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Health and Social Care Scrutiny Committee

Date: **TUESDAY, 3 NOVEMBER 2020**

Time: **11.00 am**

Venue: **VIRTUAL PUBLIC MEETING (ACCESSIBLE REMOTELY)**

Members:
Chris Boden
Michael Hudson
Vivienne Littlechild
Wendy Mead
Steve Stevenson

Enquiries: **Rofikul Islam** **Tel. No: 020 7332 1174**
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Accessing the virtual public meeting

Members of the public can observe this virtual public meeting at the below link:
https://youtu.be/ou0HFJ_Y6Ig

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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. **ORDER OF THE COURT**
   To note the order of the Court.

   For Information
   (Pages 1 - 2)

4. **ELECTION OF CHAIRMAN**
   To elect a Chairman in accordance with Standing Order 29.

   For Decision
5. **ELECTION OF DEPUTY CHAIRMAN**
   To elect a Deputy Chairman in accordance with Standing Order 30.

   For Decision
6. **CO-OPTION OF A HEALTH WATCH REPRESENTATIVE**
   To co-opt one representative from Healthwatch City of London.

   For Decision
7. **VOTE OF THANKS**

   For Decision
8. **MINUTES**
   To agree the minutes of the previous meeting held on 26 February 2020.

   For Decision
   (Pages 3 - 6)

9. **APPOINTMENT OF INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE REPRESENTATIVE(S)**
   To appoint representative(s) to the Inner North East London Joint Health Overview and Scrutiny Committee, noting that the Chairman and Deputy Chairman are typically appointed, however other Members had expressed interest at the previous meeting.

   For Decision
10. **WORKPLAN**
    To note the Committees workplan.

    For Information
    (Pages 7 - 8)

11. **UPDATE ON CHIROPODY**
    Head of Podiatric Medicine, Homerton University Hospital NHS Foundation Trust and Clinical Commissioning Group representative to be heard.

    For Information
    (Pages 9 - 14)

12. **NEAMAN PRACTICE APPOINTMENTS**
    Neaman Practice Manager to be heard.

    For Information
    (Pages 15 - 16)

13. **CITY & HACKNEY RESTORATION AND RECOVERY PLAN POST-COVID-19**
NHS City and Hackney Clinical Commissioning Group to be heard.

For Information

14. **AN INTEGRATED CARE SYSTEM FOR NORTH EAST LONDON UPDATE**
NHS City and Hackney Clinical Commissioning Group to be heard.

For Information
(Pages 17 - 46)

15. **CITY OF LONDON HEALTH PROFILE 2019**
Joint report of the Director of Community & Children's Service and the Director of Public Health.

For Information
(Pages 47 - 54)

16. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
17. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
18. **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

19. **NON-PUBLIC MINUTES**
To agree the non minutes of the previous meeting held on 26 February 2020.

For Decision
(Pages 55 - 56)

20. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
21. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

Part 3 - Confidential Minutes

22. **CONFIDENTIAL MINUTES**
To agree the confidential minutes of the previous meeting held 26 February 2020.

For Decision

23. **CONFIDENTIAL QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
24. **ANY OTHER CONFIDENTIAL BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

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RUSSELL, Mayor	**RESOLVED:** That the Court of Common Council holden in the Guildhall of the City of London on Thursday 16th July 2020, doth hereby appoint the following Committee until the first meeting of the Court in April, 2021.

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 2020/21**

5 (1) Christopher Paul Boden, *for two years*

5 (1) Michael Hudson, *for three years*

5 (1) Vivienne Littlechild, M.B.E., J.P., *for three years*

5 (1) Wendy Mead, O.B.E.

Vacancy

Vacancy

Together with 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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HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

Wednesday, 26 February 2020

Minutes of the meeting of the Health and Social Care Scrutiny Committee held at Committee Rooms, West Wing, Guildhall on Wednesday, 26 February 2020 at 11.00 am

Present

Members:
Chris Boden (Chairman)
Michael Hudson (Deputy Chairman)
Vivienne Littlechild
Deputy Edward Lord
Wendy Mead
Steve Stevenson

In Attendance

Officers:

Chloe Rew	-	Town Clerk's Department
Julie Mayer	-	Town Clerk's Department
Ruth Calderwood	-	Department of Markets and Consumer Protection
Claire Giraud	-	Community & Children's Services
Andy Liggins	-	Community & Children's Services
Jillian Reid	-	Community & Children's Services
Annie Roy	-	Community & Children's Services
Ian Tweedie	-	Community & Children's Services

Also in Attendance:

Siobhan Harper	-	NHS

1. **APOLOGIES**
   The Chairman opened the meeting thanking Julie Mayer for the work she had done for the Committee, as this was her last meeting.

   There were no apologies.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   Steve Stevenson declared a standing interest by virtue of a being a resident of Golden Lane Estate.

3. **MINUTES**
   RESOLVED – that, the minutes of the previous meeting held 30 October 2019 be agreed as correct record subject to typographical amendments for items 3 and 10.

Matters Arising:

Item 4: It was noted that the forward plan did not fully reflect Members' requests from the previous meeting. The forward plan would be amended prior to the next meeting.

Item 5: With respect to air pollution at St. Bart's, an air quality monitor had been installed following the previous meeting. The data was being analysed and officers are working with St. Bart's to address the data.

4. **ANNUAL REVIEW OF THE COMMITTEE'S TERMS OF REFERENCE**

Members considered a report of the Town Clerk & Chief Executive relative to the annual review of the Committee's Terms of Reference. It was noted that all Members' terms would come to an end this year and therefore staggered terms should be implemented.

RESOLVED – that, Committee agree the following:

1) the Composition and Terms of Reference be amended to reflect staggered terms for Members of the Committee as follows – 1 term of 4 years; two terms of 3 years; 1 term of 2 years; 2 terms of 1 year;
2) the above be referred to the Policy & Resources Committee for agreement at its next meeting; and,
3) the number of meetings per year increase to 4.

5. **IDENTIFYING CHOICE AND CONSIDERING POTENTIAL BOUNDARIES FOR CITY WORKERS TO ACCESS OUTPATIENT SERVICES NEARER TO WORKPLACE**

Members received a report of the Assistant Director Commissioning & Partnerships relative to patient choice for City workers in utilising outpatient services nearer to their workplaces.

It was noted that patients have a choice of any NHS service they wish, and referrals are typically made through the patient's GP. Out-patient services are offered through an online system, which offers a choice of a number of services based on location and wait times. Patients can, however, make suggestions directly to their GP. Costs of services are dictated by the market, and services in London are more expensive. Services are referred to the Clinical Commissioning Group (CCG) and payments are made accordingly.

It was further noted that there are limitations to the extent to which services in the City can be promoted to City workers, as the increase in referrals will cause an increase in wait times. Furthermore, doctors in the City do not have access to primary care records for patients referred from outside the City and Hackney CCG.

Members raised the issue of lack of critical care in the City, as St Bart's does not have A&E service. As members of the public often still go to St. Bart's for emergencies, perhaps there should be A&E there.

With respect to the table at appendix 1, officers clarified that as there is an 18-week timeframe for treatment to commence, 'admitted clock stops' means the patient has begun treatment; 'non-admitted clock stops' means the patient has commenced out-patient treatment, and 'incomplete pathways' refers to patient not having commenced treatment. It was further noted that in cases of suspected cancer, patients must be seen within 14 days and all test concluded within 28 days.

RESOLVED – that, the report be received and its contents noted.

6. **DEEP DIVE: CR21 AIR QUALITY**

Members received a report of the Director of Markets & Consumer Protection relative to a Deep Dive of Corporate Risk 21: Air Quality.

It was noted that data in the report showed annual averages, as pollution varies day to day. Pollution was down overall, except for at London Wall where it had increased. It was difficult to identity the cause of this increase due to traffic diversions and road works. There was increased monitoring around Beech Street due to zero emissions target. A Citizens Science Monitoring programme was in effect at the Barbican to measure pollution around the residential area.

It was further reported that planning anticipated 80% of Beech Street traffic to go through Golden Lane Estate, based on figures from diversions in previous years.

The Chairman noted that overall this was a positive story and it was important that the public be aware that air quality in the City was improving.

RESOLVED – that, the report be received and its contents noted.

7. **USE OF PERSONAL BUDGETS IN ADULT SOCIAL CARE**

Members received a report of the Director of Community and Children's Services relative to the use of personal budgets in adult social care. It was noted that the service encourages users to have a choice in their own care, however this is monitored to ensure that the service is effective and safe for the patient.

RESOLVED – that, the report be received and its contents noted.

8. **FORWARD PLAN**

RESOLVED – that, the forward plan be received and its contents noted. Members' suggested additions would be incorporated into the forward plan for future meetings in 2020. An additional meeting would be added in September 2020.

9. **FEEDBACK FROM INNER NORTH EAST LONDON HEALTH AND OVERSIGHT SCRUTINY COMMITTEE**

The Deputy Chairman reported that Waltham Forest was added to the list of Members and the quorum was increased. Wendy Mead offered to be a substitute at the meetings in the future should the Chairman or Deputy

Chairman be unavailable to attend, and the procedure for nominating an alternate would be confirmed prior to the next committee meeting. It was reported at the meeting that Moorfields Eye Hospital planned to move to St Pancras in a consolidated site.

RESOLVED – that, the update be received.

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

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

12. **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.

13. **NON-PUBLIC MINUTES**
RESOLVED – that, the non-public minutes of the previous meeting held 30 October 2019 be agreed as a correct record.

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

15. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There was one item of other business discussed in confidential session.

