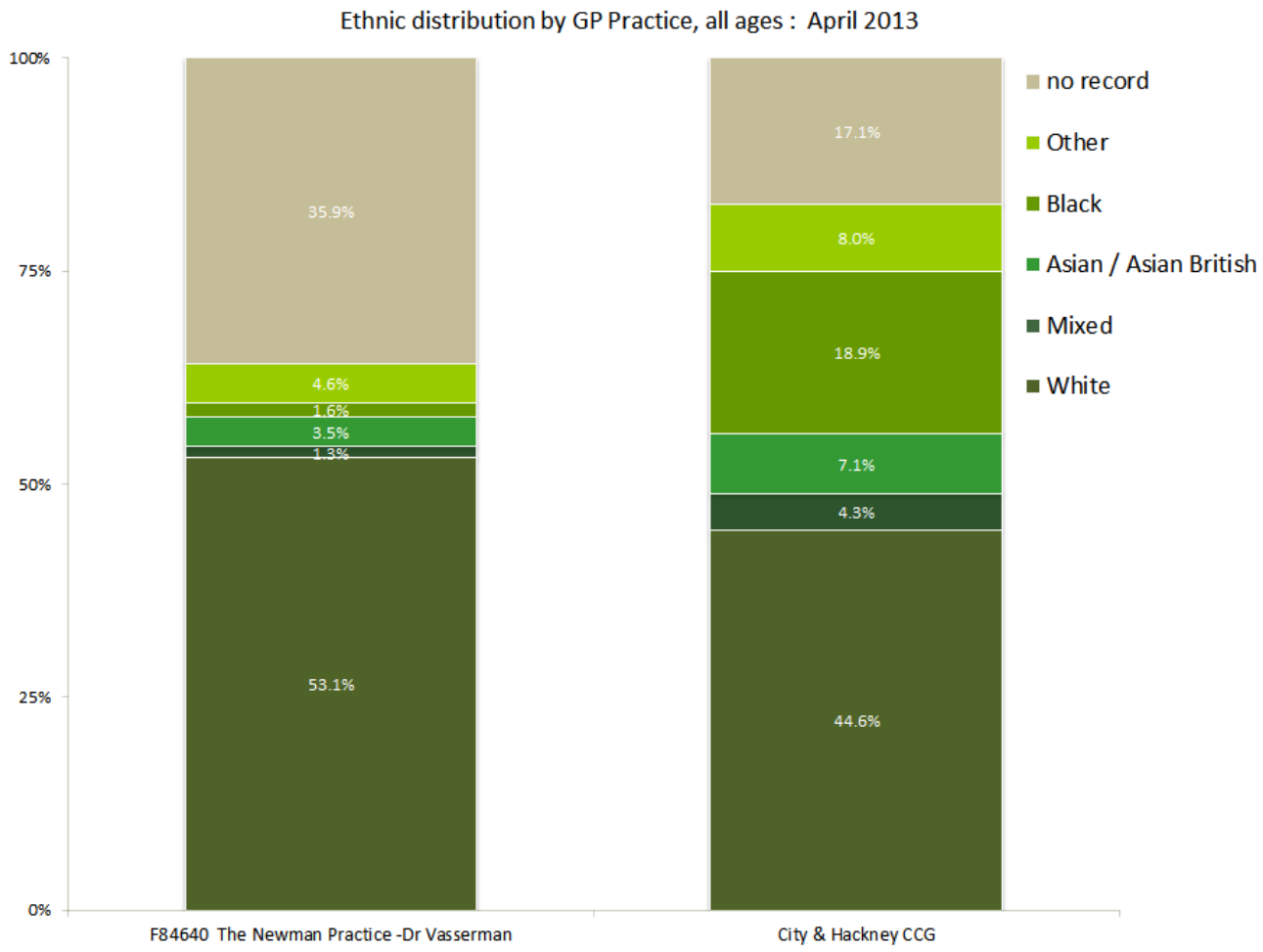
Figure 5: Practice population turnover, by GP practices: City & Hackney (CEG 2013/14)



** Note that data was unavailable for the 2 practices not using the EMIS system.*

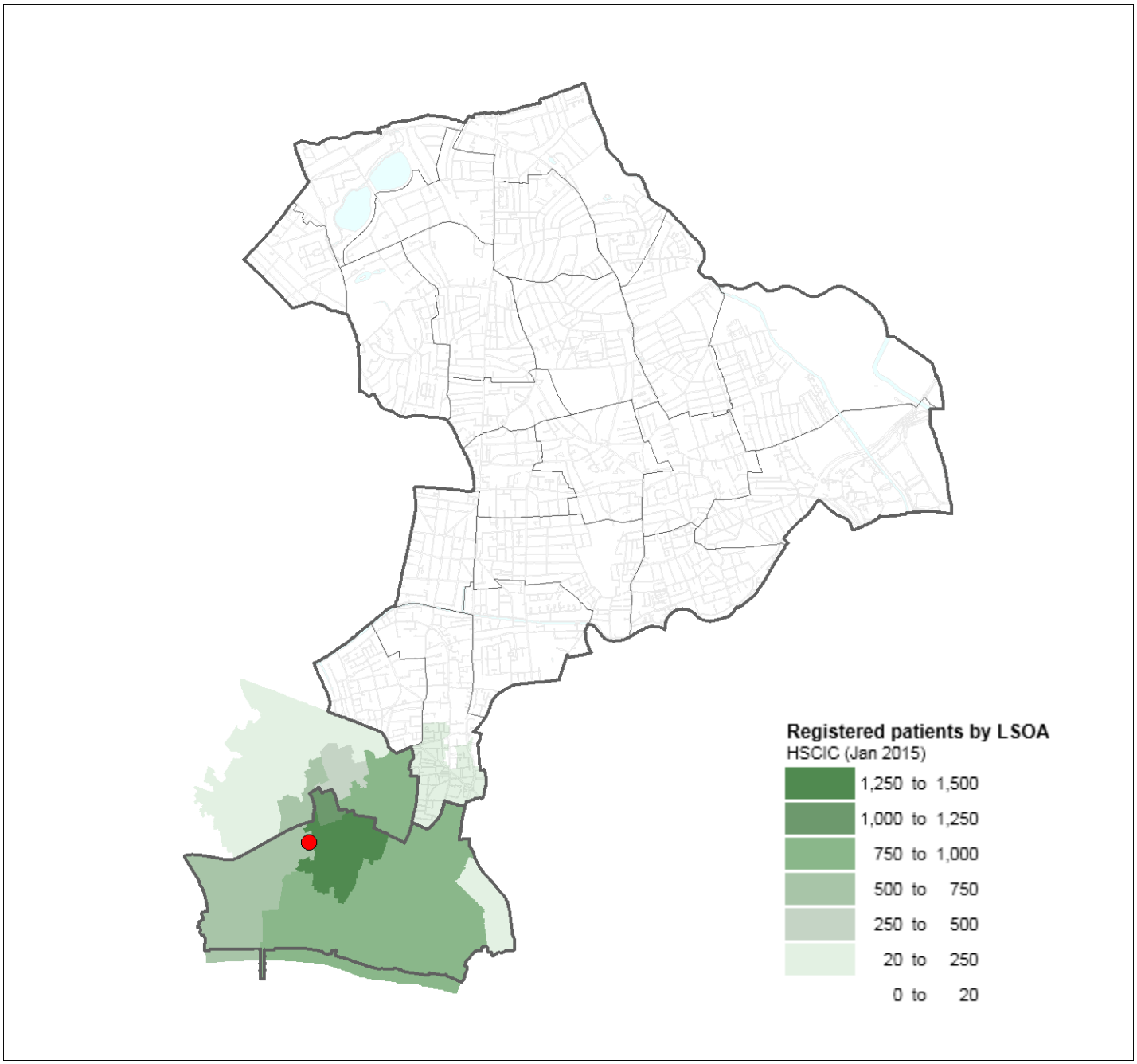
1.3 Variation by ethnicity

Figure 6: Ethnicity of the GP registered population compared with City & Hackney CCG (CEG 2013)



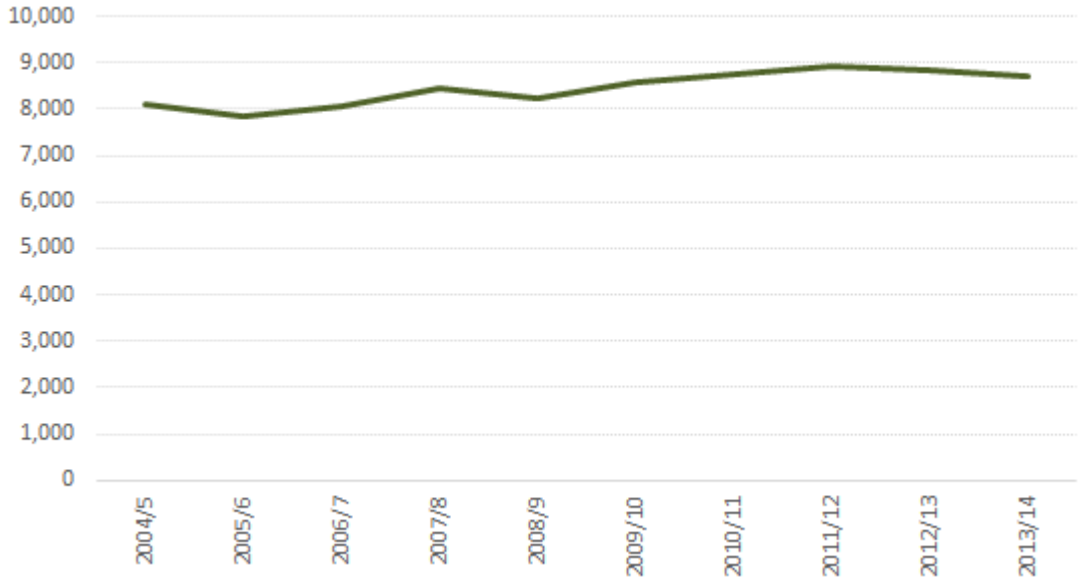
1.4 Practice geography

Figure 7: Map showing practice population by Lower Super Output Area of Residence (HSCIC 2015)



1.5 Population growth

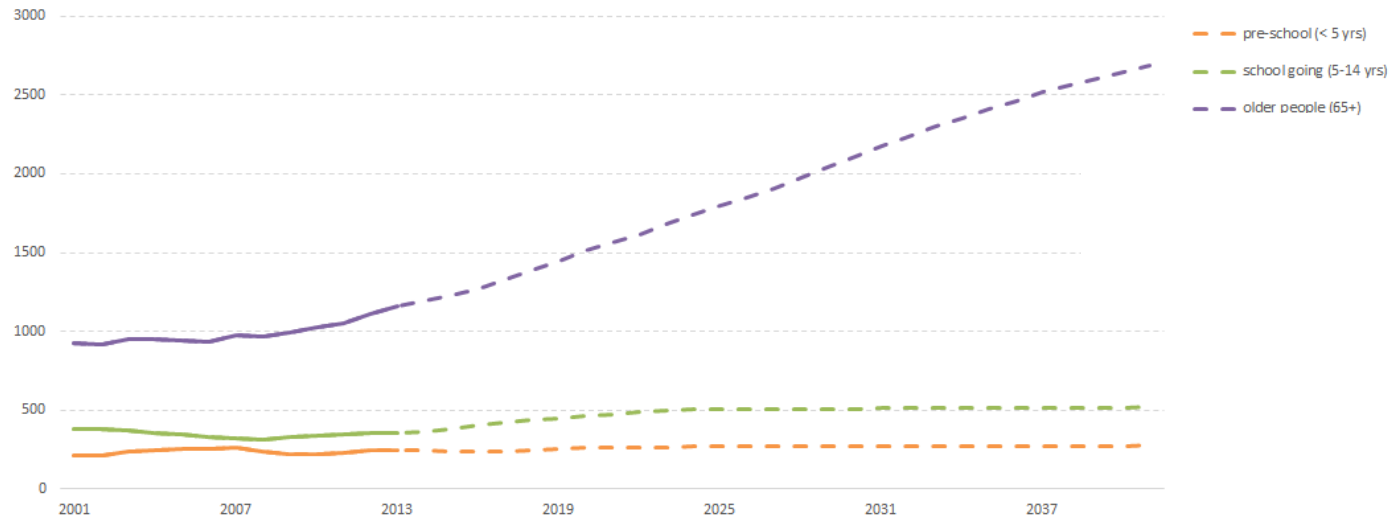
Figure 7: Practice list size over time (QOF)



Between 2005 and 2013, the practice list increased by 7%, compared to 9% population growth in the City during the same period.

The population of the City is projected to grow by 11% by 2018, and by 24% by 2023.

Figure 8: City of London population projections*

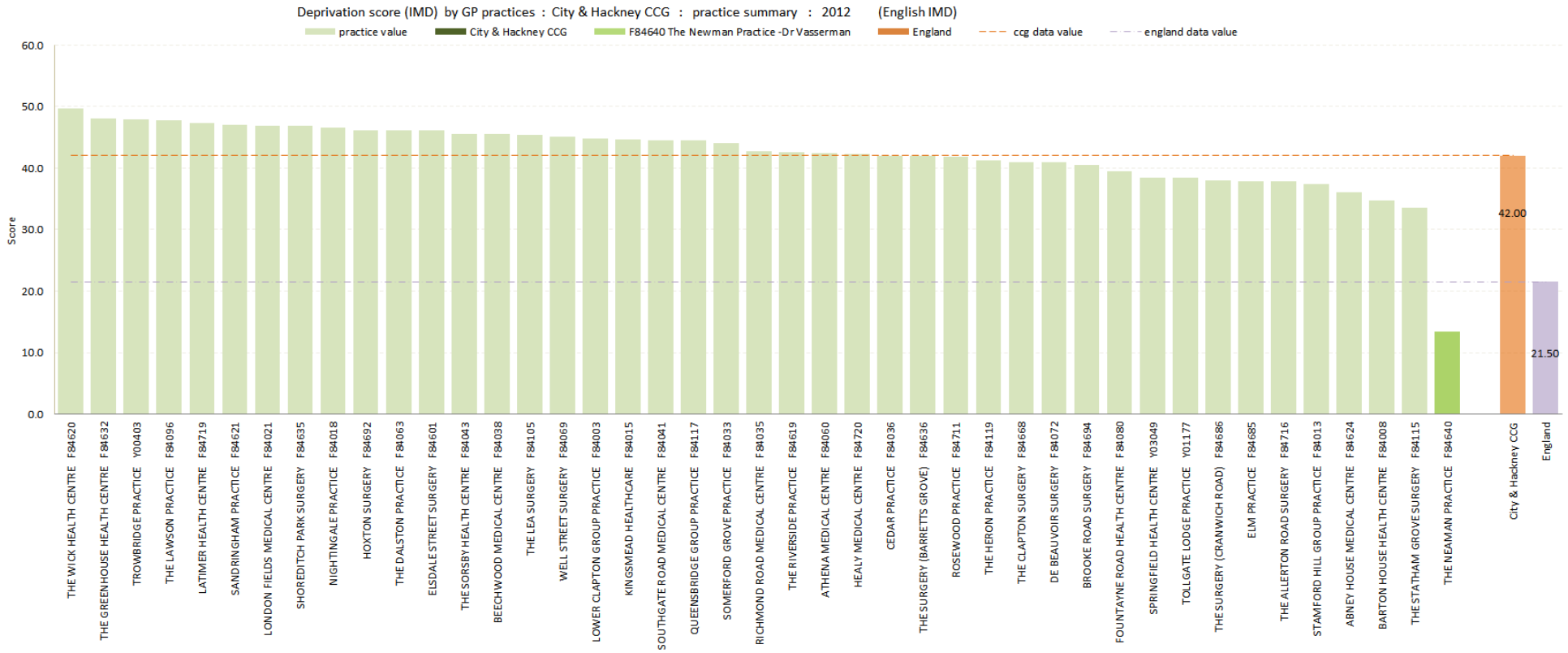


Over the longer term, the proportion of older people in the local population is expected to increase.

