TOWER HAMLETS

**Meeting of the**

# HEALTH SCRUTINY PANEL

---

**Tuesday, 27 July 2010 at 6.30 p.m.**

---

**A G E N D A**

---

**VENUE**
**Ground Floor Meeting Room of Burdett House, Mile End Hospital.**
**Bancroft Road London E1 4DG**

| **Members:** | **Deputies (if any):** |
|---|---|
| **Chair: Councillor Tim Archer**<br>**Vice-Chair: Councillor Rania Khan** | |
| **Councillor Shelina Aktar**<br>**Councillor Abdul Asad**<br>**Councillor Alibor Choudhury**<br>**Councillor Lutfur Rahman**<br>**Councillor Kosru Uddin** | Councillor Dr. Emma Jones, (Designated Deputy representing Councillor Tim Archer)<br>Councillor Mohammed Abdul Mukit MBE, (Designated Deputy representing Councillors Shelina Akhtar, Abdul Asad, Alibor Choudhury, Rania Khan, Lutfur Rahman and Kosru Uddin) |
| **[Note: The quorum for this body is 3 Members].** | |

| **Co-opted Members:** | | |
|---|---|---|
| Myra Garrett | – | (THINk) |
| Dr Amjad Rahi | – | (THINk) |

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Zoe Folley, Democratic Services,
Tel: 020 7364 4877, E-mail: zoe.folley@towerhamlets.gov.uk

# LONDON BOROUGH OF TOWER HAMLETS

# HEALTH SCRUTINY PANEL

## Tuesday, 27 July 2010

## 6.30 p.m.

## BURDETT HOUSE, MILE END HOSPITAL, SITE MAP AND TRAVEL DIRECTIONS

A site map and travel directions to the venue is attached.

**Please follow signs to the Blue Zone from the main entrance until you reach Burdett House and then follow signs to the Ground Floor meeting room.**

**If you have any difficulties please call Scrutiny Policy Officer: Katie McDonald 07914 850073.**

## 1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

## 2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

| | | PAGE NUMBER | WARD(S) AFFECTED |
|---|---|---|---|
| **3.** | **UNRESTRICTED MINUTES** | **7 - 12** | |

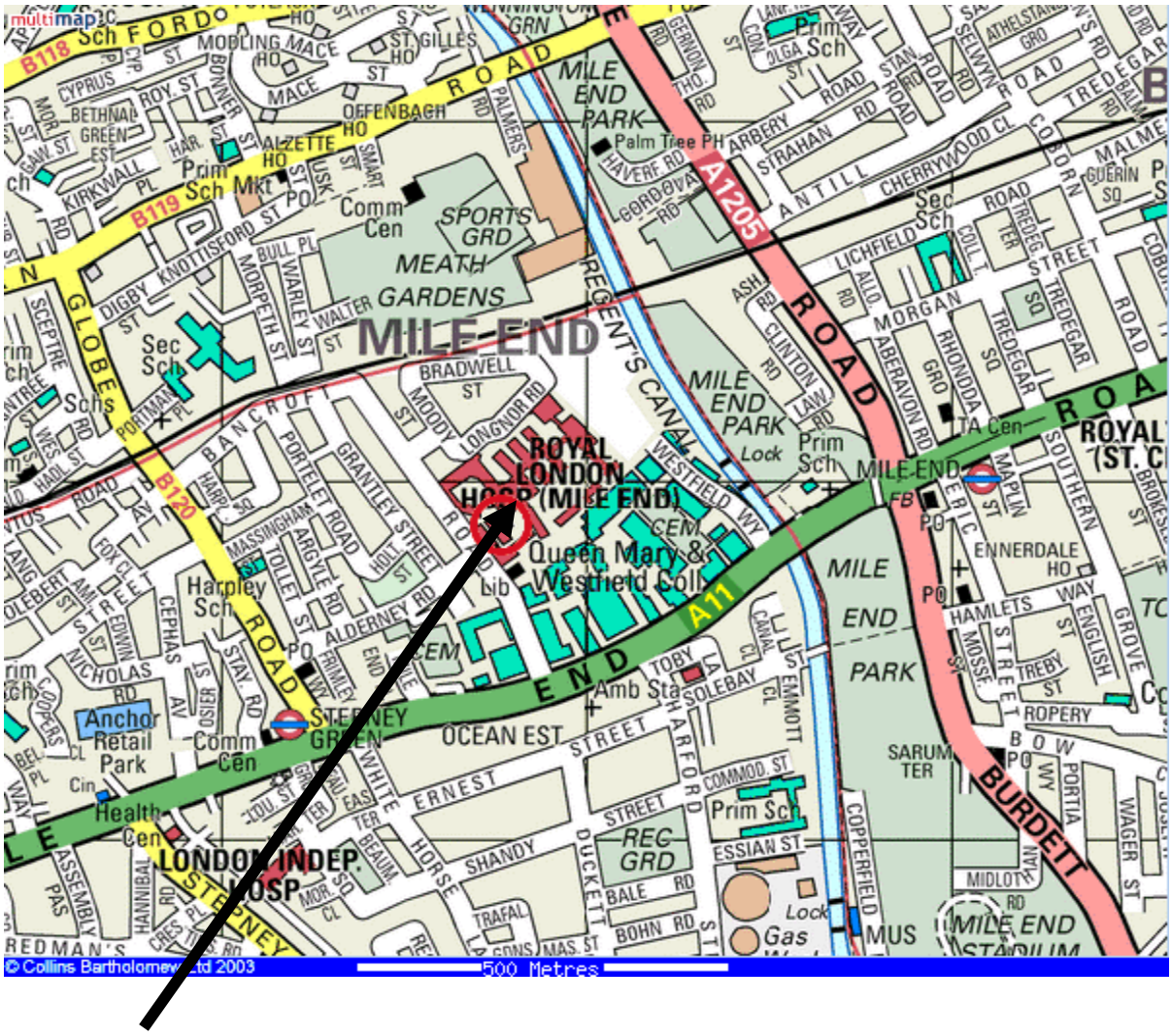
To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 22nd July 2010.

## 4. REPORTS FOR CONSIDERATION

| | | |
|---|---|---|
| **5.1** | **NHS White Paper** | |
| **5.2** | **Six Lives Panel Project - NHS London Health Self-Assessment** | **13 - 20** |
| **5.3** | **Health Scrutiny Evaluation - Summary and Action Plan** | **21 - 34** |
| **5.4** | **Health Scrutiny Panel Work Programme 2010/11 - 2011- 2012** | **35 - 44** |
| **5.5** | **Health for North East London - Response to INEL JOSC recommendations** | **45 - 84** |

## 6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

This page is intentionally left blank




Tower Hamlets PCT is located at Mile End Hospital, Bancroft Road, London E1 4DG, and is between Mile End and Stepney Green Underground Station. The route from each station is as follows:

**Train**

**Mile End** station is served by District, Hammersmith & Central Line - Exit station turn left proceed along Mile End Road and take the 3rd turning on your right. (Approx 10 mins walk) situated behind Queen Mary University

**Stepney Green** is served by District, and Hammersmith Line – Exit station turn left proceed down Mile End Road, and take the 2nd turning on your left. (Approx 5 mins walk or less)

**Bus**

Served by the 25 bus route

This page is intentionally left blank

# HOW TO FIND MILE END HOSPITAL

**Our Address**

Mile End Hospital
Bancroft Road
Ground Floor Burdett House
London
E1 4DG

**By Road**
Mile End Hospital's main entrance is situated in Bancroft Road.
You may turn into Bancroft Road from the Mile End Road only when approaching from the west. There is no entry to Bancroft Road when approaching from the other direction - ie no right turn - use Globe Road and Alderney Road instead.

**Car Parking**
Parking is limited. There are only four pay and display parking bays on the Mile End site. On site parking costs of 80p per 30 minutes. The meters accept 5p, 10p, 20p, 50p, £1 and £2 coins and no change is given.

People who are either attending an clinic appointment or delivering/collecting equipment at the Wheelchair Service , can park for a short while in the Departments specially designated parking bays. These are located immediately in-front of the Wheelchair Service.

There are pay and display meters in surrounding streets but the majority of spaces are for resident permit holders only.

**By Bus**
Mile End Road - No 25
Globe Road - No 309
Grove Road - Nos 277 and D6
Roman Road - Nos 8 and D6
Terminating at Mile End Station - Nos D5 and D7

**By Underground**
Mile End Station - District, Central and Hammersmith & City Lines
Stepney Green - District Line and Hammersmith & City Line

**Disabled Access**
There are 12 parking spaces for disabled badge holders within the hospital site and also outside the therapy unit centre in Longnor Road at no charge.
The main entrance is suitable for wheelchair users. There is lift access to all floors in the main hospital block.

This page is intentionally left blank

# DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

## Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

**What constitutes a prejudicial interest?** - Please refer to paragraph 6 of the adopted Code of Conduct.

**Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-**

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

**LONDON BOROUGH OF TOWER HAMLETS**

**MINUTES OF THE HEALTH SCRUTINY PANEL**

**HELD AT 7.30 P.M. ON TUESDAY, 22 JUNE 2010**

**ROOM M72, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG**

**Members Present:**

Councillor Tim Archer (Chair)

Councillor Shelina Akhtar
Councillor Abdul Asad
Councillor Alibor Choudhury
Councillor Kosru Uddin
Myra Garrett
Dr Amjad Rahi

**Other Councillors Present:**

**Co-opted Members Present:**

| | | |
|---|---|---|
| Myra Garrett | – | (THINk representative) |
| Dr Amjad Rahi | – | (THINk representative) |

**Guests Present:**

| | | |
|---|---|---|
| Dianne Barham | – | Director, THINk |

**Officers Present:**

| | | |
|---|---|---|
| Deborah Cohen | – | (Service Head, Commissioning and Strategy, Adults Health and Wellbeing) |
| Katie McDonald | – | Scrutiny Policy Officer |
| Rachael Chapman | – | (Strategy & Policy Officer) |
| Hafsha Ali | – | (Acting Joint Service Head Scrutiny & Equalities) |
| | – | |

## 1. ELECTION OF VICE-CHAIR

The Chair moved and Councillor Abdul Asad seconded Councillor Rania Khan as Vice-Chair.

The Committee unanimously **RESOLVED** that Councillor Rania Khan be elected Vice-Chair of the Health Scrutiny Panel.

**2. APOLOGIES FOR ABSENCE**

Apologies for lateness were received from Myra Garrett.
Ben Vinter (Head of Corporate Affairs NHS Tower Hamlets)
Paul James (Borough Director, East London Foundation Trust)

**3. DECLARATIONS OF INTEREST**

No declarations of interest were made.

**4. UNRESTRICTED MINUTES**

The minutes of the meeting of the Panel held on 23rd March 2010 were agreed as a correct record.

**5. REPORTS FOR CONSIDERATION**

**6. HEALTH SCRUTINY PANEL TERMS OF REFERENCE, QUORUM, MEMBERSHIP AND DATES OF MEETINGS (HSP001/011)**

The Committee noted its Terms of Reference, Quorum, Membership and Dates of future meetings as set out in the report.

**7. MEMBERS INDUCTION**

Improving Health & Wellbeing in Tower Hamlets

Members heard a presentation given by Dr Ian Basnett, the Director of Public Health for Tower Hamlets, which included a snapshot of the population of Tower Hamlets, together with determinants of the healthiness of residents. From this data and examination of higher than national average incidences of illnesses suffered by local people, strategies have been created to reduce these events.

Sucessful work includes investment in Primary Care, providing networking between GP practices and social services, specialist GP practices with expertise in an area, such as anti-coagulation, 'care packages' for the treatment of diabetes and other illnesses.

Councillor Alibor Choudhury asked what work was done on relieving chronic non-life threatening conditions. Dr Basnett said that care was based on the Joint Strategic Needs Assessment.

Councillor Abdul Asad asked if ethnicity was recorded with the mortality figures. Dr Basnett responded that monitoring was not routine, but deaths were linked to GP registers. From preliminary data mortality rates were higher in the white population than in the Bangladeshi population.