The meeting ended at 12.50 pm

Chairman

Contact Officer: Chloe Rew
chloe.rew@cityoflondon.gov.uk

Health and Social Care Scrutiny Committee
Forward Plan and potential topics – 2020/21

DATES OF MEETINGS – ALL START AT 11 AM
26.2.20; 03.11.2020

3 November 2020 Items:

Topic	lead
1. Neaman Practice update on delivery, sustainability and other issues at the practice (to address question from CCS Committee about urgent appointments).	Chaun Chor, Shahana Uddin
2. Chiropody (postponed from September 2020)	Siobhan Harper, Csaba Barody
3. City & Hackney Restoration and Recovery Plan Post-Covid-19	David Maher, Alice Beard
4. An Integrated Care System for North East London Update	David Maher, Alice Beard

Future topics for 2021

Topic	Suggested meeting
1. Chiropody (postponed from September 2020)	
2. St Bartholomew's Hospital (Barts) Minor Injuries Unit	
3. Neighbourhood model for health and social care	
4. Delayed Transfers of Care, including the outcome of the 'Discharge to Assess' pilot	
5. Public Involvement and Transparency in Local Integrated Commissioning and ELHCP	
6. Government Green Paper on Social Care	
7. Mental Health services and support for children and young people	
8. Early intervention and Prevention programme	
9. City of London commissioned provision to prevent or delay uptake of formal social care services and reduce isolation	
10. Annual Healthwatch Report	
11. Annual report of City and Hackney Adults Safeguarding Board	
12. Annual Assessment of the CCG	
13. Tobacco Control	
14. Integrated Commissioning workstreams: – Children Young People and Maternity/ Planned/Unplanned Care Workstream/Prevention Workstream	

15. GP Services in East of City not provided by Neaman Practices	
16. Invite Chair of Patients Forum Ambulance Services London	
17. Sexual Health Services Review	
18. Mental Health Services Review (should there be a more general one in addition to that for item regarding children and young people?)	
19. Community Trigger Update	
20. Report on untoward incidents within the health provides which work with the City Corporation	
21. Making Every Contact Count initiative - impact	Andy Liggins
22. ICU discharge protocol and pressures at the Royal London	
23. UCH Hospitalisation/Discharge System	
24. St Barts Surgical Strategy (on hold due to pandemic response)	Ralph Coulbeck

Homerton Foot Health Service Update

Service Summary

Foot Health Service provided by Homerton CHS
The service provides care, assessment, diagnosis, and advice for all conditions with a medical need, including developmental problems affecting the foot and lower limb.

Key care pathways are for **diabetes, vascular disease, rheumatology and surgical issues.**
General care is offered to patients who require care based on clinical/medical needs to prevent mobility issues, falls and allow for independent living.

The service access ranges from:

- daily walk in emergency clinic (Mon-Fri) as well as home visits including care homes and a homeless service.
- Satellite clinics are provided at Kenworthy Road, John Scott Health Centre, Greenhouse, the Homerton and the Neaman Practice

In normal times the service has extremely low wait times when compared to similar services in other boroughs – usually less than 2-3 weeks

Benefits patients by reducing pain, maintaining mobility and independence, and reducing diabetic foot complications

COVID-19 Impact

Impact of COVID-19 on service

In March in accordance with national guidance all routine services were suspended to protect staff and patients.

This meant that all satellite clinics were closed at Kenworthy Road, John Scott Health Centre, Greenhouse, the Homerton and the Neaman Practice. The clinic at St Leonards remained open during the pandemic.

High risk patients and new high risk referrals were prioritised and seen in clinic (St Leonards) or by home visits which were increased for the duration of the lockdown.

- Urgent is clinically defined as: high risk patients with active ulcerations/or likely to ulcerate
- The service continued to provide daily urgent clinics at St Leonard's Hospital but by appointment only, urgent domiciliary visits, and support to GPs and other clinicians by phone/email
- Where appointments were cancelled- the service called the patient or sent a letter- if they weren't able to make contact by phone
- The service provided appointments 'virtually' where possible – using the telephone or video consultations (Attend Anywhere)

Note: Hoxton Health, a local charity who provides some nail-cutting to patients not eligible for routine foot health care has temporarily closed it clinic services.

Recovery

Foot Health Service Recovery

The service has been working to recover from the suspension of routine services since June. New infection prevention and control measures need to be in place to protect patients and staff- this has taken time to set up at St Leonards and the satellite community sites and has the impact of reducing the number of patients the service can see per session due to social distancing requirements and other additional measures being in place (including additional cleaning and COVID 19 screening questions at point of entry). For this reason the previous urgent 'walk in 'service at St Leonards is now appointment only.

The service are prioritising patients and had over 1,000 higher risk patients to be seen first. This is why many **low risk** patients have been much waiting longer than normal.

Satellite Clinics:

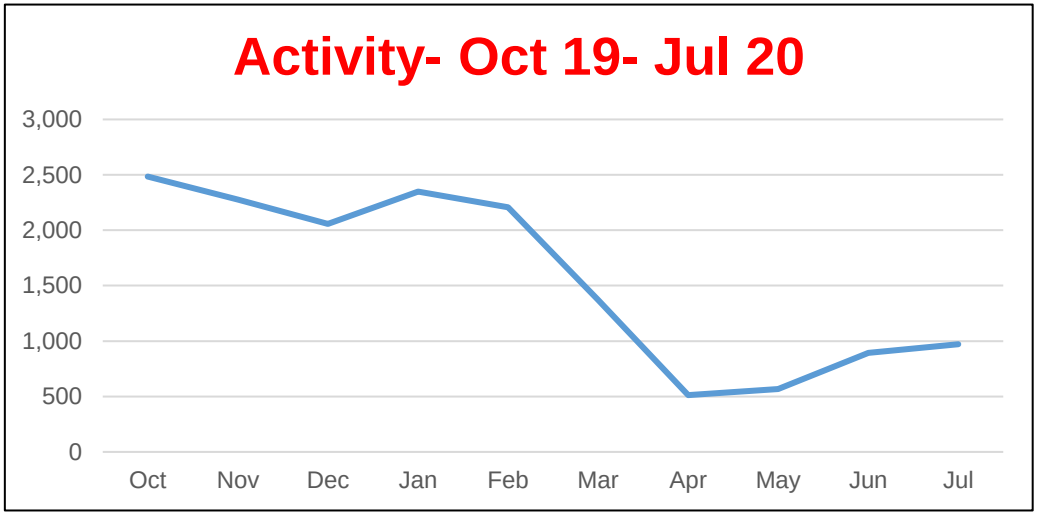
- Neaman Practice will re-open in November (low numbers attend and this sees less complex, low-risk cases)
- John Scott Health Centre is now open and will be the main site seeing routine patients
- City patients are being seen at St Leonards and the service is arranging transport for patients who need to travel
- The service is prioritising all high risk patients waiting and is working to clear the backlog of high risk waiters within the next 4-6 weeks .
- Waiting times for routine patients are currently longer than normal but the service is working towards returning to a 2-3 week wait by the end of this calendar year

Recovery

The CCG is monitoring the recovery with the Foot Health Service and reviewing options including:

- Additional resources to clear the back log at Foot Health
- Alternatives to podiatry, including preventative measures
- The CCG is in discussion with Hoxton Health in how to support them to reopen clinics and increase domiciliary visiting
- PCNs could consider recruiting a podiatrist via the PCN DES role funding that could help support general foot care outside of Foot Health. This will be raised and discussed.
- Better messaging – many routine patients who were used to being seen every 6-12 weeks have had to wait longer. These patients are generally low risk and will be seen again in the next 4-6 weeks.
- Supporting communication – to encourage patients to attend John Scott HC (where appropriate) and where capacity is available

Service Activity and Waiting Times



- Pre-COVID monthly activity: 2,300
- July activity: 1,000
- Feedback from service is more rapidly increasing activity with clinics re-opening
- Pre-COVID average waiting time: 2.8 weeks
- The service target average waiting time is 5 weeks
- Current waiting time: 10 weeks for routine appointments
- Approximately 500 high priority patients waiting to be seen (reduced from 1000)

