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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Thursday 7 September 2017	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (1)	East Havering Residents' (1)	Labour (1)
Michael White (Chairman) Dilip Patel (Vice-Chair) Carol Smith	Nic Dodin	Alex Donald	Denis O'Flynn

For information about the meeting please contact:
Anthony Clements 01708 433065
anthony.clements@oneSource.co.uk

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for

anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference:

Scrutiny of NHS Bodies under the Council's Health Scrutiny function

AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 28 June 2017 (attached) and to authorise the Chairman to sign them.

5 RESPONSES TO DELAYED REFERRALS TO TREATMENT REPORT (Pages 7 - 18)

Report and responses attached.

6 EAST LONDON HEALTH AND CARE PARTNERSHIP (Pages 19 - 46)

Report attached.

7 HEALTHWATCH HAVERING - ANNUAL REPORT (Pages 47 - 82)

Attached.

8 PUBLIC HEALTH BUDGET (Pages 83 - 92)

Report and presentation attached.

9 PERFORMANCE INFORMATION (Pages 93 - 104)

Reports attached.

10 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item be considered as a matter of urgency.

Andrew Beesley
Head of Democratic Services

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
28 June 2017 (7.00 - 7.55 pm)

Present:

Councillors Michael White (Chairman), Dilip Patel (Vice-Chair), Denis O'Flynn, Alex Donald, Carol Smith and Nic Dodin

1 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that should require the evacuation of the meeting room or building.

2 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

There were no apologies for absence.

3 **DISCLOSURE OF INTERESTS**

There were no disclosures of pecuniary or personal interests.

4 **MINUTES**

The minutes of the meeting of the Sub-Committee held on 19 April 2017 were agreed as a correct record and signed by the Chairman.

5 **DELAYED REFERRALS TO TREATMENT - JOINT TOPIC GROUP REPORT OF HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE AND HEALTHWATCH HAVERING**

A director of Healthwatch Havering presented the report of the joint topic group on Delayed Referrals to Treatment. This summarised the findings and recommendations of a review that had been undertaken jointly between the Sub-Committee and Healthwatch.

The review had taken evidence from a number of key stakeholders including BHRUT, NELFT and Council officers. The principal recommendation of the review had been that BHRUT should adopt a more robust process in the migration of data. The review had also concluded that the CCG should look more closely at the position with delayed referrals to treatment and that GPs

in particular should take a closer interest in the process of referrals of patients to hospital.

The report had now been approved by the Healthwatch board and the Sub-Committee Chairman thanked the Healthwatch director and the Clerk to the Sub-Committee for producing a very good report.

The Healthwatch director felt it was important that GPs considered how they dealt with future problems around referrals and that it was accepted by the NHS that the model of general practice in Havering needed an overhaul.

It was confirmed that all relevant health bodies were obliged to consider and respond to the report and that responses could be invited in order that they could be considered at the next meeting of the Sub-Committee. The Director of Public Health added that BHRUT had advised the Health and Wellbeing Board that the target of 92% of patients being seen within 18 weeks of referral would be reached by September 2017.

The report also made a recommendation regarding the integration of IT systems and the local CCGs were leading work on a road map to achieving this. The use of different IT systems and contracts had caused problems although most GPs in the local boroughs had now agreed to move towards the use of a common system – EMIS. In the long term, it was planned for there to be enough points of connectivity for information to be electronically shared. The Sub-Committee Chairman added that in areas such as Islington, all GPs pharmacies and patients were connected via a single on-line record and systems could be integrated.

It was **AGREED** that an update on the position with delayed referrals to treatment should be taken at the Sub-Committee in 2018.

RESOLVED:

1. **That the Sub-Committee approve the Joint Topic Group report on Delayed Referrals to Treatment.**
2. **That the Sub-Committee agree that the recommendations contained within the report should be referred to the relevant NHS organisation(s) for response.**

6 **HEALTHWATCH REPORTS**

1. QUEEN'S HOSPITAL IN-PATIENT MEALS

A director of Healthwatch Havering explained that, following a number of complaints from Healthwatch members about the quality of food at Queen's Hospital, five wards had been visited in October 2016. Although one patient

had been very critical of the food on offer, the overall conclusion from the visits was that the food at the hospital was of an acceptable standard.

This was not found to be the case however on Sunrise B ward which treated people with dementia, where meals were found to be of a very poor quality with people not being offered assistance with eating. The food offered had also been found to be insufficiently varied.

It was accepted by Healthwatch that hospital food was a difficult area to get right. Catering facilities at the hospital were contracted to Sodexho who sub-contracted hospital meal preparation to Tilbury Foods. Food was delivered pre-packed and frozen and meals were cooked on the wards. Healthwatch felt that the main problems occurred when serving food once it had been cooked.

BHRUT had responded to the report confirming that more choice was now offered and more staff were available to assist with serving etc. Healthwatch would carry out a further Enter and View visit in autumn 2017 in order to check if improvements were still in place. How food orders were taken would also be observed. It was uncertain whether Healthwatch reports were forwarded to the hospital's Patient Advice and Liaison Service.

2. NELFT MENTAL HEALT STREET TRIAGE SCHEME

It was emphasised that the Healthwatch report on the street triage scheme had been very positive. The scheme allowed Police to call out a mental health team to attend incidents of mental health crisis.

The scheme had been welcomed by the CCGs and Healthwatch had recommended there be more links between NELFT and the London Ambulance Service, allowing a quicker mental health response to incidents.

Recommendations had been made in the report to Havering Police and to the British Transport Police but no response had been received. It was **AGREED** that the matter should be referred to the Crime & Disorder Committee in order to seek to get a Police response to the Healthwatch report. The Director of Public Health added that the Police did attend the Suicide Prevention Strategy Group and that crisis management was seen as a priority. The Healthwatch report would be taken to the group as an example of good practice.

A NELFT representative thanked Healthwatch for the report and added that the service had been funded as a pilot project but it was wished to make this permanent. It was suggested that NELFT could also work with the Council on how parks staff could deal with people they encountered exhibiting mental health issues.

The Sub-Committee NOTED the Healthwatch reports.

7 ANNUAL REPORT OF SUB-COMMITTEE 2016-17

The Sub-Committee **AGREED** the Annual Report 2016-17 and that it should be referred to full Council for approval.

8 NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES

The Sub-Committee AGREED:

1. **That, line with political proportionality rules, Councillors White, Patel and Dodin should be its representatives on the Outer North East London Joint Health Overview and Scrutiny Committee for the 2017/18 municipal year.**

2. **That Councillor White be the Sub-Committee's representative at any meetings of the pan-London Joint Health Overview and Scrutiny Committee during the 2017-18 municipal year,**

9 SUB-COMMITTEE'S WORK PLAN 2017-18

The Sub-Committee considered a proposed outline work plan for the 2017-18 municipal year. It was felt that an update should be taken on work concerning the East London Health & Care Partnership (formerly Sustainability and Transformation Plan). It was felt that GP recruitment locally should also be scrutinised, perhaps at the November 2017 meeting.

It was felt that topic group work should consider, if practicable, the Council's Health and Wellbeing Board and how this was fulfilling its remit against best practice. The location of GP surgeries could also be considered as part of a topic group.

The Sub-Committee **AGREED** the outline work plan.

10 URGENT BUSINESS

The Sub-Committee considered what performance indicators it wished to scrutinise, feeling that these needed to be relevant to its work. Possible indicators included those under the Public Health Outcomes Framework such as data related to air quality. Other indicators that could be scrutinised included those covering delayed transfers of care, emergency & elective admissions. It was suggested that the 'discharge to assess' programme may be of interest to the Sub-Committee.

The Sub-Committee **AGREED** to consider, at its next meeting, what performance indicators were already reported on and then to decide which indicators it wished to scrutinise during the remainder of the year.

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Chairman

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 7 SEPTEMBER 2017

Subject Heading:	Responses to Delayed Referrals to Treatment Topic Group Report
CMT Lead:	Daniel Fenwick
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer Tel: 01708 433065 anthony.clements@onesource.co.uk**
Policy context:	**The information presented shows the responses received to the recent joint topic group report.**
Financial summary:	**No financial implications of the report itself for either the Council or Healthwatch Havering.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached documents show the responses received to the report of the joint topic group review of delayed referrals to treatment.

RECOMMENDATIONS

1. That the Sub-Committee notes the attached responses to the joint topic group report and takes any action it considers appropriate.

REPORT DETAIL

1. Members will be aware that the joint topic group review of delayed referrals to treatment, run under the auspices of the Sub-Committee and Healthwatch Havering, concluded its scrutiny earlier this year and the topic group's report was approved by the Sub-Committee at its meeting on 28 June 2017.

2. Attached to this report are responses received from Health Trusts and other relevant bodies to the topic group's review. Members are invited to note the responses received and agree any further appropriate action on this matter.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

RESPONSES TO JOINT HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE/HEALTHWATCH HAVERING REPORT ON DELAYED REFERRALS TO TREATMENT

1. BHR CCGs

Many thanks for sending over the final report. Please find below the CCGs' response to two of the four overarching recommendations of the report from P17, which I hope will provide some assurance. These are being sent across on behalf of Louise Mitchell, who led on contributing to this review for the BHR CCGs as you know. I understand from BHRUT colleagues that they are currently drafting their own response to you.

RTT report recommendation R3:

CCGs' response: 'We have a formal contractual mechanism in place, as commissioner with BHRUT. One of our key priorities is to oversee and monitor demand and capacity modelling for elective activity which we do on a monthly basis.'

RTT report recommendation R4:

CCGs' response: 'Work is underway to address this issue with a joint system approach. BHR CCGs and the Trust are now developing a business case for the establishment of a referral management system which is being overseen at a senior level by the System Delivery and Performance Board which both commissioners and providers are members of.'

Regards

Andy

Andy Strickland

Head of Communications

BHR CCGs

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Barking, Havering and Redbridge University Hospitals NHS Trust

DELAYED REFERRALS TO TREATMENT – HEALTHWATCH REPORT

BHRUT Response

TAKING PRIDE IN OUR CARE

INTRODUCTION

This document represents Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT/the Trust) formal response to the **Delayed Referrals to Treatment** report of the Joint Topic Group of the Havering Health Overview and Scrutiny Sub-Committee and Healthwatch Havering.

We are pleased to have the opportunity to respond to this report, and would like to place on record our thanks to the Joint Topic Group for their time spent on this issue.

We would also like to thank the Topic Group for the opportunity to review and input to the draft in advance.

In the main, we are pleased to be able to acknowledge this report as a good record of most of the issues and contributory factors.

Nevertheless, we do believe there are places where some additional context or amplification is helpful, to ensure that the right emphasis is placed on what we would consider to be the key elements. We feel it is important to ensure these are noted and acknowledged to provide assurance such a situation can not arise again in the future.

It is a happy circumstance that we are able to put forward this response in the same month that we were able to report nationally that the Trust has hit the 92% Referral To Treatment (RTT) incomplete standard for the first time in three years (June 2017), against a national picture of stagnating or declining performance.

This follows the success of the major recovery programme we have undertaken, delivered in partnership with local GP commissioners, which has seen us treat a huge number of patients. It therefore seems appropriate now to reflect a few of the key achievements:

- At beginning of 2014, waiting list included over 1,000 people waiting longer than 52 weeks – now down to a very small number
- Thousands of extra clinics and nearly 100,000 appointments delivered, with thousands of patients redirected by GPs
- June performance saw BHRUT exceed national average (90.3%)
- Less than 8% of patients waiting longer than 18 weeks for June

We would again like to thank our staff, patients and key partners, particularly our local GPs, who have delivered a remarkable turnaround in performance. We would also like to thank colleagues in local government and the Healthwatch groups across our community, who have helpfully supported and challenged us in a positive and constructive manner.

RESPONSE

We have responded specifically on a paragraph-by-paragraph basis for ease of reference.

Section 1

1.1

- We note and appreciate the Topic Group's acknowledgment of our openness.
- Line 5 – we would expect waiting lists of c.32,000 rather than 30,000 as published

1.4-1.7

- We do not recognise most of the numbers in this section, and would suggest that there may have been a misunderstanding (or failure on our part to successfully explain) these figures at the time.
- For example, the 9,000 extra appointments referred to in 1.4. We calculated (and have typically explained) that the additional work was equal to around 93,000 outpatient appointments, and 5,000 operations.
- Paragraph 1.6 We are not quite sure as to the origins of the assertion re: additional anaesthetists. It relates to surgery, not outpatients, as anaesthetists do not support our outpatient activity.
- The report is right to highlight the additional consultants – in total, 19 were targetted to deliver this workload.

Section 2

2.5

- A point of terminology re: "backlog" – this should read "total waiting list", as we would categorise everyone waiting 18 weeks or more as being a "backlog" – there would always be a waiting list.
- The 52,000 referenced is the total waiting list. They were awaiting treatment, not an appointment.

2.6

- While this is accurate, it is important to note that readmission is an issue largely related to ED – as the paragraph concludes, for elective patients, this is less of an issue.

Section 3

3.4

- We would echo and emphasise the importance of this point, which remains a challenge. We welcome the ongoing support for CCGs and other partners to continue to identify ways to progress this.

Section 6

6.4

- This was and remains true. We have dedicated significant time, resource and effort in conducting a Clinical Harm review. This has been run alongside the recovery plan, reviewing more than 4,000 patients, in particular those patients who had waited more than a year, and has indicated so far that no RTT patient has come to harm.

Conclusions

Overall, we believe an appropriate conclusion is that there was an absence of effective demand and capacity plans, which meant that as a Trust (and a system), we did not understand the gaps, or the ebbs and flows of demand across the specialties, and how best to manage the service and capacity appropriately.

We did not have the specialist expertise within the Trust to manage the waiting lists (a highly complex operation), and we were not consistent with our reporting, with our application of rules and processes, or with our patient classification.

The expertise and experience we have acquired in the past two years particularly means that we have taken a significant step to resolving this, and minimising the risk of any future relapse. Specifically, the processes, systems and procedures we have put in place mean that our entire operation is far more data-driven and robust.

C1

- While we recognise some of the points made within, we are concerned that this conclusion as currently phrased does not seem to tackle the main underlying issues, and we believe puts undue emphasis on the ICT factors.

