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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Thursday 30 November 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 7 September 2017 (attached) and to authorise the Chairman to sign them.

5 BHRUT WINTER PRESSURES (Pages 7 - 26)

Report and presentation attached.

6 DIGITAL ROADMAP FOR INTEGRATION BETWEEN HEALTH AND SOCIAL CARE (Pages 27 - 42)

Report and presentation attached.

7 AIR POLLUTION (Pages 43 - 60)

Report and presentation attached.

8 PERFORMANCE INFORMATION (Pages 61 - 76)

Attached.

9 URGENT BUSINESS

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

Andrew Beesley
Head of Democratic Services

MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
7 September 2017 (7.00 - 9.10 pm)

Present:

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

Also present:

Ian Buckmaster, Carol Dennis, Jenny Gregory and Di Old (Healthwatch Havering)
Mark Ansell, Director of Public Health, Barbara Nicholls, Director of Adult Services, Ian Tompkins, East London Health and Care Partnership.

11 **ANNOUNCEMENTS**

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

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

There were no apologies for absence.

13 **DISCLOSURE OF INTERESTS**

There were no declarations of interest.

14 **MINUTES**

The minutes of the meeting of the Sub-Committee held on 28 June 2017 were agreed as a correct record and signed by the Chairman.

15 **RESPONSES TO DELAYED REFERRALS TO TREATMENT REPORT**

A director of Healthwatch Havering welcomed the general acceptance by the NHS of the findings of the topic group. It was accepted that recent cyber-security attacks on the NHS did not relate directly to Referral to Treatment but this did show the need for robust governance of IT systems.

The Deputy Chief Operating of BHRUT also welcomed the report and agreed with its findings overall. The national waiting time target of 92% of patients waiting less than 18 weeks had been achieved by the Trust in June

and July 2017 but the Trust also wished to ensure that this recovery was sustainable overall.

The Trust officer added that the issue had been discovered during a change of IT suppliers but this had not been the main cause. It was also felt that demand management in primary care should be more actively managed. The Trust welcomed the outcomes of the report and the opportunity to respond to it.

Whilst progress had been made in reducing waiting times, the Trust officer added that BHRUT was also under pressure from commissioners not to overspend which could lead to an increase in waiting times for treatment. It was confirmed that only a handful of patients were now waiting more than a year for treatment and that these may have complex pathways or had in fact chosen to delay their treatment.

Healthwatch could bring an update on referral to treatment data reporting to the March 2018 meeting of the Sub-Committee. It was confirmed that the Trust was penalised if targets were not delivered by each of the CCGs, NHS England and the Trust's overseeing authority. A report on performance indicators that was going to the Health and Wellbeing Board could also be circulated to the Sub-Committee for information.

The Sub-Committee NOTED the responses to the joint topic group report.

16 **EAST LONDON HEALTH AND CARE PARTNERSHIP**

The East London Health and Care Partnership (ELHCP) had previously been known as the Sustainability and Transformation Plan (STP). It had been felt however that the STPs had been developed in isolation and had not developed sufficient levels of engagement. The plan had been developed in the context of changes in East London including a fast growing, diverse population and reduced funding to Councils.

Figures from October 2016 predicted that the North East London health economy would face a £580 million gap in funding by 2021. Whilst people were living longer, they were also suffering with more complex illnesses etc. Officers were looking to relieve this position by measures such as relocating GPs and reprocuring the NHS 111 service. Work was also in progress on prevention by for example encouraging self-care and reducing delayed discharges from hospital. It was accepted that there were difficulties in recruiting doctors and nurses as well as with the provision of key worker accommodation.

The above issues meant it was necessary to collaborate and bring services together although there were different cultures in Councils compared to the NHS as well as different financing mechanisms. The STP and now ELHCP therefore sought to bring together different parties such as Local Authorities, the NHS, carers and the voluntary sector. A document had recently been produced explaining in clear language what the ELHCP meant to local

people and a revised version of this would be circulated to the Sub-Committee.

A community group had been formed to support the Partnership which comprised many different voluntary sector groups. It was also wished to involve charities, schools, colleges and hospices in this work. The Council Chief Executive was the lead Council officer for the London-wide steering group.

A wider partnership was needed to consider cross-sector issues such as performance monitoring, assurance and GP recruitment. The provision of key worker accommodation was an issue and it was hoped that proceeds from the sale of NHS estates could be retained within East London. Work was also in progress to establish career paths within midwifery.

Concerns were raised by Members over the rising population locally and that health facilities were not sufficient to cope with this. Officers agreed that the NHS workforce was the biggest single issue and that a large amount of resources was having to be spent on agency staff. Work was under way to develop the clinical training programme as well as other initiatives such as the introduction of physician associates in Waltham Forest and trying to have community pharmacies taking on some work of GPs. Some funding was also available to recruit more GPs from overseas.

It was felt that NHS language needed to be simplified in order that people attended the right facility rather than just A & E. Other changes to the system were needed including reducing amounts spent on prescribing drugs that could be cheaply obtained in any supermarket.

It was agreed that, for the aims of the ELHCP to be achieved, different ways of working had to be found such as e.g. use of phone apps to monitor heart conditions. It was aimed to give people greater control over their own health although this would take time to achieve. Updates on progress with meeting objectives could be given to the Sub-Committee.

It was also noted that there were linkages from much of this work to the BHR Integrated Care Partnership and also to work in Havering to establish a locality model.

It was AGREED that an update on the work of the ELHCP should be taken at the meeting of the Sub-Committee in March 2018.

17 HEALTHWATCH HAVERING - ANNUAL REPORT

The director of Healthwatch Havering explained that, in the year under review, the organisation had undertaken a total of 42 enter and view visits. Seventeen of these had been to GP practices in light of serious concerns about local GP practices that had been raised to Healthwatch. It was noted

that there were a lot of smaller GP practices in Havering and the locality working group was looking at alternative ways of providing GP services.

In the coming year, Healthwatch was planning to do work on vision services and this would include visits to the Queen's Hospital Ophthalmology Department as well as to local opticians. Healthwatch was also looking at ways to improve access to A & E and reducing use of confusing terminology such as walk-in clinics etc.

Work was also continuing with parents of children with learning disabilities as well as on developing relationships with other local Healthwatch organisations.

Healthwatch Havering's report on the street triage service had been taken recently to the Crime & Disorder Sub-Committee, following a referral by this Sub-Committee. The Chief Superintendent for Havering had indicated that there would now be stronger Police buy-in to the street triage service.

Members raised concerns over two local Practices giving phone diagnoses although it was noted that patients were now given a choice of doing this and that the system was now working better.

It was accepted that there had not originally been a great demand for GP hub appointments at weekends but it was felt that demand for this service may now be increasing.

The Sub-Committee NOTED the annual report of Healthwatch Havering.

18 **PUBLIC HEALTH BUDGET**

The Director of Public Health reminded the Sub-Committee that the public health service had transferred to the Council in April 2013. The service worked with the CCG and with the rest of the Council to improve the health of local residents. Some mandated public health services were provided such as health checks and health visiting while other non-statutory services such as those for drug and alcohol addiction were also provided by Public Health.

For the first two years after the transfer of public health, funding had grown and this was initially invested in children's services. Additional funding was also received in October 2015 when the service took over the health visiting function. In 2016 however an in-year cut of £600k had been made by central Government to Havering's public health allocation. Further cuts of around 4% per year would also be made for the next four years. Reserves had been used initially to cover these cuts but savings of a further £750k would be needed by 2019/20.

Some savings had already been achieved such as £450k from the reprocurement of the Drug and Alcohol Action Team. Reductions in the public health team itself had also resulted in savings of £350k. Reserves

could however only cover current overspending against the public health allocation for the next two years.

Smoking cessation support was now only offered to pregnant women and people with serious mental illness. The demand for this service had reduced due to the rise in popularity of e-cigarettes and it was no longer cost effective to provide this.

The issue of air pollution was not likely to be made a mandated service. It would be for central Government to drive technology and changes to car design etc. It was possible however to consider what could be done locally re air pollution and an update could be given at a future meeting. Air pollution in Havering was at a relatively low level.

The Sub-Committee NOTED the position.

19 **PERFORMANCE INFORMATION**

It was clarified by officers that the Health and Wellbeing Board received a dashboard of 10 indicators covering the health of the local population etc. It was suggested that the Sub-Committee could also look at indicators covering delayed transfers of care and non-elective admissions to hospital.

Obesity levels were also suggested as an indicator that could be monitored. There was not any weight management service currently offered but Public Health did work with schools on projects such as the Healthy Schools award. Curriculum support was also provided to schools in areas such as nutrition and physical activity.

The cuts to public health budgets were a national issue and had been in the same proportions for all areas. Pooled budgets were also being used with for example a joint procurement of sexual health services with neighbouring boroughs.

Following discussion, it was agreed that the following indictors would be monitored by the Sub-Committee:

Children's obesity – Public health objective 2.6
Patient experience of primary care – NHS QF 4 (a) (ii) re the GP out of hours service.
Delayed transfers of care – ASCOF indicator 2C

It was further agreed that a report on air quality in Havering should be taken at the next meeting of the Sub-Committee.

20 **URGENT BUSINESS**

There was no urgent business raised.

Chairman

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 30 NOVEMBER 2017

Subject Heading:	BHRUT Winter Pressures
CMT Lead:	Mark Ansell/Barbara Nicholls
Report Author and contact details:	**Michael Kaiser, Programme Director for Urgent and Emergency Care, BHRUT & BHR CCGs** **01708 435022**
Policy context:	**The information presented summarises the work undertaken by local Health bodies to deal with winter pressures.**
Financial summary:	**No financial implications of the report itself for the Council.**

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

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

SUMMARY

The attached presentation gives details of recent work undertaken on air quality in Havering.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached presentation and the information within it and takes any action it considers appropriate.

REPORT DETAIL

Officers representing the local Hospitals Trust and Clinical Commissioning Group will detail preparations and work undertaken to cope with the pressures brought about by the winter peak demand period for the Health Service.

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.