The Neaman Practice

Services since Covid 19

Telephone Triage

Online Access

Online Consult

NHS 111 triage

DD Duty Doctor Service

Flu Clinic

Short Term/Long Term Plans

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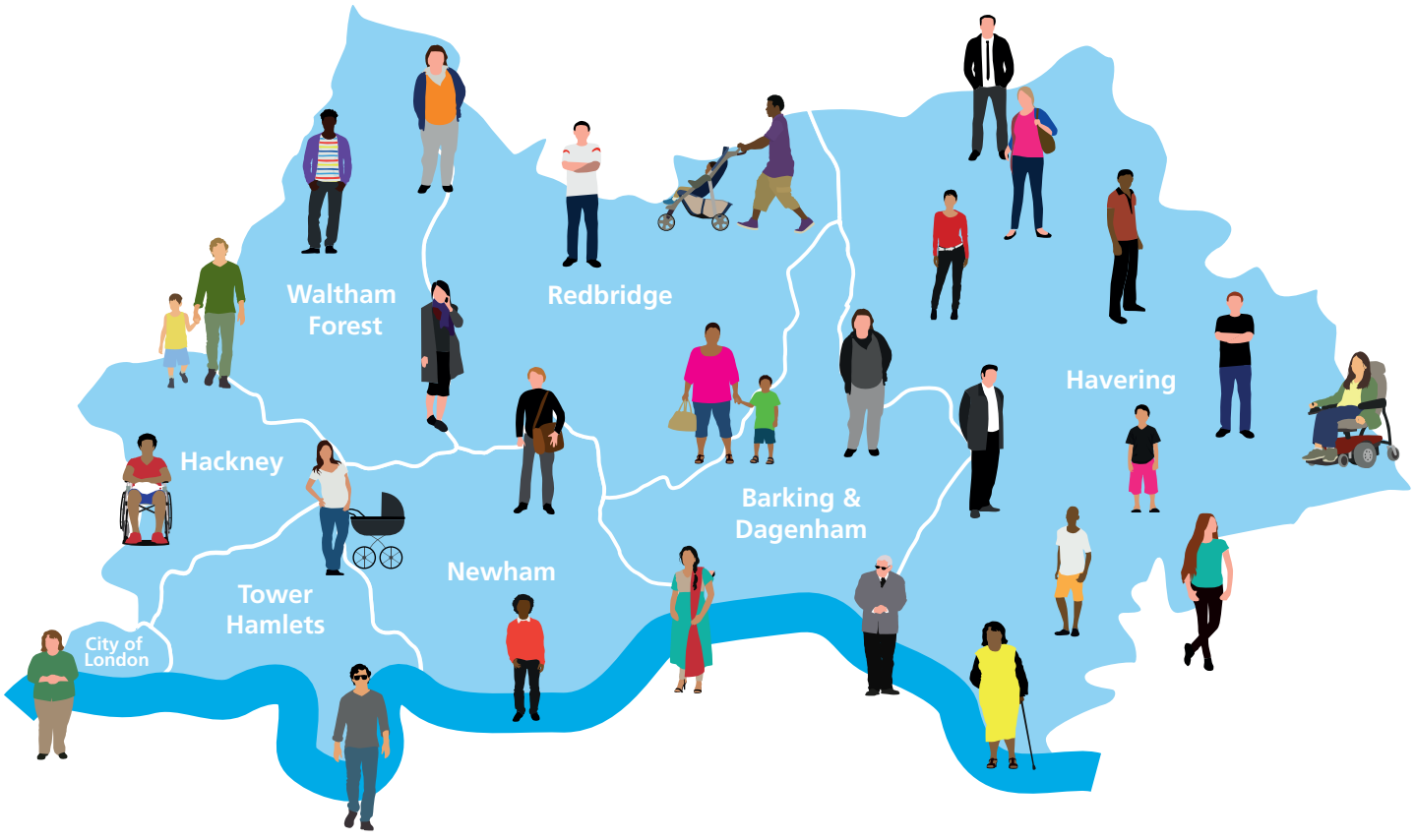
The future of health and care for the people of north east London



Produced by: North East London Commissioning Alliance

Contents

Executive summary 3

This is an overview of how we are changing the way we work across north east London (NEL) to improve the health of our communities.

By strengthening our already established local partnerships, streamlining our Clinical Commissioning Group (CCG) administrative and other functions into one joined up organisation and bringing together our partners as an integrated care system for NEL, we will have the infrastructure we need to provide the best health and care for our local populations.

Overview of health and care in north east London

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North east London (NEL) has a population of 2.3 million people and is a vibrant, diverse and distinctive area of London steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel and confirmed funding for the Whipps Cross Hospital redevelopment and a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

At the heart of NEL are its people and together as health and care partners we have a collective vision of enabling our population to live healthy lives. This vision is reliant on a wide set of determinants beyond just health and which include: access to education, job opportunities and creating a healthy environment at all stages of a person's life, ensuring they have the best chances possible. To achieve this we need to make sure patients, clinicians and managers are working together in a way that ensures they can all reach their maximum potential.

Locally led successes across NEL

We have a number of fantastic examples of local leadership and achievements across our local areas. Together we can learn from each other and share our innovations and successes for the benefit of all our local populations. Some of these include:

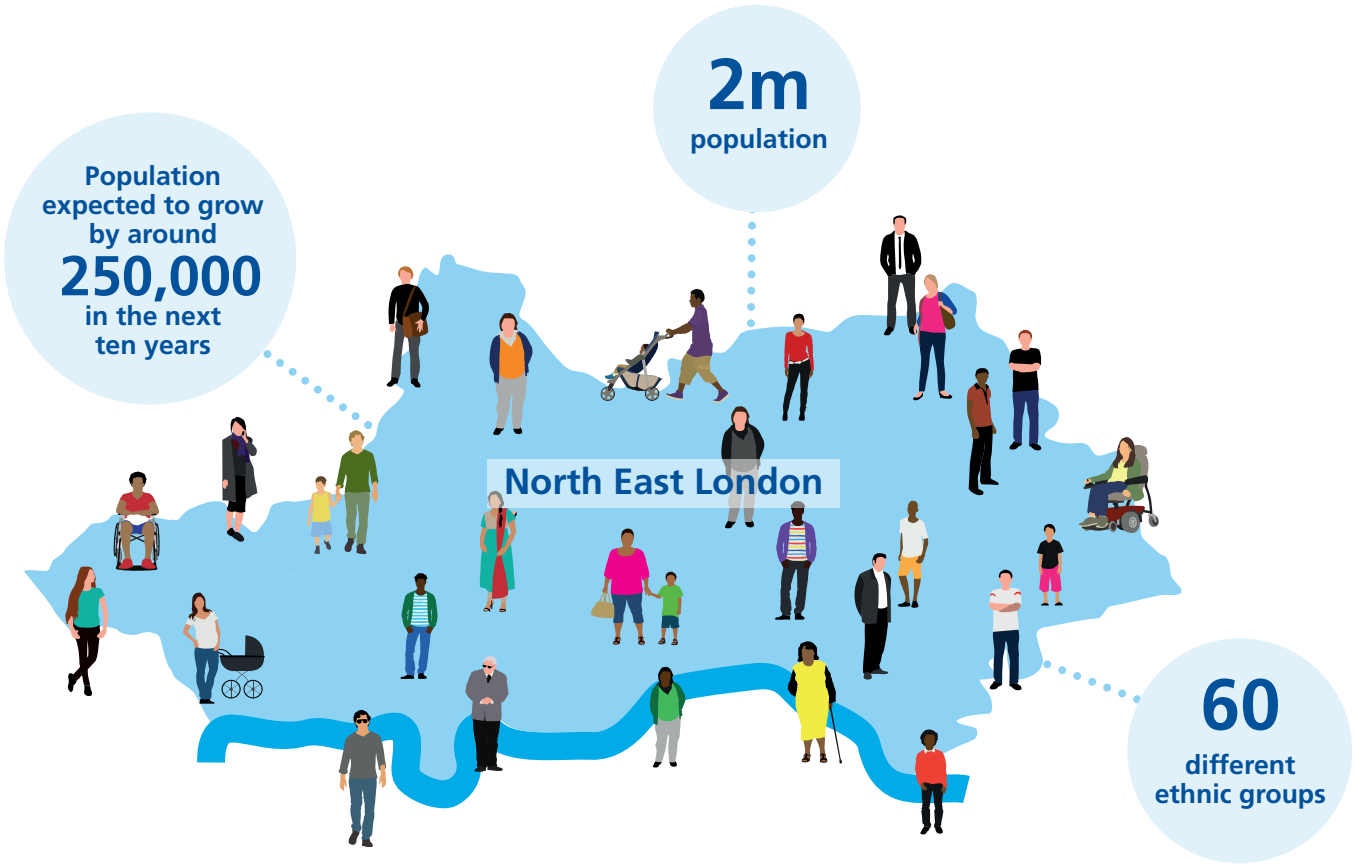
- **Working together across primary care** – across our local areas we have led the way in supporting primary care to work differently. Through Primary Care Networks GP practices are working together across neighbourhoods and with community, mental health, social care, pharmacy, hospital and voluntary services.
- **Social prescribing** – is at the heart of our work and we have a variety of models in place across our area including link workers who facilitate social prescriptions between clinicians and patients.
- **Supporting our diverse population** – as part of our recovery from Covid-19 we are collectively committed to supporting local people, training, volunteering, education and creating apprenticeships at a local level, to support the recovery of our local economies, which have been significantly impacted by the pandemic.

- **Promoting a healthy start in life** – across north east London children benefit from our healthy schools programme which supports children, families and adults to be more active and eat healthily.
- **Acute partnerships across NEL** – we are developing an acute alliance across NEL which brings together Barts Health NHS Trust, Homerton University Hospital Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust to set an overarching strategy for acute services to the benefit of all our people.
- **Urgent care** – to ensure that the Urgent and Emergency Care (UEC) needs of our population are met, we are working together to to ensure that we have staff with the right skill mix at the right place and time to care for our people.
- **Mental health** – we are committed to supporting people with severe mental health difficulties and one way of doing this is ensuring they have access to employment opportunities. Across all our partnerships we have rolled out our individual placement and support service which provides tailored support including job placements and guidance for both the employer and the employee.
- **End of life care** – through our multi-disciplinary teams we are able to support patients to die at home or in the community surrounded by their loved ones.
- **Enhancing our local estates** – the regeneration of Whipps Cross, the Barking riverside development and new health and wellbeing hub at St George's will benefit our local populations
- **Digital progress** – we know that patients want to access their own information and only to tell their story once so are committed to improving access to patient records. As a result of Covid-19 patients can engage with services in many more ways: online, telephone, video as well as face to face.
- **Maternity** - across north east London, we work together as the East London Local Maternity System. This benefits staff as they are able to work across the whole patch and also allows us to ensure equal access to services. One priority for us is ensuring more choice and control for women and their families and we are prioritising personalised care plans for vulnerable women.
- **Major long term conditions** – we are working together to improve prevention of diabetes through education and training; running community based enhanced services to support and improve the care of those living with long term conditions and working to ensure services and support are joined up.
- **Ageing well** – we are committed to ensuring our workforce are trained to support our ageing population to support them to age well and maintain their independence, one example is our joined up teams consisting of physiotherapists, occupational therapists, social workers and consultant geriatricians.
- **Homelessness** – during the Covid-19 period we have worked closely with local authorities to provide support and care to rough sleepers. The pandemic offered a unique and powerful opportunity to address the needs of thousands of London's rough sleepers. Charity partners have worked intensively with hotel residents to assess their needs and agree the next steps. Across north east London we are committed to building on what has been achieved so far, working in partnership with local authorities and our voluntary sector colleagues.