** Based on GLA 2013 SHLAA projections. Methodology can be found at http://data.london.gov.uk/datastore/package/gla-2013-round-population-and-household-projections. New council ward boundaries were introduced in Hackney in 2014 – population projections using these are not currently available.*

2. Deprivation

2.1 Index of multiple deprivation (IMD) score (DCLG 2010, applied to 2012 GP populations)

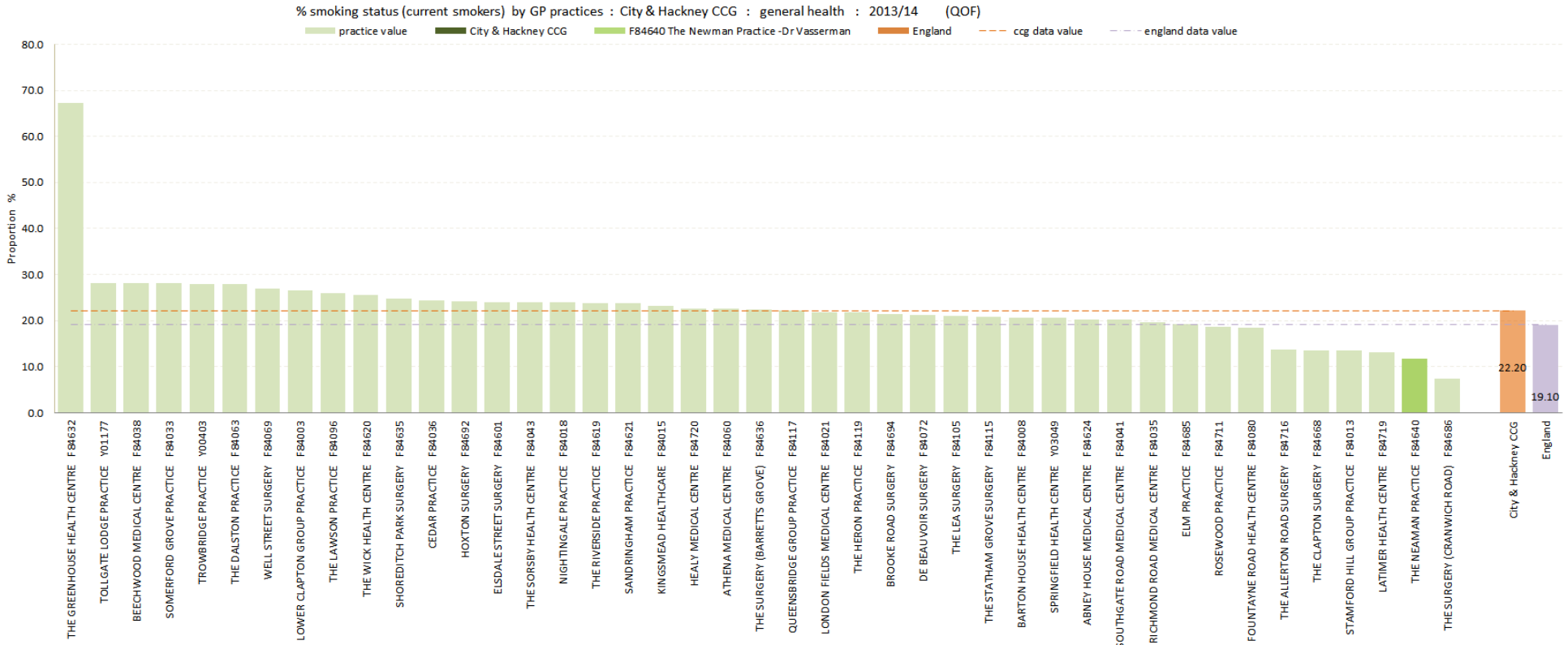


The practice level variation for Deprivation score (IMD) ranges from 13.43 to 49.68. The Neaman Practice (13.43) is below the CCG value of 42.

3. Smoking status

3.1 Current smokers: point prevalence April 2014 (source QOF)

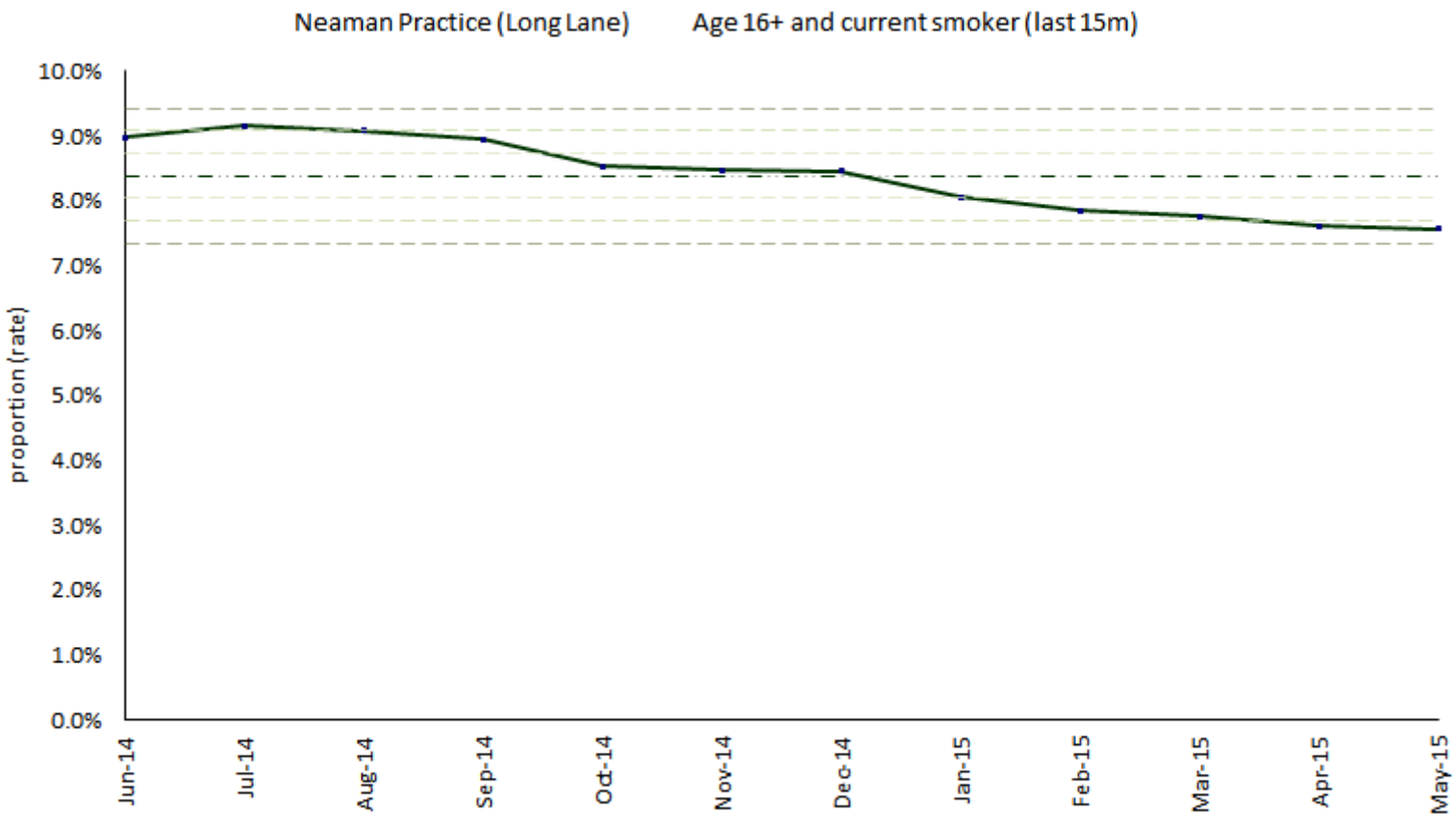
The prevalence of current smokers expressed as a proportion of the registered population aged 16 years & above.



The practice level variation for % smoking status (current smokers) ranges from 7.4% to 67.2%. The Neaman Practice (11.8%) is below the CCG value of 22.2% and is statistically significantly lower than the CCG average.

3.2 Current smokers: monthly trend (source CEG)

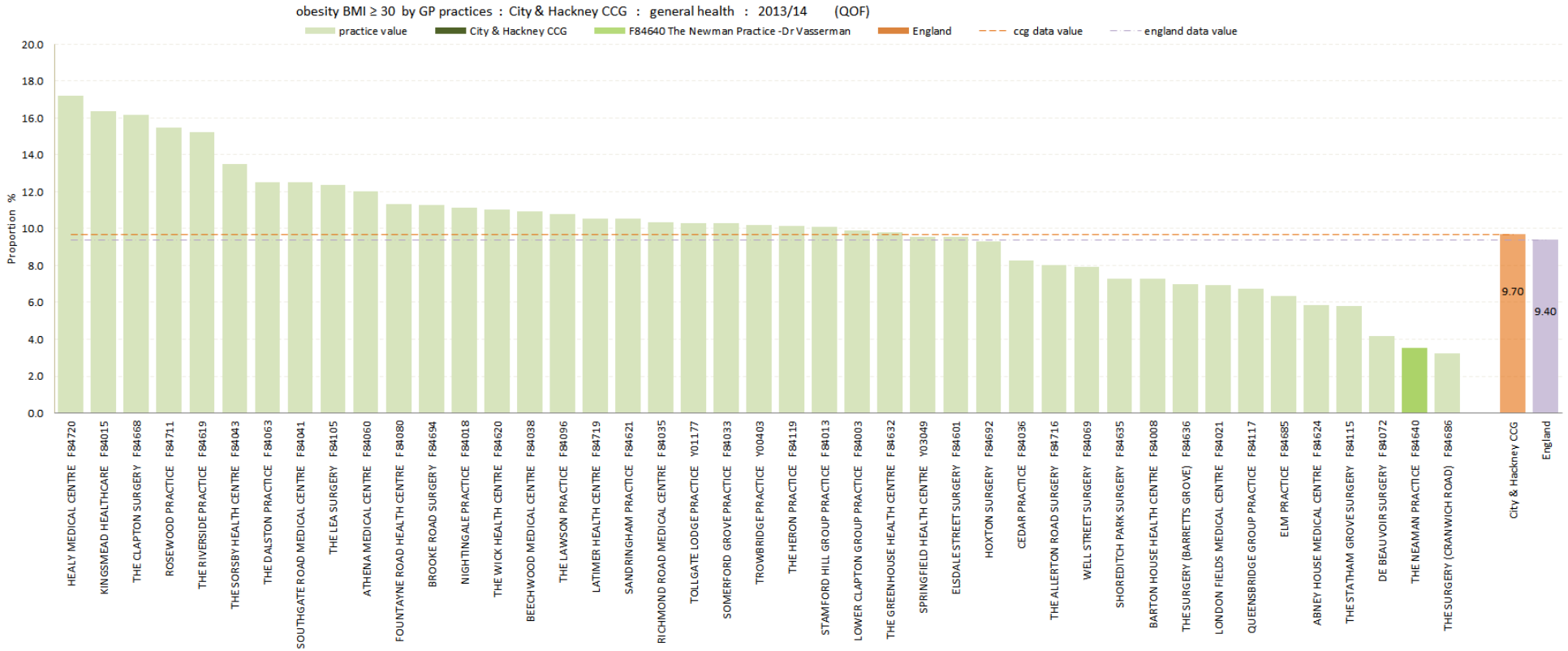
The prevalence of current smokers expressed as a proportion of the registered population aged 16 years & above with status recorded in the past 15 months.