Councillor Kosru Uddin asked what parts of the Borough had the highest mortality rates. Dr Basnett responded that there was a correlation with levels of deprivation, but no specific data about service provision.

Dr Amjad Rahi asked if there were graphs showing incidences of diabetes in each Local Areal Partnership.

Tower Hamlets Involvement Network (THINk)

Members heard a presentation from Ms Dianne Barham, Director of THINk; THINk was a network of patients, residents, user & community groups working together to improve health & social care in Tower Hamlets. Ms Barham explained that THINk actively solicited views of residents and users of services, then analysed the data before conveying people's views to commissioners, providers and scrutineers of local health and social care services. Recent successes included agreeing timescales for responses from organisations, resolving issues such as involuntary removal of patients from GPs lists, inadequate facilities for disabled patients at the Royal London Hospital, retrieval of ordered glasses from a closed down optician's shop and the continuation of funding for a Mental Health Support Officer at the Carers' Centre. Both the current Health Scrutiny Panel Co-Opted members were also members of THINk.

The Chair asked how residents interacted with THINk; Ms Barham responded that people completed questionnaires, surveys, dropped into the office, spoke to outreach staff at community events etc. THINk saw itself as a critical friend, and tried to resolve issues with commissioners initially, then would bring the issue to Health Scrutiny Panel, the Care Quality Commission and finally the Secretary of State.

Councillor Alibor Choudhury asked Ms Barham to name one big achievement; Ms Barham responded that the level of comment from the community was inspiring, and the agreement of laid down timescales for responses to data from commissioners of services was also an achievement.

Ms Deborah Cohen (Service Head, Disability & Health) said that THINk was embedded in quality control, and that was not always comfortable for providers.

Dr Basnett said that input from THINk was welcome, and had been a help in formulating the Joint Strategy.

Councillor Asad asked how many people had been removed from GPs' lists, Ms Barham responded that THINk had worked with Social Action for Health; overall there had been 600+ comments on the issue.

The Chair said that Ms Garrett had brought the issue to the attention of the Health Scrutiny Panel, and the Primary Care Trust (PCT) had been asked to attend the Health Scrutiny Panel to explain what had happened. The PCT was able to put those people back on lists who wanted to return to their old GPs.

Councillor Aktar asked if interviews were one to ones; Ms Barham said that some interviews were long, however information was sought from members

everyday. The Secretary of State had indicated that 'LINks' organisations would be retained, possibly funded through a national body. This would be part of a trend towards empowering local residents.

Ms Garret asked if the Council had a shopfront premises that THINk could use; the lease on its current accommodation was running out.

Health & Social Care

Ms Deborah Cohen and Ms Rachel Chapman described the changes in provision by local authorities, emphasising that a range of Council run services contribute to the work of the teams, such as housing. Local authorities are providing less and commissioning more, with larger budgets. It should be noted that there is a high incidence of learning disabilities in Tower Hamlets.

In response to Councillor Choudhury's question on the debate about care in the community, whether this is needs led or resource led, and what impact would Government cuts have, Ms Cohen said that adult & social care was being transformed, and moving towards a more preventative service. Cuts to preventative services would mean higher costs for longer periods in the future.

In response to Ms Garnett's question about when free swimming for older people would stop (a change announced in the Budget), investigations would be made.

In response to the Chair's question about the personalisation of care, and care packages, users are offered the facility of creating their own packages: hence a season ticket to a leisure centre may be an alternative to a day centre. It should be noted that there is a strict audit trail.

The Scrutiny Workplan for 2010/2011

Members divided into two workshops, considering the Long list of Review Topics for 2010/2011. Outcomes of their discussions are listed below:-

Group 1

I. *Mental Health*: Members felt work needed to be done on GP diagnosis, links with social services and more cooperation between mental health services and local authorities.
II. *A whole system review of the three - Trusts serving Tower Hamlets.* Ms Garrett asked what the implications for the forced amalgamation of the Trust would be.
III. *The reconfiguring of local services* for example, the introduction of polyclinics and public information. Ms Garrett said that if patients could see a consultant in hospital, or someone equally qualified in a GP surgery, they would need persuading that the level of treatment would be the same. The Chair said that he was not sure that people

understood the polysystems issue; Members would find themselves explaining to residents.

Group 2

I. *Focus on Mental Health:* particularly dementia – diagnosis and preventative work
II. *Diagnosis in general*
III. *Safeguarding elders from abuse*
IV. *Depression* – there were equality issues for black & ethnic minority women, and need for support for their families.

Further topics suggested included: polysystems (later in the year), cancer diagnosis, dementia diagnosis and structural changes in the Primary Care Trusts.

The Chair said that during the last municipal year, the Panel had conducted a comprehensive review on Childhood Obesity which had been well received and the final recommendations would be going to Cabinet later in the year.

The two groups had highlighted a number of good subjects; and health services were facing changes imposed by the new Government. It may be that the Panel would want some space capacity to examine these at a later date. Therfore the chair suggested that it might be more sensible to conduct two challenge sessions earlier in the year with the possibility that one of these could lead to a longer review in 2011.

In response to Councillor Choudhury, the Chair said that the Panel would meet formally 5 times a year, based on the Council calendar.

Members were asked to forward their comments to Ms McDonald.
The July meeting of the Panel would see the 'Six Lives' Department of Health presentation, and the external evaluation would also come to the meeting.

**8. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**

There was no urgent business.

The meeting ended at 8.45 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **27 July 2010** | **Unrestricted** | | **2** |

| Report of: | Title: |
|---|---|
| **Six Lives Project**<br><br>**NHS Tower Hamlets**<br>**London Borough of Tower Hamlets**<br><br>**Presenting Officer:**<br><br>Jane McClean Associate Director Commissioning (Long Term Conditions) for NHS Tower Hamlets.<br><br>Chair of the Health Sub Group of the Learning Disabilities Partnership Board. | **Six Lives Panel Project**<br>**NHS London health self-assessment**<br><br>**Ward(s) affected:**<br><br>All |

## 1. Summary

This briefing sets out the background to both the Six Lives Panel Project and the subsequent NHS London health self-assessment for learning disabilities.

## 2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the proposals set out in the report and DVD presentation.

This page is intentionally left blank

**Six Lives Panel Project / NHS London health self-assessment**
**Report for the Health Scrutiny Panel**

## 1. Introduction

This briefing sets out the background to both the Six Lives Panel Project and the subsequent NHS London health self-assessment for learning disabilities.

## 2. Death by Indifference

In March 2007 Mencap published a report entitled *Death by Indifference* which examined the cases of six individuals who died whilst receiving NHS care. Whilst the families of the six individuals had lodged formal complaints to the Healthcare Commission, Mencap called on the government to launch an independent investigation into all six deaths and address their claim that there is institutionalised discrimination against people with learning disabilities within the NHS.

## 3. The Six Lives Report

In July 2008 the Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities (also known as the Six Lives Report) was published following the independent inquiry chaired by Sir Jonathan Michael. The Inquiry concluded that people with learning disabilities were less likely to receive the most effective care to meet their needs, and whilst there were examples of good practice in some areas, this was not mainstreamed. In short, there was often a gap between policy, the law and the delivery of effective health services.

In response to the publication of the Six Lives report, the Ombudsmen made three recommendations in March 2009. Of most relevance for NHS and Local Authorities was that all NHS and social care organisations in England should urgently review:

- The effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas, and;

- The capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities; and:

- Should report accordingly to those responsible for the governance of those organisations within 12 months of the publication of the Ombudsmen's report.

## 4. The Six Lives Panel

In order to respond to the Ombudsmen's recommendations it was proposed that Tower Hamlets hold a Six Lives Panel meeting in order to fulfill our obligations. The Panel were made up of a variety of professionals from across

the NHS / social care sector (primary care, acute care and commissioning), along with an independent Chair, David Morris. (David was selected due to his considerable experience of the disability rights movement and links to the borough. He was involved with the process from its inception, until he sadly passed away in April 2010).

The Learning Disabilities Partnership Board took a lead on the Panel Project with a view to it being a starting point for establishing a Health sub-group. One of the key outcomes of the Panel was to draw up an action plan. This would then form the basis of the Health sub-group's work programme and they would be responsible for taking this work forward.

Also key was the involvement of service users and carers. To this end a number of workshop sessions were held prior to the Panel to ask people about their experiences of accessing healthcare services. The Rix Centre, a learning disability multi-media advocacy organisation, ran and facilitated these sessions in conjunction with three service user 'champions'. These individuals were trained in consultation techniques and the use of camera / recording equipment. This approach allowed those who may not have felt comfortable attending the Panel meeting to give their views.

The Panel took place in November 2009. Service users and carers were in attendance to ask questions and recount their experiences, and the Panel were also shown a DVD of the workshop sessions run by the Rix Centre and the champions. The Panel meeting itself was also filmed and the footage subsequently edited with that of the workshops to produce the *My Health My Say My Way: Communicating effectively with people with learning disabilities* DVD.

Following the meeting it was intended that members of the Panel would report back to their organisations and reconvene in early 2010 to report progress and agree an action plan to take forward.

**5. The NHS London health self-assessment process**

NHS London was responsible for co-ordinating a Health Self Assessment of services for people with learning disabilities across all London PCTs, to meet the Ombudsmen's recommendations.

Each PCT was asked to convene a Big Health Check Up Day where people with learning disabilities, their family members and professionals were to be involved and have their say, by March 2010. Given the similarities between this and the Six Lives Panel, the decision was taken to combine the two processes and for the reconvened meeting of the Panel to be the Big Health Check Up Day for Tower Hamlets.

As part of the self-assessment process, staff from within the Council and NHS Tower Hamlets undertook a joint exercise to gather data and evidence to inform our assessment of access to healthcare services for people with learning disabilities in the borough. As a requirement preparatory work was undertaken in the form of 'Getting Ready Meetings' which involved talking to

service users, carers, providers and the Learning Disabilities Partnership Board about how they rate services. All of this information and views were considered as part of our submission.

The Six Lives Panel Big Health Check Up day was held in February 2010. This involved members of the original Panel along with service users and carers meeting to discuss the issues in detail and vote on what they felt was an appropriate RAG rating for our self-assessment submission. This interactive day was again filmed by the Rix Centre and involved around seventy service users from a range of backgrounds talking frankly about their experiences of a range of health related issues, from healthy lifestyles to hospital admissions.

## 6. Key headlines from the self-assessment

The PCT and LBTH had already agreed to complete a Joint Strategic Needs Assessment for Learning Disabilities (this was completed in April 2010). The NHS London Self Assessment process for Tower Hamlets was completed on the 28th May 2010. Tower Hamlets received an overall AMBER rating for its self-assessment.

A Health Sub Group of the Learning Disabilities Partnership Board has been established to develop an action plan to tackle areas highlighted in the self-assessment exercise, the Six Lives Panel and the Joint Strategic Needs Assessment.

## 7. Health Scrutiny Panel input

The Health Scrutiny Panel are asked to review the self-assessment results attached at appendix A and agree the action plan of the newly established Learning Disabilities Partnership Board Health Sub Group.

**Appendix A**

**Results from the Self-Assessment for Tower Hamlets**

**Feedback from NHS London**

- The Big Health Check Day was a great success with good representation from service users and carers and also of staff from varied health and social care backgrounds.
- NHS London wish to use NHS Tower Hamlets as a gold standard example for reporting returns for next year and also to use our DVD on the Big Health Check event.
- Reports and evidence to support the self assessment were supplied in a very thorough, structured and systematised way, which made it easier to review and analyse. It was evident that a lot of hard work went into completing the exercise.
- From the evidence supplied there is a sense that services within Tower Hamlets are working well together. It was reported that 94 % of GP's are signed up to the local enhanced service, good work is going on with the acute and mental health sectors and the dementia strategy includes the needs of people with learning disabilities.

**Identified Priorities for 2010-2011**

*Target 1 – Plans are in place to meet the needs of people who are no longer receiving treatment which requires in-patient care in an acute/long-stay residential facility or hospital*

- There are no people from Tower Hamlets living in long stay hospitals and no one is living in NHS campus accommodation. Three people are reported to be in mental health units for assessment and treatment under restricted sections of the Mental Health Act.
- It will remain important to review people in Assessment and Treatment beds and to have Person-Centred Discharge Plans to reduce the potential for delayed transfers of care and to minimise the potential for resources remaining tied up in beds, rather than being used imaginatively to prevent admissions.