NEL is not without its challenges, with a high level of deprivation and inequality requiring us to work together in the best interests of patients. The Covid-19 pandemic has been a once in a lifetime challenge for all of us, testing us in every way possible not just as health and care providers but as a wider population too. Newham has been particularly impacted with the highest number of deaths in the country and more than ever before we have needed to draw on our strengths and experiences across NEL to respond to this, to learn from it and to ensure that everyone has equal opportunity to health in their lifetime.

As we continue to respond to our challenges and build on our partnership working to date, we are formalising this by coming together as an Integrated Care System (ICS). This will be how we come together as a partnership to strategically manage the health of the whole of our population and future proof ahead of any further legislative changes. Our NEL ICS and single CCG for NEL will provide support to our local places/boroughs, and in BHR's case its local system, where the vast majority of delivery and leadership will take place. We call this the 80:20 principle, placing most of our focus on delivery where it is best placed – closest to the individual. At a local level we will bring together an integrated partnership of local authorities, local acute trusts, local community services, local mental health services, local primary care, voluntary sector and most importantly local residents.

NEL – who we are

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SYLVIA
REGISTERED NURSE

A locally led system approach

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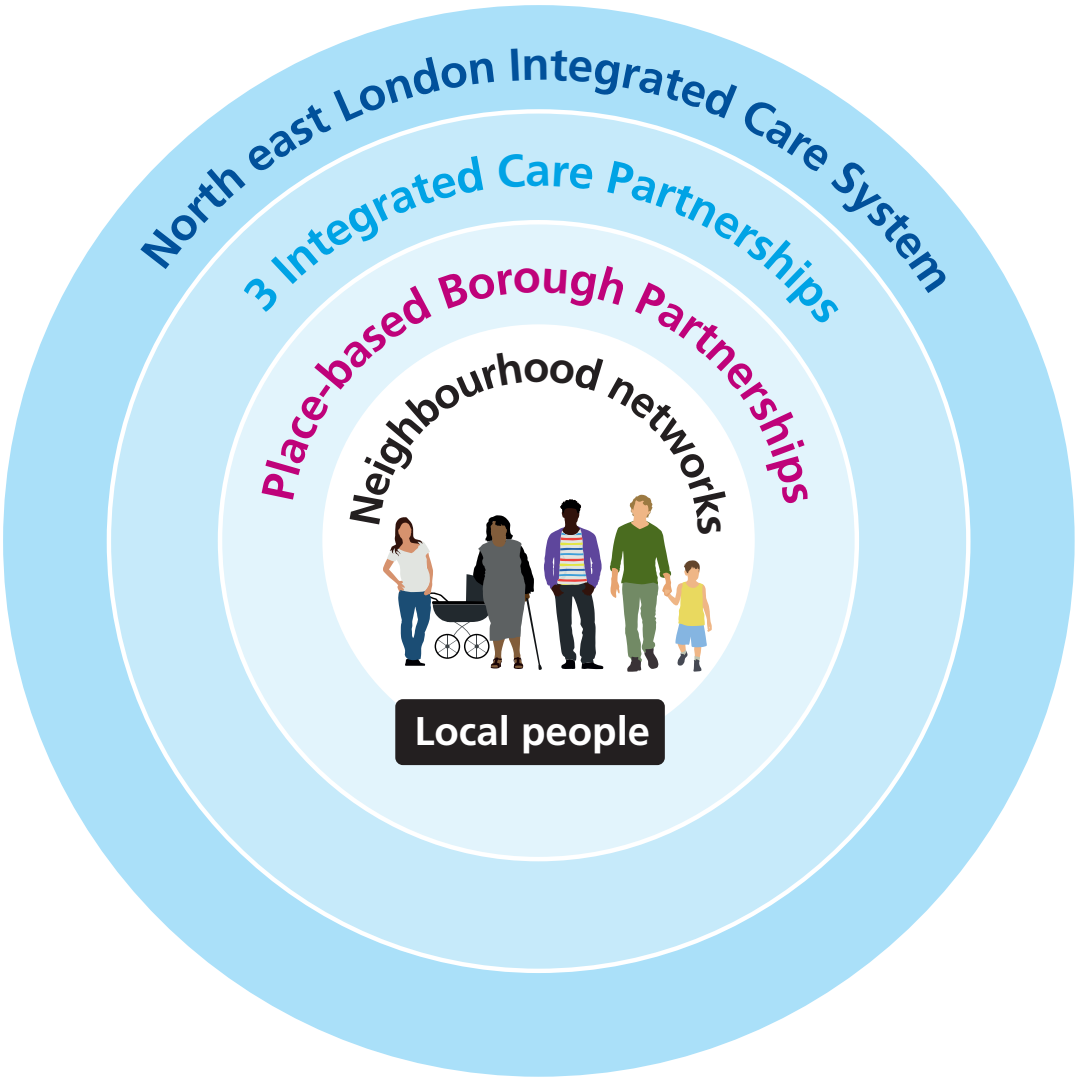
The vast majority of our health and care delivery will continue to be delivered at our local place and borough level, working together as partners with our local population.

The 80:20 principle

Our basic principle of 80:20 is in recognition of the fact that decisions about health and care will take place as close to local people as possible.

Local partnerships will decide how best to use resources in the best interests of patients.



Local integrated care partnerships and local delivery

Local delivery is critical to the success of this way of working. A key feature of our north east London partnership is our distinct population-focused collaborative systems or integrated care partnerships (ICPs): Barking and Dagenham, Havering and Redbridge (BHR); Waltham Forest, Tower Hamlets and Newham; City of London and Hackney.

Each of these systems has developed local priorities based on the needs of their populations, developed collaboratively across organisations and through working together with local communities. In some instances these priorities are place based and in some areas like BHR they have chosen to work together to develop priorities across a wider area and will continue to collaborate closely as we develop our new arrangements.

None of this is possible without the leadership of the local authority and without involvement from our voluntary sector, patients and the wider public.

At an even more local level we bring together our services to support patients with complex care needs such as frailty, those who are housebound, those who require terminal care and those with learning disabilities.

We remain committed to demonstrating collaborative leadership, this means leadership 'with', rather than leadership 'over'. An example being clinicians working with managers and with patients on developing pathways of care.

A clinically led CCG for north east London

One CCG for NEL would continue to be a clinically led organisation with strong clinical leadership and a GP voice at all levels. There would be one NEL CCG governing body and an ICS partnership board at a NEL level. Most decisions will take place through local governance arrangements. Each place will be represented by a GP chair on the NEL governing body and ICS partnership board.

GP members' forums and representative bodies will be essential to making this successful, working with the GP chair to make decisions about health and care in our local communities.

Involving lay members

We know that lay members bring a diverse range of expertise that augments the best of how we collectively work as clinicians, managers and patients. Their independent input ensures we focus on outcomes, patient voice, value for money and good governance.


ROYAL DOLPHINS

Why create an integrated care system for north east London?

11

We believe that creating an ICS across north east London will allow us to collectively respond to the challenges we face across NEL and benefit our local population in the following ways:

Benefits for people

- Closer partnership working will enable people at all stages of their life e.g. whether you are pregnant, have a long term condition, require trauma treatment or end of life care, you will have equal access to all services across the whole system.
- The amazing energy of health and care partners will be better shared so that we can keep you healthy.
- Working together with local councils, providers and the voluntary sector across north east London, we will address health inequalities and ensure we do everything possible to stop people getting ill to begin with. We will be truly responsible for the health of all our communities, not just managing health services.
- By working together across our organisations we will make sure that even if you have a complex condition requiring specialist care, you will be supported by all our services.
- We will ensure that wherever you go in the system you won't have to tell your story again if you don't want to.

Benefits for staff

- We are committed to supporting our workforce to grow and develop and to creating a wider pool of opportunities for career progression and development for everyone. We want north east London to be the place you want to live and work in.
- We want to ensure staff work in an environment with reduced bureacracy, fewer meetings and a reduction in duplication.
- We want everyone to be a leader no matter where they sit in the organisation
- Our focus will be on relationships and solving problems together.
- Together we will build on our own local plans to develop a single consistent plan for the future, helping us to improve services and reduce variation.

Financial benefits

- Our overriding priority is to make sure every single pound is spent to the benefit of every single person in north east London. This means we can focus on where we can get the best value in terms of outcomes for patients and wider social value outcomes for our communities and neighbourhoods.

Our collective vision for north east London

What do you want to achieve for our communities in the next few years?

"We support people with long term conditions to take control of their own health and care management allowing them to live full and happy lives"

Dr Atul Aggarwal, Chair, NHS Havering CCG

"Working in partnership to ensure that people are supported to age well and that quality of care is improved within our existing acute and community services"

Dr Ken Aswani, Chair, NHS Waltham Forest CCG

"Ensuring all our children in north east London have the best possible start in life, with their parents experiencing the best possible pregnancy and birth, right through to supporting schools to maximise the health of all children"

Dr Sam Everington, Chair, NHS Tower Hamlets CCG

"Making sure people have choice and control over the way they live their lives, and access to local resources and opportunities"

Dr Jagan John, Chair, NHS Barking and Dagenham CCG

"People with mental health conditions are able to live good lives – to be employed, have good relationships, somewhere comfortable to live, and to feel part of their community"

Dr Anil Mehta, Chair, NHS Redbridge CCG

"By working together we address the causes of inequality and poor health in NEL, drawing on our collective strengths and experience to improve the lives of our local people"

Dr Muhammad Naqvi, Chair, NHS Newham CCG

"Grow our neighbourhood way of working, with thriving primary care networks an essential element, to ensure that across north east London our teams are working together to support local people"

Dr Mark Rickets, Chair, NHS City and Hackney CCG

"We make every pound count and invest our health and care resource so it improves population outcomes"

Henry Black, Chief Finance Officer, NELCA

"Engaging and involving our local populations continues to be at the heart of everything we do"

Marie Gabriel, Independent Chair, NEL ICS

"The benefits of working in partnership will give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people age well"

Jane Milligan, Accountable Officer, NELCA

Have your say

In September 2020 we will produce a report on our proposal to merge, including feedback from stakeholders for consideration by NHS England who will need to approve our application later in the year.