3. Obesity

4.1 Obesity status: point prevalence April 2014 (source QOF)

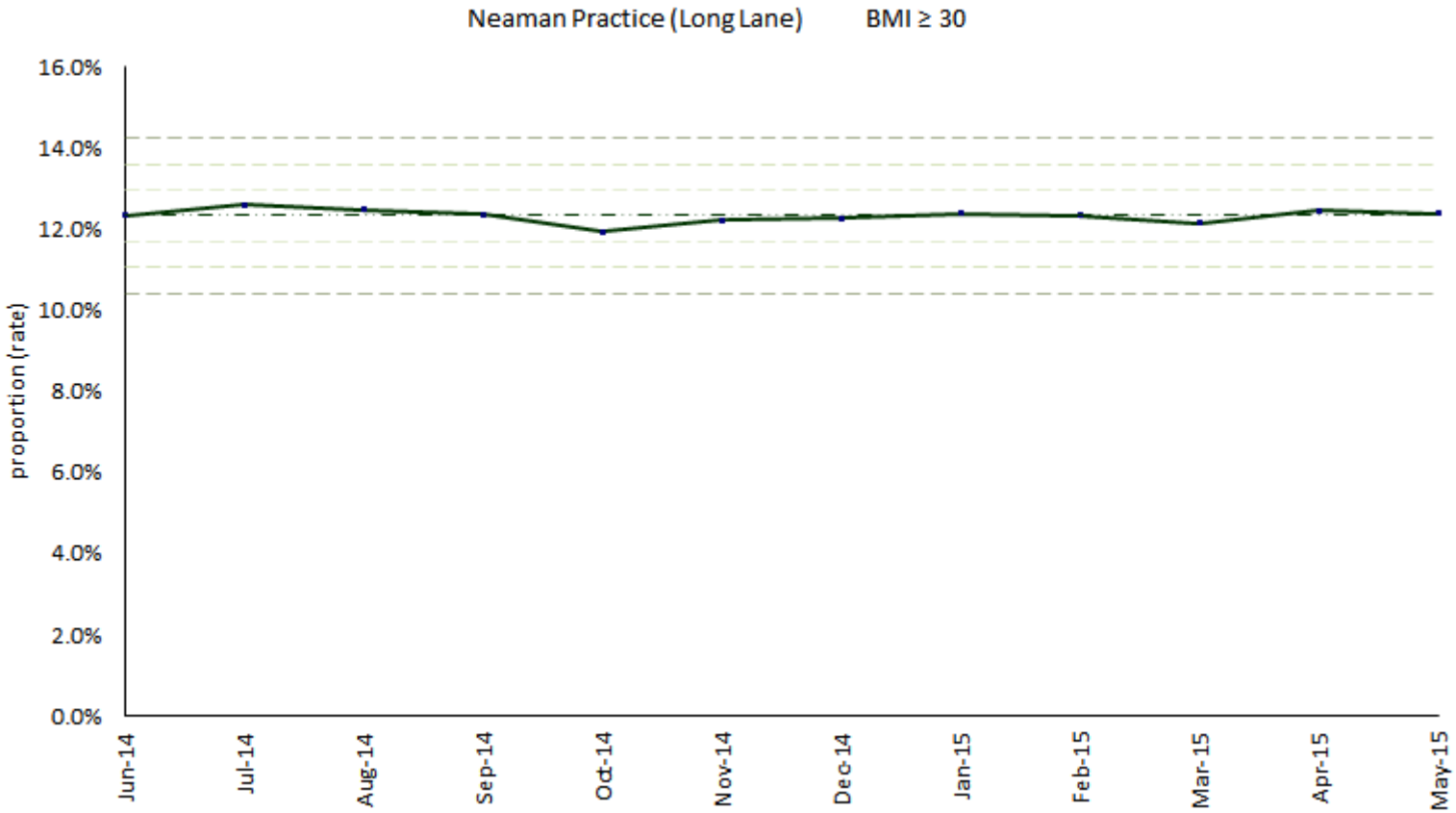
Obesity in adults is measured by using the body mass index (BMI), where the proportion of people aged 16 and over with a BMI greater than or equal to the threshold value of BMI ≥30 as recorded on practice disease registers in the past 15 months. NB. This will underestimate true prevalence



The practice level variation for obesity BMI ≥ 30 ranges from 3.2 to 17.2%. The Neaman Practice (3.5%) is below the CCG value of 9.7% and is statistically significantly lower than the CCG average.

4.2 Obesity status: monthly trend (source CEG)

The monthly prevalence of adult obesity (recorded in the past 15 months) as a proportion of the registered population aged 16 years & above with status recorded in the past 15 months.



5 Practice groupings

On the basis of the age, deprivation, ethnicity and turnover included here, this shows practices grouped with the most similar demographics in City & Hackney. Two practices – The Neaman Practice and the Greenhouse – have more distinctive populations. Otherwise, practice populations in City & Hackney show less variation than in most CCG areas.

1: More children, fewer >65s. High % Charedi. Medium/Low deprivation

THE SURGERY (CRANWICH ROAD)	F84686
STAMFORD HILL GROUP PRACTICE	F84013
THE ALLERTON ROAD SURGERY	F84716
THE CLAPTON SURGERY	F84668
SPRINGFIELD HEALTH CENTRE	Y03049
TOLLGATE LODGE PRACTICE	Y01177

2: Med/High children & >65s. Low British, high black, Med/High Deprivation, Medium Turnover

HEALY MEDICAL CENTRE	F84720
THE SORSBY HEALTH CENTRE	F84043
KINGSMEAD HEALTHCARE	F84015
ATHENA MEDICAL CENTRE	F84060
THE SURGERY (SHARIFF)	F84711

4: Low children, Med/High >65s. High black ethnicities. High deprivation

SANDRINGHAM PRACTICE	F84621
THE WICK HEALTH CENTRE	F84620
THE DALSTON PRACTICE	F84063
BEECHWOOD MEDICAL CENTRE	F84038
THE SURGERY (BARRETTS GROVE)	F84636
LATIMER HEALTH CENTRE	F84719
RICHMOND ROAD MEDICAL CENTRE	F84035
SOUTHGATE ROAD MEDICAL CENTRE	F84041
THE SURGERY (BROOKE ROAD)	F84694

3: Med/low children, med/high >65s. Med/high british. Med/Low deprivation

BARTON HOUSE HEALTH CENTRE	F84008
FOUNTAYNE ROAD HEALTH CENTRE	F84080
THE STATHAM GROVE SURGERY	F84115
ABNEY HOUSE MEDICAL CENTRE	F84624
THE NEAMAN PRACTICE	F84640
DE BEAUVOIR SURGERY	F84072
THE ELM PRACTICE	F84685

5: Medium children, med/low >65s. Med/high british and black ethnicities. Med/high deprivation. Medium turnover

WELL STREET SURGERY	F84069
LOWER CLAPTON HEALTH CENTRE	F84003
ELSDALE STREET SURGERY	F84601
QUEENSBRIDGE GROUP PRACTICE	F84117

6: Medium children, med/low >65s. Med/high british, med/low black. Med/high deprivation. Med/high turnover

SOMERFORD GROVE HEALTH CENTRE	F84033
THE HERON PRACTICE	F84119
LONDON FIELDS MEDICAL CENTRE	F84021
THE CEDAR PRACTICE	F84036
THE HOXTON SURGERY	F84692

7. Med children, med/low >65s. Med/Low British. Med/High deprivation. Med/High turnover

THE NIGHTINGALE PRACTICE	F84018
THE RIVERSIDE PRACTICE	F84619
TROWBRIDGE PRACTICE	Y00403
THE LEA SURGERY	F84105
THE LAWSON PRACTICE	F84096
SHOREDITCH PARK SURGERY	F84635
THE GREENHOUSE	F84632

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Committee(s):	Date:
Health and Social Care Scrutiny Committee	13 February 2018
Subject: Update on Changes to Cancer Services and Breast Cancer Screening	**Public**
Report of: NHS England	**For Information**

Main Report

As part of the Committee's Annual Workplan, Members have requested information about the City of London's cancer services, and following discussion at a previous meeting, breast cancer screening in the City. At Committee we will welcome representatives from the City and Hackney CCG and NHS England to speak with the Committee about cancer services in the City of London. This agenda item has two parts – an update on cancer treatment services, and information about breast cancer screening in the City. At Committee we will welcome Siobhan Harper, Director of Planned Care Workstream and Integrated Commissioning at the City and Hackney CCG, as well as Kathie Binysh, Head of Screening, NHSE London; Jo Wilson, Deputy Team Leader for Cancer Screening and Sarah Galbraith, Commissioning Manager for Breast Screening from NHS England (London Region).

The Committee has been provided with a briefing paper on breast cancer screening by NHS England (London Region) for information.

Recommendation(s)

Members are asked to note the report and briefing paper provided.

Appendices

- Appendix 1 – Briefing Paper on Breast Cancer Screening in the City of London

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Town Clerk's Department

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Breast Screening in City of London

This report describes uptake and coverage of breast cancer screening in the City of London, including recent trends and significant local influencing factors. Due to its unique boundaries, data for the City of London is grouped with the borough of Hackney and will be referred to as City & Hackney in relation to statistical illustrations unless otherwise noted.

As of March 2016, the population of the City of London was recorded as 9, 401 and Hackney as 273, 526*.

1. Background

1.1 Breast cancer

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.

1.2 Breast screening

Studies have shown that screening reduces deaths from breast cancer by between 15 and 22%,[i] [ii] and the Advisory Committee on Breast Cancer Screening in the UK has estimated that around 1,400 lives are saved every year by breast screening. [iii]

Under the NHS Breast Screening Programme, all eligible women aged 50-70 are invited for screening every three years. Screening is intended to detect breast cancer at an early stage when there is a better chance of successful treatment. Because the programme is a rolling one which invites women in a three year cycle, not every woman will receive an invitation as soon as she turns 50. Every woman should however, receive her first invitation before her 53rd birthday.

Some women outside the 50-70 core age group are also screened as part of the NHS Breast Screening Programme. Women who are over the upper age limit for routine invitations for breast screening are encouraged to make their own appointments at three yearly intervals.

The NHS Breast Screening Programme is also currently piloting an extension programme for women aged 47-49 and 71-73 as part of a national randomised control trial. During the pilot,

* ONS, Population Mid-Year Estimates 2016

50% of eligible women 47-50 and 70-73 will be invited. The extension started at selected pilot sites in 2009, women who are registered to a GP in the boroughs of City & Hackney are not currently part of this trial. If proven to be successful, age extension will be fully implemented and all women should be invited for their first screening before the age of 50.

1.3 Central and East London Breast Screening Service

The Central and East London Breast Screening Service (CELBSS) is currently based at Barts Hospital. The service provides breast screening to women in the six boroughs across Central and East London (CEL).

The City of London women, are invited to attend screening at either the Homerton (City & Hackney), Mile End (Tower Hamlets) and The Whittington (Islington) screening sites; women are able to choose any screening site if any alternative better suits their requirements. Women with protected characteristics are more often invited to attend at the Barts Hospital site if they have specifically notified the Administration Hub or have previously attended screening and require accessibility adjustments.

2. Coverage

2.1 Coverage is defined as the percentage of women in the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the last three years.

There are a variety of population and service factors that affect coverage. The most significant being uptake and round length

- Uptake is defined the proportion of people invited for screening who are screened within six months. The national target is 70%.
- Round length is defined the proportion of women who are screened with thirty six (36) months of their previous screen. The national target is 90%.

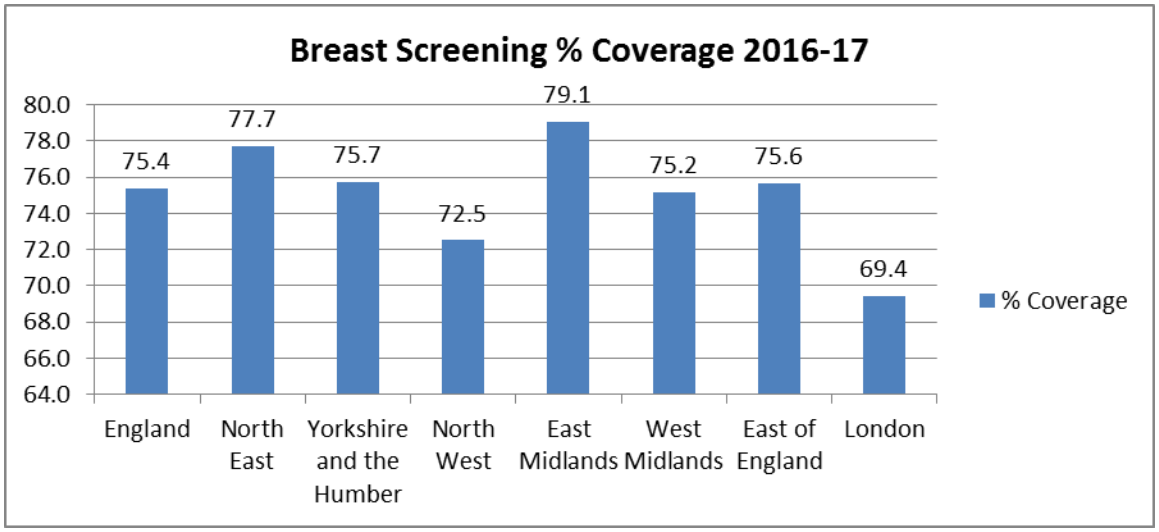
2.2 Trends in coverage

Nationally, coverage of women aged 53-70 was 75.4 per cent at 31 March 2017, compared with 75.5 per cent at the same point in 2016. 2016 illustrated the first increase in coverage

in 5 years and as of 2017 remains above the NHS Breast Cancer Screening Programme's minimum standard of 70 per cent[†].

Breast screening coverage in London remains the lowest in England (Figure 1). This is partly because of high population turnover and the ethnic diversity of the population.

Figure 1 Breast screening coverage across England 2016-2017

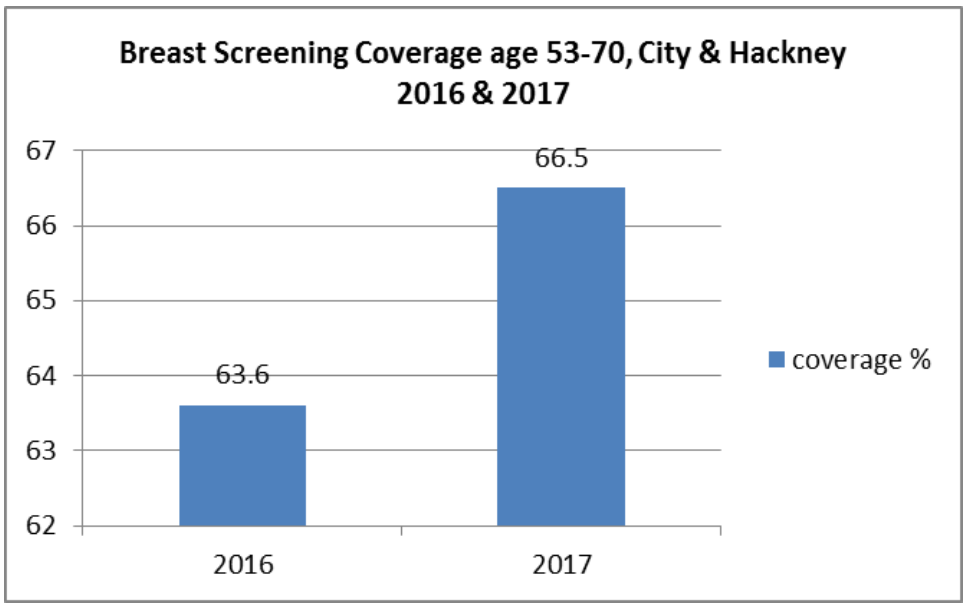


Source: KC63, NHS Digital

As of March 2017, City and Hackney coverage had increased by 2.9 per cent and was the third highest for Central and East London at 66.5 per cent compared to the same point in 2016 (63.6 per cent) (Figure 2). Compared to England, London and CEL, City and Hackney coverage was lower on average for both 2016 and 2017 (Figure 3)

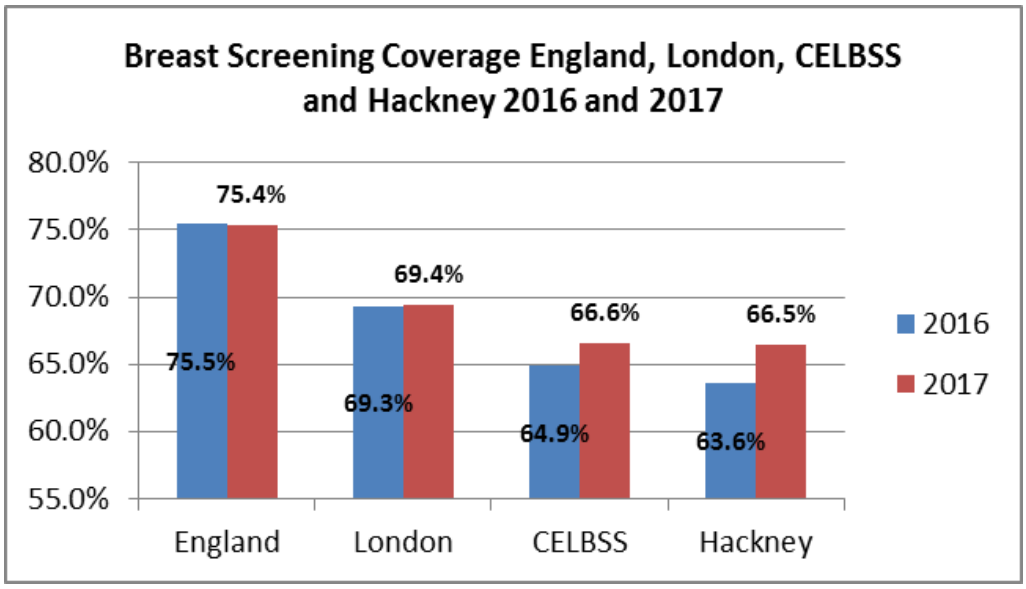
[†] https://digital.nhs.uk/catalogue/PUB30195

Figure 2 Coverage, 53- 70 yr olds, in City of London (And Hackney) 2016 and 2017.