- While we accept all the points of concern, we would want to be clear that the migration of the databases was not the root cause of the problem – rather it was this which actually uncovered the problem.

- We absolutely agree that the management was clearly inadequate prior to this.

- We believe that the reference to cybersecurity in this instance is somewhat tangential to the matter in hand. There were no cybersecurity issues relating to this circumstance.

- The suggestion made in the final paragraph, while an admirable ambition, represents a significant logistical challenge.

C2

- The “central point” of referrals does exist within BHRUT, however we absolutely recognise the potential for exploring this further as a system-wide solution, and are exploring this.

C3

- We would question whether GPs (who are already extremely busy, and working very hard) would realistically be in a position to chase every appointment or referral. We already work closely with our GPs via our GP Liaison Service, to help escalate issues and chase appointments. We send clinic letters following attendances as well as discharge records.

Recommendations

R1/2

- As per our above comments. We acknowledge and endorse the Topic Group's comments regarding the need for robust ICT governance and management, and this remains a top priority for the Trust. We also acknowledge the shortcomings here.

- We do believe it is important to note that in our view, it was not the "loss of data" which occasioned the delays. We believe that presenting this as an ICT or data transfer issue does not fully acknowledge the complexity of the problem, so would be keen to make sure this is understood.

R3

- We agree and support this recommendation. However, we would suggest that a more active verb than "modelling" – we believe that active management is required here.

- We believe that very strong progress has already been made, by us and our CCG partners to better understand the picture in our community. We now have far more information and a more accurate picture about the specific nature of the demand, in order to plan effectively to meet the need.

- We believe that tackling this is a top priority, as now we have established a reliable picture of the demand, thanks to the work we and CCG/GP colleagues have undertaken, it is showing how high these levels truly are. We are committed to playing a full role in supporting the work of partners, particularly the CCGs, in their efforts to continue to find ways to reduce this demand, and explore all solutions, whether in or out of our hospitals.

R4

- Work is already underway to address this issue with a joint system approach. We are working with the BHR CCGs to develop a business case for the establishment of a referral management system. This is being overseen at a senior level by the System Delivery and Performance Board of which which both commissioners and providers are members.

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By email only

22 August 2017

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Councillor Michael White,
Chairman
Health Overview & Scrutiny Sub-Committee
London Borough of Havering
Town Hall
Main Road
Romford
RM1 3BD

Anne-Marie Dean
Chairman,
Healthwatch Havering
Queen's Court,
9-17 Eastern Road,
Romford
RM1 3NH

Dear Michael and Anne-Marie,

Delayed Referrals to Treatment at Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT or the "trust").

I am writing to thank you both for sending to NHS Improvement the helpful *Report of a Review by a Joint Topic Group of the Havering Health Overview & Scrutiny Sub-Committee and Healthwatch Havering* dated 7th July 2017.

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

The report highlights lessons learnt in the management of patient referrals and provision of high quality patient care. In particular it highlights the significant number of improvements that have been delivered at the trust, whilst recognising that there remain potential risks that could, if not adequately addressed, result in a future recurrence of the issues that led to the system delays in patient treatment.

NHS Improvement has noted that BHRUT has developed and implemented a recovery plan which has seen it make significant progress against the Referral to Treatment (RTT) national standard including reporting compliance against the standard in June 2017 - three months ahead of plan and for the first time in three years. The trust has also made significant progress in strengthening organisational oversight and governance systems and processes.

We note the conclusions and recommendations in your report. NHS Improvement will continue to monitor the trust's performance against the national standard to ensure the improvements delivered are sustained and to secure the necessary level of assurance that the trust is continuing to deliver timely care for patients.

Yours sincerely,

Victoria Woodhatch
Delivery and Improvement Director (North Central and East London)

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 7 SEPTEMBER 2017

Subject Heading:	East London Health and Care Partnership Update
CMT Lead:	Barbara Nicholls
Report Author and contact details:	**Ian Tompkins, Director of Communications, East London Health and Care Partnership 020 8221 9052 ian.tompkins@nhs.net**
Policy context:	**The information presented summarises the current position with work on the East London Health and Caer Partnership.**
Financial summary:	**No financial implications of the report itself for either the Council or Healthwatch Havering.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached report of Healthwatch Havering details the current position with work to establish the East London Health & Care Partnership.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached update and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of work to establish the East London Health & Care Partnership.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Appendix 1: General update September 2017

Index

1. Background and context (our public narrative)

As more and more people choose to live and work in east London, the demand on health and social care services is at an all-time high. Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country. Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most and supported by the right team of staff from across health and social care, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

'Barrier busters'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

The Partnership's *NEL Sustainability and Transformation Plan* (STP) sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

It describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

The plan proposes improvements across the whole of east London, such as the availability and quality of specialist clinical treatments, how buildings and facilities could best used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The involvement of councils enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence on people's health and wellbeing.

The Partnership is committed to being transparent and engaging fully with key stakeholders and the wider public in the development of its plans.

But the biggest single factor in the long term is to prevent ill health and the time pressure and financial pressure preventable conditions put on the NHS. This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities.

Public health information and advice will be strengthened. Information and support to help us live healthier lives will be made more widely available, online and through social media. It's up to us to enjoy life to the full by doing those little things each day that help us stay healthy and fit. We can watch what ourselves and our families eat and drink and all get more active.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit and if we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it

2. The STP in detail

The *NEL Sustainability and Transformation Plan (STP)* sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the vision of the NHS Five Year Forward View.

Forty four such plans have been developed throughout England. They are geographically set around 'footprints' that have been locally defined, based on natural communities, existing working relationships, patient flows and taking into account the scale needed to deliver the services, transformation and public health programmes required.

Twenty organisations across eight local authorities have worked together to develop the local STP. They are:

NHS

CCGs: Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts: Barking, Havering and Redbridge University Hospitals Trust; Barts Health NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust

Councils

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

The STP has been defined as one for north east London (NEL) by NHS England, because it has divided the capital into five 'footprints': north east; north west; south east; south west; and north central.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the STP was submitted to NHS England and NHS Improvement on 21 October 2016.

The plan is currently only a 'draft'. It will continue to evolve as the organisations concerned develop it further, agree shared solutions, and as we receive feedback from stakeholders.

The STP describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

All of the organisations involved in the STP face common challenges, including a growing population, a rapid increase in demand for services and scarce resources. By working together they will be best placed to drive change and make sure health and care services in north east London are sustainable by 2021.

The STP builds on existing local transformation programmes and supports their implementation including:

- Barking and Dagenham, Havering & Redbridge (BHR)
- City and Hackney
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme

- The improvement programmes of our local hospitals, which include supporting Barts Health NHS Trust out of special measures.
- Vanguard projects eg Tower Hamlets Together

The organisations behind the STP are actively seeking to collaborate where it makes sense to do so, sharing learning from the devolution pilots and transformation programmes.

2.1 STP vision and priorities

The vision of the NEL STP is to:

- Measurably improve health and wellbeing outcomes for the people of east London and ensure sustainable health and social care services, built around the needs of local people.
- Develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
- Work in partnership to commission, contract and deliver services efficiently and safely.

To achieve this vision, we have identified a number of key transformation priorities:

- The right services in the right place: Matching demand with appropriate capacity in east London
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables place-based care and clearly involves key partner agencies
- Using our infrastructure better

These priorities have now been categorised under four headings:

- Healthy and independent local people
- Improving services
- Right staff, right place, right tools
- A well-run partnership

More information on this is given in Appendix 2

To deliver the STP we are building on existing local programmes and setting up eight work streams to deliver the priorities.

The work streams are cross-cutting east London-wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme.

The work streams are:

- Promote prevention and personal and psychological wellbeing in all we do

- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

Each delivery plan sets out the milestones and timeframes for implementation.

The full STP, and eight delivery plans, can be found on our website www.eastlondonhcp.nhs.uk

The delivery plans are currently being refreshed. Updated versions are due to published in the autumn.

A summary of what the Partnership is planning to do across services, such as urgent and emergency care, primary care and mental health, and what it means for local people, is given in Appendix 3.

2.2 Partnership governance

The launch of the Sustainability and Transformation Plan (STP) process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP).

The Partnership governance structure is attached as Appendix 4.

Progress has been made in bringing the governance groups together.

- ELHCP Community Group – A group of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance.

  A wide range of organisations and people (around 300 in total) from across east London have been invited to co-create the group.

  An initial meeting was held on 4 July and attended by nearly 100 people and work to develop the group is ongoing. More information is given in section 4 on page 10 below.

- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP STP

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how this Group could develop. See section 3 on page 9 below.

- ELHCP Social Care & Public Health Group – Directors of Children's and Adult Services and Directors of Public Health

  The directors of adult services are setting up a working group to look at the current and future challenges relating to the social care workforce across east London, including recruitment and key worker accommodation

- ELHCP Assurance Group – An independent group of audit chairs and local authority scrutiny members to provide assurance and scrutiny

  This Group is due to hold its first meeting soon. Borough scrutiny committees are being invited to nominate members to join the Group.

- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated east London financial strategy and plans to ensure financial sustainability of the system.

  This group is now meeting regularly. It includes council and NHS chief finance officers among its members.

The arrangements are underpinned by a Partnership Agreement (see Appendix 4) which, while not legally binding, intends to ensure a common understanding and commitment between the partner organisations of:

- The scope and objectives of the ELHCP STP governance arrangements
- The principles and processes that would underpin the ELHCP STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP STP

The Partnership Agreement has now been circulated to the member organisations of the ELHCP for signature.

3. Engagement with Local Authorities

The ELHCP is engaging widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and is being achieved through various forums.

There are now three local authority representatives on the Partnership board:

- Tim Shields, LB Hackney (for City and Hackney)
- Kim Bromley-Derry, LB Newham (for Newham, Tower Hamlets and Waltham Forest)
- Andrew Blake-Herbert, LB Havering (for Barking & Dagenham, Havering and Redbridge)

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how the Mayors and Leaders Advisory Group could develop.

At the most recent meeting, on 23 June, the cabinet members expressed a strong desire to be more involved in the work of the Partnership, and the shaping of ideas, especially in the development of proposals around accountable care systems and a single accountable officer role. A similar request for more involvement has come from the various Health & Wellbeing boards and some scrutiny committees.

The Partnership chair, Rob Whiteman, and exec lead, Jane Milligan, are now exploring ways of doing this. This includes having political representation on the Partnership board and in the development of transformation programmes.

The cabinet members have also been asked to nominate fellow members to join the Community Group (referred to in 2.2 on page 7 above).

Scrutiny members are being asked to join the Assurance Group. The INEL and ONEL JHOSCs have been invited to nominate members from each to join this Group, but this may end up happening on an individual borough basis.

The Partnership is also actively encouraging local authority officers to be involved in the transformation work streams listed on page 7 above.

4. Involving local people and communications/engagement generally

STPs have been widely criticised for being put together too hastily with little consultation.

The timescale set by NHS England to produce the initial plans was tight. As a consequence, there was only a limited time for engagement. Some key stakeholders felt disengaged from the process, as did patient representatives. Also, much of the detail behind the plans was initially kept under wraps giving rise to accusations of secrecy and the STPs being seen as no more than 'hit lists' and cuts to services.

NHS England acknowledges this criticism, but it caused significant reputational damage to what is a genuine and necessary attempt to deal with very real challenges.

The immediate priority of our communications and engagement strategy has therefore been to repair that damage.

Most, if not all, of our key stakeholders recognise and understand the challenge. We want to rebuild their trust and confidence and engage with them in a more positive way so they are involved in developing shared solutions.

A starting point has been to talk about a partnership rather than a plan. It is why we changed our name to the East London Health & Care Partnership.

The STP itself is still being referred to as such, but it is just one of many things the organisations involved can do together to protect and improve health and care services for the people of east London. Our plans to explore the link between health and housing, starting with a conference on 18 October, is one example

It was also felt east London was a more appropriate and familiar way of describing the area as a whole rather than north east London – the name used by the health service to denote the area.

Next is to communicate in an open and honest way; unravel the jargon, speak in plain and simple language and be accessible and transparent. Most importantly, we must listen to what people have to say.

Relevance is also important. Our communications will reflect a knowledge and understanding of the many different audiences we want to reach and be targeted to suit each group. What does it all mean for them? How are their interests being taken into account? What part can they play?

Local relevance and insight is particularly important. We will work closely with our communications and engagement colleagues in the partner organisations at borough level to make full use of their knowledge and networks.

An online Briefing Room has been set up as a central source of information and materials for members of the Partnership to adapt and use in local communications and engagement activities. This includes narratives around the STP (what it is and what it isn't); the various transformation plans and programmes (as they emerge); facts and figures; presentations (tailored for specific audience); information videos; and case studies.

At the heart of our stakeholder engagement will be the Community Group – a subgroup of the East London Health and Care Partnership.

Part of the Partnership's governance structure, the Community Group's principal purpose is to act as a reference group to support the development of the Partnership's strategies, plans and activities and recommend the most effective ways for it to communicate and engage with its many different audiences.

Nearly 100 representatives from the voluntary, business, education, health and care sectors attended an event on 4 July for stakeholders and partners that could form our Community Group.

It is in effect a 'group of groups', made up of a range of people from professional organisations, the education and business sector to voluntary organisations, local councillors, Healthwatch and other patient and public groups.

How such a wide and diverse group comes together and gets involved, and how the Community Group develops, is still 'work-in-progress'. A working group of some of those that attended the event on 4 July is helping plan the next steps.

In the meantime, some of the organisations and public and patient representatives are being invited to take part in the Partnership's activities, such as improvements to the signposting of services.

A determined effort is also being made to involve young people in the Community Group. This is currently being progressed through local councils, NHS organisations, colleges and universities.

Another key audience is, of course, frontline staff – not just those in the NHS, but in councils too. Their buy-in is key and we have started engaging with them to create understanding about what the Partnership, and the STP, means to them.

We very much want staff to be involved in shaping services and our internal communications will reflect this. They will recognise the contribution everyone has to make, encouraging and valuing people's achievements, opinions and ideas.

If we are to give staff the effective help and support they need it's vital we listen to what they have to say, and demonstrate what we do as a result.