How can I have my say?

Each CCG will engage with all its partners and members over the coming months. Engagement will continue through the summer, autumn and beyond. As questions come in we will develop a questions and answers document.

We also want to hear from anyone who wishes to share their views on the proposal set out in this document.

You can either email us at **nel-ics.pmo@nhs.net**

Write to us at **NELCA, 4th floor Unex Tower, Station Street, Stratford, E15 1DA**

Visit **www.eastlondonhcp.nhs.uk**

Appendix: What we have heard so far 15

As part of our work to create an Integrated Care System over the last 18 months we have undertaken engagement with a wide range of stakeholders. We have listened to feedback and already taken in to account the following:

Topic	You told us you are concerned that…	What we are doing…
Money	Budgets may be held centrally and not passed on at a local level	Ensuring that budgets are devolved to a local level to match existing budget allocation, so there is no impact at a local level
Decision-making	We may lose influence on key decisions at a local level	Putting in place new governance arrangements to ensure that decisions are made at a local level
Clinical leadership	Clinical leadership may weaken as a result of moving to a single CCG	Building on our existing relationships with our clinical leaders and getting their input to shape a new way of working. Clinical leadership will exist at every level within the ICS and will be key to our success. Clinical leadership budgets for each CCG will be maintained, with clinical leaders freed up to lead clinical transformation of services rather than some of the current bureaucratic focus
Impact on services	A single CCG may mean reducing services for patients	Existing hospitals, NHS trusts, GP surgeries and community services will continue with no impact. What we are doing is changing the way we work so that we can deliver a better patient experience with access to more services more easily. By working collectively, we can attract transformation funds to improve services for local people where they are needed most. We will address variation for patients across NEL, with a focus on the highest standards
Impact on jobs	There may be impact on CCG staff as a result of the merger	We are aiming to minimise the impact on staff, maximise opportunities for career progression and training, and to tackle inequalities across our system. We are assuming that requirements to reduce or restructure posts will be minimal

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Proposed Integrated Care Model for City & Hackney – An Overview

October/November 2020

What is changing and why – an overview

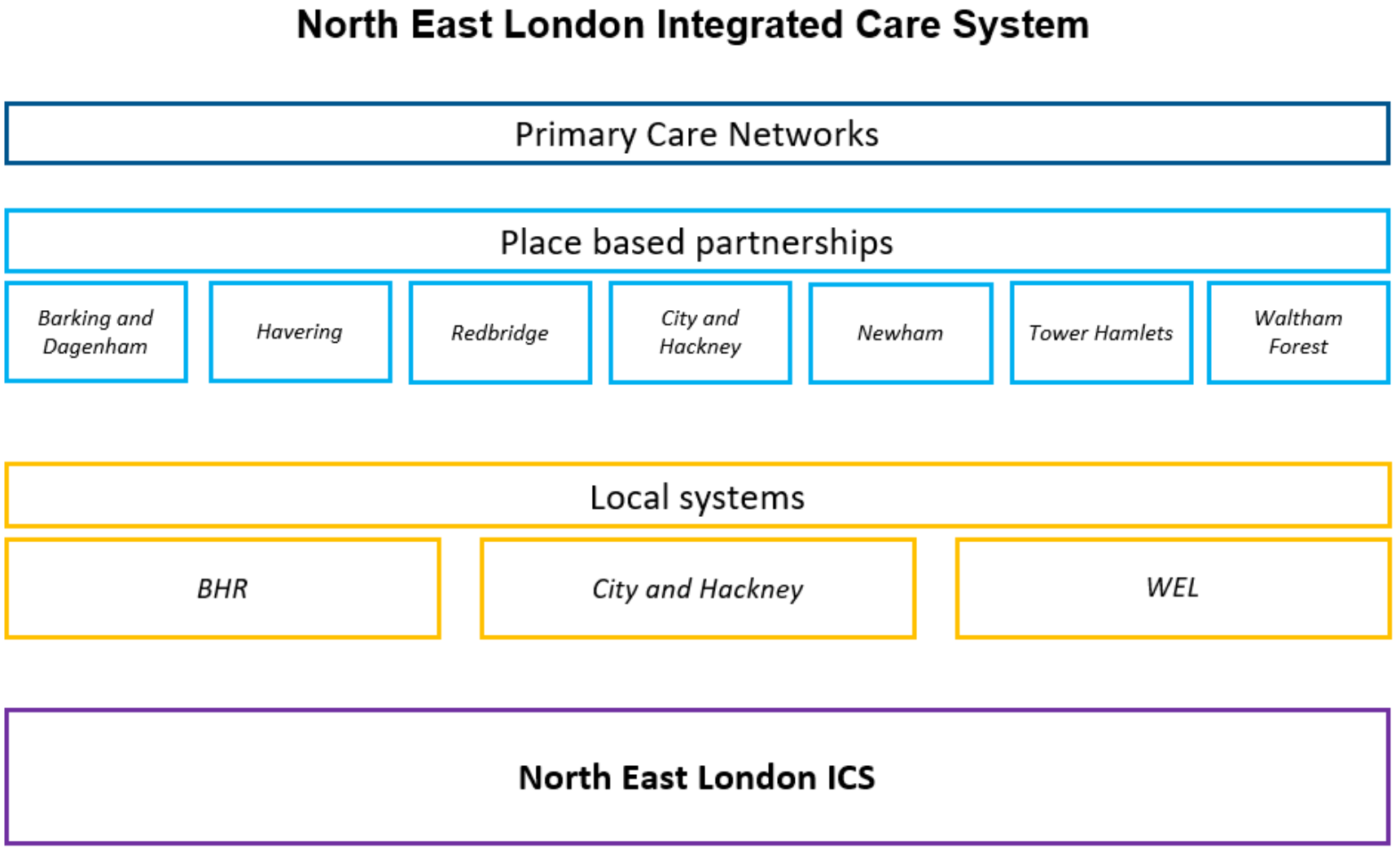
CHANGES

- NHS England's Long Term Plan sets out a timetable for establishing Integrated Care Systems **(ICS) by April 2021** and typically there should be 'a single CCG for each ICS area'
- All CCGs within NEL will merge into **a single NEL CCG** by April 2021
- This means that we are moving from a "commissioner /Provider" split towards a **system focus on supporting our frontline practitioners to deliver improved health and care outcomes** for our local population
- Within City & Hackney we intend to migrate from an Integrated Commissioning Board to an **Integrated Care Partnership Board (ICPB)** supported by a number of **subgroups.** The ICPB will be responsible for system **oversight** and **assurance**
- A City & Hackney **Neighbourhood Health & Care Services Board** will be responsible for **service planning**, **service delivery** and **service improvement.** This includes the work within workstreams, major programmes and Covid-19 Phase 2 Recovery programme

BENEFITS

- **Clinicians** will continue to lead on service improvements for patients with improved interfaces with social care and other community services
- **Primary Care leadership** will continue to be the anchor for quality improvements through the CH Members Forum, Clinical Executive and the CCG Governing Body. Primary Care will have representation on the ICPB and the NH&CB.
- Decision-making will sit as **locally as possible** with improved levels of accountability by involving partners at all levels
- An opportunity to **really build Primary Care Networks** and support and embed clinical leadership at a neighbourhood level
- The Integrated Care Partnership Board will be an opportunity for improved integration and **increased accountability** by including our providers as partners
- A NEL ICS helps strengthen what we have achieved. It allows us to **influence specialised commissioning** and creates more efficient interfaces with regulators
- **Increased transparency** for our residents with major planning decisions happening across the partnership in public and with clear clinical leadership
- Improved **opportunities for maximising the City & Hackney pound** with current CCG allocation held locally, and partner organisations accountable for maintaining financial and social value as a partnership

What will a NEL Integrated Care System (ICS) look like?



Locally led system approach

- A key feature of the north east London Integrated Care System is the distinct population-focused **integrated care partnerships (ICPs):** Barking and Dagenham, Havering and Redbridge (BHR); Waltham Forest, Tower Hamlets and Newham; **City of London and Hackney.**

- Each of these **ICPs** has developed local priorities based on the needs of their populations, **developed collaboratively** across organisations and through working together with local communities.

- The **vast majority of health and care delivery will continue to be delivered at our local place and borough level**, working together as partners with local populations. In reality 98% of the CCG allocation will be retained locally with teams and resources continuing to deliver our local agenda.

Organising Principles

Long Term Plan

- The Long Term Plan specified that each ICS area should be supported by a single CCG. Recent declarations from NHSE suggest that ICS will be placed on a legislative footing in 2021.