Source: KC63, NHS Digital

Figure 3, Annual Coverage in England / London / CELBSS and City & Hackney for women aged 53-70 in 2016 and 2017



Source: KC63, NHS Digital

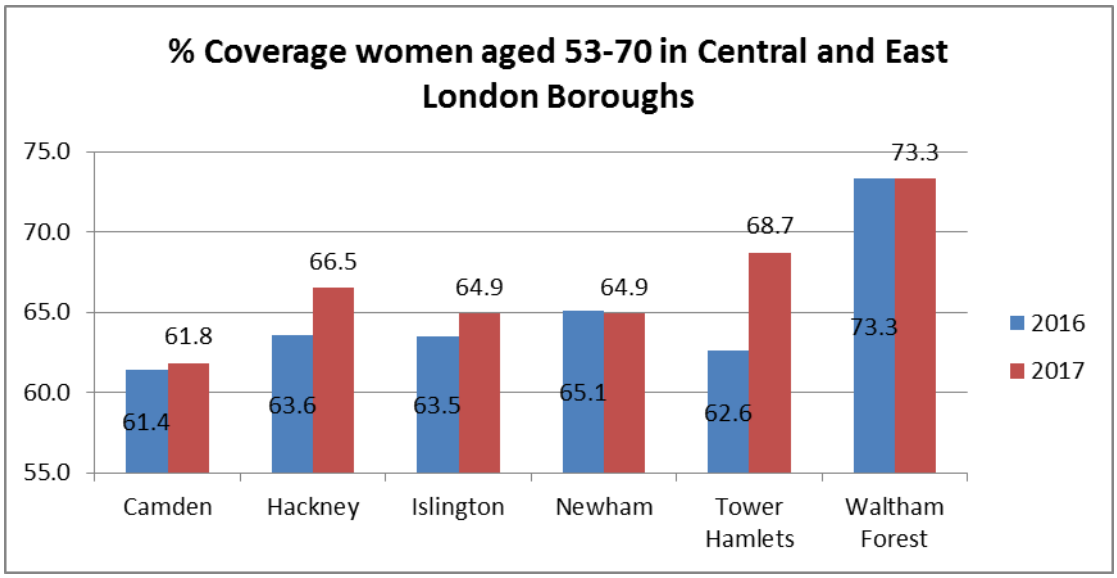
As with all but one Central and East London borough, City and Hackney has seen an increase in coverage since 2016. City and Hackney saw the second largest increase in coverage since 2016 at 2.9 per cent. The largest increase was in Tower Hamlets (6.1 per cent) with the only decline noted in Newham (-0.2 per cent) (Table 1, Figure 4).

Table 1: % change in coverage for women aged 53-70 for all Central and East London boroughs between 2016 and 2017

	Camden	Hackney	Islington	Newham	Tower Hamlets	Waltham Forest
2016	61.4	63.6	63.5	65.1	62.6	73.3
2017	61.8	66.5	64.9	64.9	68.7	73.3
%Change	0.4	2.9	1.4	-0.2	6.1	0.0

Source: KC63, NHS Digital

Figure 4 %Coverage women aged 53-70 in Central and East London Boroughs, 2016 and 2017 comparison



Source: KC63 NHS Digital

2.3 Variation in coverage by practice

City & Hackney practice coverage ranges from 33.9 per cent to 71 per cent (Table 2, Figure 5). There are a variety of reasons for this including list inflation, a transient cohort, ethnic diversity and deprivation of the practice population. Variances in practices can also be aligned to screening site and mobility, the influence of individual practices to proactively encourage women to take up their screening appointments and the availability of alternative clinic appointments within the CELBSS service to accommodate changes to appointment times and dates.

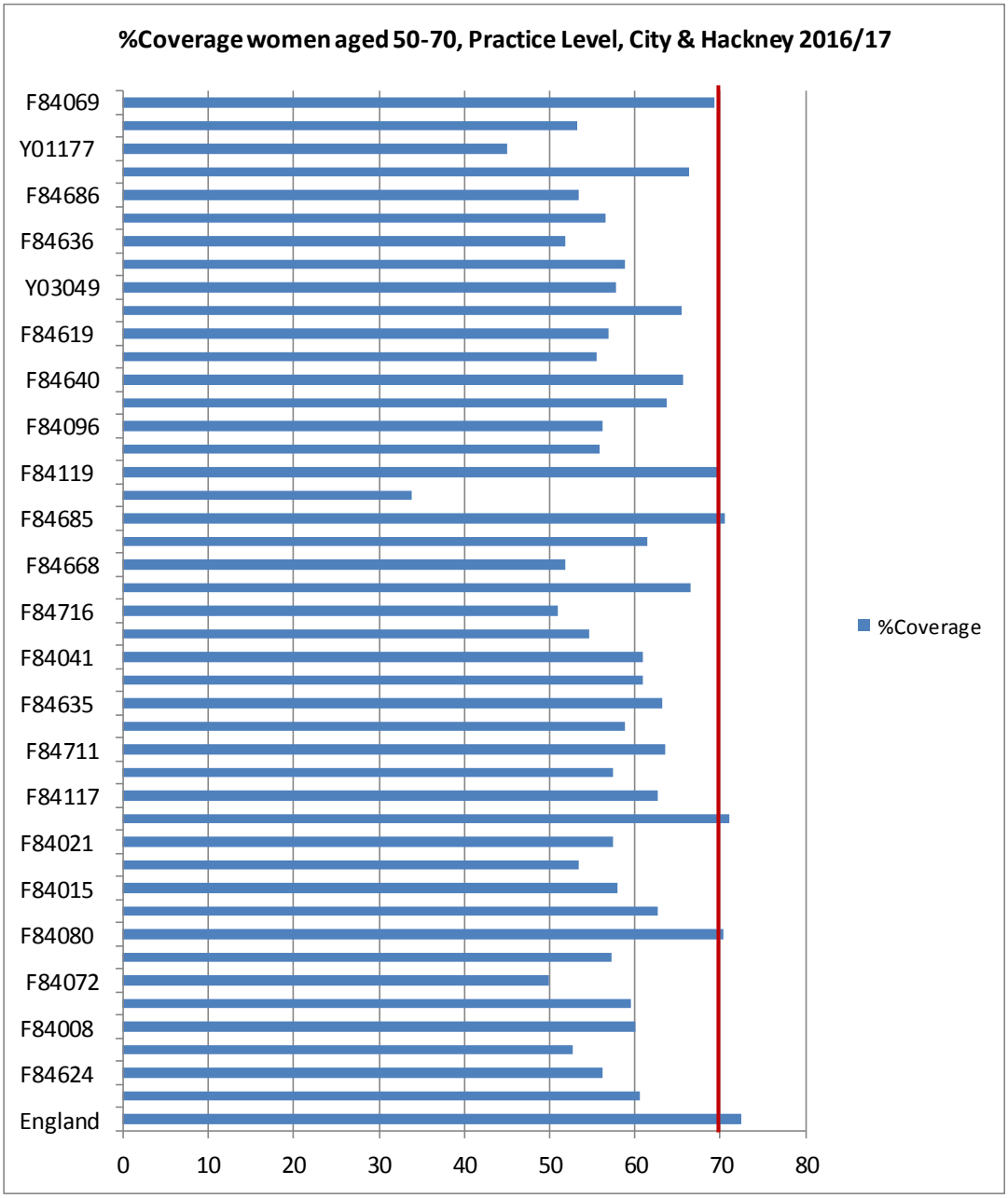
Table 2, Breast screening coverage, Females, 50-70 by general practice, City and Hackney 2016/17

Practice	%Coverage
England	**72.5**
NHS City And Hackney CCG	**60.6**
F84624	56.2
F84060	52.8
F84008	60
F84038	59.5
F84072	50
F84601	57.3
F84080	70.4
F84720	62.6
F84015	58
F84719	53.4
F84021	57.5
F84003	71
F84117	62.7
F84035	57.5
F84711	63.6
F84621	58.9
F84635	63.2
F84033	60.9
F84041	60.9
F84013	54.6
F84716	51
F84036	66.6

F84668	51.9
F84063	61.5
F84685	70.6
F84632	33.9
F84119	69.7
F84692	55.8
F84096	56.3
F84105	63.8
F84640	65.6
F84018	55.6
F84619	56.9
F84043	65.5
Y03049	57.8
F84115	58.8
F84636	51.8
F84694	56.6
F84686	53.4
F84620	66.4
Y01177	45.1
Y00403	53.3
F84069	69.4

Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme.

Figure 5 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) 2016/17



Source: http://fingertips.phe.org.uk/profile/generalpractice

3. Factors affecting coverage

3.1 Round length

Round length is the interval between a woman's last screen and her next offered appointment. The NHS Breast Screening Programme minimum standard is that 90% of women should be re-invited within 36 months.

Between Q2/3 2016/17 and Q1/2 2017/18, the roundlength for CELBSS declined by 11% (based on provisional data).

The fluctuation and decline over the last year can be associated with a variety of issues:

 : During 2015, NHSE London commenced the reconfiguration of breast screening provision across London, culminating in the re-procurement of all clinical provision (six footprints) and the procurement of a new single administration hub for London. The CEL clinical service footprint was not awarded during at this time though the service was mobilised as part of the reconfiguration process with Barts Hospital retaining management until a subsequent procurement exercise was undertaken during 2016/17 for this service specifically. The award for CEL clinical service for breast screening was made to Royal Free Hospital, who is currently mobilising for a service commencement date of 1 April 2018.

During the first mobilisation phase there was a short period of downtime whilst the relevant IT systems were configured (though this was not found to have a significant impact on standards at the unit at the service retained a roundlength over the 90 per cent standard).

 During 2015, Public Health England, implemented *a new call/recall system for breast screening (Breast Screening Select),* as part of this exercise, all services nationally were required to revise their associated screening round plans to ensure alignment to a standard practice of selecting and inviting women by GP practice registration.

As the service at CEL was already selecting women via this method, there was limited impact on standards though the round plan had to be adjusted in view of boundary changes which resulted in a net loss of 192[‡] women to the service.

[‡] Source: PHE BSS Update Edition 3, Population Boundary Updates

- During 2016 Barts Hospital communicated *a serious incident in relation to its PACs system (Picture Archiving and Communication*). This resulted in the loss of the majority of breast screening images including archive files. Due to the nature of the incident and the initial unknown impacts, the service ceased screening for four weeks in April 2017 whilst assurances were made for all subsequent screening image security. The investigation and subsequent recovery process is still ongoing and at the time of writing complete recovery of breast screening images is unknown. An agreed management process for women who are recalled to assessment has been agreed between NHSE and the Screening, Quality and Assurance Service for London and where possible, previous analogue images are being requested for any woman recalled. This has resulted in a slight increase to the number of women recalled for assessment.

- *Workforce Capacity* challenges have been noted across all London breast screening providers of late and have declined significantly at CELBSS over the last three quarters which has further challenged the unit to recover and maintain standards in relation to round length, uptake and predictably on future coverage. The reliance on agency staff to complement the existing workforce (which has declined most notably since Autumn 2017 by 50%); has resulted in the service being unable to fully project future capacity and has necessitated the late cancellation of clinics resulting in women's appointments having to be rescheduled for a later date and on some occasions to a unit outside of their normal alignment for that particular borough.

At the time of writing NHSE and the London Screening Quality Assurance Service are working closely with Barts and the team at CELBSS to reach a resolution that ensures both the safety of women at CEL and the residing workforce.

Actions to improve round length

In all cases women who breach roundlength are wherever possible brought forward and invited within three years of their last screening appointment. As part of service mobilisation, Barts are working with Royal Free to produce a recovery plan for roundlength including a due diligence exercise to risk assess workforce and clinic utilisation. The service uses a Smart clinic system to book all appointments, working on probabilities of attendance to ensure maximum capacity availability.