While staff and the other key stakeholders in the Community Group are taking precedence in the immediate future, we eventually want to reach out and engage with as many people as possible, including the wider public.

The Partnership's website has been rebuilt, with an improved design. (www.eastlondonhcp@nhs.uk)

An easy guide to what the Partnership plans to do and what it means for local people is to be published on the website in early August. Printed copies will be made available for people that don't have access to the internet, with extracts placed in local publications.

Social media and YouTube will also be used to raise awareness of the challenges to health and care in east London, promote service improvements and run prevention campaigns.

The Partnership is also planning to hold a series of public engagement events across east London during the autumn and winter.

Designed in collaboration with local councils and NHS organisations, with at least one major event in each borough, the events will be used to create awareness and understanding of what the Partnership is doing and what it means for local people. The larger events will feature a 'Question Time' session, and current and planned improvements to services will be showcased in a mini expo.

The Partnership communications and engagement team are working closely with their 300 plus colleagues in the member organisations to create shared opportunities to increase audience reach and give consistent messaging. They are also forging links with wider comms networks across London, including those in other boroughs, the Met Police, London Fire Brigade, TfL, professional organisations, eg Royal College of Nursing, and national charities. The Partnership's comms and engagement is seen as leading in the STP field.

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Appendix Two

East London Health & Care Partnership

Transformation Priorities

Four big issues and four Priorities

1	2	3	4
Poor health, growing population & more demand	Variable access and quality of services	Lack of workforce, poor technology and buildings	Unaffordable health & social care system
Healthy & independent local people	**Improving services**	**Right team, right place, right resources**	**Well run partnership**
•Preventing ill health and lose of independence •Tackling inequalities •Good mental well-being	• More services out of hospital and integrated in primary, mental, social & community care • Improved priority services: maternity, mental health, cancer, urgent & emergency care • Strong hospital & specialist services	•Healthy work places •Skills & career development, recruitment & retention •Housing for key workers •Digital & online services •Better buildings	• Partnerships • Productivity – value for money • Better organised - new organisations bringing together providers & commissioners • Living within our means

Our story

The transformation agenda for health and social care across East London is significant and exciting. We are challenging ourselves to be clear that more of the same isn't enough, or will provide fit for purpose health and care going forward. These are the four big challenges the ELHCP want to tackle:

1. Healthy and independent local people

- We have one of the largest and fastest **population** growth rates in the country - 18% over the next five to ten years
- This is both growth of a younger population and also the older population
- East London also has a transient population and areas of intense **health inequalities** and deprivation
- People want their **whole health and social care needs** considered as one and we too often treat and manage people in parts, in particular not making sure that people's mental as well as physical health are treated equally. We have also traditionally focused more on resourcing physical health needs than mental and well-being needs.

2. Improving services

- **Resources** (capacity) are not necessarily in the right part of the system, often still tied up in acute hospitals rather than in the **community,** where people tell us they want them.
- Access is too often through A&E, at a point of crisis. The front door to the system should be people's own front doors with care provided by multi-disciplinary teams across health and social care, supported by the voluntary sector and our strong local communities.
- The problem with accessing care in a crisis through A&E means our solutions tend to be too much about providing care around a few hundred hospital beds, rather than care around the one and half million beds in people's own homes.
- This support should be centred in the home, and using digital technology and more self-care support to prevent crisis and maintain independence.
- It's not only about demand and capacity not lining up, the **quality** of some of our services and the outcomes people get are variable –and we want the best standard for everyone across East London
- Access to primary care is **variable** and the Care Quality Commission has highlighted services, **quality** and **outcomes** across our providers that need to improve
- Some services are not as **resilient** as they could be, for example primary care and urgent and emergency care services
- We have a long history of innovation through working with patients and clinicians to co-design individual components of care, but this hasn't been easy to spread more widely.

Our story

3. Right team, right place, right resources

- We have the opportunity to innovate training, roles and ways of working. It's about the right care, at the right time, in the right place and most importantly – the right team.
- Community–based working often gives more autonomy to staff and releases them to innovate and provide whole person care- and this is important, as not only is capacity not always in the right part of the system, but we need new types of roles, development opportunities and ways of working as finding and keeping the **workforce** these days is challenging, especially with the cost of living and housing in London.
- We also have serious challenges our estates and technology. We have some of the best buildings, but also others that are not fit for purpose, such as Whipps Cross Hospital. We also have estate with old hospital buildings that could be re-purposed used for new integrated health and social care facilities, creating health campuses
- People live their lives on their smart phones now and there is an urgent need for health and social care services to become more **digital friendly**

4. Well run partnership

- Ultimately all our challenges above mean that the **financial** as well as service and quality sustainability of our health and care system is impacted. There is scope to be more productive and if we do not seize the opportunity our financial challenges and sustainability will continue and service stability will be affected.
- In recent years the system has become **fragmented**: causing duplication, not always working to the best advantage for the patient or local people and putting artificial barriers between professionals and organisations across health and local government services. We need to make sure we are organised well and working in partnership.
- Individual institutions will not address the financial or quality goals we have, and in order to get the best of our collective resources we need to transform how we work together using a **partnership** approach, rather than working with an individual organisation focus.

East London Health & Care Partnership

Urgent & Emergency Care

What are we doing?

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) and working towards improved links with other health services eg Mental Health, GPs, Pharmacists, Urgent Treatment Centres, ambulance services and community health professionals.
- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.
- Creating consistent Urgent Treatment Centres, so people understand what treatment can be given there
- Creating special areas in the hospital for specific emergency conditions so that people do not need to stay overnight in a hospital bed when there is no medical need for this.

What does it mean local people?

- You will be able to understand the range of local healthcare services available and how to access them.
- By calling or contacting NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) you will be able to access the most appropriate clinical advice on where your health needs will best be treated as close to your home as possible.
- You will be able to book GP appointments more easily and these will be also be available in person during evenings and the weekends as well as over the phone and online. You will be able to be seen by a range of healthcare professionals in your community in new Local HealthCare Hubs more quickly.
- Wherever you live in east London, you will be able to be seen at our Urgent Treatment Centres for the treatment of minor injuries, including broken bones and minor burns.
- You are likely to be satisfied with your experience as a patient because we will be reducing the time you need to spend in hospital.

East London Health & Care Partnership

Primary Care

What are we doing?

- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.

Quality improvement

- Helping practices improve the experience of their patients
- Helping practices improve services for people with long term conditions
- Helping practices become a better place to work and remove administrative headaches
- Training staff in proven improvement techniques
- Sharing solutions that work across east London
- Established an east London Primary Care Partnership for Quality improvement Board which will enable acceleration of quality improvement approaches, learning and case studies across the whole area.

Provider development

- Helping GP federations develop to improve care, reduce overheads and give primary care a stronger future
- We are bringing GP federations and networks together to share learning and experience, and solve common challenges - we have recently set up an east London Primary Care Provider Forum.
- Establishing a range of online resources that GP federations and practices can use to take forwards quality improvement

Workforce development

- Working out what mix and number of staff will be needed going forwards and how to find and train them
- Working together to retain current staff for longer, making east London an attractive place to work for new recruits

What does it mean local people?

- More time with GPs to avoid rushed appointments and increased accurate diagnosis.
- Patients being able to book appointments quickly, within a reasonable timeframe and a pre-booked one if they wish.
- Patients being able to see a preferred clinician if they wish to wait longer for an appointment.
- Patient access to reliable information about the practice so that they can make their own decisions
- Patients not only being able to book appointments via telephone but by other means, such as through the internet website, emails, digital TV or by text.
- Increased access to a range of health professionals to provide care best suited to individual needs
- Better support and information to enable the public to take better control of their own health.
- A service that treats patients as people not numbers.

East London Health & Care Partnership

Digital

What are we doing?

- Enabling GP appointments to be booked online.
- Allowing people to view their own health and care records.
- Putting more services, such as some GP consultations and mental health services, online.
- ·Improving information systems and sharing records to allow health and care professionals to work closer together.

What does it mean local people?

- You will be able access health and care services more quickly and easily.
- You will be able to book GP appointments or talk to your GP online.
- Doctors and other care professionals will be better placed, with the right information, to help prevent illness and give you better care, should you need it.
- You will be able to get care closer to home, or in your home.
- You will have better information on how to stay healthy and well.

East London Health & Care Partnership

Mental Health

What are we doing?

- Working with partners to address the wider determinants of mental health eg access to accommodation, education and employment.
- Supporting the roll out of digital self-management tools such as the London Digital Mental Wellbeing Service (www.digitalwellbeing.london).
- Developing an east London-wide suicide prevention strategy.
- Supporting employers to improve staff mental health and emotional wellbeing via programmes such as Mental Health First Aid.
- Developing our talking therapies services so they are more appointments with reduced waiting times.
- Integrating mental health services into GP surgeries, A&E and General Hospitals.
- Developing perinatal mental health services for expectant mums and mums of new babies.
- Improving services for people experiencing a crisis by ensuring everyone in crisis can access mental crisis support 24/7.
- Delivering mental health treatment at home.
- Delivering specialist mental health services for children and young people closer to home.
- Developing a new Child and Adolescent Mental Health Psychiatric Intensive Care Unit here in East London.

What does it mean local people?

- Improved access to and shorter waiting times for psychological therapies.
- A wider range of mental health services to be accessible via your GP
- Your mental and physical health and social care needs treated as one, wherever and whenever necessary.
- Enhanced support to access the right education, employment and accommodation opportunities for people with mental health issues.
- People in east London will have access to the same range of mental health services wherever they live.

East London Health & Care Partnership

Cancer

What are we doing?

- Ensuring that we are seeing all patients who need an urgent appointment within 2 weeks.
- Making sure that patients are receiving their tests and diagnostics on time to enhance early diagnosis and treatment and improve cancer survival.
- Educating GPs and other professionals to improve better communication with hospital consultants.
- Encouraging patients in east London to take up their screening.
- Improving IT and administrative processes to make sure the cancer referral pathway is effective and patients' care is integrated.
- Listening to patients and carers to ensure that we keep improving their care with all our partners.
- Working with Public Health services to improve prevention and lifestyle choices.

What does it mean local people?

- If you are referred urgently by your GP or another health care professional you will get seen within two weeks.
- If you have a cancer diagnosis, you will receive treatment quickly in order to improve your chances of survival.
- A number of health and social care professionals will be involved in your care to ensure your care is integrated.
- Your experience of care will be positive because we are listening and making improvements.
- If you take up screening when you get an appointment, you are likely to receive early detection and treatment.
- If we in east London improve our lifestyle choices, fewer of us will develop cancer.

East London Health & Care Partnership

Maternity

What are we doing?

- Working with and listening to local women in East London to understand their needs and design care based on those needs.
- Working to ensure that unbiased information regarding choice of place of birth is available for women.
- Ensuring the workforce is sustainable in the next 5 - 10 years to cope with the level of births in East London.
- Ensuring safe and high quality care for all mothers and babies.
- Working together to ensure each woman receives continuity of care with the same staff members throughout her pregnancy and birth

What does it mean local people?

- You will be able to see one or two midwives throughout your pregnancy to ensure continuity of care.
- If you have a long-term condition such as diabetes, or you are having twins or other multiples, you will be seen by your midwife and obstetrician regularly and may be referred to a specialist
- You will be able to use a website or app to give you more information about the places available to you to give birth in East London.
- The plan for care during your pregnancy will be developed and agreed between you and your midwife or obstetrician.
- Your overall experience of care during and after your pregnancy will be positive and of high quality.

East London Health & Care Partnership

Medication

What are we doing?

- Following national recommendations from NHS England we will review the prescribing of certain medicines, where there is either limited evidence for their effectiveness or for which there are safer alternatives. This will ultimately save money for NHS reinvestment.
- Buying specific medicines (biosimilars such as anti-inflammatory medicines infliximab and etanercept) from alternative better value suppliers, which saves money for re-investment.
- Reducing medicines waste may involve the empowerment of patients, encouraging them to take charge of their overall health. This could lead to better outcomes e.g. medication reviews with pharmacists that identify medications that are no longer needed.
- Decreasing antibiotics resistance by reducing the amount and type prescribed and educating patients and prescribers on the importance of completing courses of anti-biotics in the instances where they are necessary.
- A review of the pharmacy workforce; analysing the benefits of increasing the presence of clinical pharmacists within GP practices and/ or clinics in order to help ensure the right medicines, at the right time for the right patients.

What does it mean local people?

- You will be able to get professional medical advice for all minor ailments in all pharmacies, including out of hours pharmacies.
- Pharmacists will also give you consistent advice on the nature of medicines available to buy over the counter and available on prescription and point you in the correct direction for your symptoms.
- You will not be prescribed anti-biotics unless they are essential.
- You will be less likely to be kept in hospital waiting for medicines to be prescribed.
- The cost of prescribing medicines to you as a tax-payer will be less, meaning funds can be allocated to other parts of the health and care service.

East London Health & Care Partnership

Prevention

What are we doing?