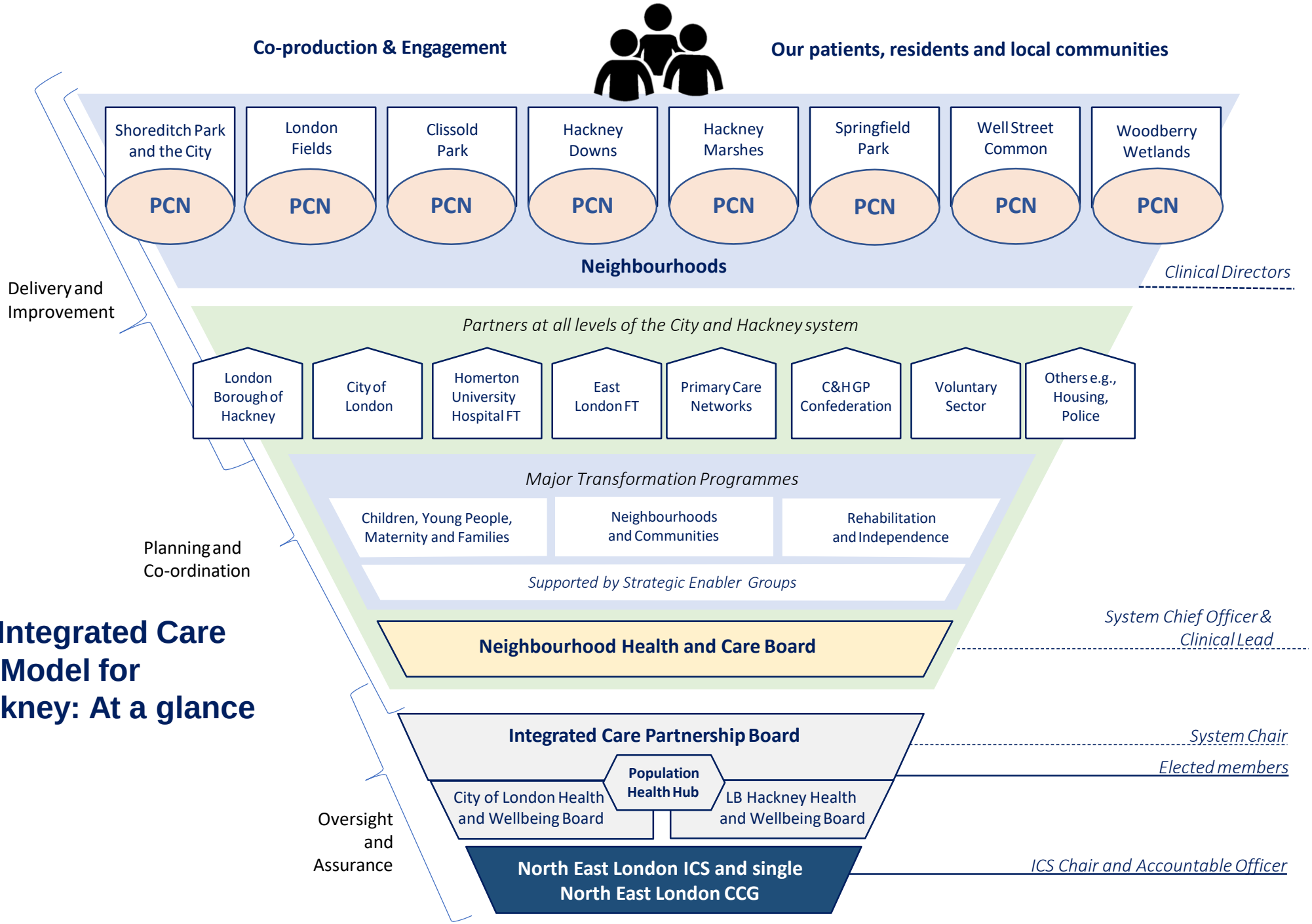
History of our local integrated working

- For us in City and Hackney, we have been working closely on building a closer Integrated Care Partnership since 2016. Part of this work included developing an Integrated Commissioning Board through which much of our commissioning administration has been done for a number of years.
- The membership of this board currently includes Local Authority elected members from Hackney and the City, plus CCG representatives. As part of becoming an Integrated Care Partnership, we are proposing to add provider colleagues and PCN directors to this board to help us shape decisions collaboratively and to ensure we co-produce new services as much as possible.

Workstreams/ Neighbourhood Health and Care Board

- In 2016 we also created integrated Workstreams within which our staff and clinicians work in an integrated way across the partnership. As our work becomes increasingly integrated and to assist our combined social and healthcare response to Covid, we are proposing that these resources should be coordinated by a Neighbourhood Health and Care Board.
- This approach will ensure that we coordinate the best of our resources across City and Hackney, and critically ensures that we have the right accountability framework in place for the delivery of improved services.
- This board will be clinically led, and supported by a Clinical Executive Group of consortia and PCN clinical directors along with the triumvirate of a clinician, a manager and a patient leading on service improvement proposals.

Proposed Integrated Care Operating Model for City & Hackney: At a glance



Organising Principles continued

Integrated Care Partnership Board

- By 2021, we should be in a very strong place to maintain our autonomous status within north east London. We will be in charge of the resources allocated to C&H residents for their healthcare, and we will have consolidated our relationships across the partnership with clearer accountability for delivery and improvement.
- A new Integrated Care Partnership Board will take responsibility for providing system oversight and maintaining a clear interface with north east London developments, and this local partnership board will include membership from across the C&H health and care community.
- The ICPB will support the Neighbourhood Health and Care Board to deliver improvements to Neighbourhoods and ensure that services are structured around Primary Care Networks.

Primary care investment

- To ensure primary care remains the bedrock of our planning, we have introduced a **triple lock** to ensure resources and leadership are appropriately weighted towards those resources closest to people and their communities. This triple lock includes a commitment to maintain or increase both core and enhanced primary care investment, plus a commitment to ensure GP voice at all levels of decision making.
- We think this lock will benefit us as we move into an Integrated Care System across NEL and ensure we keep localism at the heart of everything we do.

Commissioning and Finance Framework

- Single CCG will be the statutory body receiving a single set of NEL allocations:
  - *Programme allocation (commissioning budget)*
  - *Primary care*
  - *Running costs (RCA)*
- Budgets will be devolved to local Integrated Care Partnerships – NHSE will not set allocations at a borough level through the national formula, ***however***
  - *NEL CCG will track published CCG allocations, so the principle of population based capitation will remain*
  - *This will maintain stability of existing plans and ensure no one is made worse off by the merger*
- Circa 98% of commissioning budgets will be devolved to place
- The single CCG will retain a corporate budget for head office costs, based on the functions that have been agreed
- 0.5% contingency + 0.5% risk reserve held centrally to manage risk in areas of financial pressure and support overall sustainability
- Integrated Care Partnerships will need to use Q3 and Q4 to develop the decision making and governance framework for devolved resources before the 31st of March.
- **NOTE:** CCG allocations are subject to national policy and post-pandemic resources are likely to be subject to change as part of Comprehensive Spending Reviews

Current Position

CCG Merger Vote - Result

- The scope of the ***CCG Merger vote was reserved for GP Member Practices*** within the 7 CCGs across NEL
- The vote was held over a number of days ***(14 to 19 October)*** to ensure that GPs had sufficient time to vote
- Within City & Hackney all 40 of our GP Practices voted (i.e. ***100% turnout***). One vote per GP Practice
- The City & Hackney CCG constitution requires that ***two thirds of members must vote in favour*** for a vote for it to be carried
- ***97% of City & Hackney GP Members voted in favour of the CCG merger***
- All ***7 CCG across North East London voted in favour*** of the CCG merger

What a "yes" vote means

- We will have ***more control over City & Hackney's capabilities to shape health care services*** for our local population and to do so autonomously with our wider local partners.
- We can ***decide how to spend our financial resources*** from our allocation in line with the outcomes and priorities we set
- We can ***build on the strong and successful work*** many people across City & Hackney have been involved with over many years.
- ***Retain a clear position within the NEL ICS as an ICP with authority*** to be able to determine how we intend to coordinate and organise ourselves for better outcomes as a wider public sector partnership.

What does this mean for the City of London?

City of London Members and Leadership will have:

- An ***integral role in designing City & Hackney oversight and assurance governance arrangements*** through Membership of the Integrated Care Partnership Board (ICPB) and Neighbourhood Health & Care Board (NH&CB). We are currently working together to evolve from the Integrated Commissioning Board into the ICPB and establish the NH&CB

- Strengthened opportunities to ***shape City & Hackney's major programmes*** and set workstream priorities

- ***Improved oversight of hospital services*** across NEL including ***RLH.***

- ***Improved lines of accountability for service provision*** across partner Integrated Care Systems (ICS's) including ***UCLH***

- Opportunities to ***develop border ICS relationships*** particularly in relation to primary care and access.

Where will the City and Hackney Patient and Resident Voice be heard?

CITY AND HACKNEY CURRENT MODEL	CITY AND HACKNEY FUTURE MODEL
C&H Governing Body and Lay Members	C&H Integrated Care Partnership Board; Neighbourhood Health and Care Board
PPI Committee	People and Places Group
Communications and Engagement Enabler Group	Communications and Engagement Enabler Group
Workstream and Enabler Group representatives	TBC
PPGs & Neighbourhood Conversations	PPGs, Neighbourhood Conversations and VCS Enabler
Healthwatch, NHSCV, Older People's Reference Group, Hackney Migrant and Refugee Forum, Health and Social Care Forum, Maternity Voices, Mental Health Advisory Group, Involvement Alliance	Bringing in local authority engagement structures (e.g. Hackney Matters, Making It Real, Carers, Children and Young People, Digital Inclusion etc.), wider VC sector, provider patient experience forums etc.

Delivery

NEL ICS and NEL CCG

NEL ICS | NEL CCG

Discussions taking place with Lay Members and Healthwacthes about best model for engagement at NEL level. Incl.

- NEL Lay Members forum
- NEL PPI Forum?
- NEL communications and engagement team
- NEL Healthwatches working closely together

Declaration of principles (1 of 3)

There are 31 Declaration of Principles:

These have been created by the feedback we have received from GP members and LMCs and agreed by all the chairs of the seven CCG Chairs of North East London. These are the principles by which the merged CCG will be governed, if you vote in favour of the merger. Moving forward we will test ourselves against these and ask: are our decisions compatible with these principles.

1. **Continuous quality improvement.** Develop a culture and ways of behaving and working that promote continuous improvement in the health, care and wellbeing of the whole population.