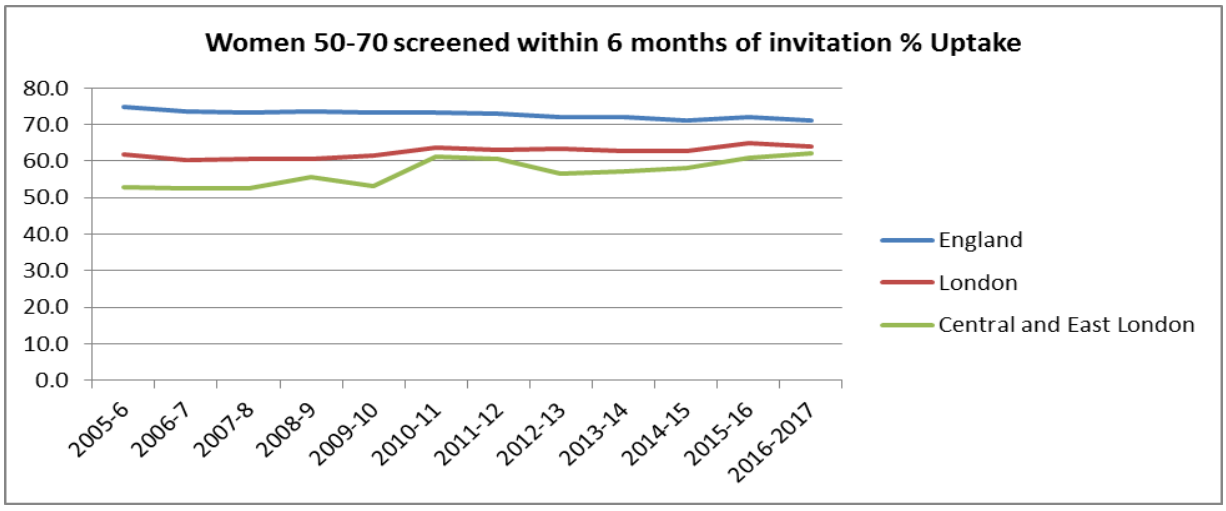
3.2 Uptake

Uptake is measure of individual behavior, i.e. a woman's response to an invitation to screening. There are varieties of factors that affect whether a woman responds to her invitation. These include:

- Social and demographic factors-age, ethnicity and deprivation, population turnover
- Individual factors- fear, embarrassment, previous attendance/non- attendance, poor awareness or knowledge of screening
- Organizational factors – inaccessible services, incorrect patient contact details, lost mail, quality of the service

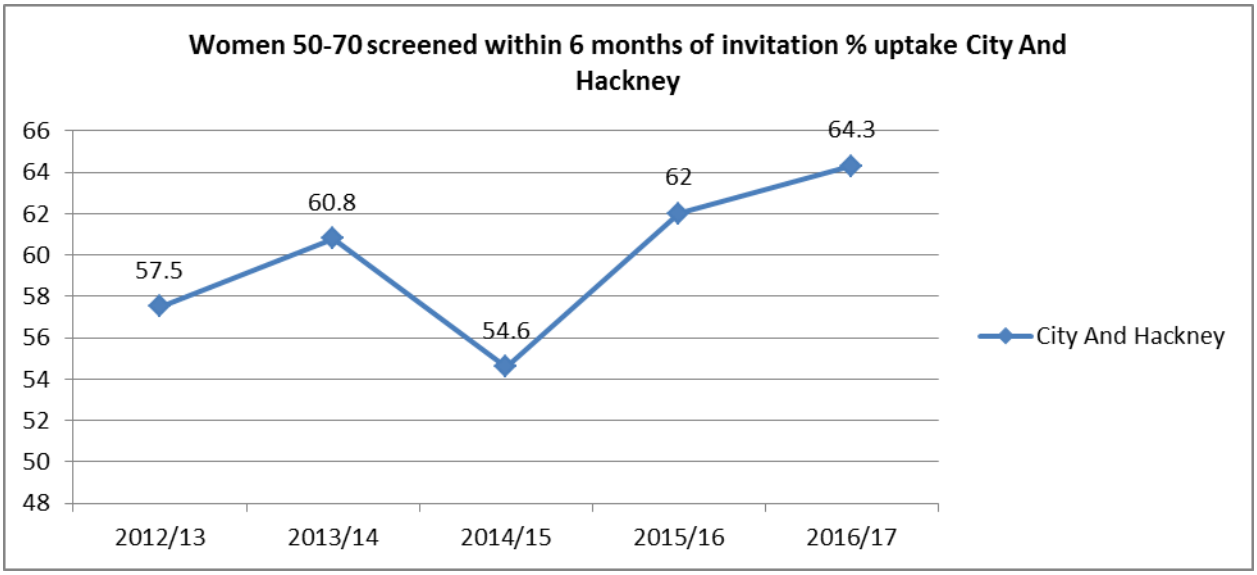
Prior to the challenges described above, overall uptake figures for CELBSS were showing an upward trend (Figure 6), this trend was mirrored in City and Hackney for a similar timeline (Figure 7)

Figure 6 % uptake of women 50-70 screened within 6 months of receiving an invitation in England / London / CEL 2012 – 2017



Source: KC63 NHS Digital

Figure 7 %uptake women 50-70 screening with 6 months of Invitation City and Hackney 2012 - 2017



Source:http://fingertips.phe.org.uk/profile/generalpractice

The most significant factors affecting uptake in City of London are summarized below

3.2.1 Deprivation

Breast screening uptake rates are lower in practices serving deprived communities (data not shown). This inverse relationship between socio-economic status and uptake is more evident when reviewed across the whole of London (Table 3)

Table 3: Breast screening uptake (routine recall) by quintile of deprivation, London, 50-69 years, 2006-2009

Deprivation group	Invited	Screened	%
1 (most affluent)	76,355	60,651	79%
2	74,639	58,751	79%
3	92,749	70,960	77%
4	123,628	91,339	74%
5 (most deprived)	129,067	90,147	70%

Source: Thames Cancer Registry

3.2.2 Type of invitation and previous attendance

Uptake of screening is lowest in women who have not previously attending a screening appointment (24.7 per cent), women who have previously attended a screening appointment but not in the last 5 years (48.1 per cent) or those who are invited for screening for the first time (56.5 per cent) (Figure 8) which are currently higher than London averages (excluding routine within 5 years) and generally lower than England averages (Table 4)

Figure 8 %uptake women 50-70 by invitation/attendance type for CEL 2016-2017

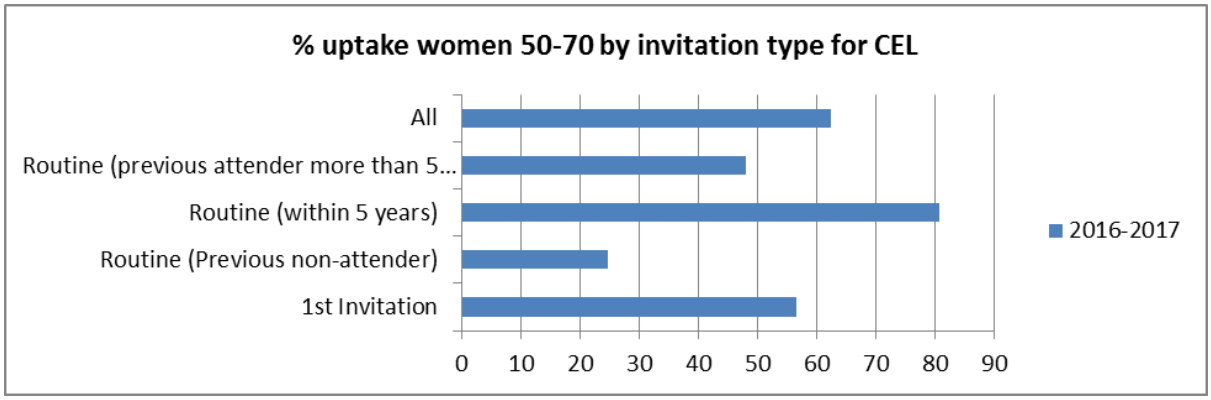


Table 4 England / London / CEL % uptake by invitation type and attendance 2016-2017

Invitation Type	CEL	London	England
1st Invitation	56.5	54.5	60.3
Routine (Previous non-attender)	24.7	21.4	20.8
Routine (within 5 years)	80.7	82.5	86.6
Routine (previous attender more than 5 years)	48.1	45.2	46.3
All	62.3	64	71.1

Source: KC63, NHS Digital

Actions to improve uptake in first time invitees and non-attenders

1. Second timed appointments

   Women who did not attend their screening appointment are offered a second appointment with a specific date and time (timed appointment). When compared to an open invitation (i.e. women contact the service to arrange a date and time), second timed appointment have been found to increase uptake by 4%. CELBSS has currently suspended the practice of sending second timed appointments whilst it recovers from its serious PACs incident (as detailed previously)
2. Contacting DNA's- phone calls

   NHSE currently commissions a third party provider (Community Links) to contact women who DNA their screening appointment in the boroughs of Camden, Islington and most recently Hackney. Data is relation to this initiative for City &

   Hackney will be available July 2018, comparatively the borough of Islington has noted a 1% increase in uptake overall from 2016 to 2017 (figures to be validated for Annual Report April 2018)
3. Pre-appointment reminder texts

   Evidence shows that this improves uptake by 5%, the London administration hub sends text reminders for all women in CEL.

3.2.3 Population Turnover

City of London has the second highest population turnover rate (both internationally and internally) for boroughs in central and east London, with Camden having the highest in both cases also. International turnover (international migration to and from the City of London) in City of London is lower than London overall but higher than London in relation to Internal turnover (migration within the City of London).

This could be explained by the higher than average ratio of business to home in City of London where there is only one General Practice listed, so population turnovers may be more greatly affected by the number of people resident on a shorter term basis

Table 5 International Population Turnover per 1000 population, London, Central and East London Boroughs, 2012 – 2016

INTERNATIONAL	London	City of London	Camden	Hackney	Islington	Newham	Tower Hamlets	Waltham Forest
2012	34.2	20.6	94.9	12	5.5	4.2	7.8	3.8
2013	31	16.4	86.2	10.9	3.5	3.8	6.4	3.3
2014	34.5	17	85.9	10.5	5.5	4.1	6.4	3.2
2015	35.5	17.5	87.7	12.5	3.9	4	8.2	2.6
2016	35.9	18.4	80.9	8.7	4.9	3.8	5.8	3
Rank		2	1	3	5	7	4	6

Migration Indicator Tool, ONS, August 2017

Table 6 Internal Population Turnover per 1000 population, London, Central and East London Boroughs, 2012 – 2016

INTERNAL	London	City of London	Camden	Hackney	Islington	Newham	Tower Hamlets	Waltham Forest
2012	55.2	143.7	176.3	40	57.3	42.6	62.1	49.9
2013	53.2	141.4	174.7	43	60.1	45.7	62.1	49.9
2014	55.9	145.8	164	44.9	63.8	46.2	62.1	49.8
2015	56.3	142.6	161.4	42.3	65.8	47.9	64.5	51.7
2016	55.8	139.3	155.5	47.8	63.3	47.4	62.6	51.6
Rank		2	1	7	4	6	3	5

Migration Indicator Tool, ONS, August 2017

Figure 9 International Population Turnover for Central and East London Boroughs compared to London overall 2012 – 2016

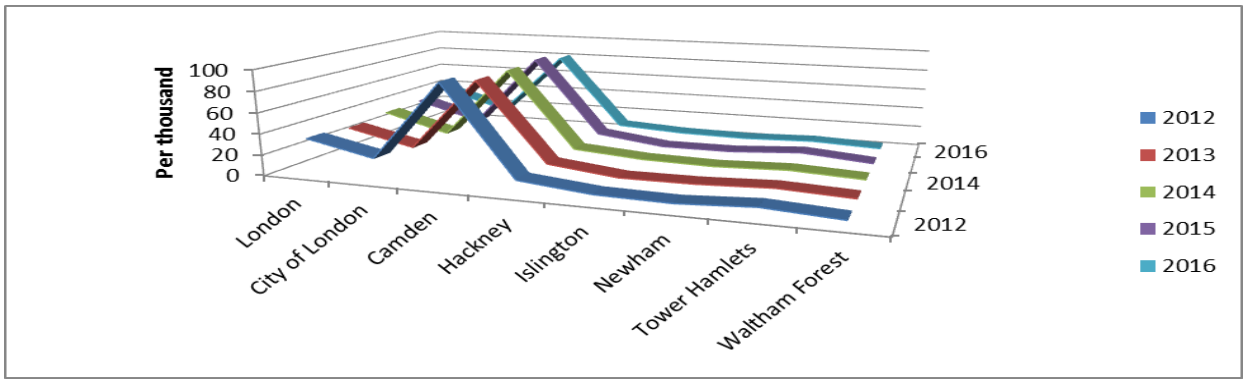
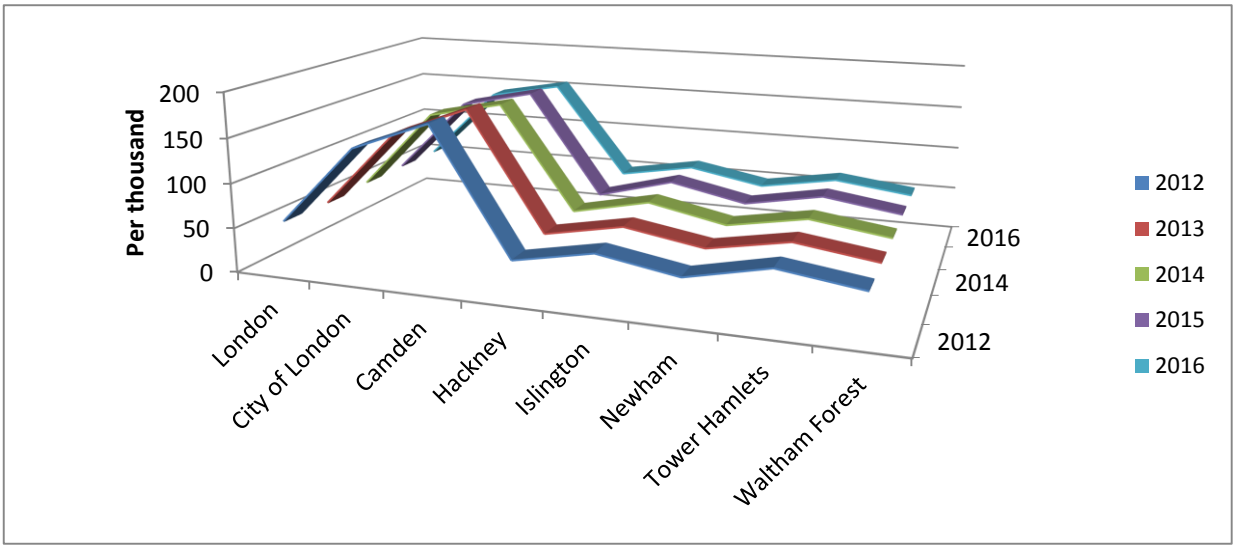


Figure 10 Internal Population Turnover for Central and East London Boroughs compared to London overall 2012-2016



While in most cases, practices endeavour to maintain their registered lists in a current and accurate state, patients often fail to notify their registered practice when leaving the area and/or country resulting in potential duplicate registrations, ghost and 'gone away' patients remaining registered on the national patient registration systems (National Health Application and Infrastructure Service, NHAIS Exeter systems).

This makes the achievement of uptake and coverage targets challenging as the population size (based on GP registers) is inflated and incorrect.