WINTER READY

Michael Kaiser

Programme Director for
Urgent and Emergency Care,
BHRUT & BHR CCGs

BHR Integrated Care Partnership
Better care, better lives, together

Barking, Havering and Redbridge University Hospitals NHS Trust

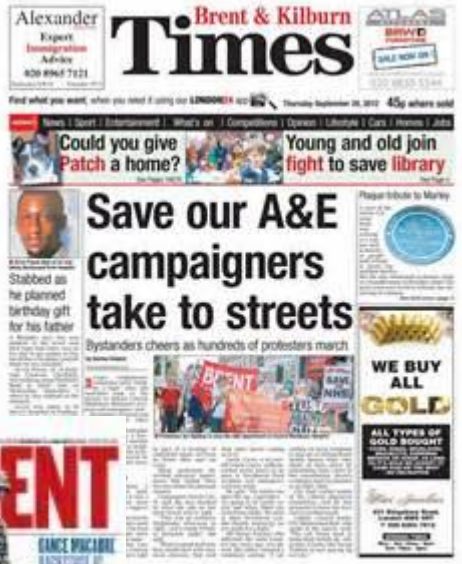
HEADLINES

BHR Integrated Care Partnership
Better care, better lives, together

- Winter is the busiest time for both NHS and social care services
- We started planning earlier than ever this year
- For the first time, we have a single action plan across the whole system
- We are working closely and collaboratively, but the next few months will undoubtedly be difficult
- Lots of advice on staying well and how/where to get help will be on the way
- We'll all be using the national materials from the Stay Well This Winter campaign
- Your support would be hugely valued to spread the word

NATIONAL NEWS EVERY DAY

BHR Integrated Care Partnership
Better care, better lives, together



KEY FIGURES

BHR Integrated Care Partnership
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Annual Attendances:

KGH 116,585
QH 169,952

BHRUT Total 286,573

Annual Admissions:

KGH 13,511
QH 29,593

BHRUT Total 43,104

BED OCCUPANCY

BHR Integrated Care Partnership
Better care, better lives, together

Based on the six week average prior to Accident & Emergency Department Delivery Board (AEDB) reconfiguration, there were always:

- 20-22 beds occupied by patients that do not need to be in them any longer at KGH (4.5-4.9%)
- 23-27 beds occupied by patients that do not need to be in them any longer at QH (2.4-2.9%)
- 43-49 beds occupied by patients that do not need to be in them any longer across BHRUT (3.1-3.5%)

PRIDE

CHALLENGES VACANCY RATES

BHR Integrated Care Partnership
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- Doctor vacancy rate is currently 44%
- Nurse vacancy rate is currently 24%
  - Overall picture fragile but improving

FOUR HOUR PERFORMANCE

BHR Integrated Care Partnership
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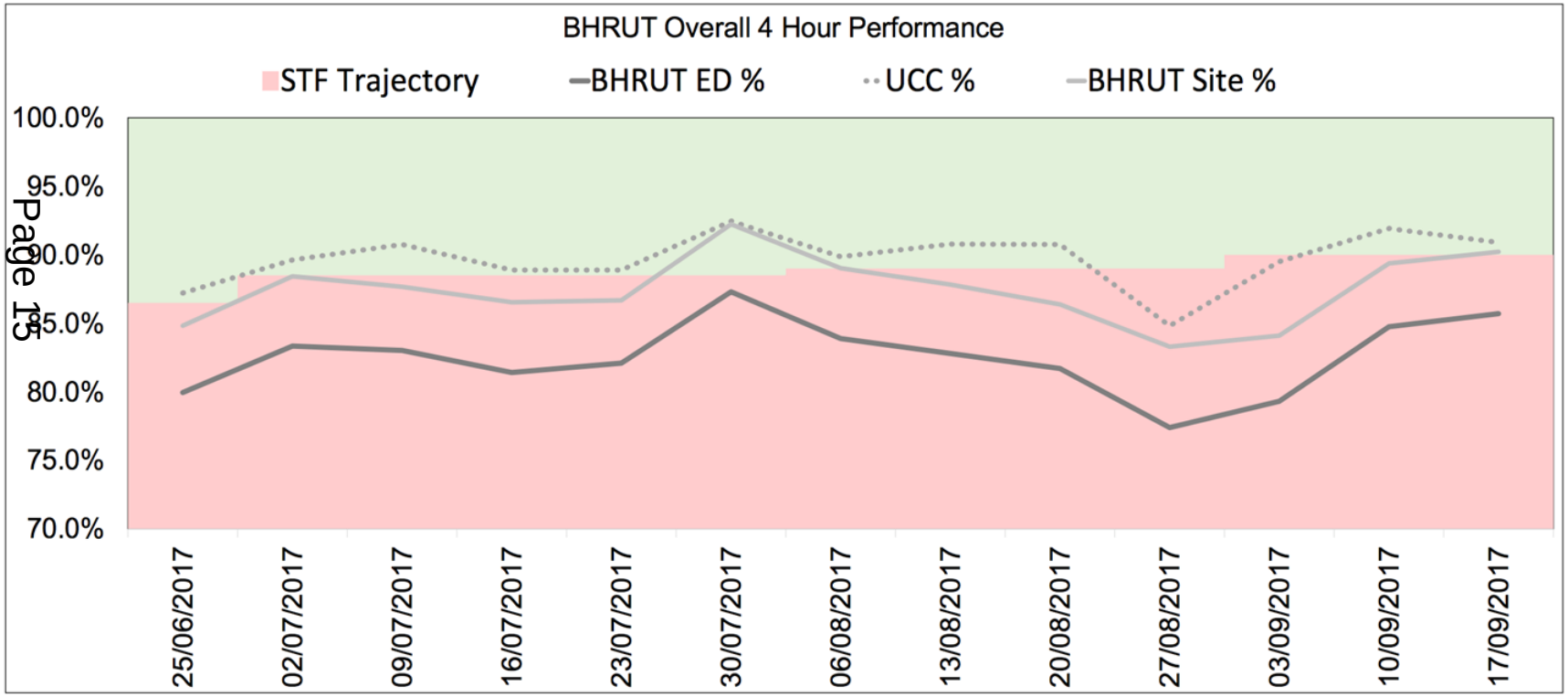
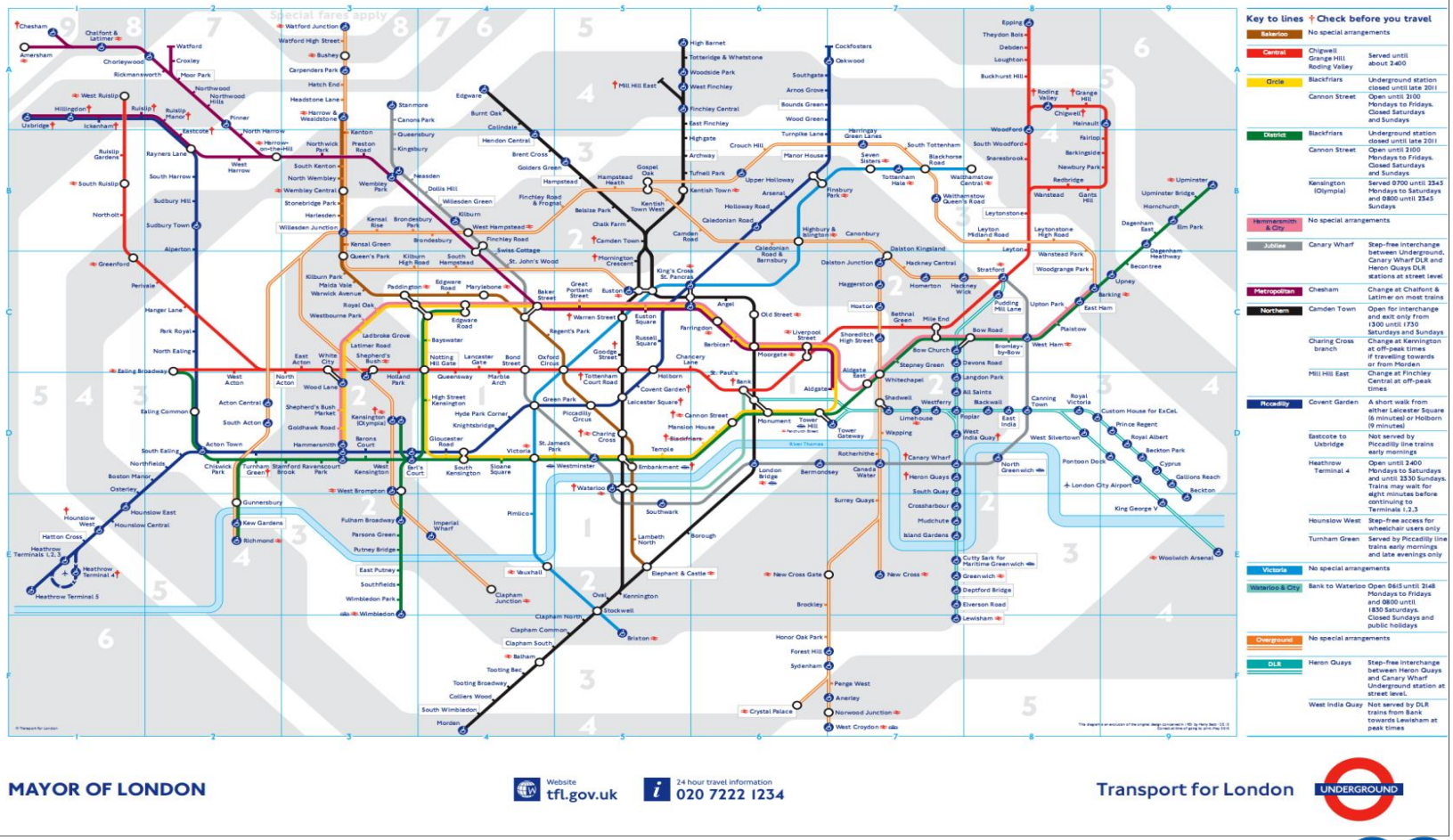
- Varied performance across two hospitals
- Non-admitted and Type three performance is low



URGENT CARE PATHWAYS

BHR Integrated Care Partnership
Better care, better lives, together

Tube map



OTHER CHALLENGES

BHR Integrated Care Partnership
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- Confusing routes to access care for patients
- High ambulance conveyance rates (Queen's Hospital among highest in London)
- Delays in accessing many out of hospital care services and pathways
- Direct speciality access
- Physical capacity
- IT for Urgent Care Centre (UCC)
- Commissioning routes

BHR Integrated Care Partnership
Better care, better lives, together

URGENT CARE GOVERNANCE STRUCTURE

- AEDB
- Discharge Improvement Working Group
- AEDB Pre Meet
- Patient Flow Programme
- NHS England and NHS Improvement:
  - Regional Assurance Calls
  - Regional Escalation Meetings
  - National Assurance Meetings
- Sustainability & Transformation Plan (STP)
- System Delivery and Performance (SDP)