2. **Transparent and accountable.** Act transparently with and between provider organisations - planning, decision making, accountabilities and spend (£) for whole population health outcomes. We will ensure contracts involving the spend of public money are made publicly available

3. **Reducing inequalities.** Focus on outcomes in terms of quality of care, performance, safety, reducing health inequalities and experience for both patients and staff. The delivery of these outcomes will be the focus of provider organisations (statutory, voluntary and community)

4. **Delivery, delivery, delivery.** Focus will be on delivery by provider organisations, including statutory bodies and the voluntary and community sector and the CCG.

5. **Holding each other to account and actively seeking local accountability.** Working as an ICS, establish a robust assurance framework that clearly shows where accountabilities and responsibilities sit for delivering high performing services and meeting national standards. Within this ensure local providers and systems hold NEL to account and NEL holds the local systems and providers to account.

6. **Distributed leadership.** Provide strategic commissioning leadership, lead strategic planning with partners and support the development of the ICS for north east London.

7. **We are all commissioners**. When making commissioning decisions, ensure all hospital and out-of-hospital organisations work together in the planning of services (including the adoption of commissioning behaviours).

8. **Being led by our communities.** Ensure there is the relevant skill set and appropriate balance on the partnership boards to deliver population health gains. This will include hospital/out of hospital representation, users and diversity of staff.

9. **Out of hospital care.** Ensure year on year an increase (in absolute and relative terms) in the quantum of financial resource (across NEL) for out-of-hospital health services.

10. **Equity.** Ensure equity of funding systems within all the providers

Declaration of principles (2 of 3)

11. **Co-production and power devolved to communities.** Ensure user involvement, co-production and clinical engagement throughout the CCG and our wider ICS.

12. **GP member voice.** NEL CCG to be formed by the membership of each of the current seven CCGs, electing a local clinical chair (during the period of transition the current CCGs will assume this role) who will sit on the single CCG Governing Body to reflect the membership voice (as part of a democratic process) and act to connect local systems with the NEL CCG and with the NEL ICS.

13. **Localising personalised services.** Support place and local authority-based integrated care partnerships (ICPs) to flourish in accordance with the 80:20 principle of CCG resource distribution.

14. **Decisions and delivery close to people.** Governance structure characterised by delegating: planning, accountability and financial decisions consistent with the 80:20 principle. Budgets will be devolved to a local level in accordance with the national allocation formula.

15. **Integration.** Support all provider organisations to work in integrated systems at the place/local authority and multi borough level (where locally agreed) and to come together at NEL STP level as a single ICS.

16. **Levelling up.** Act to reduce unwarranted variation and reduce inequity across NEL, ensuring that decisions, including those for new investments, are taken based on population health need, are supported by outcome data and seek to address legacy issues from the previous seven CCGs

17. **Acting as leaders across our communities.** Support all partners' roles as anchor institutions (working collaboratively with one another in forming an 'anchor system')

18. **Prevention.** Enhance opportunities to prevent ill health; address the wider determinants of health; promote the development of self-supporting communities with increasing social capital.

19. **Local focus.** Ensure placement of CCG employed staff and sessional clinical leads will adopt the 80:20 principle of resource distribution, so that the vast majority of staff time will be managed and directed in local systems. However everyone will have a responsibility to deliver for the whole population. Local trusted contacts and relationships will be respected and built upon.

20. **Speaking up and being heard.** Invest in staff recruitment, retention, wellbeing, development and career progression to ensure high standards of care are delivered by a workforce that is healthy and feels able to speak up when things aren't going as well as they should.

Declaration of principles (3 of 3)

21. **Growing our own.** Support at all levels a focus on promoting equality and the ambition of “growing our own” workforce that better reflects the populations we serve - recruiting and retaining people from our local communities.

22. **Our people.** Support year on year improved diversity of leadership to ensure diversity of protected characteristics, population representation and different clinical professions.

23. **Working as teams together making the most of our expertise.** We describe this as the triumvirate leadership model of a patient, a clinician and a manager shaping and leading change. Benefit from promoting a strong Lay Voice on the Governing Body and throughout the committee structures that support the governing body.

24. **Co-production.** Support clinicians and practitioners to work with managers when planning services and care pathways, with patients and the public involved throughout the process – continuing to make co-production a reality.

25. **Making it easier for patients.** Facilitate structural integration between all organisations across NEL ICS including enhanced communication; simplified record keeping; and joint executive posts and shared non-executives to make interfaces between organisations as seamless as possible.

26. **Systems that work for patients and staff.** Develop high functioning and responsive IT systems across the whole of NEL which support integrated working and improved care.

27. **Modern healthcare facilities.** Ensure all estates, particularly new developments, are designed around a holistic approach to health improvement.

28. **Making every contact count.** Ensure that everyone working in the system holds a responsibility to improve the physical, mental and social health of the population.

29. **Social and environmental sustainability.** Ensure that sustainability is core to everything we do and that this is the responsibility of everyone within the system

30. **Our people supported to grow and thrive.** On the merger, staff of the seven CCGs will be employed by the North East London CCG. We will enable our staff to work on CCG and ICS priorities across organisational boundaries, ensuring that they have opportunities to develop professionally and maximise delivery of health and health care outcomes. We can do that for example by using ‘honorary contracts’ to enable full access to different organisation’s systems.

31. **Clinical leadership** budgets for each CCG will be maintained for all seven local systems, with no cut to the clinical leadership budget in any local system. The single CCG will lead to a reduction in bureaucratic processes, freeing clinical leaders up to lead clinical transformation of services. Clinical leadership will exist at every level within the ICS and will be key to our success.

Committee: Health and Wellbeing Board – For Information Health and Social Care Scrutiny Committee – For Information	**Date:** 18 September 2020 3 November 2020
Subject: City of London Health Profile 2019	**Public**
Report of: Andrew Carter – Director of Community & Children's Services Dr Sandra Husbands – Director of Public Health	**For Information**
Report author: Xenia Koumi – Department of Community & Children's Services	

Summary

The City of London Health Profile 2019 was published in March 2020 (see Appendix 1). Public Health England produces Health Profiles for local authorities that contain summary information on the health of the people in each local authority area and factors that may influence their health.

Recommendation

Members are asked to:

- Note the City of London Health Profile 2019 and consider how they might use it to shape their forward-planning process.

Main Report

Background

1. Public Health England (PHE) produces Health Profiles for local authorities that contain summary information on the health of the people in each local authority area and factors that may influence their health. Health Profiles are Official Statistics, published by PHE according to the Statistics Release Calendar.

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

3. Health Profiles aim to:
   - provide a consistent, concise, comparable and balanced overview of the population's health

- inform local needs assessments, policy, planning, performance management, surveillance and practice
- be primarily of use to joint efforts between local government and the health service, to improve health and reduce health inequalities
- empower the wider community

4. Since 2019 Public Health England has published is Local Authority Health Profiles on its Fingertips website, however it is not possible for the City of London's profile to be made available in this way, due to the need to include indicators from multiple profiles and because some of the indicators are combined with Hackney's data (due to small numbers in the City).

5. To mitigate this, PHE has made available a PDF profile that is in a format as similar as possible to the HTML versions created for other local authorities.

Current Position

6. The 2019 City of London Health Profile (published in March 2020) includes 30 indicators. Indicators are reviewed regularly by PHE to ensure that they reflect important public health topics.

7. The 2019 Profile shows some improvements when compared with the 2018 profile; has been a reduction in the percentage of smoking during pregnancy, to 3.6% in 2018-19 from 5.0% in 2017-18. This is a combined value for Hackney and the City of London.

8. According to the 2019 Profile, the City of London performs at, or better than, the national average for the following indicators:
   - Life expectancy at birth (for males and females)
   - Premature mortality (<75 years old) from all causes
   - Mortality rates from all cardiovascular diseases and cancer
   - Emergency hospital admissions for intentional self-harm*
   - Emergency hospital admissions for hip fractures*
   - Hospital admissions for alcohol-specific and alcohol-related conditions*
   - Smoking prevalence in adults
   - Physically active adults
   - Excess weight in adults
   - Under-18 conceptions
   - Smoking during pregnancy
   - Breastfeeding initiation
   - Infant mortality
   - Children in low-income families
   - GCSE attainment
   - Statutory homelessness (temporary accommodation)
   - Excess winter deaths
   - Tuberculosis incidence

   *values for the City and Hackney are combined

9. According to Public Health England's City of London Profile 2019, the overall number of residents in 2018 was 8,706. ONS data shows that in the year to mid-

2018, the City of London was the fastest-growing local authority in England, closely followed by Westminster, Camden and Tower Hamlets.

10. The City still has a higher proportion of its population in older age groups compared to London. Compared with 2017 figures there has been a decrease in those aged below 20 and over 65 and an increase in those aged between 20 and 64.

11. Life expectancy in the City of London for both men and women remains higher than the London and England averages.

12. The premature mortality rate from all causes among City of London residents (aged <75 years old) is still significantly lower than both London and England. In 2016-18 there were a similar number of premature deaths from cardiovascular disease and cancer compared with 2015-17 and the England average.

13. The 2019 Health Profile highlights several indicators in which the City of London fared worse than regional or national comparators (marked red) , as follows:

14. **Indicator 6: Killed and seriously injured (KSI) on roads**
Rate of people reported killed or seriously injured on the roads, all ages, (crude rate per 100,000 resident population (2016-18)).

Public Health England states that "Areas with low resident populations but have high inflows of people or traffic may have artificially high rates because the at-risk resident population is not an accurate measure of exposure to transport. This is likely to affect the results for employment centres e.g. City of London."

On a day-to-day basis there are roughly half a million workers travelling in, out, and around the Square Mile during the working week, using a variety of modes of transport, including public transport, private hire, walking and cycling.