4. Conclusions

NHS England London will continue to work with a variety of partners to implement and roll out interventions that have been shown to improve uptake and coverage including:

- CEL Breast Screening Service will continue with implementation of second-timed appointments, sending of text reminders and improvement in the round length target
- General practices to support women attend screening through implementation of the NHSE/Healthy London Partnership guidance '*Good Practice in Cancer Screening for General Practice'*
- Clinical Commissioning Groups (CCGs) as commissioners of post-screening treatment services to ensure that pathways are integrated and services meet national

performance and quality standards. CCGs are lead commissioners of most screening programme hospital providers. NHSE will also work with CCGs, Clinical Support Units and Clinical Quality Review Groups, in tackling screening-related provider performance issues.

- Voluntary organisations to design and implement health promotion and awareness raising campaigns, particularly targeting ethnic minorities and deprived communities
- Services users to understand and improve their experience of services and address the barriers to attendance that they identify
- Undertake research into interventions to improve uptake and coverage

References

[i] GÃƒ¸tzsche PC, Nielsen M. Screening for breast cancer with mammography. Cochrane Database of Systematic Reviews 2006; Issue 4.

[ii] Humphrey LL et al. Breast cancer screening: a summary of the evidence for the U.S. preventive services task force. Annals of Internal Medicine 2002; 137(5): 347-367.

[iii] Advisory Committee on Breast Cancer Screening. Screening for breast cancer in England: past and future. J Med Screen. 2006;13(2):59-61.

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Additional data supplied by Owen Kennedy Senior Information Analyst NHS England London

Committee(s):	Date:
Health and Social Care Scrutiny Committee	13 February 2018
Subject: Proposal to Merge Cedar Lodge with Thames House	**Public**
Report of: City and Hackney CCG	**For Information**

Main Report

This report presents an outline proposal to merge two continuing care dementia wards to create a shared older adult dementia inpatient ward at Thames House Ward, Mile End Hospital. This would involve the closure of the Cedar Lodge site in Homerton.

The Committee has been provided with a briefing paper by the City and Hackney CCG, and will welcome Dan Burningham, Programme Director for Mental Health at the City and Hackney CCG, and Dr Waleed Fawzi, Older Adult Consultant Psychiatrist for the East London NHS Foundation Trust, to the meeting to present the proposal and speak to the Committee. The proposal will also be considered by the Health in Hackney Scrutiny Commission at their meeting on 14 February 2018.

Recommendation(s)

Members are asked to note the attached briefing paper, and to endorse the proposal that the reconfiguration proceeds without the need for any further stakeholder or public consultation, beyond that already planned or undertaken.

Appendices

- Appendix 1 – Briefing on the Proposal to merge Cedar Lodge with Thames Ward, Mile End Hospital

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To: City of London Corporation Health and Social Care Scrutiny Committee

Date: 13th February 2018

Subject: Briefing on the Proposal to merge Cedar Lodge with Thames Ward, Mile End Hospital

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Summary

Cedar Lodge and Thames House are continuing care dementia wards for people with behavioural and psychiatric symptoms. Occupancy across both wards will fall to 32% by April 2018 and Cedar ward is now isolated from other healthcare facilities, creating safety concerns. This paper presents an outline proposal to merge the 13 bed Cedar Lodge with the 18 bed Thames house to create a shared older adult dementia inpatient ward at Thames House. This proposal would:

- Eliminate the current risks related to service isolation of Cedar Ward, namely staff cover and access to rapid response services,
- Enhance the utilisation of Thames House at Mile End Hospital, which is currently operating below capacity,
- Enable investment to enhance the staffing skill mix at Thames House, improving quality of care and helping to optimise length of stay,
- Improve the ward environment for City and Hackney, with Thames House patients providing a larger more recently refurbished ward
- Improve the utilisation of the Trust's estate and enable efficiency savings, which will be re-invested into local City and Hackney mental health services including Older People's services.

In conclusion, the proposal to merge Cedar Lodge with Thames Ward, at Mile End Hospital delivers more cost effective, higher quality inpatient care, and improves utilisation of estates. Thames Ward is a purpose built older person's ward with sufficient capacity to meet the future requirements to provide inpatient continuing health care needs due to dementia for Older People from Tower Hamlets, Hackney and The City even allowing for demographic growth in the older adult population.

A travel analysis shows that, whilst there will be some increase in travel times, the impact on journey times is not excessive. Furthermore, family and carers of City and Hackney residents in Thames Ward will be able to access assistance to enable them to regularly visit the ward in Mile End. The number of patients being transferred is about 5, making the scale of the change small. All patients and families will be prepared for the transition.

The City of London Corporation Health and Social Care Scrutiny Committee is therefore asked to endorse the proposal that the reconfiguration proceeds, without the need for any further stakeholder or public consultation, beyond that already planned or undertaken.

1.0 Purpose

The purpose of this report is to outline, for consideration by the Health in Hackney Overview and Scrutiny Commission, the City & Hackney CCG and East London NHS Foundation Trust's proposal to merge Cedar Lodge with Thames House, at Mile End Hospital to create a shared Older Person's dementia continuing care inpatient ward serving - The City, Hackney and Tower Hamlets.

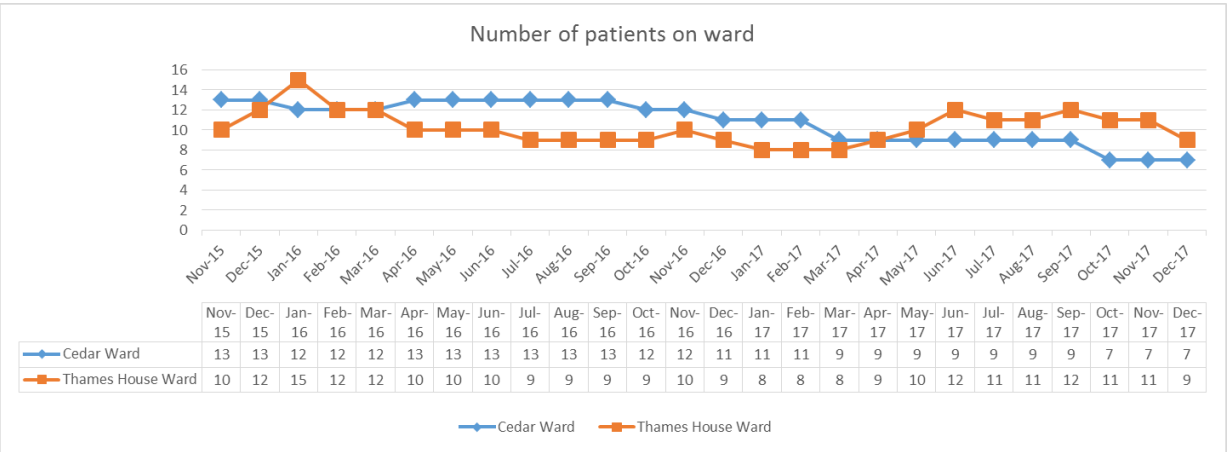
2.0 Service Change Proposal and Rationale

Cedar Lodge is a 13 bed continuing care bed continuing care unit for patients with behavioural and psychiatric symptoms of dementia, which are severe enough to warrant a longer term stay in an inpatient healthcare environment. Cedar Lodge had been one of three wards based on The Lodge site in City and Hackney, but following the merger of other wards with wards on the Mile End Hospital site, Cedar Lodge is now isolated from other adult mental health and physical health care units.

The proposal is to close Cedar Lodge, and to use Thames House, at Mile End Hospital in Tower Hamlets, as a shared facility serving The City, Hackney and Tower Hamlets. Thames House is an 18 bed dementia continuing care ward, covering the same patient cohort as Cedar Lodge.

As Table 1 illustrates, the occupancy of both Cedar Lodge and Thames House has steadily reduced since November 2015. This has been achieved by reducing delayed discharges through improvements in the discharge system and discharge pathway. The psychiatric ward environment provided by Thames and Cedar is only appropriate for patients with behavioural and psychiatric symptoms. Once these are no longer present, patients are more appropriately cared for in nursing home, particularly if physical healthcare needs are more predominate and behavioural issues have diminished.

Table 1



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Cedar Ward	13	13	12	12	12	13	13	13	13	13	13	12	12	11	11	11	9	9	9	9	9	9	9	7	7	7
Thames House Ward	10	12	15	12	12	10	10	10	9	9	9	9	10	9	8	8	8	9	10	12	11	11	12	11	11	9

As a result of this fall in occupancy, currently both Cedar Lodge and Thames House are significantly under-utilised. It is anticipated that Thames House will have just 5 patients by the end of March when the merger is planned to take place. Similarly, it is expected that there will only be 5 City & Hackney patients who would need to transfer to Thames House, should the merger proceed.

Currently there are 7 patients on Cedar Lodge. Three of these patients have been assessed as now requiring nursing home care and are in the process of being transferred to Mary Seacole Nursing Home. It is anticipated that 2 of these patients will have moved to Mary Seacole Nursing Home, by the end of March.

Table 2 Anticipated Occupancy & Gender Mix – Thames Ward (March 2018)

Borough	Male	Female	Total
City & Hackney	3	2	5
Tower Hamlets	2	3	5
Total	5	5	10

Thames House is a high quality, recently refurbished ward on the Mile End Hospital site, built to support 18 people with continuing health care needs due to dementia. Thames House is the preferred location for consolidation of older peoples inpatient services because it is the larger of the two wards and has sufficient capacity to accommodate the anticipated demand from both City & Hackney and Tower Hamlets. It is a recently refurbished, dementia friendly ward, with proximity to the other Older Persons Inpatient wards on the Mile End Site as well as direct access to specialist support based at the Tower Hamlets Centre for Mental Health.

Merging the wards would complete the modernisation of Older Adults inpatient services in City and Hackney and Tower Hamlets, which has focused on centralising services on the Mile End site to provide more cost effective, higher quality inpatient care, and improve utilisation of estates.

This proposal would:

- eliminate the current risks related to service isolation of Cedar Ward , namely staff cover and access to rapid response services,
- enhance the utilisation of Thames House at Mile End Hospital, which is currently operating below capacity,
- enable investment to enhance the staffing skill mix at Thames House, improving quality of care and helping to optimise length of stay,
- improve the ward environment for City and Hackney, with Thames House patients providing a larger more recently refurbished ward

- Improve the utilisation of the Trust's estate and enable efficiency savings, which will be re-invested into local City and Hackney mental health services.

The East London NHS Foundation NHS Trust and local Commissioners are committed to ensuring ongoing access to high quality Continuing Care provision. The merger of Cedar Lodge and Thames House is part of this process of improvement. The plan also includes the intention to enhance the clinical capability and capacity of local nursing home providers to provide Continuing Care for Older Adults with Dementia. In the future this will enable continuing care to be provided in a more appropriate, non- hospital setting closer to the patient's family and friends.

In addition there are plans to improve community care and support for people with dementia and their carers. These plans include improved support for carers, shared care plans and more responsive support in times of crisis. This extra support will be available within primary care and will further supported by the new primary care neighbourhood model.

The closure of Cedar Ward will deliver recurrent savings of £870,000 that the CCGs will reinvest into local Mental Health Services including Older Peoples Mental Health Services. The older people's investment will cover the proposals outlined above.

Pending the decision of this Commission we would be anticipate the move to Thames House being completed by 1st April 2018.

Care Pathway

Only a small proportion of people with dementia will require inpatient continuing care as part of their individualised care pathway. As discussed, patients are admitted to either Cedar Lodge or Thames House because they have challenging behaviour or care needs, which can only be met in an inpatient setting. As their dementia progresses, often their needs change and become primarily focused on physical health and personal care, which can then most appropriately met in a nursing home. At that point they would be transferred to an appropriate nursing home

The closure of Cedar Lodge and the move of these continuing care beds to Thames House at Mile End Hospital will mean a change in the location of the continuing care inpatient provision for City and Hackney patients. However, this service change will not have any adverse impacts on the wider healthcare system or on the care pathway for City and Hackney patients with dementia requiring continuing care. Furthermore, it is not anticipated that there will be a change or increase in the number of patients being transferred to the Mary Seacole Nursing Home. These decisions will continue to be made as they are currently i.e. on an individual basis, taking into consideration what is the most appropriate care setting and what is in the best interests of the patient.

3.0 Demand and Capacity Planning

As can be seen from table 2 above, following the merger, Thames ward will have a total of 10 patients. In the short term we would expect patient numbers to fluctuate between 8 and 12. Consequently occupancy on the 18 bedded ward will therefore be between 44% and 67%. This leaves plenty of spare capacity, whist ensuring the ward is maintains a viable level of occupancy.

Over the next 10 years the number of people with dementia is expected to increase. The table below is based on figures from the April 2016 City and Hackney JSNA for Mental Health and the Tower Hamlets JSNA for Older Adults. The figures show an estimated increase in the dementia population of City, Hackney and Tower Hamlets of 39% over a 10 year period. If we were to assume that there is a comparable increase in the demand for dementia continuing care from 2018-2028, then this would result in a Thames ward bed usage of 14-16 beds or 78-89% occupancy. In other words, there appears to be sufficient capacity to absorb the demand increase. Furthermore, the joint strategy of Tower Hamlets and City and Hackney CCG is to improve the capability of local nursing and residential care homes to accept patients with behavioural and psychiatric symptoms. Over the next 10 years this will reduce the demand for inpatient beds on Thames Ward creating further spare capacity.

Table 3: Estimated growth in City, Hackney and Tower Hamlets Dementia Populations

Date	Hackney	City of London	Tower Hamlets	Total	% Growth
2015	**1238**	**93**	**826**	**2157**	**0%**
2020	**1422**	**139**	**961**	**2522**	**17%**
2025	**1672**	**191**	**1140**	**3003**	**39%**

4.0 Impact of Changes for City & Hackney Service Users

It is recognised that that the move to Thames ward will be unsettling for the five individual patients, who would transfer to Mile End Hospital, and for their families. In each of these cases the Consultant Psychiatrist and nursing staff, who know and are currently caring for the patients, will work closely with them and their family to re-assess their specific needs, agree individualised transfer plans and prepare them for the move. Family and carers will also be given the opportunity to visit Thames House prior to change taking place.

Accessibility for Family & Carers

The Trust recognises the importance for older people in hospital of being able to be visited regularly by their family and carers. Therefore additional travel assistance will be offered to carers where the journey to Thames ward is significantly more complex than the journey would have been to the Cedar Lodge

How the Transport Assistance Assessment Works

At the time of admission the care co-ordinator will, in collaboration with the carer, determine if the journey to Thames House is significantly more complex than the journey would have been to Cedar Lodge. In coming to this determination the care co-ordinators will take into account:

- Mobility issues.

- Journey time.
- Number of transport changes needed to complete the journey.
- Physical, sensory or mental health problems that make travelling by public transport difficult.
- Personal safety considerations, including travelling after dark.