A&E Delivery Board

Frequency: Fortnightly (prior to assurance meetings)

Chair: Matthew Hopkins

Routine Reports: A&E Improvement Plan (Actions not Tasks), A&E Improvement Dashboard (KPIs only)

Additional Reports: High Level A&E Improvement Risk Register

Prevention

Frequency: Fortnightly (prior to AEDB)

Chair and SRO: Sharon Morrow

Clinical Lead: Richard Burack

Routine Reports: Prevention Improvement Plan (Actions and Tasks), Prevention Improvement Dashboard

Additional Reports: Prevention Risk Register

Inflow

Frequency: Fortnightly (prior to AEDB)

Chair and SRO: Mairead McCormick

Clinical Lead: Aber Eaqub

Routine Reports: Inflow Improvement Plan (Actions and Tasks), Inflow Improvement Dashboard

Additional Reports: Inflow Risk Register

Throughflow

Frequency: Fortnightly (prior to AEDB)

Chair and SRO and Clinical Leads: Ayo Ahonkai and Andy Heeps

Routine Reports: Throughflow Improvement Plan (Actions and Tasks), Throughflow Improvement Dashboard

Additional Reports: Throughflow Risk Register

Outflow

Frequency: Fortnightly (prior to AEDB)

Chair and SRO: Barbara Nicholls and Liz Sargeant

Clinical Lead: TBC

Routine Reports: Outflow Improvement Plan (Actions and Tasks), Outflow Improvement Dashboard

Additional Reports: Outflow Risk Register

SINGLE SYSTEM-WIDE ACTION PLAN

- Divided into the four work streams
- Key actions include:
  - Implementation of a 24/7 Urgent Treatment Centre at QH
  - Community Urgent Emergency Care (UEC) review
  - Ensure outpatient clinics do not operate over peak winter periods in order to release clinician capacity to cover ED and wards
  - Develop 42 Whole Time Equivalent (WTE) independent practitioners to replace medical workforce to manage non-admitted pathway
  - Building works for both Emergency Departments
  - Increase seven day discharges

ONE PLAN? REALLY?!

BHR Integrated Care Partnership
Better care, better lives, together

- A Winter checklist and planning slide has been submitted which correlate with our Action Plan
- Plan should contain actions required to deliver:
  - Eight High Impact Changes
  - Ambulance Response Programme
  - Urgent Treatment Centres
  - Evening and Weekend GP Appointments
  - Mental Heath in ED
  - Trusted Assessor
  - True Discharge to Assess (D2A)
  - 7/7 Discharge
  - All other national guidance including Red 2 Green, SAFER etc.

SINGLE SYSTEM-WIDE DASHBOARD

- Divided into the four work streams
- A KGH and QH breakdown as well as a BHRUT total is present for every metric

CURRENT POSITION

BHR Integrated Care Partnership
Better care, better lives, together

- 24/7 UTC goes live on 27 November 2017
- Demand has grown significantly, particularly for paediatric patients
- Four hour performance throughout November has dipped prior to the new 24/7 Urgent Treatment Centre (UTC)
- Bed occupancy has increased

SUMMARY

BHR Integrated Care Partnership
Better care, better lives, together

- Issues/Challenges
- Resolutions
- Action Plan
- Dashboard
- Governance Structure
- Alignment to Winter and National Guidance

SUMMARY

BHR Integrated Care Partnership
Better care, better lives, together

- Winter is the busiest time for both NHS and social care services
- We started planning earlier than ever this year
- For the first time, we have a single action plan across the whole system
- We are working closely and collaboratively, but the next few months will undoubtedly be difficult
- Lots of advice on staying well and how/where to get help will be on the way
- We'll all be using the national materials from the Stay Well This Winter campaign
- Your support would be hugely valued to spread the word

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 30 NOVEMBER 2017

Subject Heading:	BHR Local Digital Roadmap
CMT Lead:	Mark Ansell
Report Author and contact details:	**Rob Meaker, Director of Innovation, BHR CCGs** **0203 688 1470**
Policy context:	**The information presented summarises the work undertaken by local health bodies to introduce greater digital and technology services.**
Financial summary:	**No financial implications of the report itself 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	[X]

SUMMARY

The attached presentation gives details of recent work undertaken in the local health sector to increase the use of digital technology.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached presentation and the information within it and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of work being undertaken to increase the use of digital technology across health and social care services for Havering residents.

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.

NHS
Havering
Clinical Commissioning Group

BHR Local Digital Roadmap

Increasing the use of digital technology across health and social care

Havering Health Scrutiny Committee
Thursday 30 November 2017

Rob Meaker
Director of Innovation

Barking and Dagenham, Havering and Redbridge CCG

NHS
Havering
Clinical Commissioning Group

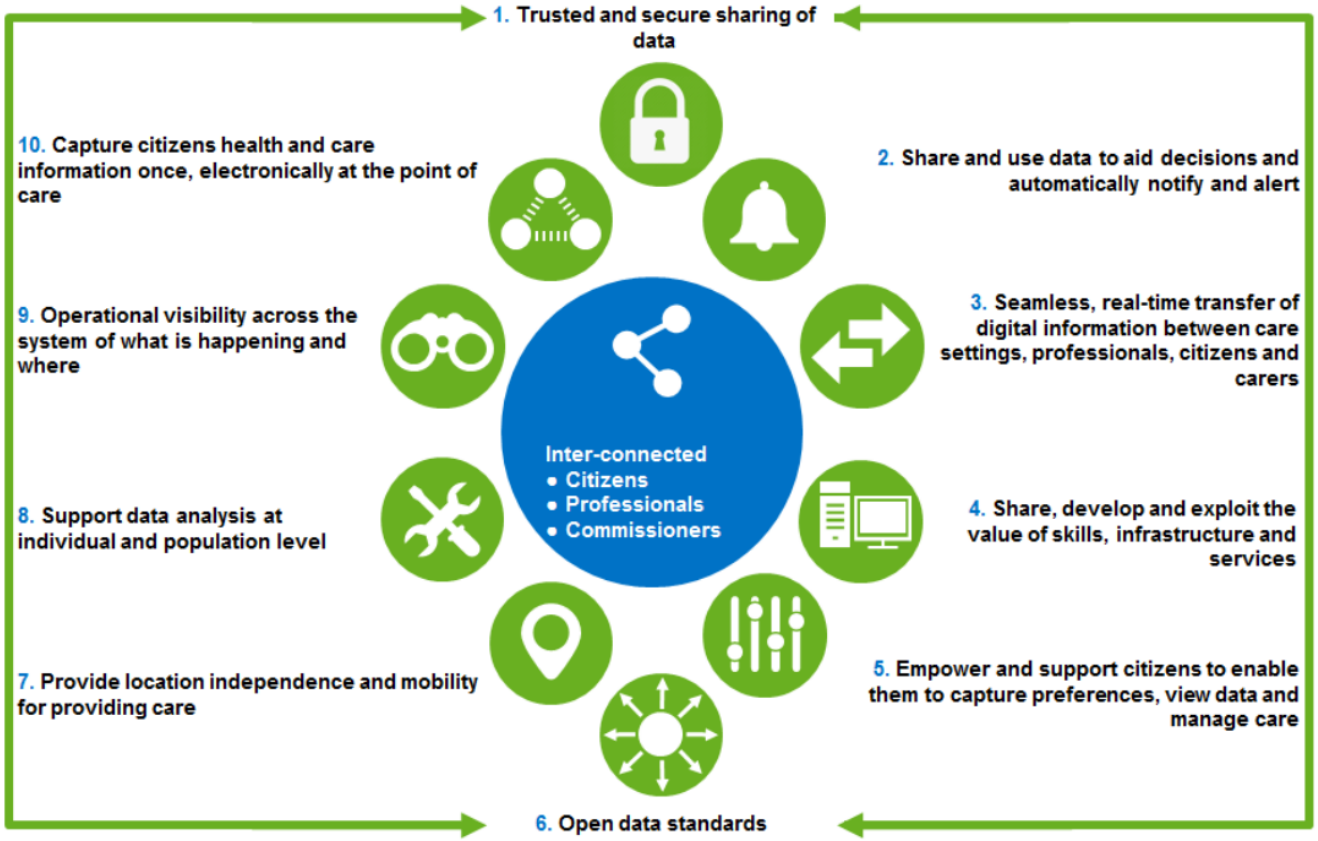
Looking to the digital future

Demand for health services is rising and we know that building our digital capacity will give healthcare professionals the technology they need to be more efficient and respond to this demand.

Local health and care systems nationally were required to produce ‘local digital roadmaps’ setting out how they will achieve the ambition of ‘paper-free’ at the point of care by 2020’, outlined in the NHS Five Year Forward View.

What are local digital roadmaps?

Roadmaps have 10 national guiding principles which provide a set of rules for digital transformation.



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Barking and Dagenham, Havering and Redbridge digital roadmap was developed jointly by the CCGs, councils and local providers.

Our roadmap presented our vision for the next five years to address local challenges. The plan outlined how we would through better use of technology make the local NHS more efficient, and improve patient experience.

Our digital roadmap will support to:

- enable local people to be able to read their own health record in the way they choose

- enable GPs, nurses and other caregivers to access patient information when they need to

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Clinical Commissioning Group

Funding

We projected that we would need funding to implement our ambitions and estimated that the cost to deliver would require approximately £42million over five years.

BHR CCGs applied for funding from NHS England, unfortunately the bid was denied on the basis that nationally there is no money available.

However, our annual GP IT funding was approved and this has enabled us to focus on alterative local projects.

NHS
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Clinical Commissioning Group

Making it easier to access patient information in different locations

Healthcare professionals are given one single log in that provides access to patient information across multiple locations.

This is currently being tested in one GP practice and if this goes well, there is a view to roll out in all GP practices over the next two years.

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How does it work?

Doctors, nurses and healthcare professionals no longer have to log in and out of different computer systems.

- no need to repeatedly type in usernames and passwords
- saves time logging into different computer systems to find out about each patient
- enables access to applications across multiple health and social care sites
- supports mobile working and quicker access to information when needed.

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Clinical Commissioning Group

Online portal

BHR CCGs and Health 1000 GP practice in Goodmayes jointly developed an online portal for the practice.

Patients can now access and view their care plans online, empowering them to have greater involvement in managing their health.

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Clinical Commissioning Group

Video consultation

We have successfully enabled the technology for video consultation in all GP practices. The technology can be used for patient consultations or GP clinical conferencing.