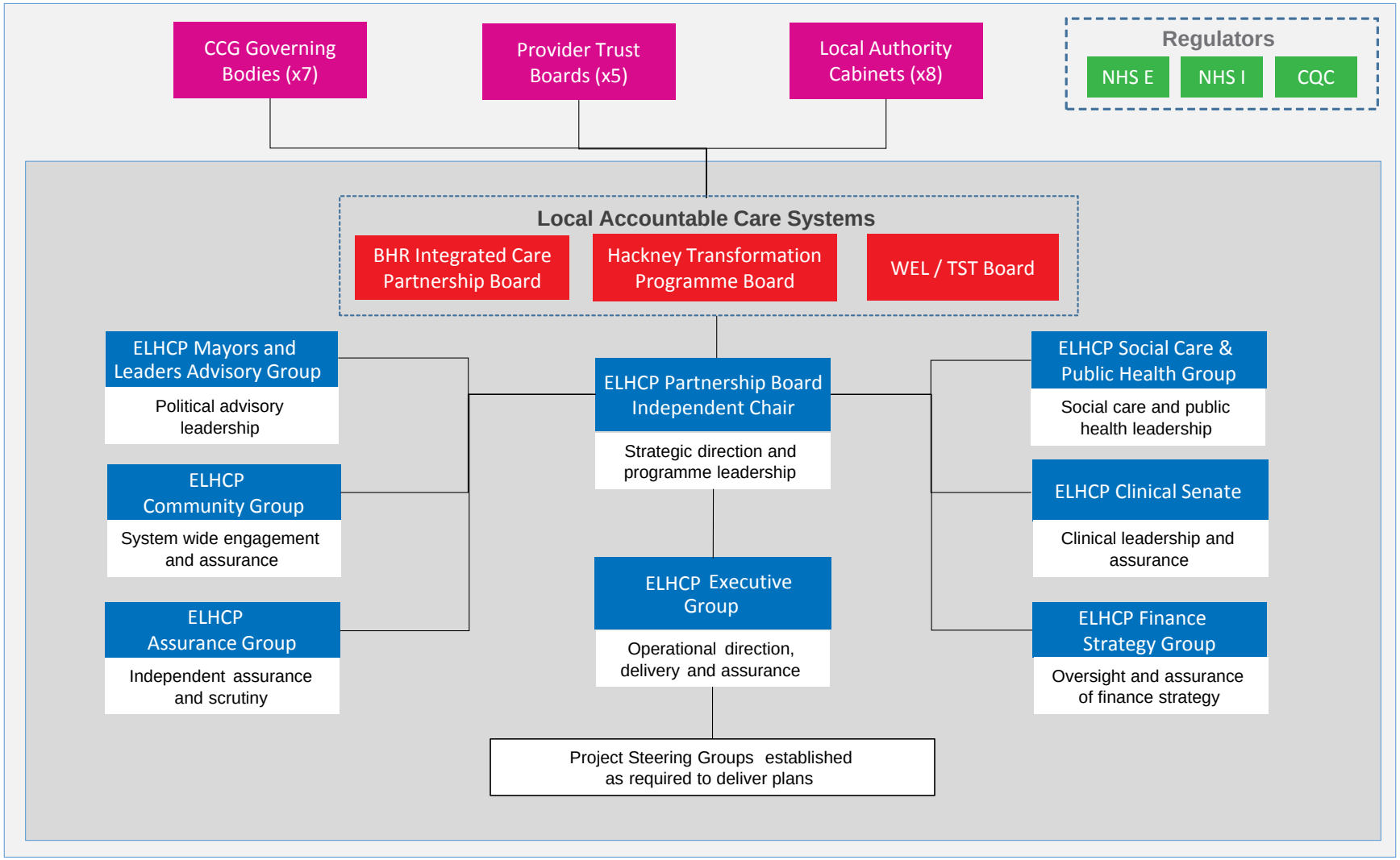
- Building better support into our hospitals, mental and community health services to help smokers quit.
- Improving workplace health across east London, starting with the NHS. Because happier, healthier NHS staff means better healthcare for patients.
- Improving screening processes to better identify those at risk of contracting Type 2 diabetes, and offering courses to help those people change their lifestyles.
- Standardising care for people with Type 1 and Type 2 diabetes in GP surgeries and hospitals across east London.
- Empowering people, through flexible self-care course, to better look after their diabetes and avoid unnecessary hospital trips.
- Working with local schools, education institutions, local employers, libraries and voluntary services, to provide better support for young people with diabetes, taking into account their social and economic context.

What does it mean local people?

- Better support to quit smoking, with help and advice available at many health and care centres, workplaces and online.
- Better screening, treatment and support for diabetes.
- New services to help young people, and pregnant women, manage diabetes better.
- Better opportunities and more support to stay healthy at work.
- Greater consistency of healthcare opportunities and support across east London.

East London Health & Care Partnership

Governance structure



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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 7 SEPTEMBER 2017

Subject Heading:	Healthwatch Havering – Annual Report
CMT Lead:	Barbara Nicholls
Report Author and contact details:	**Ian Buckmaster, Director, Healthwatch Havering 01708 303300 ian.buckmaster@healthwatchavering.co.uk**
Policy context:	**The information presented summarises the work undertaken by Healthwatch Havering in 2016/17.**
Financial summary:	**No financial implications of the report itself for either the Council or Healthwatch Havering.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached annual report of Healthwatch Havering details the work carried out by the organisation in the 2016/17 reporting year.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached Healthwatch Havering annual report and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of the attached Healthwatch Havering annual report.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

healthwatch Havering

ANNUAL REPORT, 2016/17

Still making a difference…

Presented in accordance with
"The Matters to be Addressed in Local Healthwatch Annual Reports Directions, 2013"

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organization, established by the Health and Social Care Act 2012, and can employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and several volunteers, both health and social care professionals and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organization which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organization, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'

Winston Churchill

CONTENTS

We will be sending copies of this Annual Report to the statutory recipients (including the British Library) and circulating it to local health and social care organisations. In the interests of the environment and economy, we are not producing printed copies this year but the report is available for downloading from our website www.healthwatchhavering.co.uk and a hardcopy can be supplied on request.

The electronic version of this report contains hyperlinks to the relevant sections and to external URLs Healthwatch Havering is not responsible for the content of external websites.

Foreword

Anne-Marie Dean, Chairman of Healthwatch Havering

Welcome to our fourth report. This has been a busy and interesting year. There are national initiatives that are beginning to develop into local plans, with the London Borough of Havering (LBH) and the Clinical Commissioning Group (CCG) designing more integrated and accessible care, patient groups becoming more involved in shaping their local GP and other services and timely progress on the work across the borough to improve services for people with learning disabilities. Some of our highlights are:

- ✓ The excellent work undertaken by our volunteer members has continued unabated with more Enter and View visits to Residential and Care homes, Barking, Havering and Redbridge University Hospitals Trust, North East London Foundation Trust and, this year, with a focus on developing our knowledge and expertise about GP premises.

- ✓ The joint review between Healthwatch Havering and Havering Council's Health Overview and Scrutiny Committee regarding the very significant delays in the referrals to treatment. The report is expected to be published at the end of June.
- ✓ Partnership working across the borough with CCG sub-groups, Accident & Emergency Board, Locality Design Planning group, Care Point, Patient Reference Groups, Havering Over Fifty Forum (HOFF), Havering Volunteer Centre, Positive Parents, and other organisations and individuals committed to improving services for people living with Dementia, Learning Disabilities, Sight Problems or nearing the End of Life.
- ✓ Our purpose is to help to ensure that these groups develop and embrace the need to involve the people of Havering, carers and patients in the design, delivery and assessment of care as a natural part of the way we all work together.

We would like to thank you for finding the time to read this report, and our volunteers, residents and colleagues for their hard work

THIS YEAR AT A GLANCE

ENTER AND VIEW

Question: So why do we think Enter and View visits are so important?

Answer: These visits provide a unique perspective on the provision of care and services in the borough and shared openly with our residents. Havering has one of the largest numbers of care homes in London, an acute hospital trust that is just emerging from "special measures" and nearly 50% of the GP practices have been rated as Inadequate or Requiring Improvement (with several now in "special measures"). By carrying out Enter and View visits, we can assess what these facilities are like and by chatting with staff, service users and their friends and relatives, we can find out – and report – what they think of them.

✓ Nursing and Care Homes

The residents of our Nursing and Care homes are an important part of our society in Havering. Many residents have the benefit of regular family and friends to visit them, but some may not, for many reasons. So we take pro-active measures to visit homes and assess the environment and care these people receive. We carried out:

Enter and View visits to Nursing and Care Homes	14

Follow up visits to Care Homes to see how they have fared since our most recent visit	4

✓ Hospital Services

We undertook 2 visits to Queen's Hospital. This included a series of semi-announced visits undertaken to the wards at meal times.

✓ Mental Health and Community Services

We undertook 3 visits: to the Community Rehabilitation wards at King George Hospital, Goodmayes; to the Mental Health Street Triage Scheme at Goodmayes Hospital; and to the Long-Term Conditions Centre at Harold Wood.

✓ GP Practices

We undertook 17 visits across the borough. This year the CQC completed its inspection of almost all GP practices in the borough. While some practices have been rated 'Good', too many practices have been rated Inadequate or Requires Improvement and a few have been placed in "special measures". We visited a range of practices to learn about the state of general practice in the borough.

Among the issues we raise during these visits is the relationship between the practice and its Patient Participation Group and how best use is made of the strength of input these volunteers have to the work of every practice.

Quote: "I take this opportunity to thank the team members for their visit and feedback. I must acknowledge the fact that they conducted the inspection without any disruption to the practice and were very pleasant and courteous."

✓ Other health and social care facilities

We also visited:

- Two pharmacies (associated with GP practices)
- A private Day Care facility for people with learning disabilities
- A drug and alcohol advisory service
- A dental practice

The reports of all of our visits are available on our website

www.healthwatchhavering.co.uk/enter-and-view-visits

WORKING IN PARTNERSHIP

CCG and BHRUT – working on urgent and emergency care

This year has seen us working with the Clinical Commissioning Sub-Groups and the Accident and Emergency Board, addressing issues such as the high attendances at the Queen's Hospital A & E (Emergency) Department, exploring a wider role for NHS 111 and working with the London Ambulance Service to design new pathways.

We also regularly attended the BHRUT Assurance and Surveillance Group, overseeing the transition of BHRUT and its hospitals from special measures.

Havering Health and Wellbeing Board

We take our statutory membership of Havering's Health and Wellbeing Board very seriously and our Chairman, Anne-Marie Dean, has been assiduous in attending its meetings.

Highlights from the board include Local Children's Safeguarding and Adult Safeguarding, the Dementia Strategy, the development of Integrated Care Pathway boundaries matching those of the Primary Care Networks to support better locality planning, the development of the East London Health Care Partnership which is being launched on 3rd July with the Partnership Community Groups launching on 4th July. The importance of attracting staff and providing an environment which is stimulating and supportive to staff, this included discussion about an Academy for staff and the importance of providing more key worker housing such as the opportunity which the St. Georges hospital site could offer.

Havering Locality Development Planning Group – a partnership with LBH and CCG

This newly formed group is part of the wider work being undertaken by the Accountable Care System/Integrated Care Partnership board as a

contribution to the development of the East London Health and Care Partnership [1]. This group is working to achieve a better integration of services in the primary, community and social care teams and a service that is most response and accessible. The group is at an embryonic stage of development as they begin to tackle how to innovate and design sustainable solutions for integrated health and social care services across North East London.

We have continued working with the CCG and other stakeholders on the future development of the former St George's Hospital site in Hornchurch.

Voluntary Organisations and Patient Forums

Our team has also been working with a range of local organisations such as Care Point, Patient Experience Reference Forums, the Havering Over Fifties Forum (HOFF) and Havering Volunteer Centre aimed at improving the standard and range of health and social care services across the borough from a patient and carer perspective.

All of these organisations, together with ourselves, have the key aim of ensuring that we all use our best assets, experience and wisdom and involve our communities to ensure that we have a health and social care service which is safe, dependable and sustainable for the long-term future.

[1] The East London Health and Care Partnership is taking forward the Sustainability and Transformation Plan (STP) for the North East London "footprint"

Learning Disabilities

We continue to work with some outstanding families, friends and organisations as we work together to improve the facilities and services from people with learning disabilities across the borough. Through listening to the experiences of individuals and families, we have shared these experiences with the CCG.

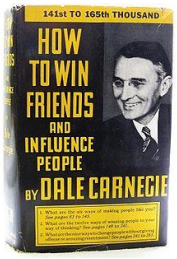
The CCG are supporting an initiative that will ensure that all GP practices in Havering are provided with access to a Toolkit for GPs – A Step by Step Guide for GP Practices for people with Learning disabilities www.rcgp.org.uk/learningdisabilities

Working with our Healthwatch colleagues

With our Healthwatch colleagues from Barking & Dagenham and Redbridge, we meet regularly with our CCG and BHRUT colleagues, enabling us to be fully informed of key issues in primary care.

This year we have worked together on a bid won by Healthwatch Barking & Dagenham to deliver training sessions to key 'front of house' health service teams who work directly with patients and carers

Across North East London the Healthwatches are working together to design information and consultation sessions that support the work of the STP and the East London Health and Care Partnership.



Influencing others

Our relationship with the range of partners that we work with gives us the opportunity to influence their thinking and their operational activity.

For example, after our attention was drawn to an unpleasant odour permeating parts of Queen's Hospital, we were able to ensure that the hospital's management team looked into the matter and took action to get rid of the odour.

Quote: "What an excellent result, which is down to your persistence in pursuing this matter. I doubt I would have had such a successful outcome without your input. So I'm sure I speak on behalf of all the staff and patients who have and still do attend these clinics, a very big thank you from us all, especially me."

REPORTS AND CONSULTATIONS

The Delayed Referrals to Treatment report

We formed a Joint Topic Group with Havering Council's Health Overview and Scrutiny committee. Its purpose was to give Healthwatch volunteer members and Councillors the opportunity to explore the issues regarding the very significant delays in the care of the patients at Queens Hospital ad King George Hospital.

Using the values of the NHS – Accountability, Probity and Openness – a total of 9 Volunteer Members and 7 Councillors met with, in all, 10 representatives from BHRUT, the BHR CCGs, NELFT and the NHS Improvement Authority.

The problem had begun in December 2013 when the Trust migrated data from one computer database to another, which exposed a discrepancy: up to 93,000 referrals from GPs for treatment had somehow been missed. The size of tackling this discrepancy had been daunting. A total of 9,000 extra appointments would be needed, a further 20,000 to cope with the additional demand on the Trust's services, 760 operations would reduce the backlog, with a further 800 needed to cope with the additional demand. The trust had the most long-waiting patients in the country, with around 850 patients waiting more than 52 weeks for treatment. By the end of March 2017, local GPs had redirected a total of 26,000

patients into alternative services, helping ease pressure on the BHRUT waiting list.

The review was not intended to apportion blame for the delays but to examine why they occurred, and to be satisfied that, so far as possible and practicable, appropriate steps had been taken to avoid their recurrence.

The report is to be published in June 2017 and we would like to express our appreciation for the assistance given by all the individuals and organisations involved, which enabled an open and transparent review to take place.

Enter and View reports and their findings

From the beginning of Healthwatch, we have taken the view that a robust programme of Enter and View visits was the best way that we could ensure that we examined on the ground how patients' and residents' needs were being met.