In situations where a journey is agreed as significantly more complex the care co-coordinator will determine with the carer how the Trust might support the individual to maintain their visiting arrangements to Thames ward. This might include the provision of taxis, payment towards parking costs or provision of hospital transport. The transport arrangements will be reviewed regularly by the ward team and the carer throughout the patients stay.

In general, previous appraisals of travel times from Hackney to Mile End have shown that the potential impact on patient and carer travel time would not be excessive as there are a number of public transport routes. An analysis that was undertaken shows the following differences in average travel times for Hackney residents:

Table 4: Average Travel Times

	Travel time to the Lodge	Travel Time to Mile End
Walking	35 mins	57 mins
Cycling	11 mins	19 mins
Driving	8 mins	13 mins
Public Transport	21 mins	33 mins

The table above refers to average travel times, however it is important to understand the impact on individual journey times. In the table below we have compared the current travel times, by public transport, for the actual carers or family of the patients currently on Cedar Lodge with their travel times to Mile End Hospital. As can be seen, although journey times, for most, increased the average increase in time was 12 minutes. Furthermore, the longest journey time was for a carer who was based out of the borough in Frien Barnet and had long distances to travel anyway.

Table 5 – Comparison of Individual Carers Travel Times

Point of travel	How often they visit	Current travel time	Travel time to Mile End	
Frien Barnet	Some weekends	**1 hour 10 minutes** 4 changes	1 hour 16 minutes 2 changes	6 mins increase – simpler journey

London Fields	Daily	24 minutes 1 bus	34 minutes 2 buses	10 mins increase
Homerton	Daily	13 Minutes Walking	41 minutes 2 buses	28 minutes increase
Shoreditch	Daily	35 minutes 2 changes	34 Minutes 2 changes	1 minute decrease
Stamford Hill	Daily	41 minutes 2 changes	58 minutes 3 changes	17 minutes increase
Victoria Park	Occasionally	18 minutes 1bus	30 minutes 1 bus	12 minutes increase

Notably, since the Dementia Assessment ward moved from Hackney to Columbia Ward in Mile End, none of carers or family from The City or Hackney have taken up the offer of assistance with transport. Furthermore all carers reported that they found the journey times manageable.

Quality Benefits

In terms of the scale, these proposals would see the transfer of 5 patients from a ward in Hackney to a ward in Tower Hamlets. This represents a comparatively small-scale service change.

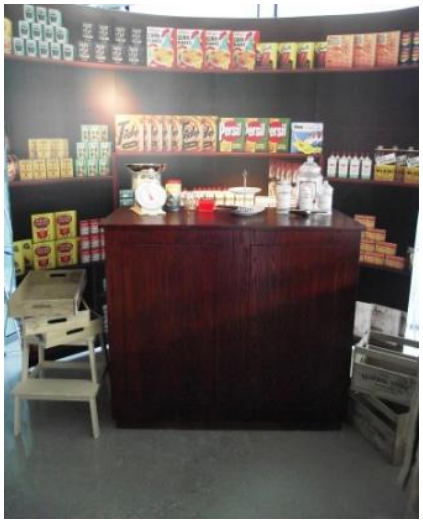
Overall the merger of Cedar Ward and Thames House will deliver a number quality benefits:

- Patients would be accommodated in a dementia-friendly unit, which has recently been refurbished, designed specifically for the older adult population. Further enhancements to the ward environment are also planned including the addition of Reminiscence Pods
- Cedar Lodge is currently the only remaining Older Persons ward on the Lodge site. Consequently there are clinical risks linked to it being isolated from other adult mental health and physical health care units. In contrast, Thames House is co-located with other older persons inpatient and community services on the Mile End Hospital site. The move to Thames House will therefore improve the care delivered to patients by locating highly expert clinicians in a centralised location thereby enhancing the delivery of integrated multi-disciplinary care, and creating a centre of excellence for dementia care.
- Being co-located with other mental health services would enable staff cover at short notice, and the service would have access to rapid response services, which are

located at Tower Hamlets Centre for Mental Health.

- The Mile End site meets the recommendations of the Royal College of Psychiatrists to locate inpatient care on a hospital site delivering physical inpatient healthcare to older people.
- The Mile End site has sufficient space available to provide most rooms with en-suite accommodation, high quality day and therapy areas.
- The current over provision of inpatient bed capacity for Continuing Care provision across Tower Hamlets and City & Hackney would be addressed by this proposal
- Further environmental enhancements - As mentioned above, the extra space available at Thames makes it possible to introduce Reminiscence Pods. The pods have interactive software including old films, television shows and life stories and they can be designed to meet the needs of people with different cultural backgrounds e.g. the Windrush pods aim to resonate with people from the Caribbean. The Pods have been successfully trialled at Columbia ward, and it is planned to introduce Reminiscence Pods on Thames House as well.

Figure 1: RemPod Images.



Consultation Plans

We have already met with the Older Person's Reference Group to discuss these proposals. There are plans to consult with the CCG's Patient and Public Involvement Committee (PPIC) and both Hackney and City of London Healthwatch. This proposal will also go before the City of London Overview and Scrutiny Committee on the 13th February 2018.

5.0 Future Plans for Cedar Lodge

The two already vacated wards on the Lodge site have been developed into Vivienne Cohen House, a base for the Specialist Psychotherapy Service and the North Hackney Recovery Team.

Various options are currently being explored for the re- use of Cedar Lodge. These include:

- The option of Cedar Ward being utilised as a base for providing Intermediate Care Beds for Hackney
- Providing a new Team Base for City & Hackney CAMHS
- Providing a new Team Base for additional Adult Mental Health Community Services covering City & Hackney – this would create, with those services already in the adjacent Vivienne Cohen House a community hub for Adult Mental Health and Recovery Services.

6.0 Conclusion and Recommendations

- The proposal to merge Cedar Lodge with Thames Ward, at Mile End Hospital delivers more cost effective, higher quality inpatient care, and improves utilisation of estates.
- Thames Ward is a purpose built Older Person's ward with sufficient capacity to meet the future requirements to provide inpatient continuing health care needs due to dementia for Older People from Tower Hamlets, Hackney and The City .
- Family and carers of City and Hackney residents in Thames Ward will be able to access assistance to enable them to regularly visit the ward in Mile End.

The City of London Corporation Health and Social Care Scrutiny Committee is therefore asked to endorse the proposal that the reconfiguration proceeds without the need for any further stakeholder or public consultation, beyond that already planned or undertaken.

Dan Burningham Programme Director – Mental Health, City & Hackney CCG

Dr Waleed Fawzi – Older Adult Consultant Psychiatrist East London NHS Foundation Trust

Dean Henderson, Borough Director C&H, East London NHS Foundation

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Committee	**Dated:**
Health and Social Care Scrutiny Committee	**13 February 2018**
Subject: Update on transformation of local sexual health services	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report author: Farrah Hart, Consultant in Public Health, DCCS	

Summary

Over the past three years, sexual health services in London have been undergoing a transformation, in order to reduce costs and improve outcomes for service users.

Locally, this has involved the procurement of clinic-based sexual health services, of which Hackney and the City of London formed a single distinct lot. This procurement was complemented by the procurement of a new London-wide sexual health e-service, to allow service users to order STI tests online, and reduce unnecessary clinic visits.

As a result of the procurement, a new provider, Homerton University Hospital NHS Trust, will be taking responsibility for the provision of sexual health clinic services within the City of London. This means that the old clinic at St Bartholemew's Hospital will close at the end of March, and a new custom-built clinic will open at 80 Leadenhall on 3rd April.

The sexual health e-service started on the 8th of January, with City and Hackney's provider being the first to roll-out the service in local clinics.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. All local authorities are mandated to provide open access sexual health services to their residents. This includes HIV prevention and sexual health promotion, open access genito-urinary medicine (GUM) and contraception services for all age groups. It does not include treatment of HIV in people who have been diagnosed (which is commissioned by NHS England), and does not include termination of pregnancy (which is commissioned by Clinical Commissioning Groups (CCGs). The open access model means that City residents can access GUM services across the country and the City of London Corporation is required to reimburse providers from the ring-fenced Public Health Grant. The cost of providing sexual health services is increasing each year; whereas the grant allocation has reduced sharply, with further cuts due for the next two years. The current situation is financially unsustainable.

1. The need for sexual health services in London is significantly higher than the England average, and has risen significantly in recent years. HIV, Sexually Transmitted Infections (STI's) and abortions are significantly higher in London than national averages, and there are significant differences and inequalities within London.

2. Currently, the City of London commissions sexual health services through an SLA with the London borough of Hackney. Despite the older age profile of City residents, rates of STI diagnoses are reported as very high for our population. Genito-urinary sexual health services (GUM) attendances by those recorded as City of London residents are extremely high, with over 2,100 attendances in 2015/16. It is likely that some of these attendances and STI diagnoses are attributable to City workers who are using a business postcode for extra anonymity when accessing sexual health services.

3. The transformation of sexual health services in London presents an opportunity to reduce costs and improve outcomes for users of sexual health services. Currently each London borough provides its own service to residents in relation to sexual health. This means that there are a multitude of providers providing the same services across the 32 London boroughs and the City, with all the duplication of costs this entails. Across Hackney and the City of London, open access sexual health clinics are currently provided by the Homerton Hospital (1 specialist site and 2 non-specialist/routine sites in Hackney) and Barts Health (1 specialist site in the City at St Bart's hospital).

4. Given London's complex pattern of open access services, there are important advantages for London boroughs to transform and commission services together. The London Sexual Health Transformation Programme aims to transform the way sexual health services are provided in London. The Programme aims to deliver high quality, innovative, equitable and accessible services that can meet the sexual health challenges we face now and in the future, and which reflect the expectations of service users and the technology they use.

5. 31 boroughs and the City have been working together on a sub-regional basis for clinical service transformation, and across London for on-line sexual health

services. This collaborative working between local authorities across London is unprecedented, and represents a step change in the way services will be designed and delivered.

6. Sexual health clinics are currently used for a variety of purposes, but the main activities are:
   - Testing for STIs
   - Contraception (including Long Acting Reversible Contraception (LARC) and emergency contraception)
   - Treatment of symptomatic STIs
   - Complex specialist treatment (e.g., for pregnant women with STIs)

Testing and the new e-healthcare service

7. The results of a waiting room survey carried out across London showed that 60% of those attending specialist sexual health services do not have any symptoms and were attending for just a check-up rather than because they were experiencing any effects. This has the result of putting more strain on services.

8. A new e-healthcare service has been developed, whereby symptomless people can order a STI testing kit online, which will be posted to them using a number of different address options (for example, they may not wish the kit to be posted to their home address). They can collect their own samples, and return the kit via post. Within a few days, they receive notification via text message that their results are available to view on the website. This type of kit is a much cheaper and more accessible way for people to get tested regularly without having to visit a specialist clinic.

9. Unless the tests are returned positive, there is no further involvement by the provider other than to notify the patient of a negative result. If the tests return a positive results for simple genital chlamydia they can receive their treatment by post, for more serious conditions a health adviser makes contact with them to discuss and arrange their treatment at a clinical service.

10. The e-healthcare service went live on 8th January 2018, with City and Hackney's provider, the Homerton Hospital, being the first site to roll out the service to its clinics. The service is currently being rolled out across London, initially in clinics and via clinic websites. Following this phase, the potential exists to target groups currently underrepresented within clinics and at high risk of infection through outreach initiatives. The City of London hosts the contract for the e-service, and related governance arrangements, on behalf of other participating London boroughs.

North Central London procurement of Genito-Urinary Medicine (GUM) and Sexual and Reproductive Health (SRH) Services

11. A paper was brought to Health and Social are Scrutiny Committee in May 2017, detailing the procurement process and outcome. For procurement of clinic-based

sexual health services, Hackney and the City of London formed a single distinct lot. As a result of the procurement, a new provider, Homerton University Hospital NHS Trust, will be taking responsibility for the provision of sexual health clinic services within the City of London.

12. This means that the old sexual health clinic at St Bartholomew's Hospital will close at the end of March, and a new custom-built clinic will open at 80 Leadenhall on 3rd April. The new clinic will provide predominantly routine/non-complex care, with some more specialist clinic sessions being held on particular days and times (for example, there will be a specialist clinic aimed at men who have sex with men, as this group has much higher rates of STIs than the general population).

13. This supports the London-wide aim to reduce the number of major level 3 GUM services (fully comprehensive consultant-led Sexual Health Services, able to treat the most complex STIs and/or provide complex contraception services). Hackney and the City of London currently host two highly specialist sexual health clinics and two clinics that can deal with routine and uncomplicated sexual health issues (which account for the majority of cases). The new model has one specialist centre, with remaining clinics providing more general/routine care.

14. The new clinic will bill according to the London Integrated Sexual Health Tariff. The advantages of this tariff are that we are able to more fully understand what we are paying for as the tariffs relate more closely to actual procedures. The new clinic will also be better able to filter out work postcodes from City workers who are attending this clinic, and so ensure the City of London Corporation does not pick up cost from other boroughs' residents.

15. Clinics across the North East London subregion (consisting of Newham, Waltham Forest, Redbridge and Tower Hamlets) are to be merged, with two new highly specialist sexual health centres to be located in Whitechapel and Stratford. These centres will continue to be open access, and will be conveniently located near transport hubs, meaning that City residents and workers will be able to easily travel to either of these sites in addition to the City and Hackney clinics.

Corporate & Strategic Implications

16. The programme of work described within this report supports the following strategic aim from the Corporate Plan: To provide modern, efficient and high quality local services, including policing, within the Square Mile for workers, residents and visitors.

17. Additionally, it supports the following Key Policy Priorities:

    a. KPP2 Improving the value for money of our services within the constraints of reduced resources; and

    b. KPP3 Engaging with London and national government on key issues of concern to our communities such as transport, housing and public health

18. It also supports the following priorities from the Department of Community and Children's Services Business Plan:

    a. Priority Two – Health and wellbeing: Promoting the health and well-being of all City residents and workers and improving access to health services in the square mile.

    b. Priority Five – Efficiency and effectiveness: Delivering value for money and outstanding services.

Implications

34. The Local Authority has statutory duties to take such steps as it considers appropriate for improving the health of the people in its area. This means that the public health grant needs to be spent as prudently as possible, in the context of the overall reduction in grant funding on improving the health of the population.

35. Some public health services are "mandated": these include the requirement to provide, either directly or indirectly, open access sexual health services for treating, testing and caring for people with such infections.

36. In order to ensure adequate public engagement has taken place, a waiting room survey was conducted with sexual health service users in clinics across London, and a local survey has been conducted at St Bart's and at 3 clinics in Hackney. Focus groups with local service users from City and Hackney have been conducted. City of London Healthwatch has also been consulted with.