- Patient video consultation is running in a limited number of sites as a pilot scheme across the three CCGs.
- We are supporting practices through the process through training and providing materials.

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Havering
Clinical Commissioning Group

Self check-in

Patients can tap in their arrival digitally in just a few seconds. The screens can help to reduce queues and also:

- meet the needs of our diverse population as text can be customised to be multilingual
- inform patients about waiting times – for example if the clinic is running late that day
- reduce patient waiting time and allow reception staff to focus on other administrative tasks
- protect patient data as names, addresses and other identifying information cannot be overheard

TV screens

- promote practice services, general health promotion and national NHS patient surveys.

NHS
Havering
Clinical Commissioning Group

Patient WiFi

In response to patient demand we are working to set up free internet access in all GP practices.

This is a 12 month programme with the ambition to have WiFi in every GP practice by the end of the roll out.

Installing WiFi allows patients to access health apps and their online GP record whilst at their appointment. This will not only empower patients to take an active role in discussing and managing their condition but also improve patient experience.

NHS
Havering
Clinical Commissioning Group

GP remote working

We have rolled out laptops to three quarters of GP practices enabling clinical remote working.

For example, a GP on a home visit would be able to access medical records whilst with the patient.

NHS
Havering
Clinical Commissioning Group

Questions

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 30 NOVEMBER 2017

Subject Heading:	Havering's Air Quality Campaign
CMT Lead:	Mark Ansell
Report Author and contact details:	**Louise Dibsdall, Senior Public Health Strategist** **01708 431811** **louise.dibsdal@havering.gov.uk**
Policy context:	**The information presented summarises the work undertaken by the Council to improve air quality in Havering.**
Financial summary:	**No financial implications of the report itself for the Council.**

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

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

SUMMARY

The attached presentation gives details of recent work undertaken on air quality in Havering.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached presentation and the information within it and takes any action it considers appropriate.

REPORT DETAIL

Officers from the Council's Public Health Service will summarise work to monitor and improve air quality in the borough.

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.

Havering
LONDON BOROUGH

Havering's Air Quality Campaign

Dr. Louise Dibsdall, Public Health

Marie-Claire Irvine, Public Protection

Types of Air Pollutants

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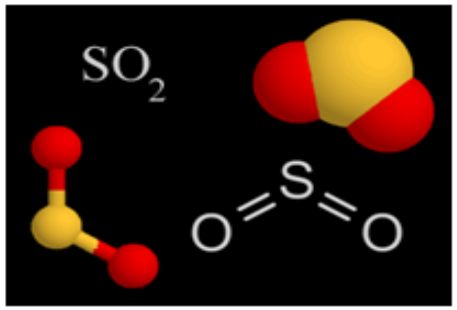
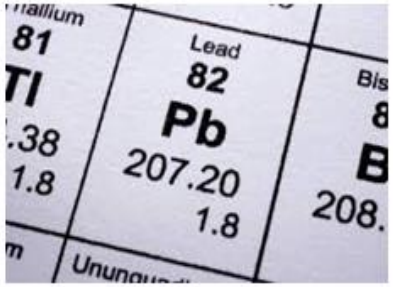
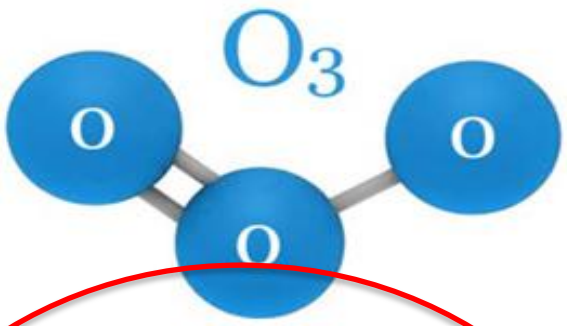
Sulphur Dioxide (SO_2)



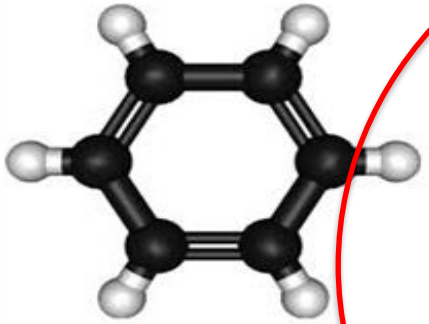
Lead



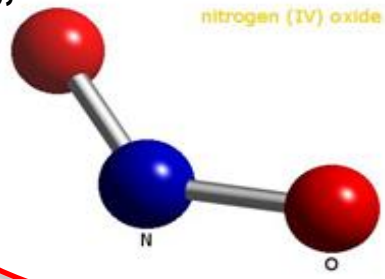
Ozone(O_3)



Benzene

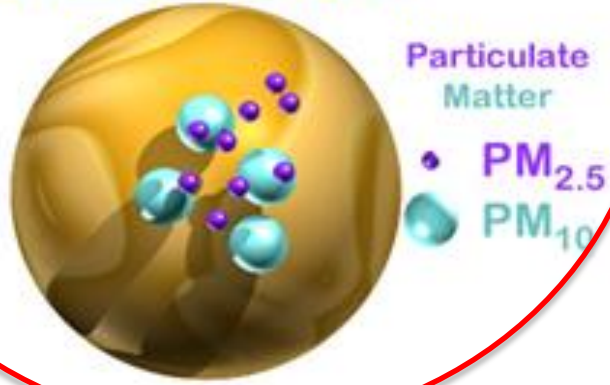


Nitrogen Dioxide (NO_2)

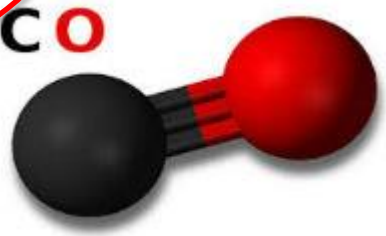


Particulate Matter ($PM_{2.5}$ & PM_{10})

Beach Sand Grain



Carbon Monoxide (CO)



Health Impacts of Air Pollutants

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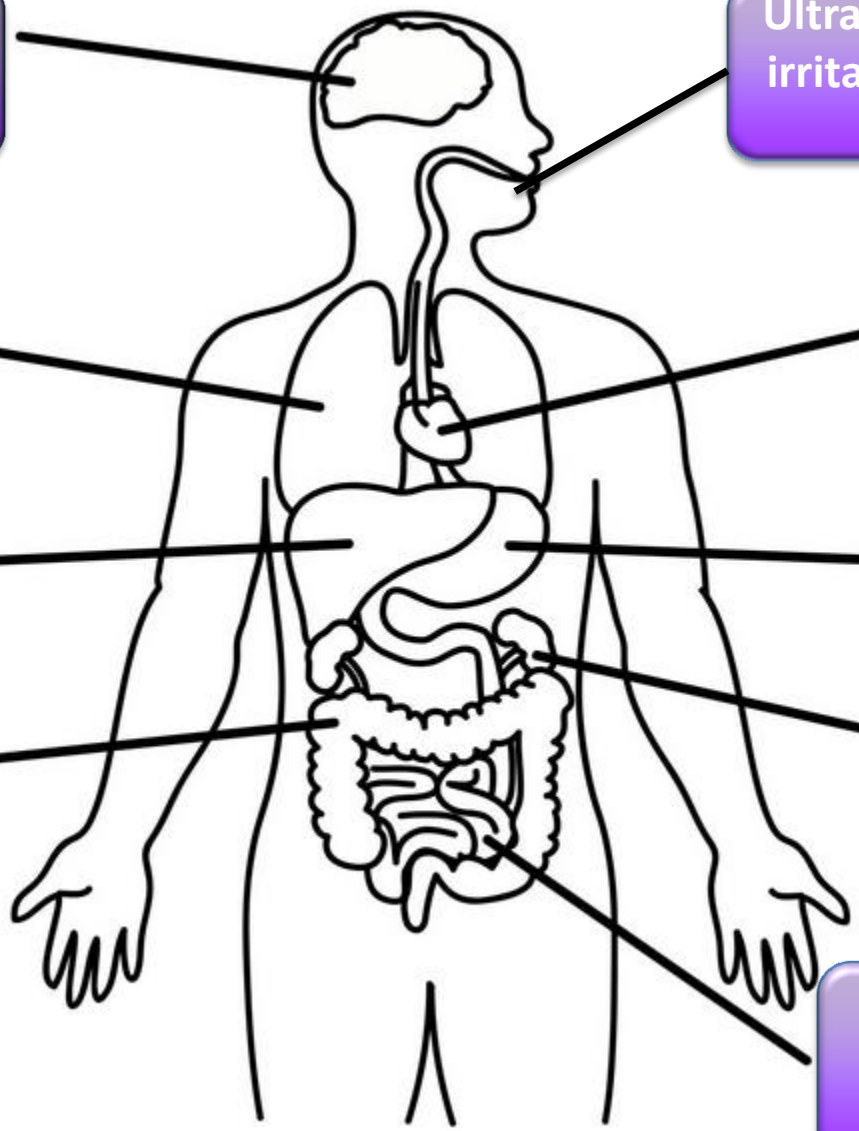