To that end, we have established a robust method for identifying premises that should be visited, with a monthly meeting of staff and volunteers at which the programme is managed, visits arranged and the findings of recent visits reviewed. In 2016/17, we carried out 42 visits (with a small number of premises visited more than once), including, for the first time, several GP practices, several pharmacies and a dental practice. The full list appears in Appendix 1.

Our visiting teams were generally made welcome and managers and proprietors were very co-operative in facilitating the visits. The team members were made to feel welcome by staff, residents and residents' relatives and friends alike.

Few major problems were identified and mentioned in our teams' reports of their visits. Where we did make recommendations, we have been, or will be, following up to see what effect they have had.

All reports of our visits have been published on our website www.healthwatchhavering.co.uk/enter-and-view-visits and shared with the home, GPs or hospital, the Care Quality Commission, the Clinical Commissioning Group, Havering Council and other relevant agencies. Owing to the thorough nature of pre-publication checks, not all reports of the visits during the past year had been published at the date this report was prepared.

Spending Money Wisely Consultation

The CCG together with the GP Clinical Directors for Havering, Barking and Dagenham and Redbridge have sought to consult local people's opinion on a range of treatments and prescribing. These are treatments or prescribing where there is no evidence of clinical value and to limit other

treatments and prescribing to much closer scrutiny always allowing for clinical decision making where appropriate.

The planning for this exercise began in March 2016 and we have worked closely with the CCG in designing the process ensuring that the information was clear and easy to read and that there were sufficient opportunities for local people to attend events. The consultation process completes in mid-May.

Means of consultation

We did not carry out any formal consultation exercises this year. We have continued to receive, and act on, contacts from the public about health and social care matters through a variety of sources, including personal contacts, telephone calls, email, letters and our Tell Us What You Think Cards[2].

We also consulted a range of local commissioners and providers of health and social care services about a range of services. None refused to co-operate with us or to provide information.

[2] These are pre-paid postage postcards available from various locations that enable the public to let us have information – good or bad – about health and social care facilities.

GOVERNANCE

Our decision making

How we focus our time and energy is influenced by our volunteer members, the people who live and work in Havering and local organisations.

The board, which consists of directors, staff and volunteer members, establishes our priorities which are set out below in 'Our Plans for 2017/2018' and our programme of 'Enter and View' visits is set by our volunteer members at the monthly Panel Meeting.

Our policies and procedures are discussed and agreed in public board meetings and our board minutes are accessible on our website. The governance documents ensure that we operate efficiently and fairly in accordance with our statutory and legal requirements.

As part of our governance this year we reviewed the document 'A guide to the legislation affecting Healthwatch Havering'.

Because we have considerably widened the range and the complexity of the issues we now address as part of the 'Enter and View' programme, we have reviewed and widened the pro-forma of questions that volunteer members ask when undertaking visits.

We have bi-annual Away Days with all our members, to which we invite outside speakers to talk to us about their services and challenges. Our speakers help us to align our plan with critical issues happening in our borough. This year our speakers addressed the following subjects

- Irvine Muronzi and Wellington Makala of NELFT, about how to approach patients receiving hospital care for mental health issues
- Dr Sanomi – Local GP Clinical Director – 'Spending Money Wisely' consultation and the challenges facing Primary Care
- Ben Campbell and Sandy Foskett, of the Commissioning Team from the London Borough of Havering – talking about the commissioning of Domiciliary Care Services for the Boroughs older and vulnerable community.
- Patrick Farrell, Consultant Paramedic, Darzi Fellow in clinical decision making, attached to Queens and King George Hospital Accident and Emergency Department.

Healthwatch Havering is, in legal terms, a company limited by guarantee called Havering Healthwatch Limited. As a company limited by guarantee, it has no shareholders and is prohibited by law from distributing any financial surplus (or profit). Registration particulars and other contact details appear at the end of this report.

Our volunteers

Although Healthwatch has statutory powers and is established by law, it relies for the exercise of its functions mainly on the efforts of its volunteer members. The majority of the volunteers who work in Healthwatch Havering have a professional background within the health and social care sector or have many years' familiarity with health and social care needs. This gives them valuable insight into the work that they do and enables them to report authoritatively on the Enter & View visits that they carry out.

Our volunteers give unstintingly of their time – something that is appreciated not only by Healthwatch but also by the wider community. We are delighted to report that, in June 2017, a number of Healthwatch volunteers received awards from the Havering Volunteer Centre in recognition of their efforts.

Healthwatch Havering Volunteers receive their awards, 9 June 2017

Left to right:
Shelley Hart of Havering Volunteer Centre; Dianne Old; Ron Wright;
Deputy Mayor of Havering, Cllr Dilip Patel; Diane Meid; Dawn Ladbrook; Jenny Gregory; Carol Dennis;
and Emma Lexton
(photo: Harvey Lexton)

Financial Report

Funding

Havering Council provided grant in 2016/17 to fund our activities at the same level as pertained for the financial years 2013/14 to 2015/16, £117,359.

Allowing for use of reserves, Corporation Tax adjustments, interest received and other miscellaneous income, the amount carried forward at the end of 2016/17 was £3,533.

A summary of the detailed accounts is set out in Appendix 2. The full audited accounts are available on our website at http://www.healthwatchhavering.co.uk/our-activities

Staff

Staff remained unchanged during 2016/17 from those in post at the end of March 2016. There are three directors – two who are engaged in executive roles as Chairman and Company Secretary respectively for 21 hours per week, while the third undertakes a non-executive role – and two part-time employees.

Our Plans for 2017/18

In April, we had an Away Day to choose our priorities for 2017/18. These are

1) To develop our relationship with the Strategic Transformation Board, the Accountable Care System/Integrated Care Partnership for BHR and the Locality Development to ensure that we can understand, influence and support the engagement and consultation process for our residents.
2) Patient Empowerment will continue to be developed continuing to support people and families with Learning Disabilities and services with the Primary Care setting.
3) To work with the Commissioning team in the Borough on the recently procured Domiciliary Care Services to learn more about the services and the opportunities for resident's feedback. These services are provided to residents many of whom are among the most vulnerable in our community
4) To work with Queens Hospital and the Public Health team to design a process to engage patients and visitors to be more aware of the importance of 'No Smoking' in the hospital environment.
5) Continue with the Enter and View programme and to begin to explore the opportunity of creating a learning opportunity between the organisations using the knowledge gained by our E & V visits.

In all of this, we will be following the national guidance in the Healthwatch England Business Plan for 2017/18 – to bring the public's views to the heart of local decisions

The "Healthwatch" logo and trademark

Havering Healthwatch Limited has a licence agreement with Healthwatch England governing use of the Healthwatch logo and trademark.

The Healthwatch logo is used widely for Healthwatch Havering activity. It is used on:

- The Healthwatch Havering website
- This Annual Report
- Publications such as reports of public consultation events and Enter & View visits
- Reports to official bodies, such as the Health & Wellbeing Board and Overview & Scrutiny Committees
- Official stationery, including letterheads and business cards
- Members' identity cards
- Newspaper advertisements and flyers for events

Appendix 1 Enter and View visits.

In addition to having one of the largest residential and care home sectors in Greater London, Havering has the largest number of GP practices in London rated by the CQC as Inadequate or Requiring Improvement, a major hospital Trust (BHRUT) that is only now emerging from Special Measures following a 2013 inspection that found it Inadequate, a community health services Trust (NELFT) rated as Requiring Improvement, and a CCG that is under immense financial pressure and subject to Directions by NHS England. Moreover, the local health economy generally is under considerable strain because of the demands of urgent care needs, residential and domiciliary care needs and the imminence of the retirement of a number of GPs working single-handedly or in small partnerships.

From the beginning of Healthwatch, we have taken the view that a robust programme of Enter and View visits was the best way that we could ensure that we examined on the ground how patients' and residents' needs were being met.

To that end, we have established a robust method for identifying premises that should be visited, with a monthly meeting of staff and

volunteers at which the programme is managed, visits arranged and the findings of recent visits reviewed. In 2016/17, we carried out 42 visits (with a small number of premises visited more than once), including for the first time a number of GP practices, several pharmacies and a dental practice. The full list appears below.

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We did not exercise Enter and View powers at an ophthalmology practice during this year.

The powers of Healthwatch to carry out Enter and View visits are set out in legislation[3] and most visits were carried out in exercise of them. On 8 occasions however, noted in the table that follows, visits were carried out at the invitation of the establishment's owners/managers and there was no need for the exercise of our statutory powers; but that has not affected how we have reported on such visits.

[3] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

We did not find it necessary to make recommendations to Healthwatch England on special reviews etc.

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
12 April	Cranham Court	Nursing Home	To observe the home in normal operation following CQC rating of Good
12 April	Little Gaynes	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
26 April	Alton House	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
1 May	Foxglove Ward and Japonica Ward, King George Hospital	Community Rehabilitation Wards	By invitation of NELFT; joint visit with Health Overview & Scrutiny Committee members
16 May	Rosewood Surgery as Hub practice	GP practice	As part of review of operation of GP Hub service
17 May	King's Park Well Pharmacy pre-6.30pm	Pharmacy	As part of review of operation of GP Hub service
17 May	King's Park GP pre-6.30pm	GP practice	As part of review of operation of GP Hub service
17 May	Rosewood Surgery	GP practice	As part of review of operation of GP Hub service
19 May	King's Park GP after 6.30pm	GP practice	As part of review of operation of GP Hub service

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
19 May	King's Park Well Pharmacy after 6.30pm	Pharmacy	As part of review of operation of GP Hub service
24 May	Petersfield GP Practice	GP practice	As part of review of operation of GP Hub service
25 May	North Street GP Practice	GP practice	As part of review of operation of GP Hub service
23 July	North Street GP Practice as Hub practice	GP practice	As part of review of operation of GP Hub service
28 July	Moreland House	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
13 September	Havering Court	Residential Care Home	To observe the home in normal operation
27 September	Arran Manor	Residential Care Home	To observe the home in normal operation following CQC rating of Good
6 October	Queens Hospital: In-patient meals	Acute Hospital	Following expressions of concern about the standard and serving of meals in certain wards
11 October	WDP Havering	Drug and alcohol advisory service	By invitation in advance of CQC inspection

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
27 October	Maylands Health Centre (GP Practice)	GP practice	By invitation, following catastrophic flooding of premises in June
27 October	Maylands Health Centre (Pharmacy)	Pharmacy	By invitation, following catastrophic flooding of premises in June
27 October	Maylands Health Centre (Parkview Dental Practice)	Dental practice	By invitation, following catastrophic flooding of premises in June
1 November	Straight Road GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
7 November	Greenwood GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
14 November	High Street (Hornchurch) GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
15 November	Ravenscourt	Residential Care Home	To observe the home in normal operation following CQC rating of Good (qualified by "Well Led" Requires Improvement)
18 November	Berwick Surgery GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2016	
21 November	Mawney Road GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate
23 November	Mental Health Street Triage Service	Community Health Service	By invitation of NELFT to learn about the service
5 December	Long Term Conditions Centre, Harold Wood	Community Health Service	By invitation of NELFT to learn about the service
8 December	Suttons Avenue GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Inadequate
		2017	
17 January	Beech Court	Residential Care Home	To observe the home in normal operation following CQC rating of Requires Improvement
23 January	Mungo Park GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
2 February	Lilliputs Centre (Second visit)	Complex of Residential Care Units for people with learning disabilities	To observe the home in normal operation following CQC ratings of Requires Improvement of certain units within the complex

Date of visit	Establishment visited		Reasons for visit
	Name	Type	
		2017	
6 March	The Oaks	Residential Care Home	To observe the home in normal operation following CQC rating of Good
16 March	Modern Medical Centre GP Practice	GP practice	To observe the practice in normal operation, following CQC rating of Requires Improvement
21 March	Sarnett House	Residential Care Home for people with learning disabilities	To observe the home in normal operation following CQC rating of Requires Improvement
29 March	Barleycroft	Residential Care Home	To observe the home in normal operation following CQC ratings of Requires Improvement (current and previous)

Future programme

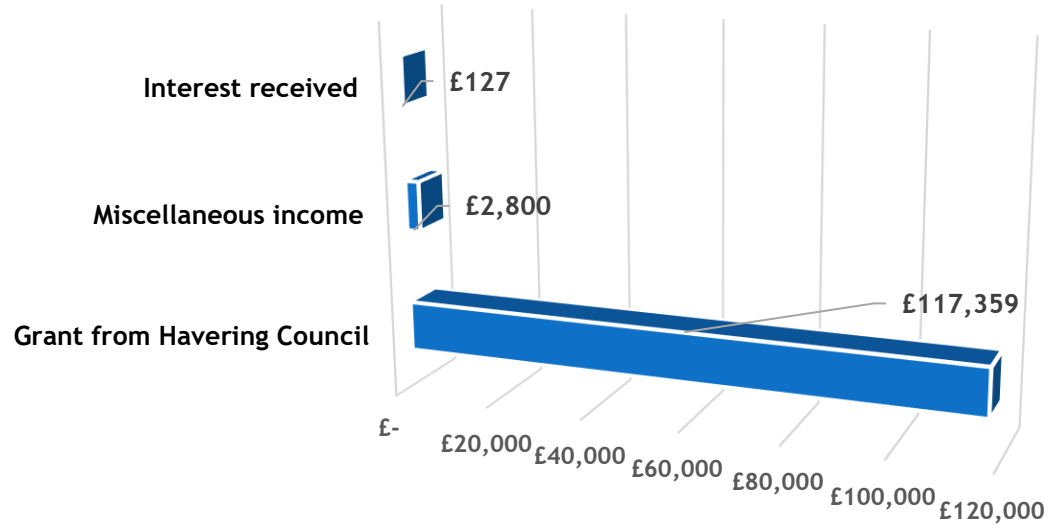
Our future Enter and View visit programme will continue to be informed by CQC reports on establishments, by information gathered through meetings with local regulatory agencies and by complaints (and compliments, should we receive any) from service users.

We have already identified a number of establishments that we plan to visit during the course of 2017/18.