37. There has been extensive consultation with London clinicians, and input from commissioners across London and wider. There has also been engagement with national expert bodies in sexual health provision who have helped with expert content. The LSHTP programme has also involved and or sought advice from other key stakeholders including the London Safeguarding Children's Board and wider.

38. An equality impact assessment has been completed for this piece of work, and is available on request.

Conclusion

Background papers
Local procurement of sexual health services, May 2017

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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 THURSDAY, 9 NOVEMBER 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 Susan Masters	INEL JHOSC Representative for Newham Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representative for London Borough of Hackney
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council

Other Councillors Present:

Councillor Richard Sweden	Waltham Forest

In Attendance:

Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Daniel Kerr	Strategy, Policy & Performance Officer, LBTH
Denise Radley	Corporate Director, Health, Adults & Community
Rehan Khan	East London Local Maternity Service
Wendy Matthews	East London Local Maternity Service
Kate Brintworth	East London Local Maternity Service
James Cain	Health Education England
Tracey Fletcher	East London Community Health Partnership
Sanjiv Ahlumalia	Health Education England
Ian Tomkins	East London Health and Care Partnership
Steve Gilvin	Newham Clinical Commissioning Group
David Knight	Senior Democratic Services Officer
Rushena Miah	Committee Services Officer

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Muhammad Ansar Mustaquim and Councilman Christopher Bolden.

2. DECLARATIONS OF INTEREST

The Chair declared a non-specific interest in that she was employed by UNISON union.

Councillor Ben Hayhurst declared he is a Governor at Homerton University Hospital.

Councillor Sweden declared that he is manged by North East London Foundation Trust but he is not employed by them.

3. MINUTES OF THE LAST MEETING AND MATTERS ARISING

Correction on page 10 of the pack, change Terry Bay to Terry Day.

Correction on page 10 – Chairs of JHOSC are not members of the STP board. Statement to be removed.

Clarification on page 13 of the pack, paragraph 4 – Ian Tompkins, Director of Communications East London Health and Care Partnership, added the East London Health Partnership was launched in July 2017 as an internal meeting but there were reps present. The meeting is targeted at health partners and other government transformation groups. The work on the payment programme has been extended to September 2017. There will be further engagement with interested parties in the New Year.

Councillor Anne Munn added that her interpretation of the discussion was that Councillor Maxwell was asking for an update on the east London health payment system consultation and requested to receive a report on this at the February meeting of this group.

In order to have more time to discuss the topic, the Chair decided that an update on the East London Health and Care Partnership Consultation should be added to the February agenda of this meeting.

It was decided a standing item for updates from the new Single Accountable Officer (Jane Milligan) should be added to future agendas.

Very briefly Mr Tomkins confirmed Jane Milligan has been appointed Accountable Officer from 1st December 2017. Shadow arrangements will be in place until April 2018. One of her first tasks will be to look at governance arrangements and the scheme of delegation. He advised this topic should be revisited at the next meeting.

Councillor Hayhurst expressed concern that Hackney's population may be too small to form a Sustainability and Transformation Partnership (STP). It was confirmed that there is no minimum population figure to form an STP, the half a million figure was guidance and not a requirement.

Having noted the above amendments, the minutes were agreed as an accurate record of the meeting.

ACTIONS

1. **An update on the East London Health and Care Partnership Payment System Consultation to be added to the February agenda of this meeting.**

2. **Chair to provide list of working groups.**

4. STATEMENTS FROM MEMBERS OF PUBLIC

Michael Vidal

'Will the commission consider referring the decisions of the CCG Boards to the Secretary of State?' My reasons for making this request are:

1. The question of how you can legally remove the existing Accountable Officers and replacing them has not been given a satisfactory answer. I would refer the Commission to paragraph 4.1 of my August submission to the last meeting of the Commission.
2. It is clear from the comments made by some of the members of the City and Hackney CCG Board in approving the proposal they only did so because of a threat from NHS England to use its intervention powers if they did not agree to the proposals.
3. The power to make these arrangements under s.14Z3 of the NHS Act 2006 (as amended) is a discretionary power as can be seen by the use of the word may and not must in the section. Accordingly, in making the threat NHS England caused the NHS City and Hackney CCG Board to unlawfully fetter its discretion.
4. NHS England in saying that matters have to be done at the NEL level are subjecting the statutory function of the CCGs which only relate to people in its area to the need to comply with a non-statutory requirement.
5. The proposal seeks to circumvent the abolishing of Strategic Health Authorities by s.33 of the Health and Social Care Act 2012 by creating bodies with a strategic role but no legal basis.

Mr Vidal's questions were noted.

Jackie Applebee

Our question is: When the NHS is on the point of collapse due to unprecedented underfunding by the current Government, do the councils agree with us that this money would be much better spent on front line patient care?
We also urge the councils to note the most recent Kings Fund report which expresses concerns about STPs and their ability to deliver within the financial constraints:
https://www.kingsfund.org.uk/sites/default/files/2017-09/STPs-London-Kings-Fund-September-2017_1.pdf
and to join with us in insisting that these plans are not deliverable without swingeing cuts to NHS services."

Ms Applebee's questions were noted.

5. ITEM 4. MATERNITY

Kate Brintworth, Head of Maternity - East London Health and Care Partnership, introduced the item. As part of the Five Year Forward View the Maternity Transformation Board was set up by NHS England to ensure recommendations from the Better Births Review were delivered. Key areas of action included, reducing still birth, learning, ensuring women have a better experience of care, continuity of care and the option to give birth in a midwifery setting.

It was recognised that collective action would be required to meet the new standards so Local Maternity Systems were introduced to take leadership and action. The East London Local Maternity System (ELMS) provided a report on their activities over 2016/17.

With reference to page 55 of the reports pack, Councillor Ann Munn asked to learn more about the new models of cross boundary working. The Chair of the East London LMS used the Neighbourhood Midwives social enterprise as an example where there is continuity of care throughout pregnancy to six weeks after birth.

Councillor Ben Hayhurst asked how continuity of processes is maintained when they have five hospital sites across the patch and the trust is a separate entity.

Ms Brintworth explained that communication between the sites is good because there is an existing network in place that regularly meets. There are five delivery packs used across the sites which have been standardised to save £80,000.

Councillor Susan Masters queried how the ELMS programme will be funded over the next five years. Tracey Fletcher, Chief Executive of Homerton

Hospital, explained an NHS England bid for £7.5 million has been submitted and feedback on the bid will be given in the New Year.

There was a discussion on the flow of patients across London. Ms Fletcher informed the group that a piece of research has been conducted on demand levels but it was very difficult to specify what birth numbers would be due to changing demographics. She said the birth rate is expected to go up but this is unlikely to be by a huge amount. This year there were 2000 less births than the 5000 predicted. There has been a recent trend in more women, particularly from Hackney, choosing to go to north east London hospitals such as the new University College London Hospital (UCLH).

Representatives from Homerton Hospital acknowledged Hackney's changing demographics. They said they needed to challenge the local perception that new hospitals like UCLH had better maternity care because on the whole UCLH and Homerton provide a comparable service.

The discussion moved on to maternal mortality rates. Councillor Hayhurst suggested the death rate being higher in east London may be driving patients away. Ms Brintworth explained that the mortality rate is relatively low considering the number of high risk cases that are presented. East London hospitals are seeing an increase in the number of older women, diabetic women, obese women and women diagnosed with cancer choosing to give birth. These factors can influence the maternal mortality rate.

Councillor Hayhurst asked what measures were in place to handle a maternity related death. Ms Brintworth said there is an action plan in place and a report has been written on the topic.

The Chair asked if patients were being tracked between births. Ms Brintworth said all of the providers within the ELMS have a bereavement team that can track a patient's wellbeing up to their next birth. Patients also have a birth record which goes from hospital to hospital. One provider piloted a National Care Bereavement Pathway for traumatic birth; this service includes the support of a consultant midwife who will be available for advice up until the next pregnancy. The pilot has produced successful case studies.

It was noted that the slightly higher mortality rate figures between the years 2013-2015 were an anomaly.

It was confirmed that maternity care would be provided to all women regardless of their citizenship status. Overseas patients who have elected to have maternity care in the UK will be billed. A migrant or refugee would not be turned away if they required care but could not afford it.

The Chair thanked speakers for their report and invited them to the Tower Hamlets Health Scrutiny Committee meeting on 8th January 2018 which will be discussing a report on the Royal London Hospital Maternity Services.

RESOLVED

(a) To note the report

6. ITEM 5. WORKFORCE

James Cain, Head of Workforce Transformation, Health Education England, presented the report on Workforce. He said that when the 44 STPs were formed Health Education England was tasked with creating 44 multi-agency action boards.

Population growth has resulted in pressure on health services.
There are pockets in east London which are under doctored. In addition to this the nursing workforce is migrating away due to affordable housing issues.

Workforce retention is included in a work stream. Providing people with careers as opposed to jobs is a key theme in the work. The apprentice levy has increased to enable more local people to enter the workforce as local people are more likely to stay on longer term.

The national target for increasing the number of GPs is 500. North East London has a target of employing 19 additional GPs. Given the population demand, new roles are to be introduced into primary care including physician associate and care navigator. In secondary care a nursing associate role will be introduced.

Dr Sam Everington said that investment is a key factor in retention. Commissioners have invested in training science graduates to learn some GP skills over a 2 year training course. He argued that the diversification of roles is an essential benefit to a changing workforce and used the example of utilising pharmacists, who are over represented in the borough, to support GPs with paperwork and prescriptions. He also advocated for e-contact consultations.

The Chair asked primary care colleagues what they thought about virtual consultations, also referred to as the Babylon Project. On the whole the GP's agreed that it was a major risk and encouraged 'cherry picking'. They thought the funding formula was rather crude, for example a young person with significant needs would generate the same charge as a low risk patient.

Steve Gilvin, Chief Officer, Newham Clinical Commissioning Group, acknowledged that cherry picking is an issue but said there will be a menu of options on what can be provided which is a good thing.

Wendy Matthews, Deputy Chief Nurse /Director of Midwifery, Barking, Havering and Redbridge University Hospital NHS Trust, asked what impact Brexit would have on European nurses.

Mr Cain replied that on average European junior nurses leave after two years but experienced nurses tend to stay on. Health Education England is focussing efforts on training newly qualified nurses. There is a Capital Nurse Programme to ensure London nurses are given the best training. With regard to Brexit, there has not been a significant shift towards nurses leaving the country but the reduction of the pound has resulted in difficulty in attracting European nurses on salary.

Councillor Hayhurst asked a question about housing options available to nurses and whether the health service and local authority worked in a joined up way to ensure key workers are provided with suitable housing.

It was noted that there has been little joined up working with the health service and local authorities on key worker housing. Members suggested offering workers a suite of benefits such as nursery places, housing, and training to encourage people into entering the profession.

Councillor Susan Masters asked about the job roles of these physician associates. Dr Everington said some of them will be trained on hospital work and some on GP work. It is envisaged that the roles will specialise in areas such as chronic conditions but this will depend on the individual's strengths.

A member asked what the contingency plan would be if these roles could not be filled. Mr Gilvin responded saying that the GP Resilience Programme has allocated some funding to practices that are struggling. It is not a huge amount but the workstream is there in case intervention and advice is required.

There was a discussion on NHS estates and the sale of land.
Mr Tompkins explained that any sale of NHS assets goes into a general pot with no guarantee the funds will be allocated to an east London Trust.

Councillor Richard Sweden asked how GPs felt about the dilution of their profession with the introduction of the new roles. Dr Everington responded that initially there was some opposition to the idea but it is now widely welcomed due to the demands on the service.

Mr Gilvin informed the committee about a piece of work on quality improvement with Newham CCG that is being piloted.

RESOLVED

(a) To note the report

The Chair thanked delegates for their contributions and brought the meeting to a close.

7. ANY OTHER BUSINESS

There was no other business.

The meeting ended at 8.30 p.m.

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

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
Neaman Practice	8th May 2017	The GP practice to reassure the Committee of arrangements after Dr Vasserman's departure.	13th February 2018
Sexual Health Transformation for London/Leadenhall local service	8th May 2017	An overview of the London-wide transformation of sexual health services and information on Leadenhall clinic	13th February 2018
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 and Breast Cancer Screening	8th May 2017	Members requested an update on the changes to cancer services and breast cancer screening in the City be provided at the next meeting.	13th February 2018
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
Employment of Individuals with Learning Difficulties	30th October 2017	To discuss work going on the Corporation to encourage employment and address stigma.	TBC

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Committee: Health and Social Care Scrutiny Committee	**Date:** 13 February 2018
Subject: Annual Review of the Committee's Terms of Reference	**Public**
Report of: Town Clerk	**For Decision**
Report Author: Joseph Anstee, Committee & Members' Services Officer	

Main Report

All Committees/Boards are asked to review their terms of reference annually. This will enable any proposed changes to be considered in time for the reappointment of Committees by the Court of Common Council.

The terms of reference of the Health and Social Care Scrutiny Committee are attached as an appendix to this report for your consideration.

Currently the Health and Social Care Scrutiny Committee meets three times a year and these meetings are held in February, May and October.

Recommendation(s)

That, subject to any comments, the terms of reference of the Committee be approved for submission to the Court as set out in the appendix.

The Committee are also asked to consider the frequency of their meetings going forward.

Appendices

- Appendix 1 – Health and Social Care Scrutiny Committee Terms of Reference

Contact:
Joseph Anstee
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Background Papers

HEALTH & SOCIAL CARE SCRUTINY COMMITTEE

1. **Constitution**
A non-Ward Committee consisting of:

- Any 6 Members appointed by the Court of Common Council
- 1 Co-opted Healthwatch representative.

The above shall not be Members of the Community & Children's Services Committee or the Health & Wellbeing Board.

2. **Quorum**
The quorum consists of any three Members. [N.B. - the co-opted Member does not count towards the quorum]

3. **Membership**

2 (2) Christopher Paul Boden
2 (2) Alison Gowman, Alderman
2 (2) Michael Hudson
2 (2) Vivienne Littlechild, J.P.
2 (2) Wendy Mead, O.B.E.
1 (1) Emma Edhem

together with one Member to be appointed this day and the co-opted Member referred to in paragraph 1 above.

4. **Terms of Reference**
To be responsible for: -

(a) fulfilling the City's health and social care scrutiny role in keeping with the aims expounded in the Health and Social Care Act 2001 and Part 14 of the Local Government and Public Health Act 2007 (Patient and Public Involvement in Care and Social Care);

(b) agreeing and implementing an annual work programme; and

(c) receiving and taking account of the views of relevant stakeholders and service providers by inviting representations to be made at appropriate meetings.

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