*Target 2 – PCT's are working closely with the local Partnership Board and statutory and other partners, to address the health inequalities faced by people with learning disabilities.*

- To improve the information available in Primary Care regarding the particular health needs of people with learning disabilities and their family carers, through the use of existing data collection processes.
- To increase the numbers of people who have a Health Action Plan and to link this explicitly to the Annual Health Check.
- To produce accessible information on available health services, as well as information which informs people of their rights and mechanisms through which they can give feedback to organisations about their experiences using services.

- To improve the range and accessibility of health promotion and education opportunities for people with learning disabilities and their carers.

*Target 3 – People with learning disabilities who are in services that the NHS commissions or provides, are safe.*

- To improve access to acute hospitals through working with colleagues across organisations and teams to review the progress of current initiatives, and then identify actions which will move this target forward.
- To conduct an audit of acute trusts on issues of treatment and significant care decisions for patients who have learning disabilities and to assess staff knowledge and skills in this area (to be completed by March 2011)
- To pro-actively utilise PALS and PPI to seek feedback from service users and their carers, and for this to be included in annual complaint and compliment reporting. In this way, organisations will also be able to demonstrate 'reasonable adjustment' of existing Complaints Processes.

*Target 4 – progress is being made in the health service reforms and development described in 'Valuing People Now'*

- To work with the Learning Disabilities Partnership Board to develop strategies which will improve the care of people with a range of conditions, including Challenging Needs, Mental Health and Autistic Spectrum Disorder, as well as to improve the experiences of young people in Transition to Adult Services.

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **27th July 2010** | **Unrestricted** | | |

| Report of: | Title: |
|---|---|
| **Originating Officer(s):**<br><br>Katie McDonald<br>Scrutiny Policy Officer | *Health Scrutiny Evaluation – Summary and Action Plan*<br><br>**Ward(s) affected: All** |

## 1. Summary

1.1 This report submits the Summary and Action Plan in response to the Health Scrutiny Evaluation conducted in January and February 2010. The Final Evaluation Report was considered by the Health Scrutiny Panel in March 2010.

## 2. Recommendations

2.1 The Health Scrutiny Panel is asked to consider and comment on the Action Plan.

---

**LOCAL GOVERNMENT ACT, 1972 (AS AMENDED) SECTION 100D**

***LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT***

| Background paper | Name and telephone number of and address where open to inspection |
|---|---|
| | **Katie McDonald**<br>**Ext 0941** |

## 3. Background

3.1 As the Health Scrutiny Panel's four- year work programme approached its end. It was agreed in October 2009 that it would be beneficial for an external evaluation.

LB Tower Hamlets commissioned Tim Young, a scrutiny advisor, to carry out the evaluation and submit a report in February 2010.

3.2 The review is based on the Centre for Public Scrutiny's principles of good scrutiny and the evaluation tested views from across the authority and its partners on the effectiveness of the four-year programme. The bulk of the work involved in this evaluation took place in January and early February 2010. The approach was based on a review of extensive documentation from the Council and all health partners; a range of interviews with Members, council officers and health partner's personnel as well as an observation of the Health Scrutiny Panel meeting on 26th January 2010.

3.3 It was an important piece of work identifying both strengths and weaknesses as well as providing recommendations for improvements to the HSP as we look to the 2010/2011 programme.

3.4 The Summary and Action Plan were produced in response to this report and It is important that they are formally discussed and agreed by the Members of the Health Scrutiny Panel. The Summary with the Action Plan is attached at Appendix A.

## 4. Concurrent Report of the Assistant Chief Executive (Legal)

4.1 The Health and Social Care Act 2001, added to the duties of Overview and Scrutiny Committees to set up Health Scrutiny Panels to review and scrutinise matters relating to the health service in the authority's area and to make reports and recommendations on such matters in accordance with the relevant regulations.

## 5. Comments of the Chief Financial Officer

5.1 This report provides the Summary and Action Plan in response to the Health Scrutiny Evaluation conducted in January and February 2010 and the final report was subsequently considered in March.

5.2 There are no specific financial implications emanating from this report, and any additional costs that arise from implementing the Action Plan, must be contained within directorate revenue budgets. Also, if the Council agrees further action in response to this report's recommendations then officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

## 6. One Tower Hamlets consideration

6.1 This Action Plan incorporates key aspects of One Tower Hamlets considerations to strengthen community leadership and tackling inequalities which is central to the work of the Health Scrutiny Panel and this is reflected in the actions around access to services its aims to strengthen community leadership through increasing resident engagement in the democratic process of health scrutiny.

## 7. Risk Management

7.1 There are no direct risk management implications arising from Action Plan.

**Apendix A:**

**Health Scrutiny Evaluation Action Plan - May 2010**

## 1. Context

In February 2010, Tower Hamlet's Health Scrutiny function was independently reviewed by, Tim Young an associate of the Centre for Public Scrutiny. The Scrutiny Team advised at the last HSP meeting of the 2009/2010 municipal year that they would respond to the evaluation with an action plan.

## 2. Summary:

The evaluation acknowledges that much has been done to build the credibility and effectiveness of health scrutiny in the borough, stating that this improvement was recognised by the Council's Corporate Assessment in 2008 in which inspectors judged that scrutiny locally makes a real and positive difference within Tower Hamlets and it is evident that Health Scrutiny has played a large part in this. There have been a number of successes in contributing to the shaping and improvement of services strategies and provision aimed at tackling local health issues, for example through the GP and dentistry services and tobacco cessation reviews.

Tower Hamlets has many of the required elements of effective scrutiny in place, the evaluation found that:

- The HSP has worked hard to construct a coherent scrutiny programme, taking account of other audits and reviews, and has sought to provide effective public accountability.
- Over the four years the HSP has taken board substantial pieces of work, involving joint health overview and scrutiny committees on a sub-regional and pan-London basis.
- One of the HSP's strengths is that it has been broadly effective at 'the reactive agenda' – in picking up and dealing with local residents' pressing health issues.
- Elected members are engaging more effectively with service users and NHS trusts across the borough.
- Tower Hamlets has a strong platform on which to build, particularly given the enthusiasm and willingness of the Trusts to engage.

However, there are areas where improvements can be made; the report highlighted some issues that have inhibited the effective delivery of a coherent and proportionate programme of health scrutiny in Tower Hamlets:

- The sheer scale of health problems and inequalities in Tower Hamlets poses problems for the HSP in constructing and prioritising its agenda.
- The HSP is inclined towards employing a 'broad and shallow' as opposed to a 'narrow and deep' approach and as a result rigorous scrutiny and holding to account can suffer.
- The practice of only doing one review a year might be reconsidered, since two more focused reviews completed in a shorter timescale might be of greater value.
- There are improvements that the HSP could make to planning and managing its agenda – there is a case for following a less is more approach, to ensure more manageable agendas lead to more robust scrutiny, which could have more impact in adding value.
- There are further improvements to be considered to make HSP meetings more effective, i.e. being briefed about the key issues, drawing more fully on patient and service user experiences, and developing questioning strategies before the meetings take place would enable HSP members to offer a more robust 'critical challenge' to the professionals.
- Further improvements need to be made to the partnership working approach, for the new HSP programme beginning in 2010, it will be important to draw on previous experience to employ the most effective ways of engaging HSP members - including the Panel's co-optees – and health partners in its planning, especially developing the HSP's working relationship with THINk, to make use of its gathering of patient and public experiences of health and social care services.
- Particular attention needs to be directed to the way in which Members' role as community leaders in constructively informing and shaping proposed changes to service provision might be supported and enhanced.
- Efforts to engage patients and residents in scrutiny review should continue – a clearer understanding about areas of responsibility and operation between the HSP and THINk could help to reap the benefits of effective joint working through co-ordination of effort.

The recommendations put forward to the health scrutiny programme in the evaluation are offered to assist Members and all health partners to make the journey, as one of the evaluation contributors put it, "from good to great."

The action plan is attached and outlines our actions and responses to the recommendations as well as tracking milestones to indicate progress.