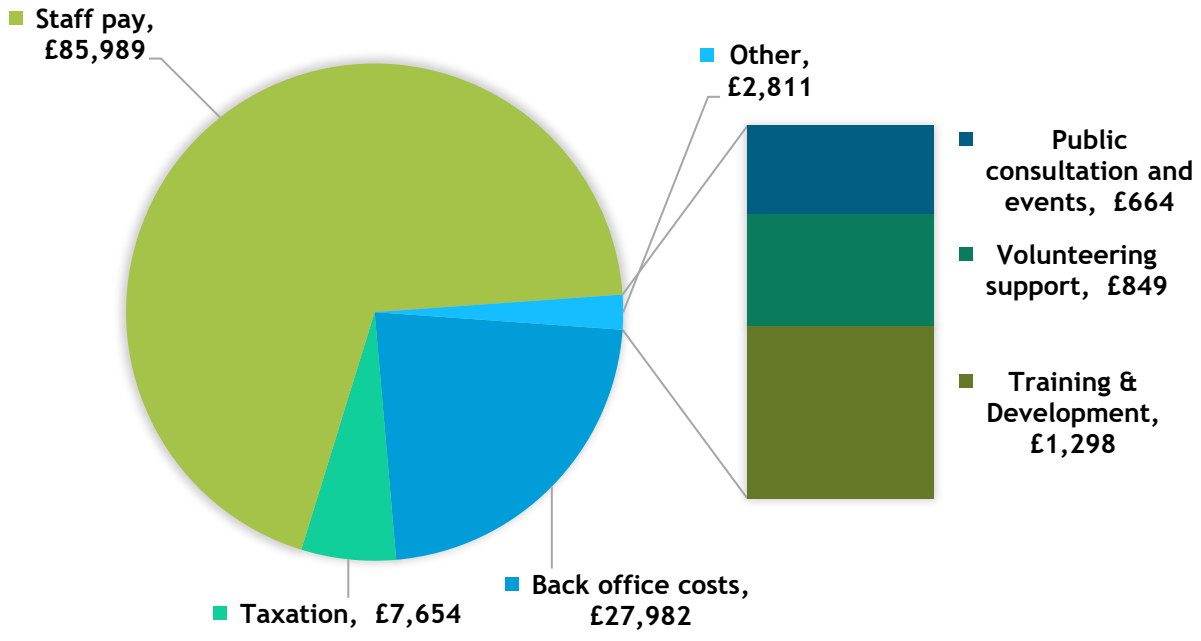
Appendix 2 Summary statement of Income and Expenditure

For more detail, please refer to the annual accounts available on our website at http://www.healthwatchhavering.co.uk/our-activities

INCOME SUMMARY



EXPENDITURE SUMMARY



Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Public Health Service Budget Report Presentation
SLT Lead:	Mark Ansell, Acting Director of Public Health
Report Author and contact details:	Mark Ansell, Acting Director of Public Health (mark.ansell@havering.gov.uk)
Policy context:	Public Health Allocation is deployed to support delivery of Council's statutory duty to improve the health of local residents.
Financial summary:	The presentation sets out the public health budget for 2017/18, and variation in the PH Allocation and spending against it overtime.

The subject matter of this report deals with the following Council Objectives

Communities making Havering: Healthy and Active Lives	**[X]**
Places making Havering	*[]*
Opportunities making Havering	*[]*
Connections making Havering	*[]*

SUMMARY

The presentation provides information on the public health budget for 2017/18, and variation in the Public Health allocation and spending against it overtime.

RECOMMENDATIONS

Members are asked to note the information provided within the Public Health Service Budget Report Presentation.

REPORT DETAIL

The presentation on the Public Health Service Budget for the Health Overview and Scrutiny Sub-Committee provides information covering the following topics;

1. Overview of the Service
2. Public health functions
3. Changes in allocation and spend against it (£ms)
4. Breakdown of proposed spend against PH allocation
5. Savings achieved since 2015
6. The requirement for additional spending reductions in coming years.

IMPLICATIONS AND RISKS

Financial implications and risks:
There are no financial implications arising directly from this report which is for information only.

Legal implications and risks:
There are no legal implications arising directly from this report which is for information only.

Human Resources implications and risks:
There are no specific Human Resource implications and risks.

Equalities implications and risks:
There are no direct equalities implications and risks

BACKGROUND PAPERS

None

Report on the Public Health Service Budget for the Health Overview and Scrutiny Sub-Committee

Presentation by Mark Ansell Acting DPH

- Budget information for 2017/18
- Allocation and spending (past, present and future)

Overview of the Service

- Transferred to LBH on 1st April 2013
- The Public Health Service assists the Council to meets its statutory duty to improve the health of residents by: -
  - Oversight of local health protection arrangements
  - Advice to health care commissioners
  - Advice to a variety of partners within / outside Council to foster an environment in which healthier choices are the norm
  - Directly supporting residents to make healthier choices
- Comprises
  - DPH
  - Small team of PH specialists
  - Commissioned (with JCU) PH services

Public health functions

Mandated;

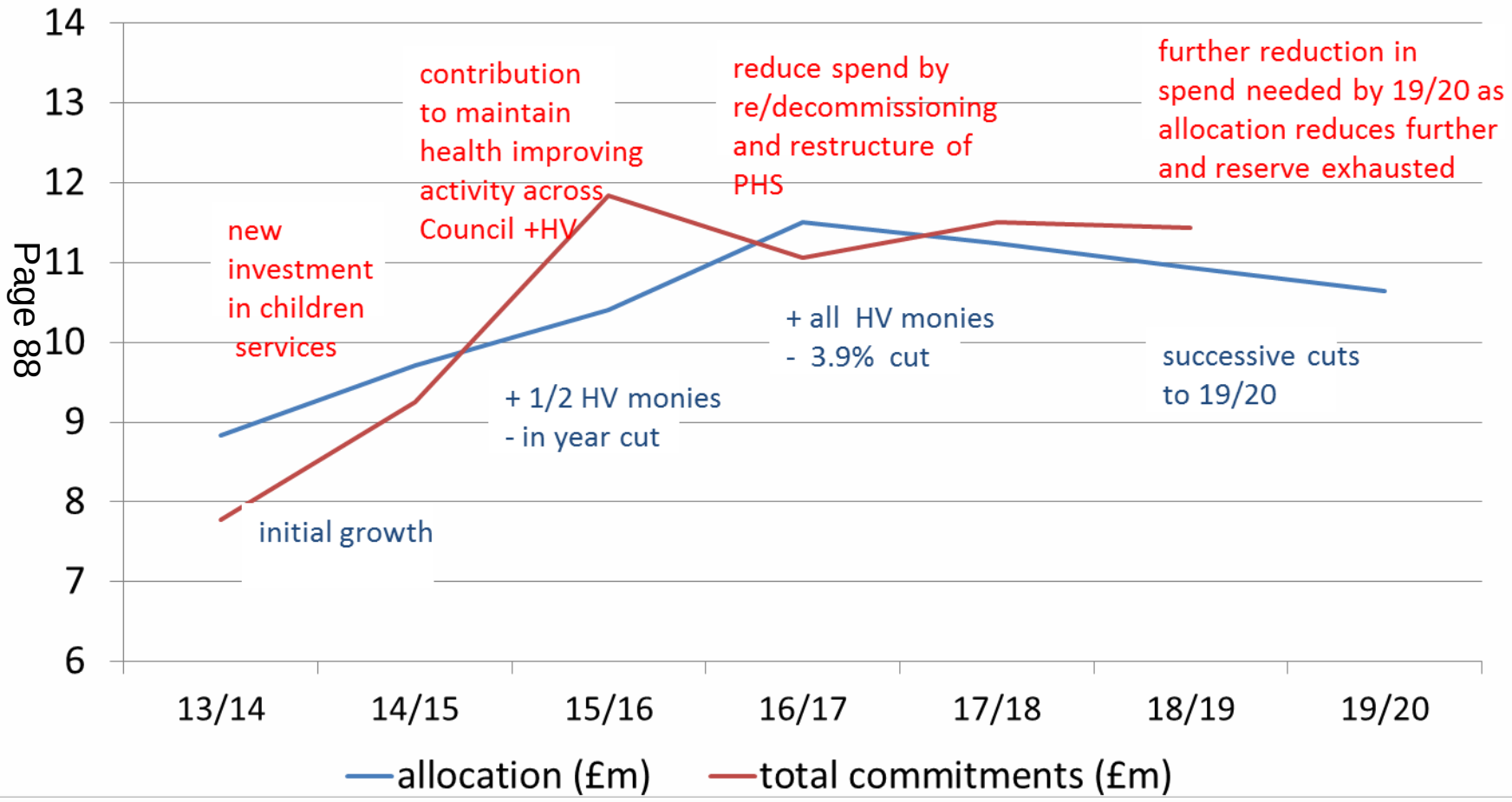
- 'Core offer' of PH support to CCG
- Health protection oversight
- Open access sexual health services
- Healthchecks
- National Child Measurement Programme (NCMP)
- Health Visiting Service (transferred to LAs in Oct.'15)

Other priorities to be locally determined;

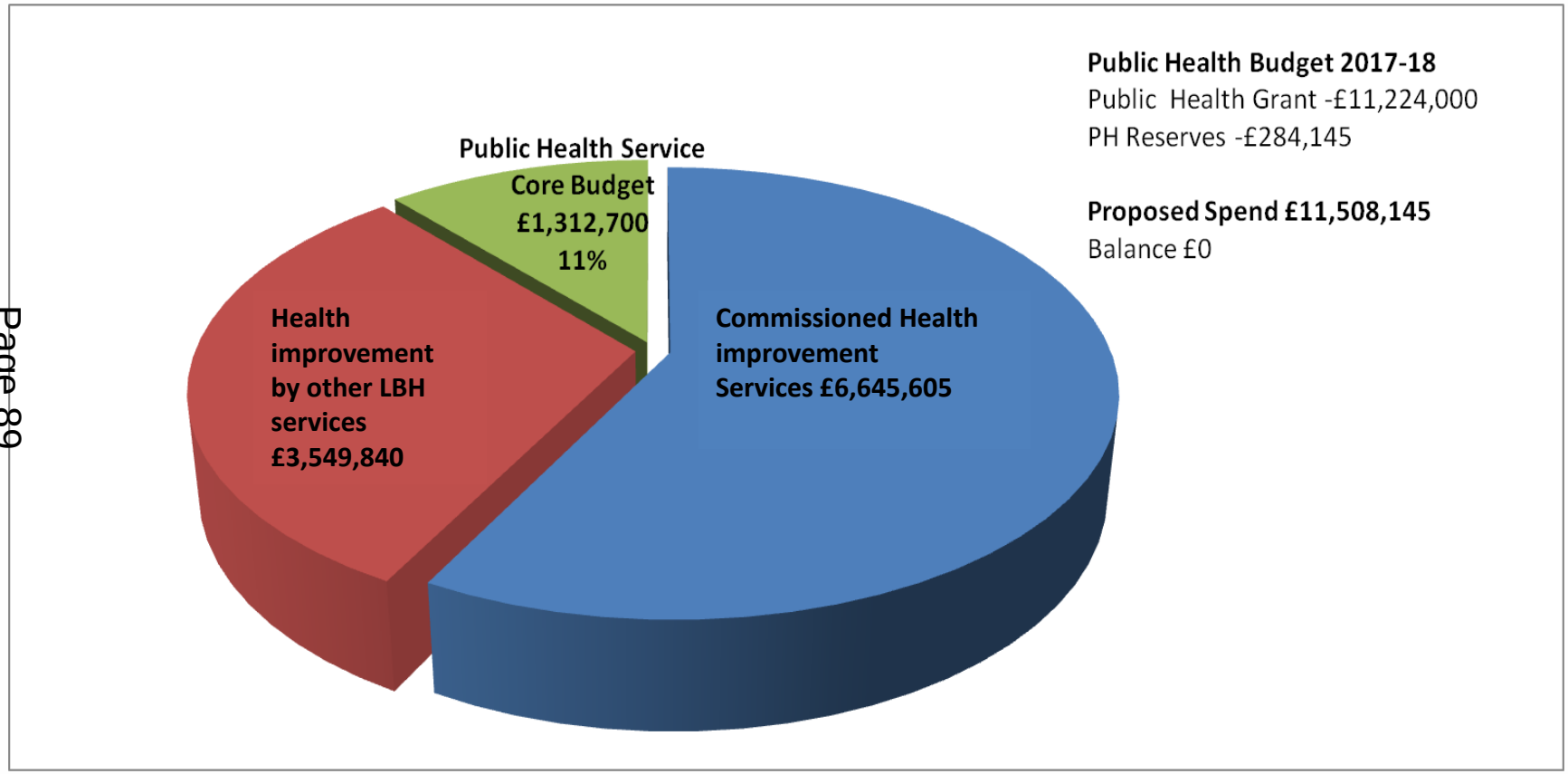
- Drugs and alcohol treatment services (adults and children)
- School nursing services
- Tobacco control
- Obesity prevention
- Action to promote physical activity and healthy nutrition
- Air pollution
- Etc

Funded from ring fenced PH allocation from central government

Changes in allocation and spend against it (£ms)



Breakdown of proposed spend against PH allocation and reserves in 17/18



£1.837m savings since 2015…

Procurement of Drugs and Alcohol Service

provided recurrent savings of **£453k per annum;**

Between February 2014 and April 2015, the PH service completed its Procurement of Drugs and Alcohol Service by awarding a new integrated service to a new provider with effect from October 2015.

Public Health Restructure

provided recurrent savings of **£351k per annum;**

During 2016, the PH service completed its staff restructure which reduced its FTE from 34 to 25 FTE.
Further staff were relocated to Policy and Performance Team and the JCU.
The service currently comprises 16 FTE .