When looking at the count, rather than the rate, between 2016 and 2018 there were 193 KSI casualties in the City of London, which is the sixth lowest count across all 33 London local authorities. Westminster and Tower Hamlets, which both include employment centres, had rates of 715 (the highest) and 473 respectively.

15. **Indicator 10: Diabetes diagnoses**
% proportion of the City's population (estimated diagnosis rate for people with diabetes aged 17 and over) in 2018.
This is an estimate of the number of people diagnosed with diabetes, expressed as a proportion of the estimated number of those with diabetes, given the characteristics of the local population.

The City of London has a single GP practice – the Neaman Practice. Patients registered at the Neaman have one of the lowest rates of diabetes within the City and Hackney practices. However, the higher rates of diabetes in neighbouring Hackney may skew local estimates of diabetes.

The lower-than-average estimated diagnosis rate may be explained by the fact that the estimates for Local Authorities are created by aggregating GP-level data, which means that data from the Neaman Practice as well as other Hackney GP practices, may be used to create the City of London estimate.

In addition, patient data from the Neaman Practice – the City of London's only GP practice – shows that diabetes prevalence among its patients (2018/19) was statistically significantly lower than the England average. This needs to be investigated to determine whether or not there is really a low prevalence of diabetes among City residents, or whether it is being underdiagnosed, which could lead to complications and early mortality.

16. **Indicator 11: Dementia diagnoses**
% proportion of those aged 65+ (2019).
This is an estimate of the number of people aged 65+ diagnosed with dementia, expressed as a proportion of the estimated number of those with dementia, given the characteristics of the local population.

Public Health England states that "organisations with a smaller denominator population…should be interpreted with caution".

As with the diabetes indicator (above), this data is likely to underestimate the number of people living with dementia in the City of London, and hence the diagnosis rate seems to be lower than it should be.

Patient data from the Neaman Practice shows that dementia prevalence among its patients (2018/19) was statistically significantly lower than the England average, which, as with the diabetes indicator above, may also help to explain the lower-than-average estimated diagnosis rate. Again, this needs to be investigated to ascertain the true prevalence of dementia among City residents.

17. **Indicator 21: Obese children (including severe obesity)**
Combined figures for City of London and Hackney for children aged 10 to 11 years, given as a % proportion (2018/19).

Data is taken from the National Child Measurement Programme (NCMP), which collects pupils' BMI (height and weight information) from state maintained primary schools – only one of which exists in the City of London (The Aldgate Church of England Primary School). City-specific data has been combined with data from London Borough of Hackney to prevent potential disclosure of individuals.

18. **Indicator 29: New STI diagnoses (exc. Chlamydia in <25s)**
All new sexually transmitted infection diagnoses (excluding Chlamydia in under 25 year olds) (crude rate per 100,000 population aged 15 to 64) (2018).

PHE states that "diagnosis rates of STIs should be interpreted alongside the corresponding testing rate and positivity. A high diagnosis rate is indicative of a high burden of infection, however a low diagnosis rate may be explained by other factors as well".

The rate of new STI diagnoses in the City of London as significantly higher than the national value may be due to a number of reasons, including that due to the small resident population used as the denominator, any small changes in the numerator (new diagnoses) are likely to be represented as large fluctuations due to the crude rate methodology. In addition, City workers accessing sexual health services who provide their workplace postcode, who do not provide their home address, or who are from overseas, are automatically allocated to the City of London.

The City of London's STI testing rate (excluding chlamydia aged <25) per 100,000 population is better than the England average and the highest in London (2018). The percentage of STI testing positivity (excluding Chlamydia aged <25) is higher than the England average (3.4% and 2.3% respectively, in 2018).

Corporate & Strategic Implications

19. This information informs the City and Hackney Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy of the City Corporation's Health and Wellbeing Board, as well as the development and implementation of other health and social-care related strategies and action plans.

Conclusion

20. While the City of London's Health Profile 2019 provides a useful starting point for looking at performance, the small numbers must be treated with caution, as they can paint an inaccurate picture of health and factors influencing health locally.

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

Appendices

- Appendix 1 – City of London Health Profile 2019

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Public Health England

City of London

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Local Authority Health Profile 2019

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

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Health in summary

The health of people in City of London is generally better compared with the England average. City of London is one of the 40% least deprived counties/unitary authorities in England, however, about 9.6% of children live in low income families. Life expectancy for both men and women is higher than average.

Child health

In Year 6, 24.8% of children are classified as obese, worse than the average for England. Levels of breast feeding and smoking at time of delivery, and GCSE attainment (average attainment 8 score) are better than the England average.

Adult health

The rate for admissions for alcohol-related conditions is 539*, better than the average for England. The rate for emergency admissions for self-harm is 73.8*, better than the average for England. Estimated levels of adult excess weight (18+) and physically active adults (19+) are better than the England average. The rates of killed and seriously injured on roads, STIs and estimated dementia diagnosis are worse than average. The rate of emergency admissions for hip fractures is better than average.

*rate per 100,000 population

Health summary for City of London

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
Life expectancy and causes of death							
1.Life expectancy at birth (male)	All ages	2013-17	n/a	88.8	n/a,	79.5	⇔
2.Life expectancy at birth (female)	All ages	2013-17	n/a	90.7	n/a,	83.1	⇔
3.Under 75 mortality rate from all causes	<75 yrs	2016-18	48	221.9	303.3	330.5	⇔
4.Mortality rate from all cardiovascular diseases	<75 yrs	2016-18	11	50.8	70.5	71.7	⇔
5.Mortality rate from cancer	<75 yrs	2016-18	21	97.0	120.1	132.3	⇔
Injuries and ill-health							
6.Killed and seriously injured (KSI) rate on England's roads	All ages	2016-18	193	840.5	39.5	42.6	
7.Emergency hospital admission rate for intentional self-harm*	All ages	2018/19	215	73.8	83.4	193.4	⇔
8.Emergency hospital admission rate for hip fractures*	65+ yrs	2018/19	90	418.1	485.3	558.4	⇔
9.Percentage of cancer diagnosed at early stage	All ages	2017	8	38.1	52.7	52.2	⇔
10.Estimated diabetes diagnosis rate	17+ yrs	2018	n/a	43.3	71.4	78.0	⇔
11.Estimated dementia diagnosis rate~	65+ yrs	2019	39	49.2	72.6	68.7	⇔
Behavioural risk factors							
12.Hospital admission rate for alcohol-specific conditions*	<18 yrs	2016/17-2018/19	30	15.6	16.5	31.6	⇔
13.Hospital admission rate for alcohol-related conditions*	All ages	2018/19	1158	539.1	556.5	663.7	⇔
14.Smoking prevalence in adults (18+) - current smokers (GPPS)	18+ yrs	2018/19	n/a	18.4	15.2	14.5	⇔
15.Percentage of physically active adults	19+ yrs	2017/18	n/a	73.2	66.4	66.3	⇔
16.Percentage of adults classified as overweight or obese	18+ yrs	2017/18	n/a	45.4	55.9	62.0	⇔
Child health							
17.Teenage conception rate*	<18 yrs	2017	83	19.4	16.4	17.8	⇔
18.Percentage of smoking during pregnancy*	All ages	2018/19	164	3.6	4.8	10.6	↓
19.Percentage of breastfeeding initiation	All ages	2016/17	48	90.6	n/a	74.5	⇔
20.Infant mortality rate*	<1 yr	2016-18	53	4.0	3.3	3.9	⇔
21.Year 6: Prevalence of obesity (including severe obesity)*	10-11 yrs	2018/19	626	24.8	23.2	20.2	⇔
Inequalities							
22.Deprivation score (IMD 2019)	All ages	2019	n/a	14.7	21.8	21.7	
Wider determinants of health							
23.Percentage of children in low income families	<16 yrs	2016	60	9.6	18.8	17.0	⇔
24.GCSE attainment (average attainment 8 score)*	15-16 yrs	2016	n/a	49.3	50.0	46.9	⇔
25.Percentage of people in employment	16-64 yrs	2018/19	6400	76.8	74.2	75.6	
26.Statutory homelessness rate - (temporary accommodation)	NA	2017/18	15	3.0	14.9	3.4	⇔
27.Violent crime - violent offence rate	All ages	2018/19	1201	156.0	24.5	27.8	↑
Health protection							
28.Excess winter deaths index*	All ages	Aug 2017 - Jul 2018	81	25.2	27.1	30.1	⇔
29.New STI diagnoses rate (exc chlamydia aged <25)	15-64 yrs	2018	234	4615	1713	851	↑
30.TB incidence rate	All ages	2016-18	5	21.2	21.9	9.2	⇔

*Values for City of London and Hackney combined

~Comparison with goal: **≥66.7% (significantly)**, **similar to 66.7%**, **<66.7% (significantly)**

Indicator value types

1,2 Life expectancy - years, 3,4,5 Directly age-standardised rate per 100,000 population aged under 75, 6 Crude rate per 100,000 population 7 Directly age-standardised rate per 100,000 population 8 Directly age-standardised rate per 100,000 population aged 65 and over 9 Proportion - % cancers diagnosed at stage 1 or 2 10 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 11 Proportion - % recorded diagnosis of dementia as proportion of estimated number with dementia 12 Crude rate per 100,000 population aged under 18 13 Directly age-standardised rate per 100,000 population 14,15,16 Proportion 17 Crude rate per 1,000 females aged 15-17 18,19 Proportion 20 Crude rate per 1,000 live births 21 Proportion 22 Index of multiple deprivation (IMD) 2019 score 23 Proportion 24 Mean average across 8 qualifications 25 Proportion 26 Crude rate per 1,000 households 27 Crude rate per 1,000 population 28 Ratio of excess winter deaths to average of non-winter deaths 29 Crude rate per 100,000 population aged 15-64 (excluding chlamydia) 30 Crude rate per 100,000 population

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