Particulate Matter can cause Strokes

Ultrafine PM, NO_2 and SO_2 irritate the eyes, nose and throat

Lung Cancer, Asthma, COPD, Bronchitis

A few hours of $PM_{2.5}$ can bring on existing illness or heart attacks

Ultrafine PM can get into the body through the blood

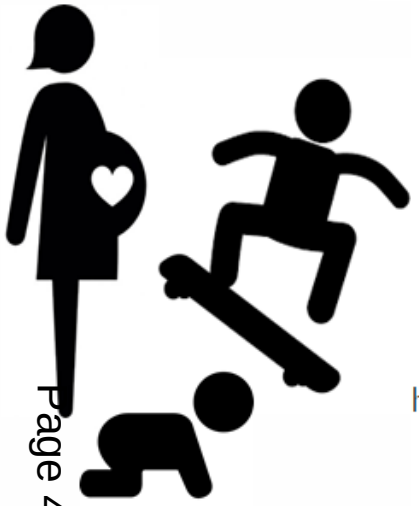
Increased risk of stomach cancer

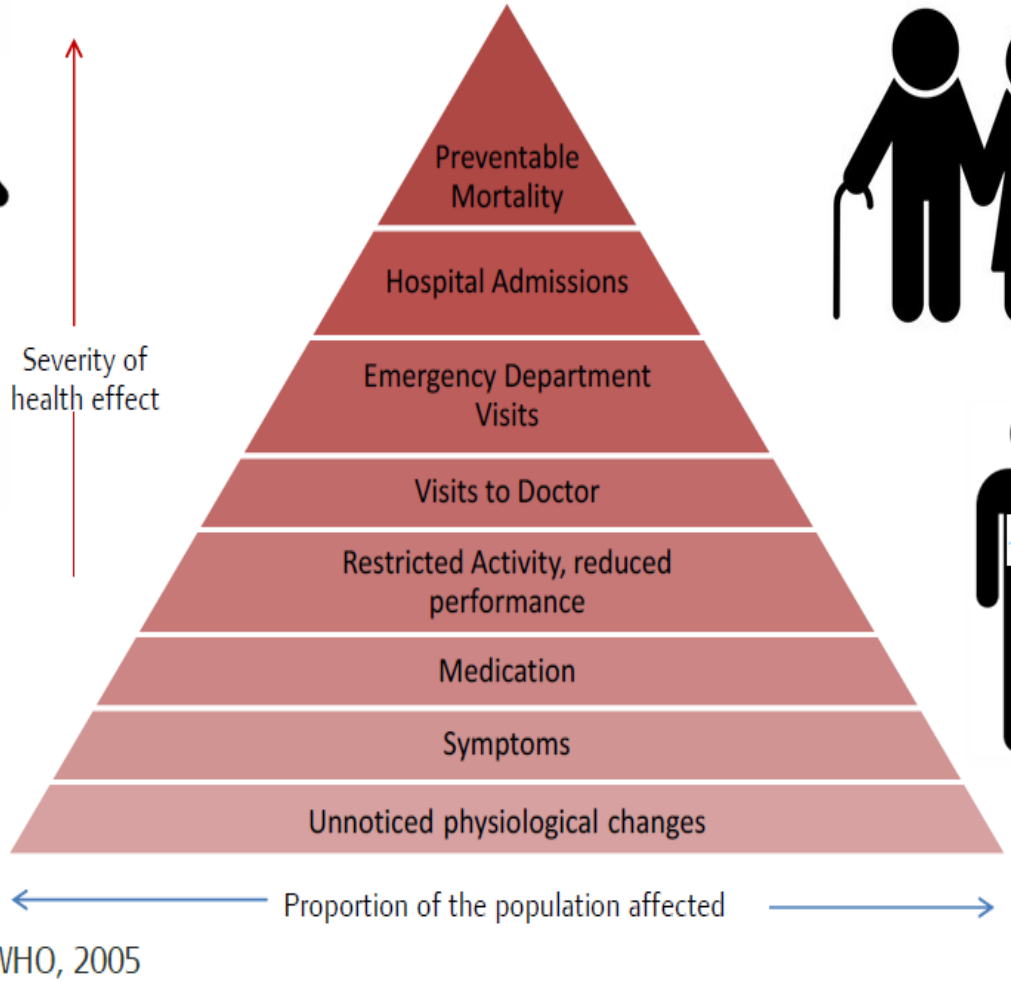
$PM_{2.5}$ and NO_2 has been linked to bowel cancer

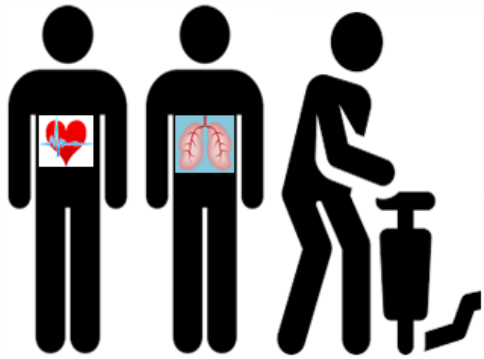
Air Pollution can cause kidney cancer

PM has been found in the reproductive organs and in unborn children

Who is Most at Risk?







Measuring Air Quality

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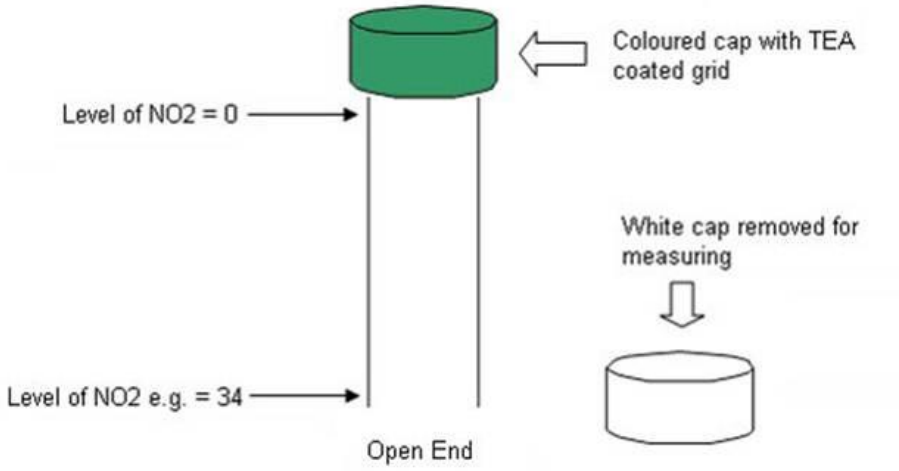

National Air Quality Standards & Objectives

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Pollutant	UK Objective	Averaging Period	Date (by which to be achieved and maintained thereafter)
Nitrogen dioxide - NO_2	200 µg m^{-3} not to be exceeded more than 18 times a year	1-hour mean	31 Dec 2005
	40 µg m^{-3}	Annual mean	31 Dec 2005
Particles - PM_{10}	50 µg m^{-3} not to be exceeded more than 35 times a year	24-hour mean	31 Dec 2004
	40 µg m^{-3}	Annual mean	31 Dec 2004
Particles – $PM_{2.5}$	25 µg m^{-3}	Annual mean	2020
	Target of 15% (20% EU) reduction in concentration at urban background locations	3 year mean	Between 2010 and 2020

Annual Mean NO_2 Concentrations

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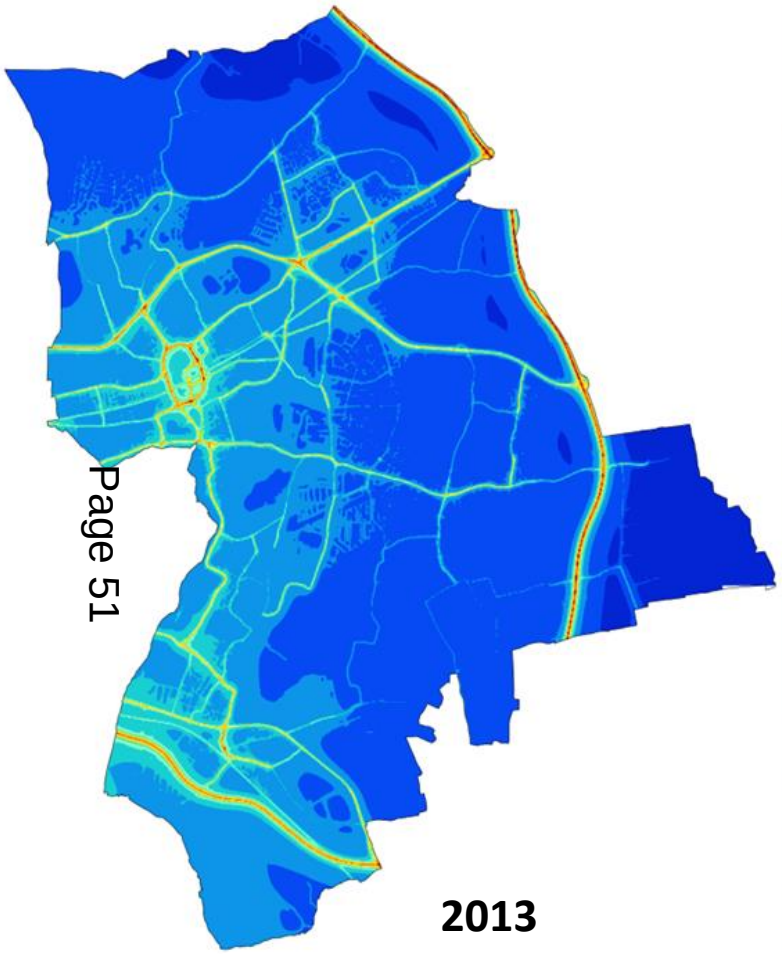
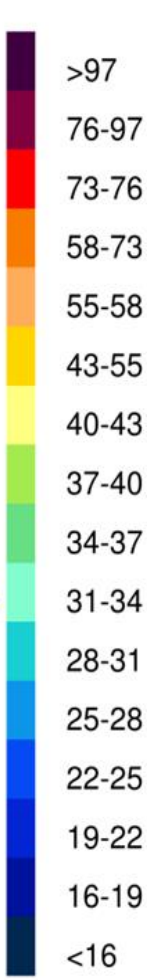
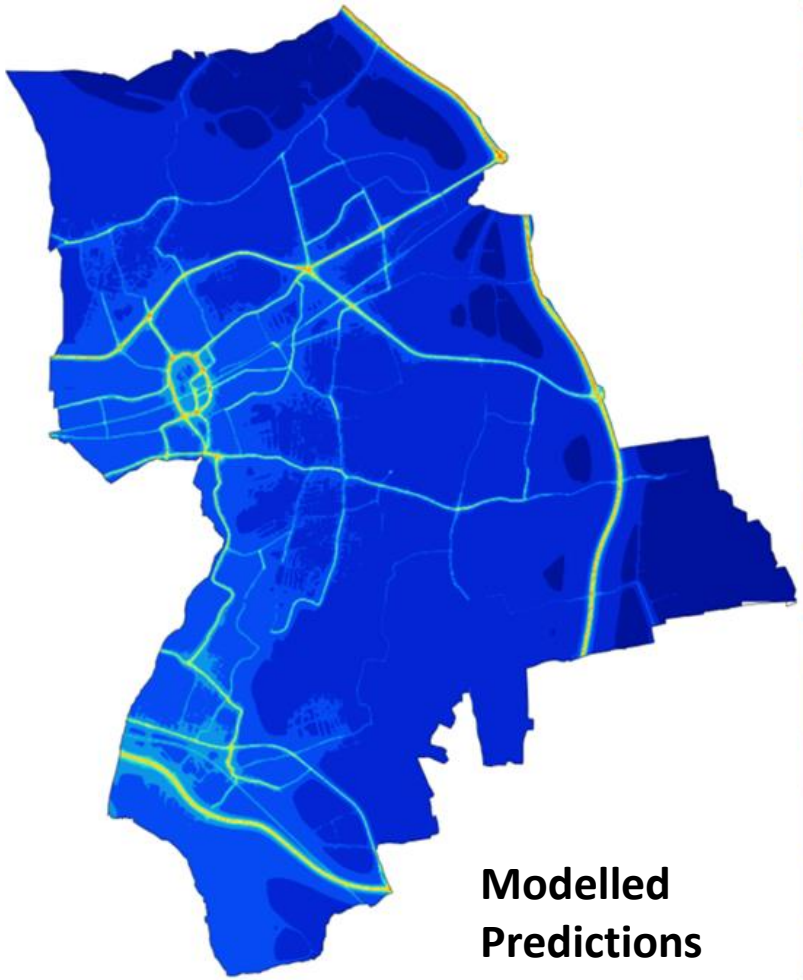
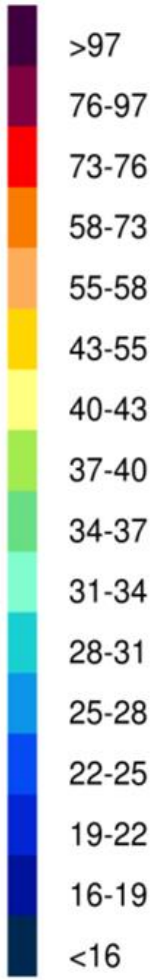