**3. ACTION PLAN**

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| **Objective 1: *Ensuring scrutiny incorporates best practice in addressing health inequalities*** | | | |
| 1.1 Ensure the implications of the Marmot are incorporated into the work programme. | - Produce summary and action points relevant to LBTH from Marmot Review.<br>- Include in the induction programme | June 2010<br>Induction programme delivered June 2010 | **KM**<br>**KM** |
| 1.2 Benchmark the HSPs work and that of Tower Hamlets against those authorities which have been awarded beacon status for reducing health inequalities. | - Benchmark against other local authorities, the GLA and third sector to explore best practice examples in health scrutiny | On – going | **KM** |
| **Objective 2: *Improving the approach to programming health scrutiny and carrying out reviews*** | | | |
| 2.1 Try new ways of carrying out and gathering evidence for scrutiny reviews to help keep the approach fresh, innovative and securely evidence based. | - The start of each review to include a discussion point exploring more innovative ways of gathering evidence, this will be added to the HSP protocol to ensure engagement of members. | September 2010 | **KM** |
| 2.2 Consider taking a cross-sectoral, 'Total Place' approach to the overall framing of the new health scrutiny programme for 2010-14. Ensuring that all health partners, the Council and the voluntary and community sector in LBTH are able to play their part in addressing key health issues. | - All health partners and key stakeholders to be included in the setting up of the work programme for 2010-14 through a well developed and thorough induction programme. | Invite comments from partners May 2010. | KM |
| 2.3 Review the practice of doing only one HSP scrutiny review a year, to see if two more focused reviews completed in shorter timescale, might be of greater value. | - Present only one detailed review each year to retain focus.<br>- Reviews to be completed by January to | On-going | KM |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| | enable shorter reviews or challenge sessions to take place from January to the end of the municipal year. | | |
| 2.4 Consider making improvements in the quality of the recommendations that the HSP produces in its work, to enable clearer measures of success to be drawn from the recommendations and facilitate more effective monitoring and holding to account of Cabinet, Council Officers and health partners | - Ensure members have access to experts in the field of chosen review.<br>- Support members in developing SMART recommendations by liaising with other directorates and service areas. | On-going process | KM<br><br>AH/KM |
| 2.4 Explore holding agenda planning conversations with health partners at a higher level to try to ensure that agendas can do justice to the 'big issues' in health | - New HSP protocols will allow meetings to be more focused.<br>- Explore recommendation 2.4 during the induction process | On-going<br><br>June/July 2010 | KM |
| **Objective 3: *Improving the partnership approach to health scrutiny*** | | | |
| 3.1 Explore following the 'less is more' approach to agenda planning in order to add more value by giving fewer but better resourced work items more robust scrutiny | - Issues on the agenda and HSP meetings to be addressed in a new protocol, which will include the following guidance:<br>- The agenda to have no more than 5 items (not including AOB).<br>- Full reports not to be covered at HSP (only summary presentations)<br>- Presentations to be 12 slides or less<br>- Agenda items to be given maximum of 30 minutes each. | Protocols to be discussed during the induction process and agreed July 2010 | KM |
| 3.2 Explore using the most appropriate method for considering different scrutiny items, in order to use the HSP's time and resources more effectively. | - New protocol to include following suggestions:<br>- Pre meetings before HSP (discretion of | Protocol to be agreed June/July 2010 | KM |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| | individual committee and Chair)<br>- Separate sessions for key members on emerging issues.<br>- Officer commitment for pre-planning meeting 2-3 days before meeting.<br>- Develop the use of service visits as a way of solving emerging issues.<br>- Individual panel members to be responsible for different pieces of work. | On-going | |
| 3.3 Ensure the induction programme for new HSP members (including Panel's co-optees) in 2010/11 draws on experience of previous inductions to employ the most cost effective ways of engaging members and enabling them to a) acquire a clear picture of current health issues and strategies; and b) start to develop effective working relationships with key health partner contacts | - Develop a comprehensive induction programme, drawing on previous experience setting out clearly the roles of members and the benefits of joint working.<br>- Support the development of the Health Scrutiny Lead through better engagement with the Healthy Partnership Delivery Group. Open invites to both Chairs to all meetings. | Induction plan delivered end of May/ beginning of June.<br><br>June 2010, on-going | KM<br><br>KM |
| 3.4 Ensure the induction process for new councillors includes discussions with Tower Hamlets Local Involvement Network (THINk) and consider ways to share information collected by THINk patients and the public. | - Attendance at the THINk steering group sessions to improve partnership working.<br>- THINk to be involved in the induction programme.<br>- Develop a protocol between the HSP and THINk. | First meeting May 2010<br><br>June 2010<br><br>September 2010 | KM<br><br>KM<br><br>KM |
| 3.5 Strengthen the relationship between health partners and health scrutiny and continue to seek ways to strengthen the relationship between Overview and Scrutiny and the Tower Hamlets Partnership to help deliver the priorities of the Community Plan. | - Ensure HSP work programme incorporated key areas identified by the Community Plan.<br>- Explore the possibility of HSP working with other sectors in the borough, i.e. Social Action for Health, Medical Council, and Health Trainers etc. | On-going process<br><br>June/July 2010 | KM<br><br>KM/AH |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| **Objective 4: *Mainstreaming health inequalities and health scrutiny work*** | | | |
| 4.1 Review how the HSP could do more to develop and use its relationship with the Lead Member for Health and Wellbeing , as a way of firming up the strong leadership and vision needed as one of the 'strategic levers' underpinning the successful tackling of health inequalities. | - Ensure standard invitation to HSP for AHWB and CSF.<br>- Introduce two informal meetings annually between scrutiny lead and cabinet member with the aim of more scrutiny taking place member to member. | On-going<br>June/July | KM<br>KM/AH |
| 4.2 Promote consideration of the health impacts of strategies, policies and services by all council directorates, as a method of mainstreaming health inequalities work. | - Regular communication with Tower Hamlets Partnership, AHW and CSF to reduce overlap and promote the work of all directorates. | On-going | KM |
| 4.3 Request Executive Leads to encourage partnership working with NHS colleagues and others working in the health and social care field not just at the strategic and most senior levels but also lower down the officer structure. | - The council already has good working relationships with the NHS throughout the both organisations demonstrated by a number of strategies for improvement and well-being, for example tobacco cessation and healthy eating. | On - going | KM |
| 4.4 Promote the development of a core group of public health champions in decision-making positions across all functions, through the use of a health training course for senior/third tier managers. | - An element of this already exists within Council/partner organisations and key officers. | N/A | KM |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| 4.5 Ensure that a health dimension is included in the Overview and Scrutiny Committee's considerations of topics for scrutiny reviews and that its Scrutiny Leads are aware of what is available in terms of evidence sources and witnesses, from inside and outside the Council, to make reviews as soundly based as possible in terms of health impacts. | - Overview and Scrutiny already explores relevant health issues when looking at review topics, for example the Choice Based Lettings review considered medical issues. | On-going | KM |
| 4.6 Ensure that the relevant council directorates, in particular the Adults' Health and Wellbeing and Children, Schools and Families directorates, are as fully engaged as possible in the HSP's work directly and that directorates are made aware of the criteria which the HSP uses to assess whether topics are sufficiently important to be included in the work programme. | - Continue working with Policy Officer link in AHW and establish a link with a PO for CSF (see 3.5 and 4.2)<br>- Establish bi-monthly meetings before each HSP with the Service Heads and Policy Officers to pick up any previous issues and agenda items coming up. | June 2010<br><br>July 2010. | KM |
| 4.7 Ensure the new 2010-2014 health scrutiny programme is ' an informed joint enterprise' by holding extensive open discussions about its priorities and content, to produce a realistic but challenging programme and increase the likelihood of partners' buy-in and co-operation. | To organise an 'open discussion' section within the induction programme. To ensure input from all partners, including THINk and establish open communication throughout the process to ensure a robust work programme. | June/July 2010<br><br>On-going process | KM |
| 4.8 Explore opportunities to increase the HSP's 'critical challenge' function through topic briefings, holding all-party pre-meetings to develop questioning strategies in advance and attending a questioning skills development session. | - Explore external training sessions for members around health scrutiny including the development of questioning skills.<br>- Thorough but concise briefings to be produced three days before HSP to allow time for Member queries and any questions prior to the meeting. | June/July 2010<br><br>On-going process | KM<br><br>KM |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| **Objective 5:** ***Developing the Health Scrutiny Panel's abilities and Members' community leadership role*** | | | |
| 5.1 Consider co-opting a representative from the East London NHS Foundation Trust's Council to bring in particular experiences that might otherwise be lacking on the HSP panel | - Contact East London NHS Foundation Trust and invite co-Optees o the induction process to develop their role as advisors to the HSP. | July 2010 | KM |
| 5.2 Explore how to develop a wider appreciation of how Members can use their community leadership role and skills as part of the problem-solving in health and social care. | - Ensure that the induction process for the HSP is developed with the key focus that the member's Community Leadership Role is exercised in a problem solving capacity to improve services for local residents. | On-going | AH/KM |
| 5.3 Ensure that the recommendations of the Scrutiny Review Working Group on Strengthening Local Community Leadership are considered in tandem with this report, so that there is a health dimension to this developing work on community leadership. | - Consider the Strengthening Local Community Leadership Review in the Induction Programme and share with Members | June/July 2010 | KM |
| 5.4 Ensure that in the HSP's future work programme account is taken of the strong possibility the further pan-London and sub-regional health service changes may require a substantial investment of time and effort participating in Joint Health Overview and Scrutiny Committees | - Attend Inner North East London Officer Meetings, Sub Regional and Pan London events to identify any issues at an early stage.<br>- Report back to members on above issues on a regular basis through email bulletins and HSP meetings. | On-going | KM |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| **Objective 6:** ***Laying foundations for the next four year health scrutiny programme*** | | | |
| 6.1 Continue efforts to engage patients and residents in scrutiny reviews, while considering other means of public engagement, such as co-options, holding some HSP meetings in more geographically accessible locations, increasing dialogue with THINks membership and increasing the publicity effort for health scrutiny. | - Recommendation 6.1 to be considered as part of the induction process.<br>- Scrutiny Policy Officer to be responsible for addressing innovative ways to engage residents through better publicity and the organisation of a possible conference with health partners and key stakeholders.<br>- Liaise with THINk to explore the development of the non-executive stakeholder's role and non-executive director's role at the NHS Foundation Trust. | June/July 2010-05-04<br><br>September 2010<br><br>June 2010 | KM<br><br>KM |
| 6.2 Review the relationship with both LAPs and THINk to develop clarity about respective roles vis-à-vis holding health and social care services to account, and to reap the benefits of effective liaison and joint working. | - A key recommendation in the recent Scrutiny Review Group's report on Strengthening Community Leadership is to strengthen local area partnerships and the community leadership role as well as the link between Overview and Scrutiny with the LAPS.<br>- Where the HSP is looking at a specific area the LAP chair will be invited to HSP. | Add to HSP protocol June/July 2010<br><br>(On – going) | KM |
| 6.3 Consider increasing the scrutiny staffing resources so that there is a dedicated health scrutiny officer, as is common in a number of other authorities of comparable size to Tower Hamlets, to enable the post to assume a more strategic role around workload planning, prioritisation, analysis of information, | - To be considered by the Scrutiny Service Head. | | HA |

| Recommendation | Activities / Response | Progress Milestones | Lead Officer |
|---|---|---|---|
| commissioning of additional research and providing support for HSP members. | | | |
| 6.4 Explore how to achieve the necessary high degree of continuity in the membership of the HSP over the life of the next four year programme and how to facilitate HSP members' input and engagement with the work for maximum effectiveness. | - Scrutiny Team to liaise with Members and advisors to explore the nominations process for HSP. | On-going | AH |

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **27 July 2010** | **Unrestricted** | | **4** |

| Report of: | Title: |
|---|---|
| **Originating Officer(s):**<br>**Katie McDonald**<br>**Scrutiny Policy Officer** | **Health Scrutiny Panel Work Programme 2010/11 – 2011-2012**<br><br>**Ward(s) affected: All** |

## 1. Summary


1.1 This report outlines the draft two year work programme for the Health Scrutiny Panel (HSP) for municipal years 2010/2011 and 2011-2012

1.2 The report sets out the process used to develop the Health Scrutiny Work Programme and suggests a number of ways in which the Panel may wish to approach the workload.

1.3 Appendix 1 sets out the schedule for items across the Panel Meetings for 2010/2011


## 2. Recommendations

The Health Scrutiny Panel is asked to:

2.1 Consider and comment on the draft work programme items and schedule attached at Appendix 1 and 2

2.2 Agree options for managing the work programme

2.3 Agree to review the work programme every quarter



---

**LOCAL GOVERNMENT ACT, 2000 (SECTION 97)**
**LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT**

| Background paper | Name and telephone number of and address where open to inspection |
|---|---|
| **N/A** | **Katie McDonald**<br>**020 7364 4548** |

## 3. Background

3.1 The scrutiny of health is an important part of the Council's commitment to place patients and the public at the centre of health services in the borough. It is a fundamental way by which democratically elected Councillors may voice the views of their constituents and require local NHS bodies to listen and respond. In this way, the Council can assist to reduce health inequalities and promote and support health improvement.

The Health Scrutiny Panel's remit covers local health service provision and social care services for adults and older people. A major role for the Panel is being a statutory consultee for all substantial service change and development of local health services. The statutory duty and powers given to local authorities for Health Scrutiny were established through the Health and Social Care Act 2001. Local authorities with Social Services responsibilities are required to have an Overview and Scrutiny function that can respond to consultation by NHS bodies on significant changes and developments in health services and take up the power of Overview and Scrutiny on broader health and wellbeing issues. The Local Government and Public Involvement in Health Act 2007 strengthened these powers further; it provides powers for Overview and Scrutiny Committees to review and scrutinise the performance of public service providers to meet the LAA targets, as well as empowering councillors to raise issues with Overview and Scrutiny Committees through a 'councillor call for action'.

3.2 The primary aims of health scrutiny is to:

- identify whether health and health services reflect the views and aspirations of the local community
- ensure all sections of the community have equal access to services
- And have an equal chance of a successful outcome from services.

3.3 In Tower Hamlets the Health Scrutiny Panel has been established as a sub-committee of the Overview and Scrutiny Committee. Its Terms of Reference are:

- To review and scrutinise matters relating to the health and social care within the Council's area and make reports and recommendations in accordance with any regulations made
- To respond to consultation exercises undertaken by an NHS body
- To question appropriate officers of local NHS bodies in relation to the policies adopted and the provision of the services.

3.4 During the induction process Members of the Health Scrutiny Panel met to set out the strategic focus for the Panel for the two years 2010 – 2012. Instead of the previous four year cycle the Panel will look to develop a two year cycle with a one year rolling programme. It has been agreed that the Panel will work under the same overarching theme of the previous cycle and the purpose for Health Scrutiny in Tower Hamlets should remain as tackling health inequalities.

3.5 The broad cross-cutting themes of the rolling work programme remain:

- health promotion and prevention through work with health partners and other third sector organisations
- developing better integration and partnership to improve joint service provision
- Improving access to services as a key way of tackling health inequalities.

## 4 The work of the Health Scrutiny Panel in 2009/2010

4.1 The Panel delivered an in depth review looking at Childhood Obesity. A summary of the review is outlined below.

**Scrutiny Review: Reducing Childhood Obesity – Increasing the availability of healthy choices**

4.2 The review looked at reducing childhood obesity with a focus on promoting healthy eating by increasing the availability of and access to healthy food choices and reducing the availability of and access to foods that are high in fat, sugar and salt.

4.3 The review had a number of key objectives.

- To develop appropriate recommendations to ensure the issue around prevention of an over-concentration of fast food outlets can be operationalised.
- To explore the possibility for offering healthy free school meals for all.
- To support schools to maintain their commitment to providing food in a pleasant, sociable environment with promotion of healthy choices.
- To examine the possibility of further investment into improving school dining facilities.
- To continue to develop current initiatives particularly under the Healthy Borough programme such as business advice to encourage healthier food choices.