Public Health Service Decommissioning

provided recurrent savings of **£1.033m per annum;**

During 2016/17, the PH service completed the decommissioning of the following services:-

- Stop Smoking Services and Intervention
- Chlamydia screening office inc GP/Pharmacies
- Targeted Sexual Health Services
- Phoenix Counselling
- PARS for Cancer Patients
- Oral Health Promotion service
- etc

Public Health Allocation Gap

- Expecting £250K overspend against allocation in 17/18
- Increasing to £500K in 18/19
- Covering overspend will exhaust PH reserve
- Working with Finance and SMT to develop proposals to close gap in 19/20 which by then will have risen to £750K due to further cut to allocation.
- Additional complication is that allocation itself is likely to be replaced by 100% business retention in 19/20

Contact Details

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Acting Director of Public Health

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Health OSC Performance Indicators - Quarter 1 (2017/18)
SLT Lead:	Mark Ansell (Director of Public Health)
Report Author and contact details:	Oriean Kay, Public Health Business Manager (oriean.kay@havering.gov.uk)
Policy context:	The report sets out Quarter 1 performance for indicators relevant to the committee
Financial summary:	No financial implications

The subject matter of this report deals with the following Council Objectives

Communities making Havering: Healthy and Active Lives	**[X]**
Places making Havering	*[]*
Opportunities making Havering	*[]*
Connections making Havering	*[]*

SUMMARY

The report provides information on the performance indicators previously requested by the Health Overview and Scrutiny Committee.

This is the first report in which these measures have been utilised.

RECOMMENDATIONS

Members are asked to review performance set out in;

- **Appendix1:** Quarter 1 2017/18 Corporate Performance Report
- **Appendix 2:** Quarter 1 2017/18 Demand Pressure Report

REPORT DETAIL

'The number of people who die from preventable causes (like accidents and air quality – but not related to clinical care) per 100,000 population'

- This indicator is rated **Green**.
- Performance (157 per 100,000 population)
- Havering's mortality rate from preventable causes (period: 2013-2015) is significantly lower than the London (169/100,000) and England (184/100,000) averages.

Improvement required: None

IMPLICATIONS AND RISKS

Financial implications and risks:
There are no financial implications arising directly from this report which is for information only.

Legal implications and risks:
Whilst reporting on performance is not a statutory requirement, it is considered best practice to review the Council's progress against the Corporate Plan and Service Plans on a regular basis.

Human Resources implications and risks:
There are no specific Human Resource implications and risks.

Equalities implications and risks:
There are no direct equalities implications and risks

BACKGROUND PAPERS

The Corporate Plan 2017/18 is available on the council's intranet at https://intranet.havering.gov.uk/about-havering/corporate-plans/

Appendix1: Quarter 1 2017/18 Corporate Performance Report for Health Overview and Scrutiny Sub Committee

RAG Rating		Direction of Travel (DOT)	
Green	On or within the 'variable tolerance' of the quarter target	↑	**Short Term**: Performance is better than the previous quarter **Long Term:** Performance is better than at the same point last year
Amber	More than the 'variable tolerance' off the quarter target but where performance has improved or been maintained.	→	**Short Term:** Performance is the same as the previous quarter **Long Term:** Performance is the same as at the same point last year
Red	More than the 'variable tolerance' off the quarter target and where performance is worsening	↓	**Short Term:** Performance is worse than the previous quarter **Long Term:** Performance is worse than at the same point last year

Description	
Corporate Plan Indicator	
Outturns reported cumulatively	**(C)**
Outturns reported as snapshot	**(S)**
Outturns reported as rolling year	**(R)**

Ref.	Indicator	Value	2017/18 Annual Target	2017/18 Quarter 1 Target	Variable Tolerance	2017/18 Quarter 1 Performance	Short Term DOT against 2016/17 (Q4)		Long Term DOT against 2016/17 (Q1)		Comments	Service	O&S Sub-Committee
Communities: Healthy and Active Lives													
NEW	The number of people who die from preventable causes like deprivation, accidents, and air quality – but not related to clinical care, per 100,000 population	Smaller is Better	Better than England (Annual 3-year rolling period)	n/a	5%	157 per 100,000 population	n/a	n/a	n/a	NEW (available June 2018)	Havering's mortality rate from preventable causes (period: 2013-2015) is significantly lower than the London (169/100,000) and England (184/100,000) averages.	**Public Health** *Local performance indicator*	**Health**

Outturns

	Red	Amber	Green	N/A
Communities	0	0	1	
Places				
Opportunities				
Connections				

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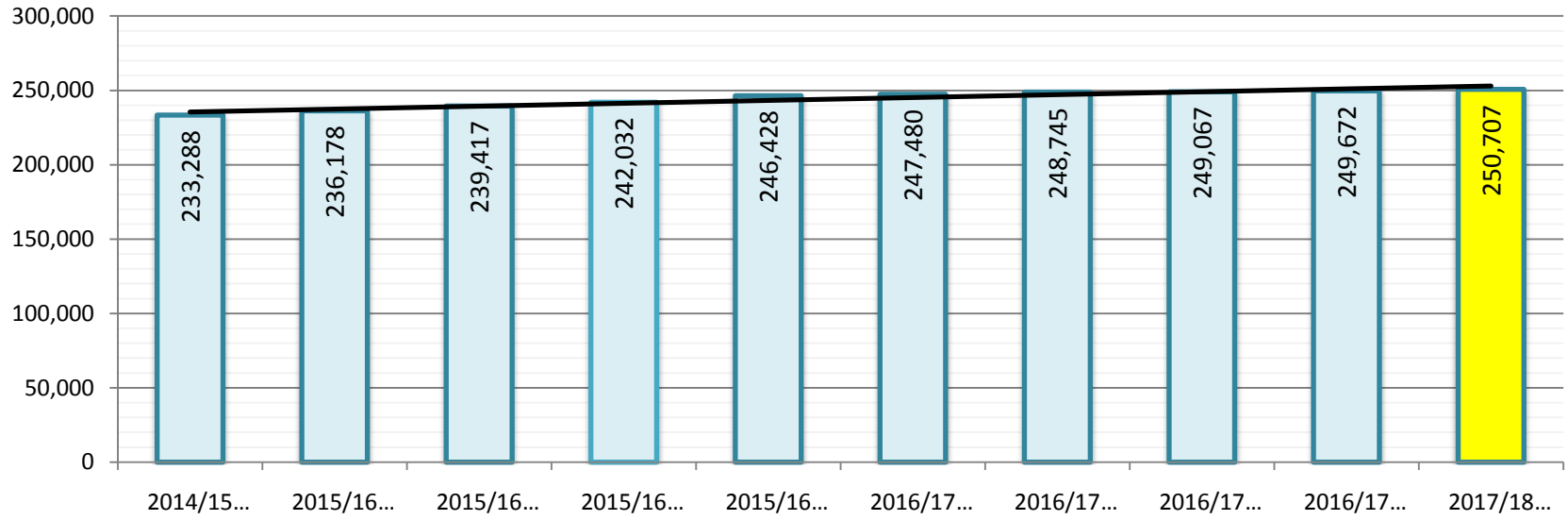
Appendix 2: Quarter 1 2017/18 Demand Pressure Report

DP 03:	2014/15 (Q4)	2015/16 (Q1)	2015/16 (Q2)	2015/16 (Q3)	2015/16 (Q4)	2016/17 (Q1)	2016/17 (Q2)	2016/17 (Q3)	2016/17 (Q4)	2017/18 (Q1)	Increase since previous quarter
GP Registrations	233,288	236,178	239,417	242,032	246,428	247,480	248,745	249,067	249,672	250,707	1,035

POPULATION



The most current data recieved is for Q1 2017/18 and it shows Havering's GP registrations are continuing to increase

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 7 SEPTEMBER 2017

Subject Heading:	Performance monitoring by the Health Overview and Scrutiny Sub-Committee
SLT Lead:	Sarah Homer, Interim Chief Operating Officer
Report Author and contact details:	Pippa Brent-Isherwood, Assistant Director of Policy, Performance and Community phillipa.brent-isherwood@havering.gov.uk (01708) 431950
Policy context:	The report suggests a range of performance indicators that the Health Overview and Scrutiny Sub Committee considers tracking during the 2017/18 financial year
Financial summary:	There are no immediate financial implications arising from this report, although adverse performance against some Corporate Performance Indicators may have financial implications for the Council.

The subject matter of this report deals with the following Council Objectives:

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

This report responds to a request from the Health Overview and Scrutiny Sub-Committee to review and reconsider the performance indicators that it may wish to track during the 2017/18 financial year.

RECOMMENDATION

That the Health Overview and Scrutiny Sub-Committee selects a maximum of three indicators from those suggested for tracking throughout the 2017/18 financial year.

REPORT DETAIL

The Corporate Performance Report which is presented to the Cabinet on a quarterly basis provides an overview of the Council's performance against each of the strategic goals. Historically, the Overview and Scrutiny Board has also scrutinised this data. However, for 2017/18, the Board has decided instead to scrutinise a selection of more operational performance indicators, to be determined by the six overview and scrutiny sub-committees. To this end, each of the sub-committees were tasked by the Overview and Scrutiny Board (at its meeting in May) with identifying two to three performance indicators that they wished to track over the course of the year. At its last meeting, the Health Overview and Scrutiny Sub-Committee selected the following indicators for monitoring:

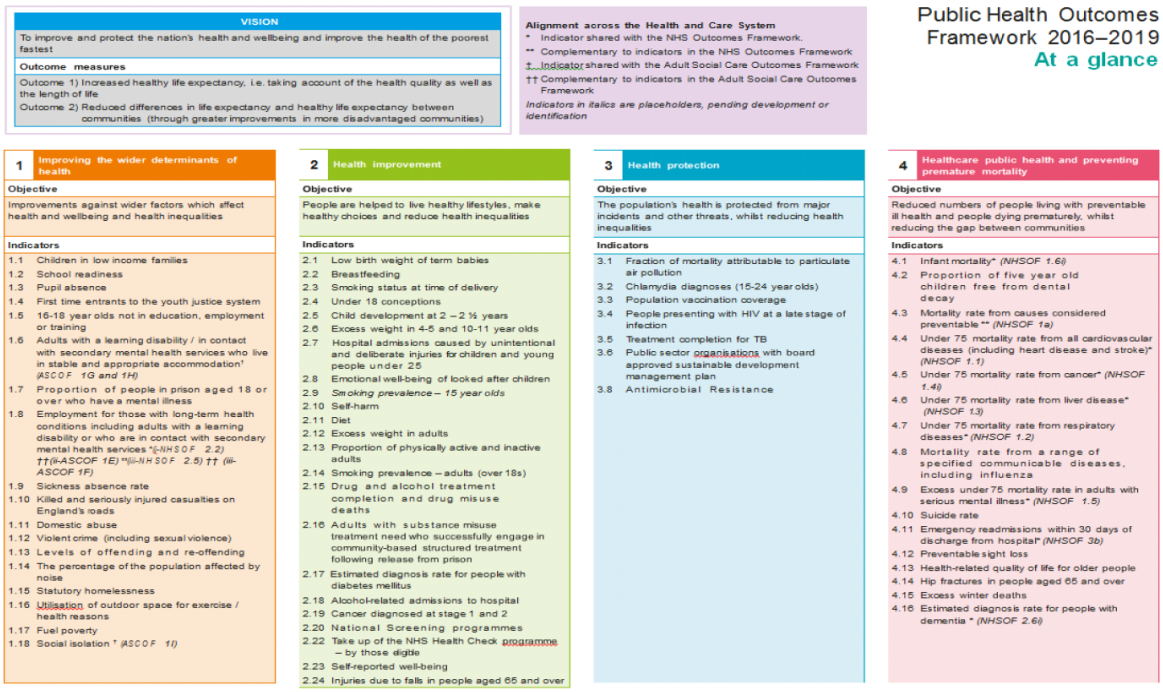
- The number of people who die from preventable causes linked to air quality, per 100,000 population
- The number of instances where an adult patient is ready to leave hospital for home or a less acute stage of care but is prevented from doing so (delayed transfers of care), per 100,000 population
- Non-elective admissions into hospital

However, the Committee also expressed a wish to undertake a more detailed review of the performance indicators it could possibly track.

A number of indicators could be monitored by the Health Overview and Scrutiny Sub-Committee, sourced from a number of key indicator sets, many of which are already reported elsewhere within the Council's corporate performance reporting framework. The national Adult Social Care Outcomes Framework (ASCOF), for example, contains a number of indicators, as follows:

1: Enhancing quality of life for people with care and support needs	2: Delaying and reducing the need for care and support	3: Ensuring people have a positive experience of care and support	4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm
Overarching measures 1A. Social care-related quality of life 1J – Adjusted Social care-related quality of life – impact of Adult Social Care Services **Outcome measures** ***People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs*** 1B. Proportion of people who use services who have control over their daily life 1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments ***Carers can balance their caring roles and maintain their desired quality of life*** 1D. Carer-reported quality of life ***People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation*** 1E. Proportion of adults with a learning disability in paid employment 1F. Proportion of adults in contact with secondary mental health services in paid employment 1G. Proportion of adults with a learning disability who live in their own home or with their family 1H. Proportion of adults in contact with secondary mental health services living independently, with or without support 1I. Proportion of people who use services and carers, who reported that they had as much social contact as they would like	**Overarching measure** 2A. Long-term support needs met by admission to residential and nursing care homes, per 100,000 population **Outcome measures** ***Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs*** ***Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services*** 2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services 2D.Outcomes of short-term services: sequel to service. *Placeholder 2E: The effectiveness of reablement services* ***When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence*** 2C. Delayed transfers of care from hospital, and those attributable to adult social care *Placeholder 2F: Dementia – measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*	**Overarching measures** ***People who use social care and their carers are satisfied with their experience of care and support services*** 3A. Overall satisfaction of people who use services with their care and support 3B. Overall satisfaction of carers with social services *Placeholder 3E. Effectiveness of integrated care* **Outcome Measures** **Carers feel that they are respected as equal partners throughout the care process** 3C. Proportion of carers who report that they have been included or consulted in discussions about the person they care for ***People know what choices are available to them locally, what they are entitled to, and who to contact when they need help*** 3D. Proportion of people who use services and carers who find it easy to find information about support ***People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual*** This information is contained in the Adult Social Care Survey and used for analysis at the local level	**Overarching measure** 4A. Proportion of people who use services who feel safe **Outcome measures** ***Everyone enjoys physical activity and feels secure*** ***People are free from physical and emotional abuse, harassment, neglect and self-harm*** ***People are protected as far as possible from avoidable harm, disease and injuries*** ***People are supported to plan ahead and have the freedom to manage risks the way that they wish*** 4B. Proportion of people who use services who say that those services have made them feel safe and secure

Similarly, Public Health has its own national outcomes framework, summarised below:



VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

‡ Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification

Public Health Outcomes Framework 2016–2019
At a glance

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in low income families
1.2 School readiness
1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training
1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation* *(ASCOF 1G and 1H)*
1.7 Proportion of people in prison aged 18 or over who have a mental illness
1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F)*
1.9 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Levels of offending and re-offending
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation * *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2 – 2 ½ years
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries for children and young people under 25
2.8 Emotional well-being of looked after children
2.9 *Smoking prevalence – 15 year olds*
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Drug and alcohol treatment completion and drug misuse deaths
2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17 Estimated diagnosis rate for people with diabetes mellitus
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2
2.20 National Screening programmes
2.22 Take up of the NHS Health Check programme – by those digible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.1 Fraction of mortality attributable to particulate air pollution
3.2 Chlamydia diagnoses (15-24 year olds)
3.3 Population vaccination coverage
3.4 People presenting with HIV at a late stage of infection
3.5 Treatment completion for TB
3.6 Public sector organisations with board approved sustainable development management plan
3.8 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* *(NHSOF 1.6i)*
4.2 Proportion of five year old children free from dental decay
4.3 Mortality rate from causes considered preventable ** *(NHSOF 1a)*
4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*
4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.8 Mortality rate from a range of specified communicable diseases, including influenza
4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)*
4.10 Suicide rate
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

The Better Care Fund includes a number of additional indicators, as set out below:

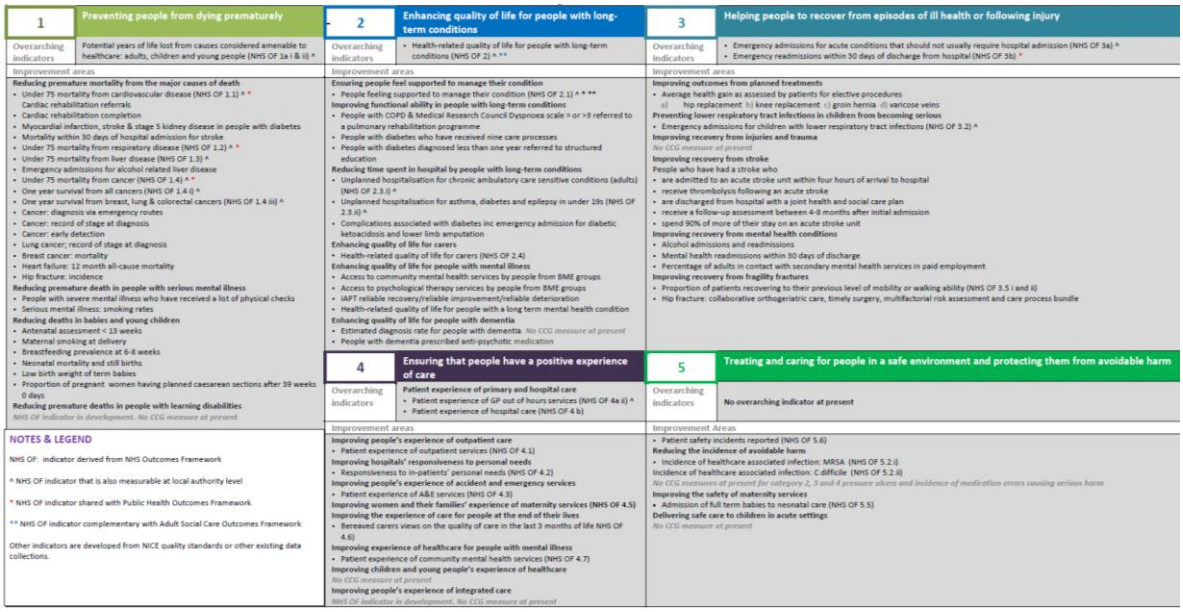
- Total non-elective spells (specific acute) per 100,000 population
- Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population (*this is monitored as part of the ASCOF data set (above) and is presented to Individuals Overview & Scrutiny Sub-Committee*)

- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (*this is monitored as part of the ASCOF data set and is only collected during Q4*)
- Delayed transfers of care [number of nights] from hospital per 100,000 population

Taking into account which of these indicators are already monitored elsewhere within the Council's governance structures, as well as the Council's ability to influence performance against them, officers would recommend that the Health Overview and Scrutiny Sub-Committee selects a small number of the following indicators relevant to Adult Social Care and Public Health:

- Adult Social Care Performance Indicators
  - Total non-elective admissions into hospital
  - Number of nights delayed transfers of care
- Public Health Performance Indicators
  - % of eligible adults aged 65+ who have received the flu vaccine
  - % of women who smoke at time of delivery
  - % of people eligible for bowel cancer screening who were screened
  - Cumulative % of the eligible population offered an NHS Health Check

In addition, Clinical Commissioning Groups have their own national Outcomes Indicator Set, just as the National Health Service has its own Outcomes Framework (both summarised below), and Members of the Committee may wish to discuss with the CCG and Health colleagues tracking performance against one or two of these indicators as part of their regular monitoring.



1 Preventing people from dying prematurely

Overarching indicators: Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii) ^

Improvement areas

Reducing premature mortality from the major causes of death
- Under 75 mortality from cardiovascular disease (NHS OF 1.1) ^ *
- Cardiac rehabilitation referrals
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke
- Under 75 mortality from respiratory disease (NHS OF 1.2) ^ *
- Under 75 mortality from liver disease (NHS OF 1.3) ^
- Emergency admissions for alcohol related liver disease
- Under 75 mortality from cancer (NHS OF 1.4) ^ *
- One year survival from all cancers (NHS OF 1.4 i) ^
- One year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii) ^
- Cancer: diagnosis via emergency routes
- Cancer: record of stage at diagnosis
- Cancer: early detection
- Lung cancer; record of stage at diagnosis
- Breast cancer: mortality
- Heart failure: 12 month all-cause mortality
- Hip fracture: incidence

Reducing premature death in people with serious mental illness
- People with severe mental illness who have received a list of physical checks
- Serious mental illness: smoking rates

Reducing deaths in babies and young children
- Antenatal assessment < 13 weeks
- Maternal smoking at delivery
- Breastfeeding prevalence at 6-8 weeks
- Neonatal mortality and still births
- Low birth weight of term babies
- Proportion of pregnant women having planned caesarean sections after 39 weeks 0 days

Reducing premature deaths in people with learning disabilities

NHS OF indicator in development. No CCG measure at present

NOTES & LEGEND

NHS OF: indicator derived from NHS Outcomes Framework

^ NHS OF indicator that is also measurable at local authority level

* NHS OF indicator shared with Public Health Outcomes Framework

** NHS OF indicator complementary with Adult Social Care Outcomes Framework

Other indicators are developed from NICE quality standards or other existing data collections.

2 Enhancing quality of life for people with long-term conditions

Overarching indicators: Health-related quality of life for people with long-term conditions (NHS OF 2) ^ **

Improvement areas

Ensuring people feel supported to manage their condition
- People feeling supported to manage their condition (NHS OF 2.1) ^ * **

Improving functional ability in people with long-term conditions
- People with COPD & Medical Research Council Dyspnoea scale = or >3 referred to a pulmonary rehabilitation programme
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than one year referred to structured education

Reducing time spent in hospital by people with long-term conditions
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i) ^
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHS OF 2.3.ii) ^
- Complications associated with diabetes inc emergency admission for diabetic ketoacidosis and lower limb amputation

Enhancing quality of life for carers
- Health-related quality of life for carers (NHS OF 2.4)

Enhancing quality of life for people with mental illness
- Access to community mental health services by people from BME groups
- Access to psychological therapy services by people from BME groups
- IAPT reliable recovery/reliable improvement/reliable deterioration
- Health-related quality of life for people with a long term mental health condition

Enhancing quality of life for people with dementia
- Estimated diagnosis rate for people with dementia *No CCG measure at present*
- People with dementia prescribed anti-psychotic medication

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators:
- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b) *

Improvement areas

Improving outcomes from planned treatments
- Average health gain as assessed by patients for elective procedures

a) hip replacement b) knee replacement c) groin hernia d) varicose veins

Preventing lower respiratory tract infections in children from becoming serious
- Emergency admissions for children with lower respiratory tract infections (NHS OF 3.2) ^

Improving recovery from injuries and trauma

No CCG measure at present

Improving recovery from stroke

People who have had a stroke who
- are admitted to an acute stroke unit within four hours of arrival to hospital
- receive thrombolysis following an acute stroke
- are discharged from hospital with a joint health and social care plan
- receive a follow-up assessment between 4-8 months after initial admission
- spend 90% of more of their stay on an acute stroke unit

Improving recovery from mental health conditions
- Alcohol admissions and readmissions
- Mental health readmissions within 30 days of discharge
- Percentage of adults in contact with secondary mental health services in paid employment

Improving recovery from fragility fractures
- Proportion of patients recovering to their previous level of mobility or walking ability (NHS OF 3.5 i and ii)
- Hip fracture: collaborative orthogeriatric care, timely surgery, multifactorial risk assessment and care process bundle

4 Ensuring that people have a positive experience of care

Overarching indicators: **Patient experience of primary and hospital care**
- Patient experience of GP out of hours services (NHS OF 4a ii) ^
- Patient experience of hospital care (NHS OF 4 b)

Improvement areas

Improving people's experience of outpatient care
- Patient experience of outpatient services (NHS OF 4.1)

Improving hospitals' responsiveness to personal needs
- Responsiveness to in-patients' personal needs (NHS OF 4.2)

Improving people's experience of accident and emergency services
- Patient experience of A&E services (NHS OF 4.3)

Improving women and their families' experience of maternity services (NHS OF 4.5)

Improving the experience of care for people at the end of their lives
- Bereaved carers views on the quality of care in the last 3 months of life NHS OF 4.6)

Improving experience of healthcare for people with mental illness
- Patient experience of community mental health services (NHS OF 4.7)

Improving children and young people's experience of healthcare

No CCG measure at present

Improving people's experience of integrated care

NHS OF indicator in development. No CCG measure at present

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators: No overarching indicator at present

Improvement Areas
- Patient safety incidents reported (NHS OF 5.6)

Reducing the incidence of avoidable harm
- Incidence of healthcare associated infection: MRSA (NHS OF 5.2.i)

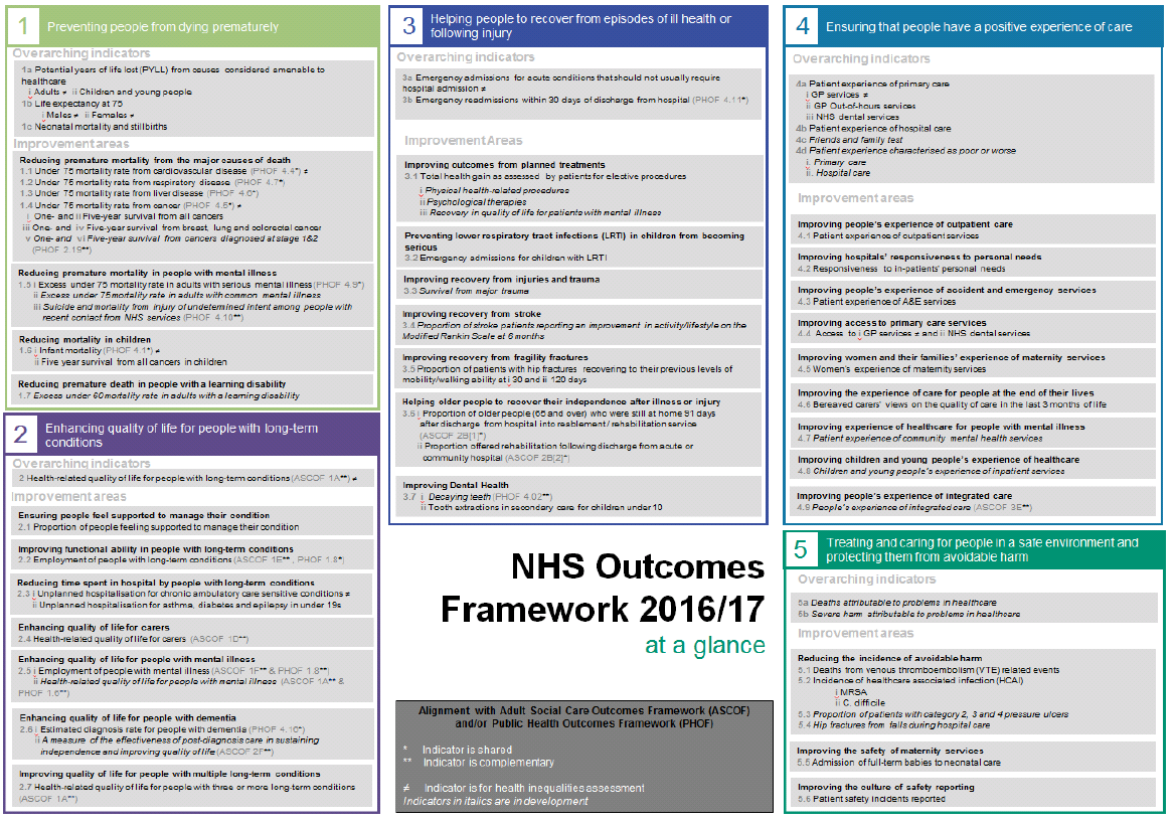
Incidence of healthcare associated infection: C difficile (NHS OF 5.2.ii)

No CCG measures at present for category 2, 3 and 4 pressure ulcers and incidence of medication errors causing serious harm

Improving the safety of maternity services
- Admission of full term babies to neonatal care (NHS OF 5.5)

Delivering safe care to children in acute settings

No CCG measure at present



IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications arising directly from this report which is for information only.

Adverse performance against some performance indicators may have financial implications for the Council, particularly where targets are explicitly linked with particular funding streams and / or levies from other bodies.

Robust ongoing monitoring is undertaken as part of the established financial and service management processes. Should it not be possible to deliver targets within approved budgets this will be raised through the appropriate channels as required.

Legal implications and risks:

Whilst reporting on performance is not a statutory requirement, it is considered best practice to regularly review performance.

Human Resources implications and risks:

There are no HR implications or risks, involving the Council or its workforce that can be identified from the recommendations made in this report.

Equalities implications and risks:

There are no financial implications arising directly from this report.

BACKGROUND PAPERS

None