2013

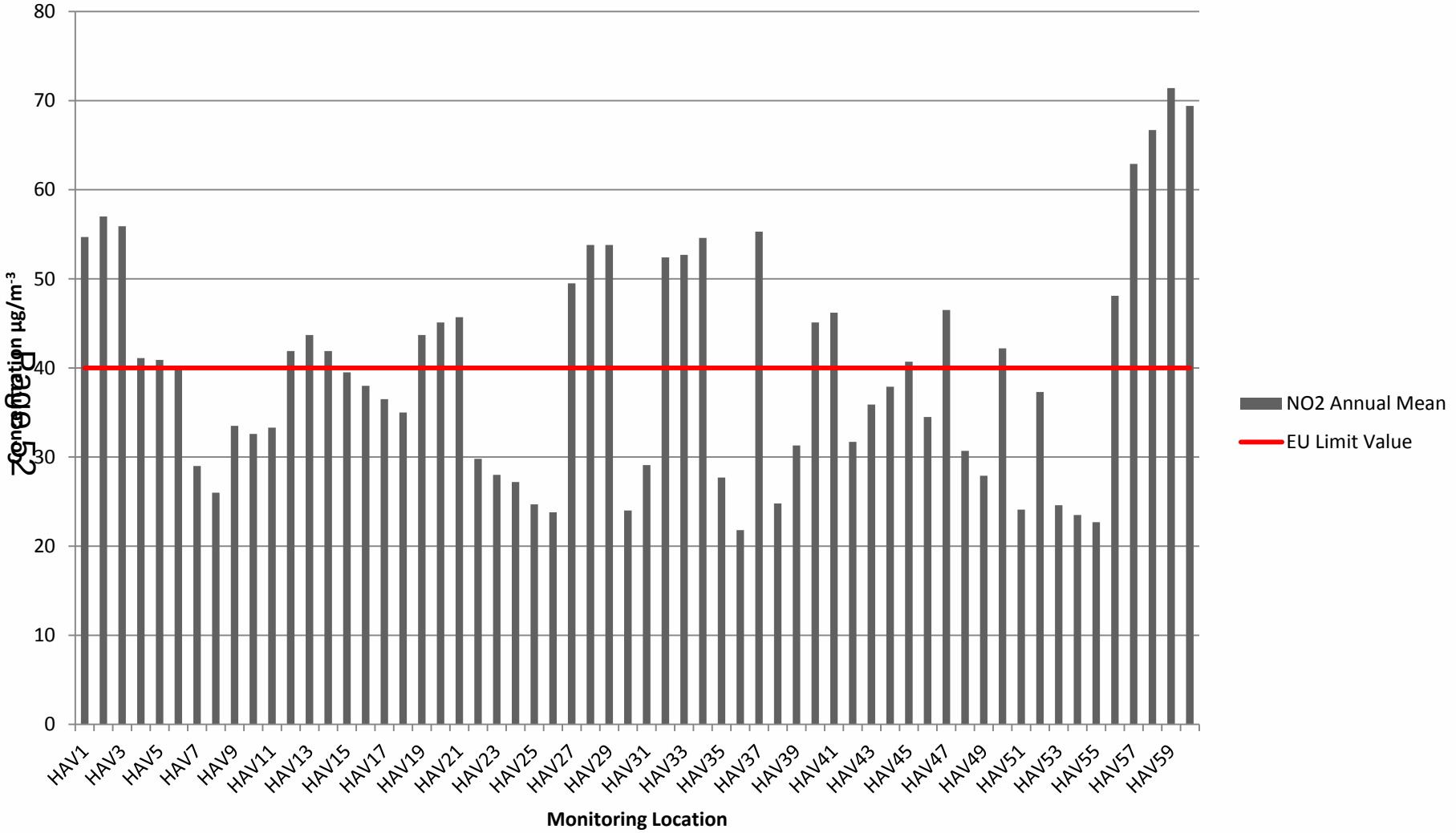




Modelled Predictions for 2020

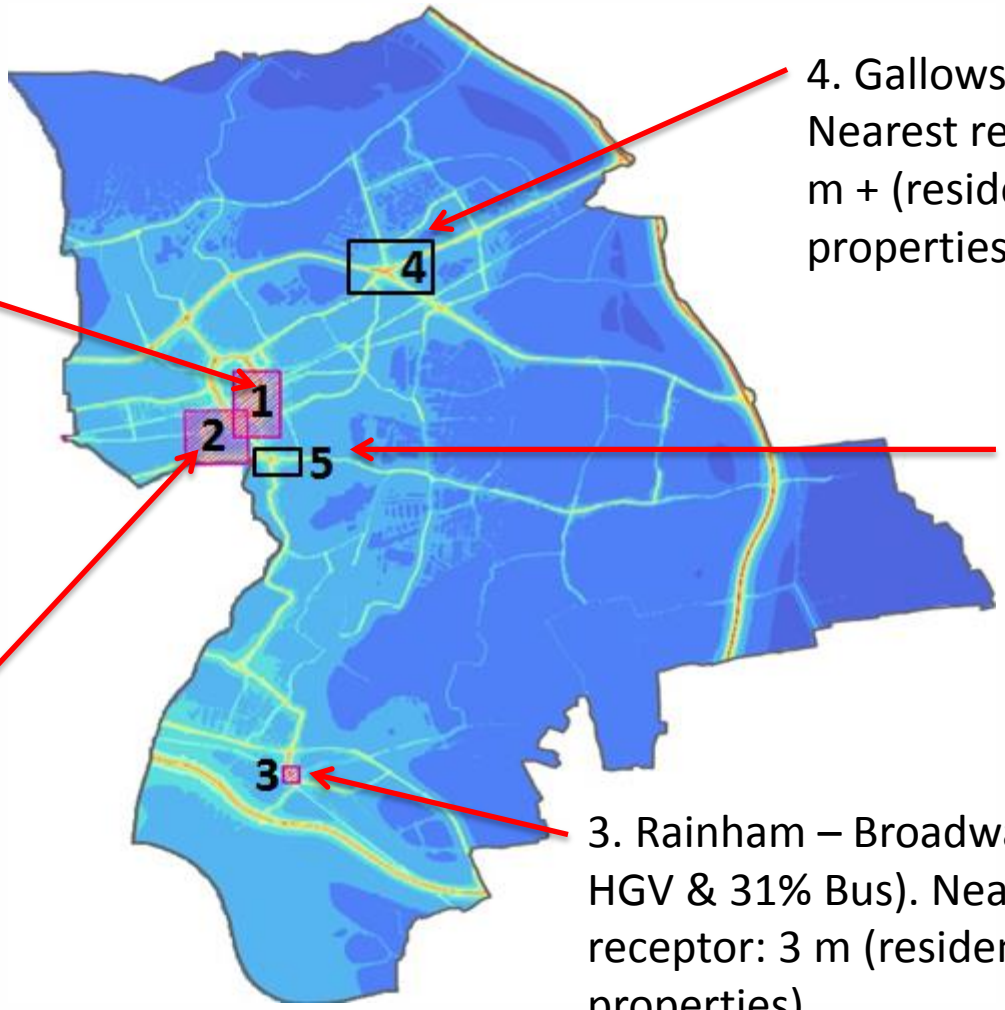


LBH Monitoring versus EU Limit Value



Local 'Hotspots' in Havering

1. Romford Town Centre – Thurloe Gardens (77% bus & 11% cars). Nearest receptor: 5 m (residential properties)



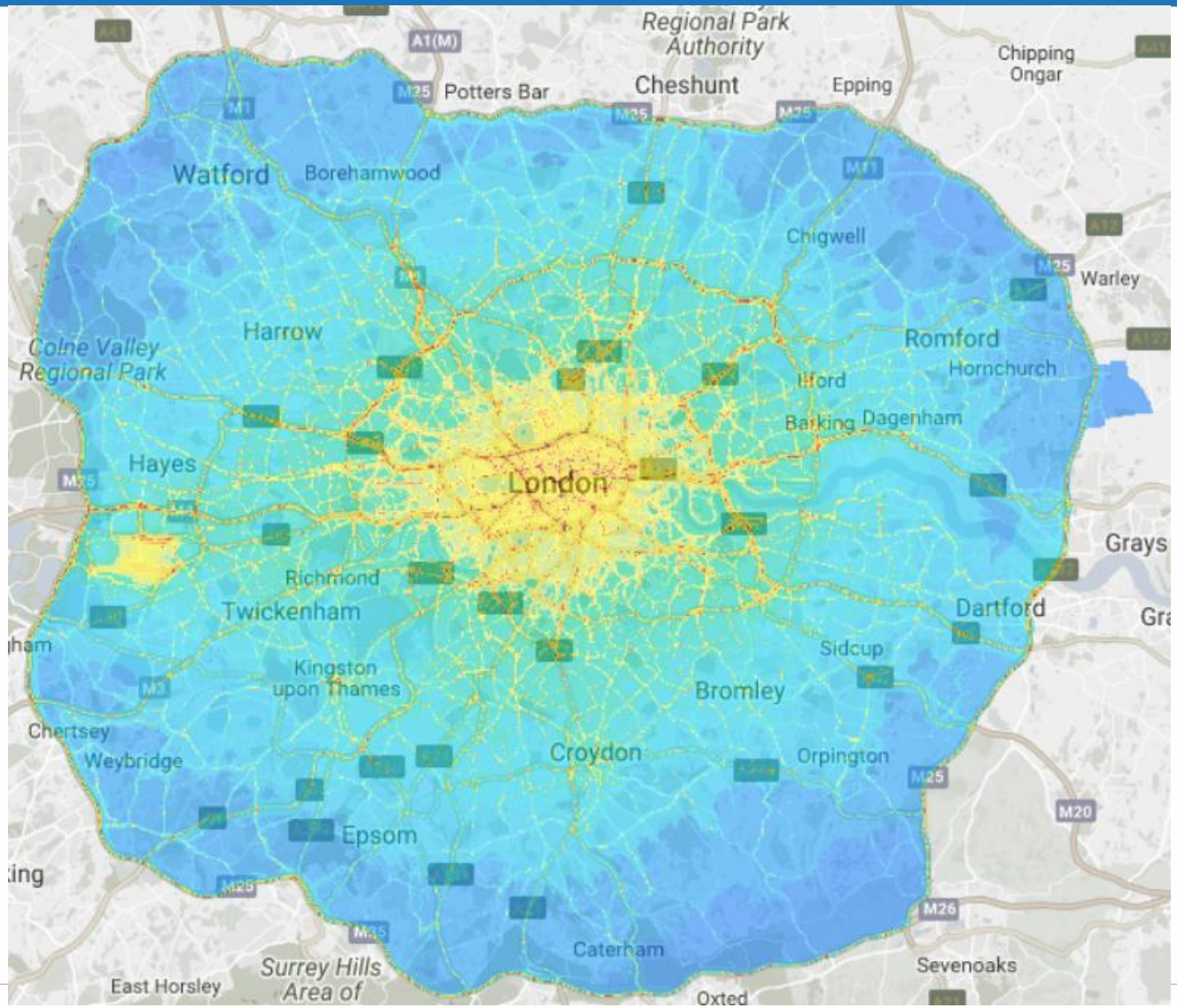
4. Gallows Corner. Nearest receptor: 20 m + (residential properties)

5. Roneo Corner. Nearest receptor: 5 m (residential properties)

2. Romford/ Rush Green A124 Rush Green Road and Rom Valley Way (36% Bus & 37% HGV). Nearest receptor: 8 m (residential properties)

3. Rainham – Broadway (41% HGV & 31% Bus). Nearest receptor: 3 m (residential properties)

Annual Mean NO_2 Concentrations in London 2013



Why is Air Pollution important to Havering?

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61.7 per 100,000 deaths from COPD
(London = 49.9; England = 52.6)

5.1% of all-cause mortality attributable to pollution
(London = 5.6%; England = 4.7%)

1 in 3 people have at least one Long Term Condition

Havering
Making a Greater London

www.havering.gov.uk

What are we currently doing?

- Public Space Protection Orders (PSPOs)
- Air Quality Monitoring Network
- Promotion of AirTEXT app http://www.airtext.info/signup
- Delivery of Air Quality initiatives in schools (Smarter Travel)
- 'Clean-up' of Havering's fleet vehicles
- Inclusion of Air Quality Projects within the Youth Travel Ambassador Scheme
- Air Quality Policies included in Local Plan
- Air Quality Awareness and Behaviour Change Campaign
  - Miles the Mole "Do your Share & Let's Clear the Air"
  - Accompanied by live performance and lesson plans

Miles the Mole Air Quality Campaign

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NATIONAL AIR QUALITY
Conference & Awards
Finalist 2017

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Miles the Mole in Primary Schools

Future Air Quality Actions?

- We need to take a variety of action across the council to improve air quality. Examples include:
  - Deliver schemes that provide options for people to travel sustainably
  - Promote walking, cycling, use of public transport and STARS accredited travel planning programme
  - Lobby TfL to invest in improved public transport in Havering, such as cross-borough transport e.g. Rainham to Romford
  - Consider energy usage and provision of sustainable transport in all growth and development projects
  - Assess the Council's own fleet vehicles and sustainable travel policies and practices
  - Monitoring & modelling to ensure we have intelligence on air quality hotspots
  - Greater cross-departmental working, e.g. with planning, regeneration, transport planning, housing & economic development

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HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 30 NOVEMBER 2017

Subject Heading:	Quarter 2 performance information
SLT Lead:	Sarah Homer, Interim Chief Operating Officer
Report Author and contact details:	Thomas Goldrick, Senior Policy and Performance Officer (x4770)
Policy context:	The report sets out Quarter 2 performance relevant to the Health Overview and Scrutiny Sub-Committee
Financial summary:	There are no direct financial implications arising from this report. However adverse performance against some performance indicators may have financial implications for the Council. All service directorates are required to achieve their performance targets within approved budgets. The Senior Leadership Team (SLT) is actively monitoring and managing resources to remain within budgets, although several service areas (including adult social care) continue to experience financial pressures from demand led services.

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

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

SUMMARY

This report supplements the presentation attached as **Appendix 1**, which sets out the Council's performance within the remit of the Health Overview and Scrutiny Sub-Committee for Quarter 2 (July 2017- Sept 2017).

RECOMMENDATIONS

That the Health Overview and Scrutiny Sub-Committee notes the contents of the report and presentation and makes any recommendations as appropriate.

REPORT DETAIL