4.4 The Health Scrutiny Panel were keen to ensure that their work added value to existing work that had taken place in the borough on tackling obesity. The Panel considered how the Council might directly address the problem with the proliferation of fast-food outlets, particularly in the vicinity of schools, and the quality of the food they provide. The Working Group examined the lettings policies of public sector landlords and Registered Social Landlords with regards to fast food outlets to identify what action can be taken as well as the possibility of Tower Hamlets offering healthy free school meals for all.

4.5 Key Recommendations from the report were:

- That the Children, Schools and Families Directorate find additional resources to provide free school meals for all pupils in Tower Hamlets.
- That Children, Schools and Families Directorate work with schools to develop a staggered lunch hour, so that pupils are not queuing for long periods over lunch.
- That Development and Renewal Directorate develop an evidence base to underpin emerging policy on managing fast food outlets in Tower Hamlets as outlined in the 'Healthy Borough Programme' report with a view of developing a means to restrict the over-concentration of fast food outlets in the borough, particularly those outside of town centres and within close proximity to schools.
- That a report be presented to the Overview and Scrutiny Committee detailing the success of the Healthy Borough Programme. This paper should form the basis for strengthening proposals for requesting further funding beyond March 2011.

Impact:

- Service responses to the recommendations are still being drafted

4.6 **Health for North East London Consultation – Joint Overview Scrutiny Committee (JOSC)**

Health for North East London (H4NEL) is the NHS programme review, run on behalf of the north east London's Primary Care Trusts (PCT) and acute hospital trusts. The aim of the health for north east London consultation was to significantly improve the health of thousands of patients and ensure the NHS delivers the best possible care by taking advantage of new medical developments and improving the way it delivers care to patients by bringing some services closer to people's homes and centralising others to provide better specialist care.

Two Members of the Health Scrutiny Panel and the Chair, Cllr Tim Archer were nominated to represent the borough on the Inner North East London JOSC with Members from the London Boroughs of Hackney, Newham and the City of London. They considered and responded to the proposals set out in the PCT consultation document, and examined whether the Health for North East London proposals would deliver better healthcare for the people of North East London. The JOSC had the opportunity to collect evidence from clinical specialists, the London Ambulance Service, Transport for London and service users to reach its conclusions. The consultation has now finished but the work is still on-going and it is likely that members of the HSP will be asked to comment on the findings and final recommendations produced by H4NEL.

4.7 **Evaluation of the Health Scrutiny Panel 4 year programme March 2010**

As the Health Scrutiny Panel's four-year work programme approached its end. It was agreed in October 2009 that it would be beneficial for an external evaluation. The evaluation was based on the Centre for Public Scrutiny's principles of good scrutiny and tested views from across the authority and its partners on the effectiveness of the four-year programme. The bulk of the evaluation took place in January and early February 2010. The approach was based on a review of extensive documentation from the Council and all health partners; a range of interviews with Members, council officers and health partner's personnel as well as an observation of the Health Scrutiny Panel meeting on 26th January 2010.

It is an important piece of work identifying both strengths and weaknesses as well as providing recommendations for improvements to the Panel as we look to the 2010/2011 programme. In response to this report the Scrutiny Team have put together an Action Plan which will guide the way the Health Scrutiny Panel conducts its work over the next two years.

The evaluation recognises that Tower Hamlets has built strong foundations for its health scrutiny function but there are improvements that need to be made. Particularly in relation to improving the partnership approach to health scrutiny and developing the Health Scrutiny Panel's abilities and Member's community leadership role. The suggestions will assist Members and all health partners to make the journey as one contributor in the report quotes "from good to great.

## 5. Health Scrutiny Panel Work Programme 2010/2011

5.1 Health inequalities remain a key challenge for the borough. Tower Hamlets is the third most deprived borough in the country and there are areas of deprivation in every part of the borough. There is strong evidence that areas with deprivation have worse health and greater health inequalities. The life expectancy for a boy born in Bethnal Green North is 8.5 years less than that for a boy born in Millwall, in 2006, the probability of survival to age 75 for a man in Tower Hamlets was 54% compared to 66% nationally. Although life expectancy is increasing and death rates appear to be falling steadily year on year. There is little evidence of a reduction in the gap between

5.2 The Borough's Community Plan explains how the Council will improve the quality of life in Tower Hamlets. The aspiration of 'One Tower Hamlets' runs throughout the plan and a key component is to reduce the inequalities and poverty that we see around us, strengthening cohesion and making sure communities continue to live well together.The HSP will support the Tower Hamlets Partnership to build 'One Tower Hamlets' by :

- Focusing on reducing the health inequalities that exist within the borough and narrowing the gap between Tower Hamlets and the healthiest parts of the country
- Supporting people to lead healthier lifestyles

- Making sure that health services are accessible –including at a time and place that suits residents
- Recognising the strong links between health and other areas such as employment, housing and the environment

5.5 The process for preparing a long list of items for the Health Scrutiny Work Programme has been to draw on a number of sources. The Health Scrutiny Panel has key business, policy and performance items that it must respond to for example Tower Hamlets NHS Commissioning Intentions, responding and the Healthcare for North East London review. Members of the Panel have been invited to comment on a draft list of items which includes the above and to suggest further issues. As in previous years the Panel want to make sure that patient, users and local people influence how services are designed; therefore the Tower Hamlets Involvement Network (THINk) was also involved in agreeing items for the programme. The three NHS Trusts were also requested to feedback on possible areas to evaluate and where Health Scrutiny could add value to existing programmes of work.

5.6 This year the Health Scrutiny Panel will look to carry out two challenge sessions in 2010 with the possibility of a longer review later in the year.

5.7 The challenge sessions agreed are:

1) **Polysystems and Reconfiguration of Local Services** – what this means for local residents?

This session will aim to:

- scrutinise public engagement in the reconfiguration of health services in Tower Hamlets
- provide residents with the correct information on how they will be affected by the reconfiguration of health services in the Borough.

It will assist in addressing the challenges outlined in the Joint Strategic Needs Assessment around service delivery and access to health services. As well as addressing those issues around variation in health outcomes, the low uptake of screen services and the need to integrate services by engaging residents and providing necessary information. There has been a large clinical focus on polysystems and reconfiguration of health services over the last year but there is still work to be done to engage residents which this challenge session will focus on.

2) **Cancer – The development of preventative services** - early diagnosis and rapid referral

This session will aim to:

- To improve life expectancy in the borough. Tower Hamlets has amongst the highest prevalence of risk factors for cancer in London.
- To improve resident understanding and knowledge around this issue

A challenge session would address the gaps identified by the 2008-09 report from Joint Director of Public Health, Ian Basnett and Joint Strategic Needs Assessment 2009 surrounding the low uptake of screening services. In 2005 life expectancy in Tower Hamlets was 75.2 in males and 80.2 in females. This is 2.1 years shorter in males and 1.3 years shorter in females compared to England and ranks Tower Hamlets in the bottom 20% of all local authorities. There were 614 new cases of cancer in 2006. Tower Hamlets has higher rates of diagnoses of lung, cervical, bowel and stomach cancers compared to London and national figures. There is a consistent pattern of poorer survival which may be linked to later diagnosis. Cancer is a major concern that Tower Hamlets continues to be significantly off target. It is a hard trend to shift and this is scrutiny challenge session would go some way to intensifying efforts to improve early detection rates in the Borough.

## 6 Other work of the Panel

6.1 Over the next few years there are a number of policy developments and issues that will have an impact on health scrutiny and its work programme:

- **Care Quality Commission** ( development of commissioner assessment)
- **Increasingly challenging financial climate**.
- **Increasing integration** (health and social care, NHS and local government, acute and community services – links to "Total Place")
- **The Marmot Review** (Opportunities for the Health Scrutiny Panel to consider the health issues outlined in its work).
- **The NHS White Paper** (What this will mean for health care in Tower Hamlets)
- **Locally –** Executive Mayor and Mayoral System
- **Further work with the Tower Hamlets Involvement Network (THINk)** to increase resident participation and link its work with the HSP.

6.2 The NHS is undergoing a period of unprecedented change and modernisation affecting the way health partners are developing and providing services to local people. It would be helpful for the Panel to develop a deeper understanding of these changes to inform its role and work. These include:

- The NHS White Paper (2010) – (including NHS Trusts gaining foundation trust status by 2013)
- Finance and funding of services including payment by results;
- Commissioning;
- Performance Management through Quality Accounts and the Care Quality Commission

6.3 Outside of the main work of the Panel the two challenge sessions will be conducted with a possibility of a longer review later in the year. Alongside a programme of briefings, seminars and site visits to inform and develop understanding of the key health issues in the borough. During the second year of the cycle, the Health Scrutiny Panel have proposed an in-depth review looking at Mental Health services in the Borough.

6.4 The proposed work programme for the next year is set out in further detail in Appendix 1. At the request of the Chair the meetings in January and March have been left clear to provide the Health Scrutiny Panel with a degree of flexibility given the current climate and major changes in health policy. Once the overall work programme is agreed, the scope and exact timing of issues will be developed in consultation with relevant NHS partners and services. This will ensure that the work is focused and delivers its objectives. A proposed work programme has also been included at Appendix 2 for 2011/2012. Members of the Health Scrutiny Panel will be invited to add to this plan throughout the year.

6.5 The implementation of past scrutiny reviews and recommendations will continue to be monitored. In addition, other issues may be identified as the Panel develops its programme and links with both NHS and community organisations.

## 7. Role of Health Scrutiny Panel Members

7.1 To maximise the value of health scrutiny in improving services Members of the Panel can play various roles. These include:

- The Community Leadership Role linking with community groups, residents and LAP meetings to consult and engage residents – in particular deeper level of engagement with the Partnership work under the Healthy Community, Community Plan Theme;
- The active promotion of health scrutiny and gathering of information from residents and community groups to raise with the Panel and Health Partners;

- Undertaking an individual link role by liaising with health partners by visiting and meeting as appropriate and reporting back to the Panel.

7.2 The changing role of community leaders with more emphasis on leadership of place rather than services highlights the potential for scrutiny in influencing and shaping the local area. With many services being jointly provided or commissioned scrutiny of partnership will be an area of growing interest for non-executive councillors looking to improve the overall quality of life for residents.

7.3 Learning and development will also need to run alongside the rest of the work programme. The Scrutiny Policy Team will be supporting Members to tailor this to their individual needs.

**8. Concurrent Report of the Assistant Chief Executive (Legal Services)**

8.1 By virtue of the Health and Social Care Act 2001, duties were added to Overview and Scrutiny Committees for Health Scrutiny Panels to review and scrutinise matters relating to the health service in the authority's area and to make reports and recommendations on such matters in accordance with the relevant regulations.

**9. Comments of the Chief Financial Officer**

9.1 This report describes the draft two year work programme for the Health Scrutiny Panel (HSP) for municipal years 2010/2011 and 2011-2012. The government have recently announced changes to the delivery of health services in London particular the future existence of Primary Care Trusts (PCTS) that are likely to impact on the scope and nature of the proposed work programme of the Health Scrutiny Panel over the next two years and its associated costs.

9.2 There are no specific financial implications emanating from this report, and any additional costs that arise from the work programme of the Health Scrutiny Panel, must be contained within directorate revenue budgets. Also, if the Council agrees further action in response to this report's recommendations then officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

**10. One Tower Hamlets consideration**

10.1 Tackling inequalities and reducing poverty is central to the work of the Overview and Scrutiny Committee and Health Scrutiny Panel and this is reflected in work around access to health services and work around health promotion and prevention. Equal opportunities and diversity implications will be considered during each of the scrutiny reviews.