1. The report and attached presentation provide an overview of the Council's performance against the corporate performance indicators relevant to the Health Overview and Scrutiny Sub Committee. The presentation highlights areas of strong performance and potential areas for improvement.

2. The report and presentation identify where the Council is performing well (**Green**) and not so well (**Red**). The ratings for the 2017/18 reports are as follows:

   - **Red** = off the quarterly target
   - **Green** = on or better than the quarterly target

3. Where performance is off the quarterly target and the rating is '**Red**', 'Improvements required' are included in the presentation. This highlights what action the Council will take to address poor performance.

4. Also included in the presentation are Direction of Travel (DoT) columns, which compare:

   - Short-term performance – with the previous quarter (Quarter 1 2017/18)
   - Long-term performance – with the same time the previous year (Quarter 2 2016/17)

5. A green arrow (↑) means performance is better and a red arrow (↓) means performance is worse. An amber arrow (→) means that performance has remained the same.

6. In total, three performance indicators have been included in the Quarter 2 2017/18 report and presentation. Performance data is available for two of the

three indicators. Of these, one has been given a '**green**' status, the other a '**red**' status

7. Data is not available for the indicator "The number of instances where an adult patient is ready to leave hospital for home or move to a less acute stage of care but is prevented from doing so, per 100,000 population" as we are waiting for national guidance on a new definition, which is likely also to change the local target. Commentary has been provided in the presentation on the "Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both)", which measures the average time of delays instead of the number of patients experiencing a delay.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications arising directly from this report which is for information only. However adverse performance against some performance indicators may have financial implications for the Council.

All service directorates are required to achieve their performance targets within approved budgets. The Senior Leadership Team (SLT) is actively monitoring and managing resources to remain within budgets, although several service areas continue to experience significant financial pressures in relation to a number of demand led services, such as adults' social care. SLT officers are focused upon controlling expenditure within approved directorate budgets and within the total General Fund budget through delivery of savings plans and mitigation plans to address new pressures that are arising within the year.

Further information on the financial performance of the Council has been reported as part of the Medium Term Financial Strategy (MTFS) report to Cabinet in October.

Legal implications and risks:

Whilst reporting on performance is not a statutory requirement, it is considered best practice to review the Council's progress regularly.

Human Resources implications and risks:

There are no HR implications or risks arising directly from this report.

Equalities implications and risks:

There are no equalities or social inclusion implications or risks identified at present.

BACKGROUND PAPERS

Appendix 1: Quarter 2 Health Overview and Scrutiny Performance Presentation 2017/18

Havering

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Quarter 2 Performance Report 2017/18

Health O&S Sub-Committee

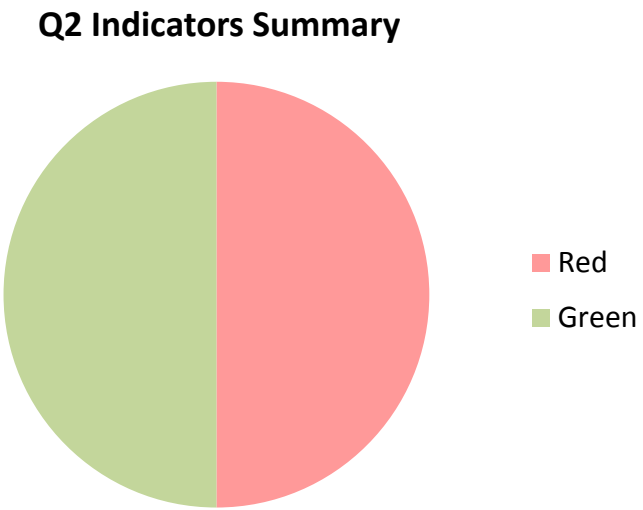
30 November 2017

About the Health O&S Committee Performance Report

- Overview of the key performance indicators as selected by the Health Overview and Scrutiny Sub-Committee
- The report identifies where the Council is performing well (**Green**) and not so well (**Red**).
- Where the RAG rating is '**Red**', '**Corrective Action**' is included. This highlights what action the Council will take to address poor performance.

OVERVIEW OF HEALTH INDICATORS

- 3 Performance Indicators are reported to the Health Overview & Scrutiny Sub-Committee.
- Performance ratings are available for 2 of the 3 indicators.



In summary of the 2 indicators:

1 (50%) has status of Green (on target)

1 (50%) has a status of Red (off target)

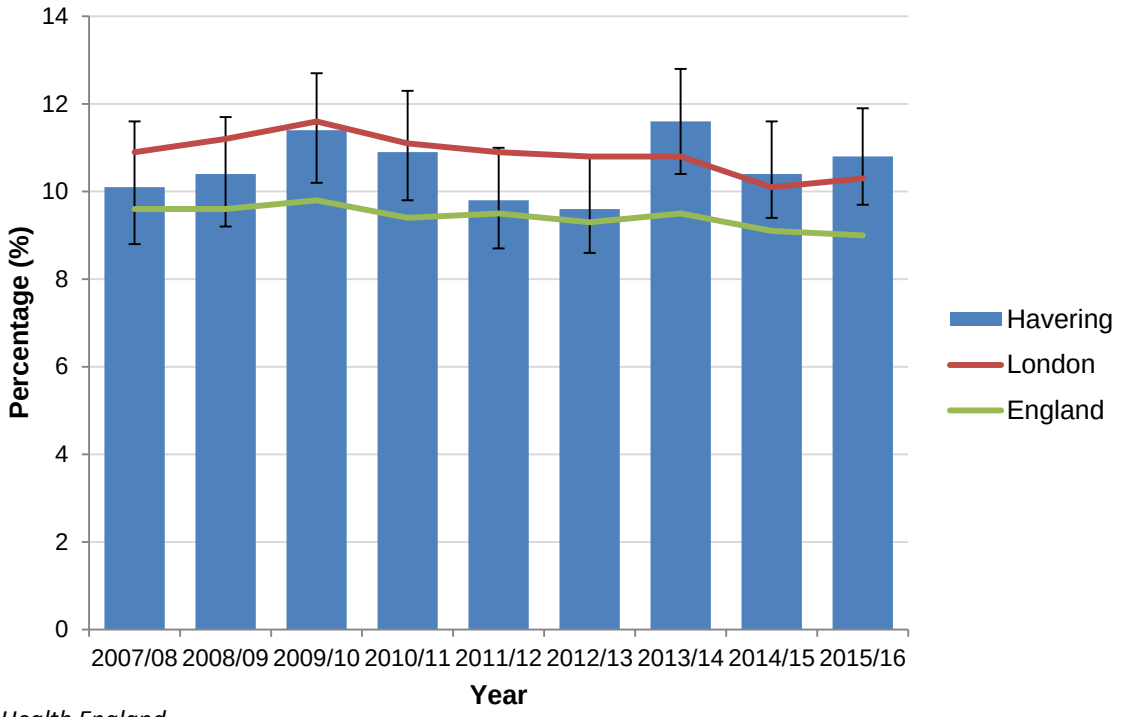
Quarter 2 Performance

Indicator and Description	Value	2017/18 Annual Target	2017/18 Q2 Target	2017/18 Q2 Performance	Short Term DOT against Q1 2017/18		Long Term DOT against Q2 2016/17		Service
Obese Children (4-5 years)	Smaller is better	Similar to or Better than England (9%)	N/A	10.8% (2015/16) RED	-	N/A	↓	10.4% (2014/15)	**Public Health**
Percentage of patients who are satisfied with the GP out of hours services (Partnership PI)	Bigger is better	Better than England (66%) (TBC by Havering CCG)	N/A	67% (2017) GREEN	-	N/A	↓	68% (2016)	**Havering CCG**
The number of instances where an adult patient is ready to leave hospital for home or move to a less acute stage of care but is prevented from doing so, per 100,000 population (delayed transfers of care)	Smaller is better	TBC	TBC	N/A	-	N/A	-	N/A	**Adult Social Care**

About Childhood Obesity

- Prevalence of obesity amongst 4-5 year olds in Havering has seen no significant change over the past 8 years.
- In 2015/16 Havering remained significantly worse than England but similar to London

Percentage of Obese Children, Havering, London & England, 2007/08 – 2015/16



Source: Public Health England

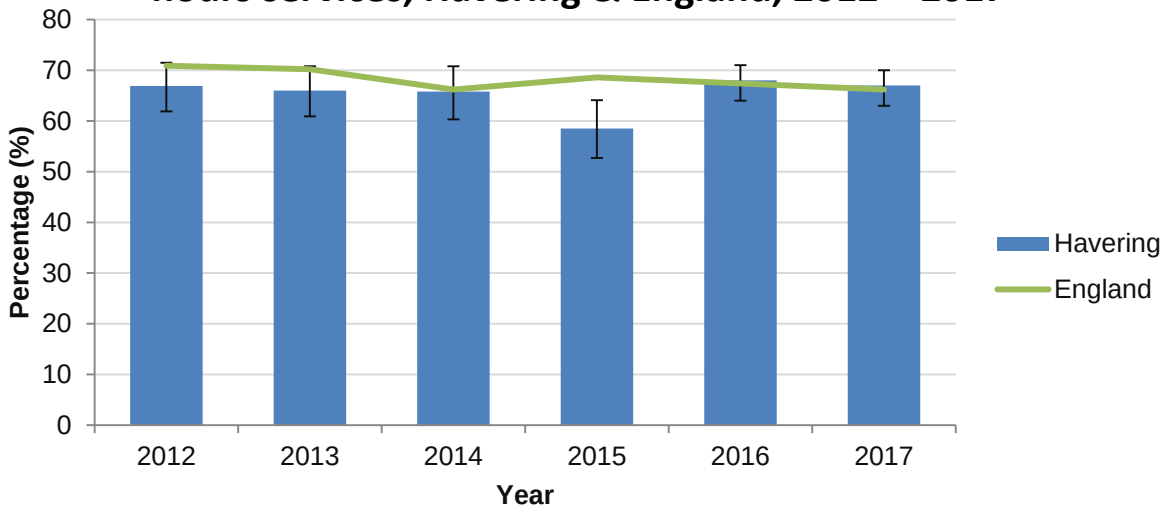
Improvements Required: Childhood Obesity

- Directed by Havering's 'Prevention of Obesity Strategy 2016-19', our borough working group continues to progress actions that are within the gift of the local authority and partners, and within available budgets.
- These actions include:
  - Increasing support for breastfeeding via infant feeding cafés in children's centres and launching a Breastfeeding Welcome scheme for local venues and businesses to sign up to.
  - Health Visitors and Early Help Practitioners developing a 'Starting Solid Foods' workshop to co-deliver in Children's Centres.
  - Increasing promotion of Healthy Start vouchers for free fruit, vegetables and milk to low-income families, and working with local businesses to increase acceptance of these.
  - The Health and Wellbeing in Schools Service, Havering Catering Services, Havering Sports Collective and School Nursing Service working together to streamline and develop the healthy eating and physical activity support they offer to children and families via schools.
  - Developing a Sugar Smart campaign, encouraging public venues and local businesses to make pledges to reduce promotion, sales and, ultimately, consumption of sugar.
- The group meets quarterly and at the next meeting will be reviewing progress of actions over the past year, and commencing work on refreshing the action plan for 2018/19.
- Obesity is a complex issue and many of the influences on it fall outside of local authority control.
- Work continues at national level, guided by the national 'Childhood Obesity: A Plan for Action' and we continue to link with national campaigns and programmes where appropriate.

About Patient Experience of GP Out-of-Hours Services

- The latest available data (July 2017*) shows no significant difference between the percentage of patients who are satisfied with the service in Havering (67%) and the England average (66%).
- Overall, a similar trend has been observed over the last 6 years except for 2015 when the Havering rate (59%) was significantly lower than the England average (69%).
- Havering CCG is responsible for this performance indicator.

The percentage of patients who are satisfied with the GP out of hours services, Havering & England, 2012 – 2017



Source: NHS Digital & GP Patient Survey Database

*Refers to the July 2017 GP survey publication (January to March 2017 surveys). The average figures for 2017 may change when the second wave of surveys are completed and data included in calculations.

About Delayed Transfer of Care

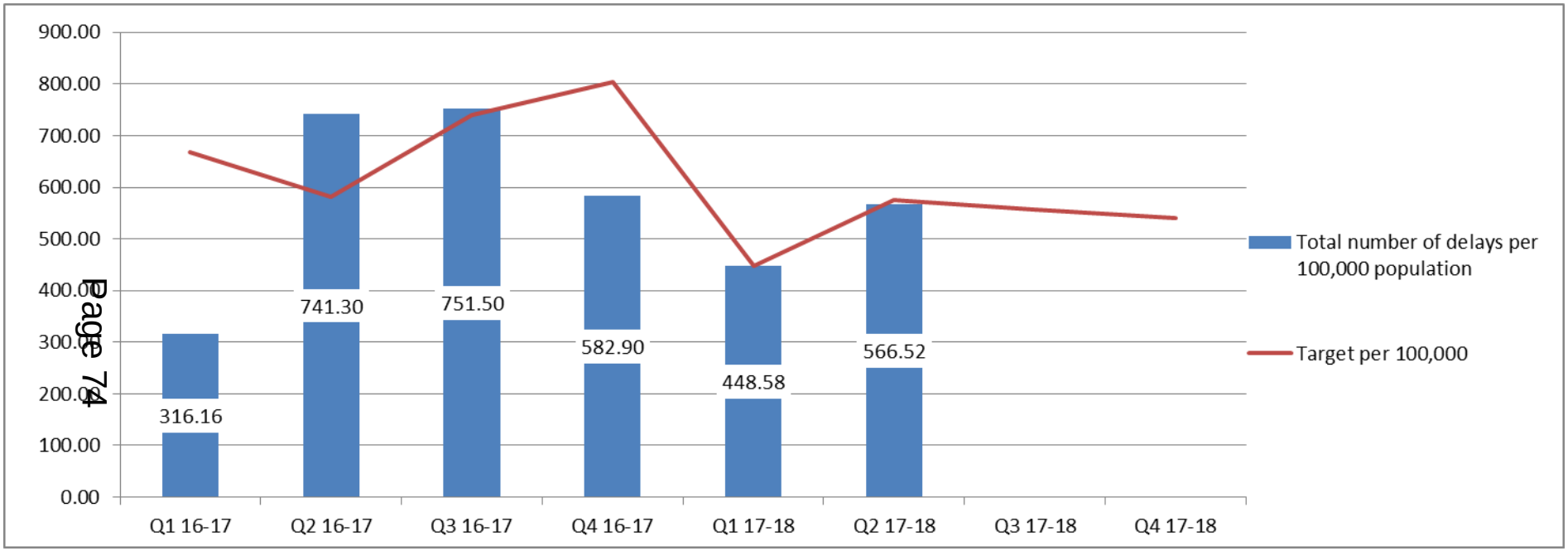
- Measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from hospital of adults. It is therefore an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

- We are currently awaiting national guidance on the new definition of this Delayed Transfer of Care (DTOC) measure

- As part of the Better Care Fund, the total number of days delayed per month in a hospital setting is being monitored. Delays being transferred to a less acute stage of care reduces the Hospital's ability to treat other patients as well as potentially affecting the patient's health (for example, increasing the risk of infection, increasing the risk of muscle strength loss for older patients).

- The graph on the next slide shows the total number of days delayed per 100,000 population (attributable to either NHS, Social Care or both) per quarter for Havering.

Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per quarter



- Performance for Q2 17/18 is better than the same period last year (where smaller is better) and is better than target, however is worse than last quarter.

Any questions?

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