**Appendix 1 – Health Scrutiny Panel Meetings**

**2010/11**

| Panel Date | Reports / Topic | Method |
|---|---|---|
| June 2010 | • Induction Programme<br>• Update on THINk<br>• Work Programme discussion | Presentation Meeting & Verbal updates |
| July 2010 | • The NHS White Paper<br>• Six Lives Panel Project<br>• 2010/2011 Draft Work Programme<br>• Health Scrutiny Evaluation Report - Action Plan<br>• Health4nel response to INEL JOSC | Verbal Update<br>Report and Presentation<br>Draft Report<br>Report<br><br>Report and Verbal update |
| October 2010 | • HSP Work Programme<br>• Joint Reporting of Complaints – across all Three Trusts<br>• Access to GP services – the Ocean Estate<br>• THINk Work programme<br>• East London NHS Foundation Annual Plan 10/11 and Service Update | Report<br>Presentation<br><br>Presentation/Briefing<br>Report/presentation<br>Report/presentation |
| January 2011 | • NHS Tower Hamlets – Operating and Commissioning Priorities<br>• Transformation of Adult Social Care and the Personalisation Agenda<br>• Update on Review and Challenge Session<br>• Work | Report/Presentation<br><br>Briefing<br><br>Report |
| March 2011 | • Excellence in Quality Strategy Report and Presentation, Barts and the London NHS Trust<br>• Operating Plan NHS Tower Hamlets<br>• Update on Review and Challenge Session | Report and Presentation<br><br>Report and Presentation<br>Briefing |

**Appendix 2 – Health Scrutiny Panel Meetings**

**2011/12**

| Panel Date | Reports / Topic | Method |
|---|---|---|
| June 2011 | • Induction Programme<br>• Update on THINk<br>• Work Programme discussion<br>• Mental Health Review | Presentation Meeting & Verbal updates |
| July 2011 | • 2011/2012 Draft Work Programme<br>• Complaints Reporting on all three Trusts | Verbal Update<br>Report/presentations |
| October 2011 | • HSP Work Programme<br>• Joint reporting of complaints<br>• East London NHS Foundation Annual Plan 11/12 | Report<br>Presentation<br>Report/presentation |
| January 2012 | • NHS Tower Hamlets – Operating and Commissioning Priorities 2011/12<br>• Update on Review and Challenge Session Work | Report/Presentation<br>Report |
| March 2012 | • Excellence in Quality Strategy Report and Presentation, Barts and the London NHS Trust<br>• Operating Plan NHS Tower Hamlets<br>• Update on Review and Challenge Session | Report and Presentation<br>Report and Presentation<br>Briefing |

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **27 July 2010** | **Unrestricted** | | **5** |

| Reports of: | Title: |
|---|---|
| **a) c) Health for North East London**<br><br>**b) Mott MacDonald and Public Health Action Support Team (PHAST)**<br><br>**Presenting Officer:**<br><br>**Katie McDonald**<br>**Scrutiny Policy Officer**<br><br>. | **a) Health for North east London response to INEL JOSC recommendations**<br><br>**b) Health for North East London Integrated Impact Assessment**<br><br>**c) What will happen next?**<br><br>**Ward(s) affected:**<br><br>All |

## 1. Summary

The reports included are to provide the Health Scrutiny Panel with an update following a review of the proposals for the reconfiguration of acute services in North East London by the health scrutiny committees from Inner North East London Boroughs (London Borough of Tower Hamlets, Hackney, Newham and City of London) which was completed in April 2010.

The first document is the response from Health for North East London (Programme Team) to the Inner North East London Joint Overview and Scrutiny Committee Report.

Followed by the Independent Integrated Impact Assessment undertaken by Mott MacDonald and PHAST and a presentation from the H4NEL programme director, Helen Brown on the next stages of the consultation.

## 2. Recommendations

The Health Scrutiny Panel is asked to consider the reports and note for information.

This page is intentionally left blank

# Health for north east London response to INEL JOSC recommendations

**Recommendation 1 – Children's Services**

*a. Assurance is given that there is capacity within the system to ensure the smooth transfer of patients (children and adults) to designated specialist services for their patient catchment areas, for example, INEL residents to The Royal London Hospital and back to local hospital.*

The Joint INEL and ONEL Joint Committees of Primary Care Trusts (JJCPCT) made a commitment in November 2009 that no changes would be implemented until the JJCPCT was absolutely assured that sufficient capacity is in place across the whole of the healthcare system to safely and effectively manage the new service model. In order to assure that the capacity is available we are currently reviewing and updating the modelling that has been undertaken to forecast activity flows and required additional capacity at specialist centres and will be happy to share this with the Committee in due course.

We are also currently considering the best organisational and commissioning arrangements to support any new models of care for children's services. I can assure you, on behalf of the JJCPCT that we will only make changes to current care pathways and models when we are confident that we have in place the appropriate capacity and mechanisms within and across all organisations to manage the new pathways effectively and deliver the intended benefits for children. As part of the implementation planning phase of the programme we will be working with all organisations to describe a set of clear standards for new paediatric care pathways and agree a clear set of standards against which the new model of care can be measured.

*b. That Specialist Centres and local trusts have robust Safeguarding governance procedures in place for all patients (adults and children), ensuring that cross border arrangements are in place.*

*c. Request clarity on procedures for social care responsibility for cross border patients using Specialist Centres, for example, the provision of office accommodation for local authority social care staff for patients expected to use Specialist Centres such as The Royal London.*

*d. That Specialist Centres are asked to confirm they have access to and resources to provide accommodation facilities for families with children in their care.*

These issues will need to be considered as part of implementation planning, in partnership with local authority colleagues, once decision-making has taken place.

As set out above a clear set of standards will be need to be defined and agreed to support the new model of care, we expect this to cover issues relating to partnership working, safeguarding and accommodation for parents. One of the key messages from the consultation has been in relation to overnight accommodation for parents of children receiving care at specialist centres.

*e. Recommend proposal related to urgent non complex surgery on post pubescent 'children' under the age of 16 is reviewed by Health for North East London Programme to explore giving surgeon's discretion to make the decision to conduct the surgery if competent to do so but consistently across the NEL sector.*

This issue will be reviewed by the Children and Young people's Clinical Working Group (CWG) and further recommendations will be brought the JJCPCT to consider.

**Recommendation 2 – Maternity and Newborn Services**

*a. That a strategy be developed to demonstrate how large birthing units will be managed by Acute Trusts anticipated to have in excess of 6,000 births per year.*

*b. That a strategy for each Trust be produced with details of how the vacancy rates for midwives will be reduced.*

The Clinical Working Group for Maternity and Newborn will be involved in supporting implementation planning, and will be involving key stakeholders in this work. Based on work done at a London level we will be setting clear standards for maternity birthing services intended to ensure that services are as women-centred as possible. A key element of this will be a drive towards increased midwifery led care in all settings (home, free standing midwifery led care, co-located midwifery led care on hospital site). We will involve local maternity services liaison committees and other stakeholders such as the National Childbirth Trust in this work.

All NHS organisations have been working on action plans to improve maternity services since the Healthcare Commission review in 2008. Significant additional investment has been made to support recruitment of additional midwives and increase medical staffing levels. These action plans, along with the implementation of the Department of Health's *Maternity Matters* policy (2007), are monitored by NHS London. The maternity clinical working group will oversee the development of a sector wide maternity workforce strategy, with each Trust developing local plans to support recruitment and retention of midwives.

**Recommendation 3 – Specialist Services**

*a. Assurance is given that there is capacity within the system to ensure the smooth transfer of patients (children and adults) to designated specialist services for their patient catchment areas, for example, INEL residents to The Royal London Hospital and back to local hospital.*

As noted above no changes will be made until there is assurance that sufficient capacity is in place across the whole of the healthcare system to manage changes safely and effectively and the finance and activity modelling is being reviewed in order to provide this assurance. It should be noted that there is no requirement for rehabilitation following vascular surgery. Patients admitted for surgery will complete their entire inpatient episode at the hospital where they undergo surgery and will then be discharged home. The vascular network will be developing a detailed pathway model with key standards at each stage of the pathway. This will be available to share with the Committee in due course.

*b. That Specialist Centres and local trusts have robust Safeguarding governance procedures in place for all patients (adults and children), ensuring that cross border arrangements are in place.*

This is an area that will need to be addressed in implementation planning, in conjunction with local authority partners.

*c. That assurances are given that appropriate training will be given to all NHS and London Ambulance staff to ensure accurate assessment in respect of transferring patients to Specialist Centres.*

It should be noted that the model of care proposed for complex vascular surgery is already in place in inner north east London across Homerton, Newham and the Royal London. There will be no additional requirement for ambulance crews to diagnose vascular conditions as the need for complex vascular surgery is determined on assessment in A&E by a senior A&E doctor or senior physician/general surgeon.

For children the initial assessment will be undertaken in A&E / paediatric assessment and treatment services at the local hospital site.

*d. That designated Specialist Centres have monitoring procedures in place to identify pressure points in system so quality of care/services will not be affected.*

The Cardiac and Vascular network have a role in monitoring the time taken to diagnose and transfer patients to specialist centres. Commissioners analyse this information to ensure services are running effectively and work with providers to ensure any issues identified are addressed.

*e. That assurance is given that all agencies involved in the discharge/transfer of patients from specialist centres to local setting have robust governance and working arrangement to ensure smooth transition from one service provision to the other.*

This will be considered as part of implementation planning, although as noted above this model of care is already in place for complex vascular surgery in inner north east London.

**Recommendation 4 – Planned Care**

*a. That specialist centres such as The Royal London give assurances and can demonstrate that co-location of urgent and planned care services will not compromise one another or affect the level and quality of care/service provision for their local residents.*

*b. Assurance is given that designated Specialist Centres / Urgent Care Services (UCS) have monitoring procedures in place to identify pressure points in system so quality of care/services will not be affected.*

Clear standards will be agreed with all service providers, led by the East London and the City Alliance (ELCA) sector acute commissioning unit in relation to both urgent and planned care. This will be linked to the annual contracting process and will include clear monitoring mechanisms.

In relation to specialist centres, the ELCA sector acute commissioning unit (SACU) has a role as host commissioner for all London PCTs for Barts and the London.
As part of this role, the SACU agrees each year a demand and capacity plan with the Trust, which provides a monitoring framework to ensure that both urgent care and planned care meet quality and access standards; these are defined in the contract with the Trust.

The three INEL PCTs have established a sector-wide Emergency and Urgent Care Board, which takes an overview of current and projected future demand on urgent care services, and how this is best managed.

**Recommendation 5 – A&E**

*a. Assurance is given there is capacity within the system to absorb the additional patients expected to attend the other A&E departments remaining within NEL.*

As noted above no changes will be made until the JJCPCT is assured that sufficient capacity is in place across the whole of the healthcare system to manage changes safely and effectively

The finance and activity modelling undertaken to support pre consultation business case (PCBC) development is currently being reviewed and updated to support final decision making and implementation planning.

The modelling undertaken at pre consultation business case stage suggests that the impact of changes to A&E at King George Hospital will impact most significantly (from an INEL perspective) on Newham University Hospitals NHS Trust. The Trust will need to plan for between 3,000 and 7,000 additional A&E attendances per year, in addition to significant additional growth related to the growing local population. The Trust will need to develop additional capacity to manage this work, including additional acute medical and surgical beds as well as A&E capacity. The detail of when and how this is delivered will be worked up as part of implementation planning, alongside planning for the additional capacity required at Whipps Cross and Queen's Hospitals and I can give an assurance that the JJCPCTs will not approve implementation of changes to A&E provision at King George Hospital until they are themselves assured that the required capacity is in place across the system.

The impacts at the Royal London (other than for specialist services highlighted above) and Homerton Hospitals are marginal.

**Recommendation 6 – Polysystems (polyclinics)**

*a. The Commission requests that the evaluation of the first three polyclinics is shared with local health Overview and Scrutiny Committees in NEL once completed.*

*b. The Committee recommends and wishes to see all polyclinics established in NEL have consistent core services and availability of diagnostics therefore request to be notified what the core services and diagnostics in polysystem / polyclinics will be.*

*c. The Committee encourages the development of a model of care with integrated services in polyclinics that are consistent across the NEL sector.*

Work is currently underway that will enable a consistent approach to the commissioning and delivery of core services in polysystems, with additional services being provided to meet the specific needs of their localities. A polysystems workforce strategy for north east London is also being developed. Key components of the polysystem work include:

**Core and additional services:** Inner north east London has established a joint working group to ensure a consistent approach to the development of polyclinics and will formally agree the core range of services to be provided within each of the polyclinics established in Tower Hamlets, Newham and City & Hackney. This will ensure services such as diagnostics are readily available within each polysystem to improve access to care closer to home. Each polyclinic may have additional services located within the facility to meet local need but this will be in addition to the core services as specified locally to comply with the Healthcare for London vision.

**Care pathway development**: Work is on-going with leadership provided by the Clinical Partnership Group to design care pathways for services to be provided within polysystems. The development of one-stop clinics will be prioritised within the overall aim of improving the range and quality of services provided within each polysystem.

**Formal evaluation**: The 2-year evaluation of polysystems by the London School of Hygiene and Tropical Medicine was launched by Commissioning Support for London in December 2009. Initial evaluation will focus upon a small group of early polyclinics with the first phase of evaluation involving the Loxford polyclinic in Redbridge and the second wave to include the Barkantine. Reports will be provided to the Committee as they become available.

This work is being brought together in a sector polysystems Strategic Outline Case which is being developed across the three PCTs, to be completed in outline by July, focusing initially upon the design of the polysystems across the four boroughs, the core specification for polyclinics together with a high level implementation plan.

We understand that this will be an area of ongoing interest to the JOSC and local OSCs and we will be very happy to provide the Committee and local OSCs with regular updates on progress.

**Recommendation 7 – IT systems**

*a. The Committee seeks to be assured that the Summary Care Record system will be implemented on schedule and before the introduction of polysystems. The Committee requests details about the new IT system and when it will be operational to provide health professionals with access to patient medical history.*

The ELCA Polysystems Programme Board will be working with the PCTs to establish a timeframe to implement a common IT solution across inner north east London to support both unscheduled appointments to be provided within polyclinics, and urgent care activity concentrated within the UCCs co-located with A&E departments. This follows a delay in the roll out of the Summary Care Record (SCR) nationally following a dispute between the British Medical Association (BMA) and the Department of Health. In order to agree a revised implementation timetable, PCTs are required to work with local GP practices to agree a way forward to meet the following criteria:
- Residents have been adequately informed about the process and properly enabled to opt out should they wish
- GP practices feel supported and informed to upload data
- GP practices and the PCT are satisfied that the data is of an appropriate quality for sharing
- Sufficient public awareness has been carried out
- Sufficient professional awareness has been carried out.

We are happy to provide updates to the Committee on this issue as they become available.

**Recommendation 8 – Housing**

*a. The Committee encourages discussions to be held with partners impacted by these proposals i.e. housing services and LA and recommends partnership working plans are developed.*

**Recommendations 9 – Finance**

*a. The Committee requests that the NHS and local councils in NE London work together to develop a better understanding of the financial implications of the shift towards more care being carried out in the community and in people's homes.*

Local PCTs and Trusts are fully committed to working in partnership with local partners, including local social services and housing departments, to ensure that the overall system works as effectively as possible for the benefit of local residents. We believe this work is best led by local PCTs, linked to sector commissioning arrangements as appropriate. We would be happy to discuss further with the committee their view of what the impacts of these changes will be on local authority services to ensure that any areas of concern are addressed and appropriate monitoring and review arrangements in place.
It should be noted that strong partnership arrangements are already in place within inner north east London. Each of the PCTs are fully engaged in their local strategic partnerships, which enable development of joint strategies and provide the mechanisms to bring together health planning with other key policy areas, including housing. This has resulted in the explicit statement of health objectives in the Local Development Framework in Tower Hamlets for example.

We recognise that there is concern that changes to acute services (including targets to reduce admissions to hospital and reduce acute length of stay) will have an impact on social care; however we have yet to see any firm evidence of this and have not identified any additional costs.

In fact we believe that in the medium to long-term, improved care pathways and better management of long term conditions will reduce the overall burden of ill-health on the health and social care economy. Improved stroke care is a good example of this. Plans to improve care of long term conditions (LTCs) also point to reducing the burden on social care by better managing conditions such as diabetes. This will result in fewer people with complex diabetes and related disability.

New approaches to care package commissioning for LTCs have already led to demonstrable improvements in diagnosis and clinical control of those people diagnosed, critical steps in avoiding disability and associated social care costs in the

long term. Improving management of diabetes in primary care is a common strategic initiative in INEL as described in the Operating Plans of the three PCTs.

More broadly, as part of strengthening commissioning across London, all PCTs and London boroughs are reviewing joint working arrangements with a view to strengthening these. In some areas this will result in closer joint commissioning arrangements which will maximise efficiency and value for money, and not result in extra costs for social care.

We remain committed to working closely with local authority colleagues to ensure that resources are aligned effectively to get the best possible outcomes for local residents across both health and social care.

*b. The Committee would like to see forecasts of the financial impact of the changes in Health for North East London on all parts of the NEL health economy.*

The pre-consultation business case set out the financial modelling for the Health for north east London proposals; this will be revisited and reissued for decision-making and implementation planning purposes.

PCT and sector commissioning strategy plans provide a detailed account of financial plans and assumptions about relative spend on different types of care.

If it would be helpful we would be very happy to arrange for an overview of PCT and sector commissioning strategy and financial plans to be presented to the committee.

**Recommendation 10 – General**

*a. The Committee would like reassurance that Health for North East London is confident that the plans will be managed in such a way that will not be to the detriment of our most vulnerable residents.*

The primary drive for the changes to services that we have consulted on is to improve the health of our local residents through developing the best possible services across both primary, community and hospital services.

The Integrated Impact Assessment will provide an external and independent view of the health equalities impacts of the proposals along with recommendation for mitigating actions for any negative impacts identified; particularly for disadvantaged groups. The final IIA will be published for consideration by the Joint JCPCT in June.

At the appropriate stage in the process the JCPCTs will carefully review implementation plans to assure themselves that the changes will not adversely impact our most vulnerable residents

**Recommendation 11 – Access and Accessibility**

*a. Produce robust monitoring framework to capture quality of care, satisfaction for whole service provision including transfers between facilities.*

"Benefits realisation" is a core concept as the programme moves towards implementation and we will be working to define clearly service standards and expected benefits across care pathways from any changes that are taken forward. This will build on work that was undertaken during the development of the pre consultation business case – see section 3 of that document.

**Recommendation 12 – Travel**

*a. Recommend PCTs insist all acute trusts and major healthcare facilities produce quality travel plans that cover patients, visitors and staff.*

*b. For Travel plans to be approved by Transport for London or highway authority.*

*c. A Trust Board Member is given responsibility for transport and access including the production, maintenance and periodic review of a comprehensive travel plan.*

*d. Seek assurance that patient transport services provided by trusts and PCTs will be accessible and reflective of changes e.g. cross border transport for patients. Appropriately covering the wider region and takes account of the locations of new provisions such as UCC and polyclinics.*

*e. Encourage PCTs to hold discussions with relevant highway authorities (TFL, Local Authority or Highway Agency) to make sure that clear and adequate signage is provided both on site and in the surrounding areas of all new healthcare facilities implemented.*

We are absolutely committed to working with our local communities and partners to fully understand current and future access and travel issues for local health service provision and are committed to making services as easy to access as possible. Our overall strategy is very much based on the ethos of delivering services as close to home as possible, with extended access in primary care and polyclinics a key element of this. Set against this is the need to centralise or consolidate some more specialist services to ensure quality and safety, as per the proposals under this consultation.

We will be establishing a north east London wide travel and access group that all health partners will be linked into. The draft terms of reference for this group are available on request and we would be very happy to discuss this further with you if this is helpful.

The remit of this group will include ensuring that all NHS provider organisations have high quality travel plans in place, reviewing patient transport services and liaison with local authorities and TfL on improvements to public transport services. We are liaising with Tracey Anderson in respect of potential local authority representatives on this group. This group will review these recommendations and advise on actions needed to take them forward.

**Recommendation 13 - Communication**

*a. The Committee recommends the development of a communication strategy for the sector and each PCT area giving a clear consistent message about the changes to services - facility location, services available, opening times and when and why they should use different services.*

*b. Communication to the public about the assurance of LAS staff capability and travel times to transport patients to the correct health care facility and specialist centre.*

*c. Following confirmation of the decision taken by JCPCT. All PCTs to provide the public with progress updates about the implementation of the vision across sector and in each area.*

We intend to write to all respondents to the consultation (where we have their contact details) to advise them of the decisions and recommendations. We understand the ongoing importance of communication with local residents and service users about changes going forward and will continue to prioritise communications in the decision making and implementation planning phases of the programme. We will ensure that the ONEL People's Platform and LINks organisations are given the opportunity to inform and comment on our communications strategies and materials and would be happy to discuss these further with the committee at the appropriate stage in the programme. We clearly recognise the need to communicate clearly with our public and patients about what services are available, when, where and how to access them and will prioritise this work over the coming year.

**Recommendation 14 – Health Outcomes**

*a. The Committee seeks to find out how the different changes taking place in the NHS are being considered together and not in isolation and would like assurance that the impact of other NHS changes being implemented will be taken into consideration prior to any final decision being made.*

The Committee should be assured that the review of acute services is being undertaken in conjunction with out of hospital developments.

The PCTs and sectors Commissioning Strategy Plans bring together at a high level the commissioning strategy and financial plans for the next five years including the investment in community and primary care planned alongside the containment of demand for hospital and specialist services.

The proposed changes for acute services are also closely linked to some of the potential organisational changes – the proposal to create a new trust bringing together Homerton, Newham and Whipps Cross is part of the three Trusts' response to the challenges of delivering acute service changes.

All of these changes, including those to PCT provider services are considered regularly by the JCPCTs and Boards of the local NHS organisations.

**Recommendation 15 – Training**

*a. That steps be taken to ensure that the impact of staff being relocated and detached from the local community does not affect the needs of the individual.*

*b. A workforce strategy be produced detailing how staff minimum training needs, the impact of the relocation on service provision, workloads and staff travel affected by the proposals will be addressed.*

*c. Assurance that the impact of other NHS changes being implemented will be taken into consideration prior to any final decision being made.*

*d. To ensure that the shift to community-led nursing is fully planned for, the cooperation of educational institutions to run suitable diploma courses be secured.*

*e. How differences in the demographics of staff to community group being served for specialist centres and cross border services will be overcome and the needs of each community group catered for as they would do at their local service provider.*

We are currently reviewing the workforce implications of the proposals and variations to the proposals that have arisen in the consultation process and a summary of this work will be provided to support Joint JCPCT decision-making in July. As we move into implementation of any changes, workforce will clearly be a central issue, fundamental to the success of any changes. It will as such be a key area of work going forward. The recommendations above will be considered as part of this work.

**Recommendation 16 – Recruitment**
*a. That a strategy for each PCT be produced with details of how the vacancy rates for midwives will be reduced.*

See above recommendation 2(b). PCTs will work with their key local provider to develop local workforce strategies, linked to a north east London wide strategy.

**Recommendation 17 – Mental Health**

*a. The Committee requests the local PCTs to hold discussions with the East London NHS Foundation Trust about co-location of community mental heath teams in polyclinics, UCS and GP led health centres to help provide support and expertise with assessment or support for a crisis.*

*b. The Committee would strongly recommend staff in the new health services set up in the community are provided with the correct training, support services to treat, manage and refer mental health service users should they present in the service provision.*

The three INEL PCTs already work collaboratively to commission mental health services from the main provider: East London Foundation Trust.

This arrangement has recently been strengthened through the addition of an East London and City Alliance Strategic Executive Group (chaired by Melanie Walker, CEO NHS Newham) and a clinical and social care advisory group to address sector-wide mental health commissioning issues. One of the priorities for the sector in terms of mental health is building skills in primary care including training programmes for GPs and community staff groups. This features in the sector Commissioning Strategy Plan.

In addition the Strategic Executive Group has considered potential redesign of community mental health team structures and development of primary care capacity and skills to ensure a more community-based approach for mental health. This approach is now being developed further with clinicians with the objective of a pilot in at least one polysystem in INEL in 10/11. Evaluation of such a pilot will inform roll out to other polysystems.

East London and the City Alliance

**Chief Executive's Office**
Aneurin Bevan House
81-91 Commercial Road
London
E1 1RD
Tel: 020 7092 5840
Email: alwen.williams@elca.nhs.uk

14 May 2010

Dear Chair and Vice Chair

**Final Report of the Joint Inner North East London Overview and Scrutiny Committee for Health on the Health for north east London acute services review of April 2010**

I am writing to thank you for the *Final Report of the Joint Inner North East London Overview and Scrutiny Committee for Health on the Health for north east London acute services review of April 2010*. I would particularly like to thank you for the time and attention that the committee has given to scrutinising the proposals and for producing such a comprehensive and thorough report.

I am glad that you broadly welcome the proposals and agree that they provide a real opportunity to drive up quality and improve access to healthcare. I also recognise the challenges to successful implementation that you raise; we will be considering carefully your recommendations throughout the decision-making and implementation planning processes.

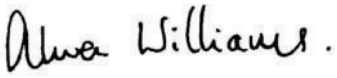
This report, along with the report from the Outer North East London Joint Health Overview and Scrutiny Committee, will be considered by the ONEL and INEL Joint Committees of Primary Care Trusts (JCPCT) when they meet as a Joint JCPCT (JJCPCT) in June. The JJCPCT is then expected to make decisions on the proposals at a further meeting in July. Both these meetings will be held in public and I very much hope you will be able to attend. The programme team is also arranging a briefing for key stakeholders in early June to which you will be invited.

Given that decisions are yet to be made on the proposals, the response that is attached to this letter sets out our thinking so far on how your findings and recommendations will be taken forward. We are keen to have ongoing dialogue with Committee members as the programme progresses into independent review and implementation phases. I note also your interest in several areas that you wish to receive further information on when available, namely:

- the potential changes to the organisational structures of Homerton, Newham and Whipps Cross Hospitals
- the development of polysystems and a care out of hospital strategy
- funding of the London Ambulance Service.

I would be very happy to provide further briefings to the committee on these issues as work progresses.

I look forward to discussing this with you further and to continuing to work together to improve the health and wellbeing of the people of East London and the City.



**Alwen Williams**
**CEO, East London and the City Alliance**

**Enclosures: Health for north east London response to recommendations**

# Press release 6 July 2010

**Public, patients and staff have their say on improving hospital services in north east London**

Many of the proposals developed by GPs, patients, doctors, nurses and other healthcare professionals to reorganise health services in north east London have received broad support from local residents.

Over 60,000 documents were distributed and around 10,000 people got involved in roadshows, meetings and other events during the Health for north east London consultation which ran from 30 Nov 2009 to 22 March 2010.

More than 3,000 residents and organisations responded to the consultation offering their views and suggestions on proposed changes to health services in the area. The findings, published today, will be formally presented at a meeting, held in public, on 13 July at West Ham Football Club.

The Secretary of State has instructed primary care trusts to stop and review their reconfiguration proposals with local GPs and local authorities in order to provide assurance that their proposals meet additional tests of local support. The findings from this consultation will be carefully considered by local clinicians, including GPs, hospital doctors, nurses and other health professionals as part of the review process and used to inform a final set of proposals for change. No decisions will be made on any of the proposals until this work has been undertaken and all feedback has been reviewed.

Dr Mike Gill, Joint Clinical Director, Health for north east London and Medical Director and Consultant Geriatrician at Newham University Hospital NHS Trust said;

> "The Health for north east London consultation has been a great success. We discussed our ideas for future health services with thousands of people and the feedback shows local people and patients want to see real changes in the NHS. People provided us with well-thought through answers which will help me and my colleagues during the coming months. We will now work closely with local partners to consider all the feedback and pull together a final set of clinical recommendations for change. No decisions will be made until this work has been undertaken."

Most respondents to the consultation agreed with the proposal to perform complex vascular surgery at The Royal London and Queen's Hospitals which will lead to better, safer care. The principles of separating planned and emergency surgery and separating children's and adults' A&Es were also welcomed by respondents. A number of the proposals for developing services at King George Hospital were also broadly supported including more planned surgery, renal dialysis, specialist services for children and enhanced services for adults and older people.

There was more support than disagreement for the following proposals;

- Providing surgery on children under two only at The Royal London (and not at Whipps Cross, Newham or King George Hospital)
- Providing urgent surgery and complex surgery on children under 15 at The Royal London and Queen's Hospital (and not at Whipps Cross, Newham or King George Hospital)
- Providing care for children with more complex needs at The Royal London and Queen's (and not at Homerton, Whipps Cross, Newham or King George Hospital)
- Moving all uncomplicated planned surgery from Queen's Hospital to King George Hospital
- The Royal London and Queen's becoming the major acute hospitals for the sector.

There was more disagreement than support from respondents about;

- Changing the number of A&Es and maternity delivery departments from six to five
- Over a third of respondents did not agree with proposals to move A&E and maternity delivery services from King George Hospital.

Dr John Coakley, joint Clinical Director of the Health for north east London programme and Consultant in Intensive Care Medicine at Homerton Hospital said;

> "We are very grateful for the support of Local Involvement Networks (LINks), councils' Joint Health Overview and Scrutiny Committees and other local groups, which have helped us to understand the views of thousands of local people.
>
> "More doctors, nurses, GPs and health professionals have been invited to join the clinical working groups to review the feedback from consultation. We are also looking at ways we can further strengthen the role of councils, patients and the public in shaping local health services."

An independent assessment of the impact of the proposals found that patients would benefit from change.

Sir Cyril Chantler, Chair of the Integrated Impact Assessment steering group said;

> "The reconfiguration proposals have the potential to bring benefit to the population of north east London in terms of improved health, wellbeing and clinical outcomes. Many of the positive impacts would be of particular advantage to people from equality groups, such as older people, disabled people, people from BME groups and those living in deprived areas. There are some areas of concern and the committee has made suggestions to deal with these."

During the consultation respondents expressed concerns about the proposals for maternity services, particularly about the size of proposed maternity units.

Carol Drummond, Head of Midwifery, Queen's Hospital said;

> "The most important change we want to make to maternity services is to give every mother in north east London the same high quality, one to one care no matter where she lives or where she chooses to have her baby. Women who are considered to have a low-risk pregnancy should be able to give birth at home or in a less clinical environment if they wish.
>
> "Early in the consultation we recognised that many people wanted smaller, more personal midwife-led units to be developed alongside the doctor-led units in the area. Midwives, doctors and GPs are now working together to see how we can amend our plans to provide more personal care."

**ENDS**

**Notes to editors:**

1. Following advice from the Independent Reconfiguration Panel (IRP) the Secretary of State, Andrew Lansley confirmed on 24 June 2010 that the Health for north east London consultation should continue; "The IRP considers that it is in the best interests of local health services for the current consultation process to run its full course…This referral is not suitable for full review." Read the full IRP's statement here

2. The Secretary of State has introduced a moratorium for all reconfiguration proposals in order for the NHS to provide assurance that their proposals meet four new tests (in addition to the existing legislative framework). The tests will require reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement (including local authorities);
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

Over the coming months we will be strengthening our engagement with GPs and local authorities and developing proposals that will improve the health of the local population.

In addition to our ongoing work with the JOSCs, informal discussions and consideration of council responses to the consultation, we will agree a process to further strengthen our engagement with local authorities in line with the Secretary of State's announcement.

3. The consultation was led by doctors, nurses and other healthcare professionals from:
    - NHS Barking and Dagenham
    - NHS City and Hackney
    - NHS Havering
    - NHS Newham
    - NHS Redbridge
    - NHS Tower Hamlets
    - NHS Waltham Forest
    - Barts and the London NHS Trust
    - Barking, Havering and Redbridge University Hospitals NHS Trust
    - Homerton University Hospital NHS Foundation Trust
    - Newham University Hospital NHS Trust
    - Whipps Cross University Hospital NHS Trust

4. Consultation responses were analysed by external assessors Ipsos MORI who prepared an independent report on their findings. Full results of the consultation can be found here

5. An **NHS primary care trust** (PCT) is a type of NHS trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and are responsible for commissioning secondary care.

6. Journalists are invited to attend the meeting of the Joint Committee of Primary Care Trusts, 5pm – 8.30pm, 13 July, West Ham Football Club. If you require any further information, would like to attend the meeting or would like to interview any of our spokespeople please contact Una Carney on una.carney@thpct.nhs.uk or 020 7092 5495. The number for urgent out of hours queries is 07813 023 740.

This page is intentionally left blank

# Health for North East London
# Integrated Impact Assessment

**Joint Meeting of the INEL and ONEL**

**Joint Committees Primary Care Trusts (JCPCT) Meeting**

**13th July 2010**

PHAST Public Health Action Support Team

Mott MacDonald

# Introduction

In September 2009, Health for north east London commissioned Mott MacDonald and the Public Health Action Support Team (PHAST) to undertake an independent Integrated Impact Assessment (IIA).

**Mott MacDonald:** a world-wide management, engineering and development consultancy, engaged in public and private sector development across a broad range of markets, from education and health, to power and transport.
**PHAST:** an independent social enterprise Community Interest Company (CIC), established and run by public health professionals.

The joint IIA team reported to an independent Steering Group (IIASG), chaired by Sir Cyril Chantler, Chairman of the King's Fund and former Chairman of Great Ormond Street Hospital.

The IIASG included members of the People's Platforms, an assembly member of the GLA, and Public Health Officials from local PCTs and NHS London.

# Scope of the Integrated Impact Assessment

The objective of this IIA is to identify the positive and negative impacts of the proposed reconfiguration of acute health services in north east London upon the local population and to identify mitigation measures and strategies

Specifically, the IIA focuses upon impacts in the following areas:

- Health Outcomes
- Equalities (Six statutory groups: gender, age, race/ethnicity, disability, faith/religion, sexual orientation – and deprived communities)
- Access (Transport mode; patient flows; wider access issues e.g. parking, signage; 'social access')
- Carbon (Procurement (e.g. goods and services); buildings and energy; transport)

This was a complex piece of work which consequently has considerable detail in the report

This depth of information enables enhancement/mitigation action to be targeted and also assures transparency



PHAST Public Health Action Support Team

Mott MacDonald

# What is an Health IIA?

- An assessment of plans, projects, programmes or policies prior to implementation
- Predicts the impacts of these proposals
- Recommends enhancement and mitigation measures and strategies
- Health IIA – focuses on 'health and well being' rather than just service provision or clinical care and utilises both quantitative and qualitative data
- Qualitative evidence is key as it:
  - Incorporates 'real world' experience, knowledge, opinions and perceptions
  - Provides useful information on certain impacts where it is not possible to make a quantitative estimate
  - Provides new perspectives on health inequalities that may not emerge from quantitative findings
- An IIA It is not designed to produce new research
- Activities include:
  - Accessing resources
  - Identifying stakeholders
  - Gathering and analysing quantitative and qualitative data
  - Synthesising and appraising information

# Assessment Methodology

- Documentation Review
  - Clinical Working and Clinical Reference Groups papers, Pre Consultation Business Case, Patient Surveys, JSNAs (Joint Strategic Needs Assessments), Ipsos MORI and Article 13 Reports
- Stakeholder Engagement
  - Facilitated workshops, 1:1 meetings, Traditionally Under represented Groups (TUG) meetings
- Access Modelling
  - Private, Public transport
- Access Assessment
  - Site visits
  - Interviews with PALs
- Carbon Emissions Modelling

# Headline Findings

- For all services, improved **health and clinical outcomes** is the major benefit of the proposals and outweighs the disadvantages, e.g. longer travel times.
- In terms of **access**, average travel times, for both private and public transport would increase for all of the services.
  - The travel impacts are highest for the most complex services which have the lowest demand e.g surgery for the under two year olds and complex vascular surgery
  - For the higher demand services e.g A&E and maternity delivery services the impact upon travel times is less with average journey times increasing by 4 and 5 minutes respectively
- In most cases, high demand services such as outpatients (including ante and post natal clinics) and diagnostics would be provided in settings closer to home such as urgent care centres and other community based settings such as polyclinics and children's centres.
- The proposals are likely to deliver **carbon** reductions in future compared to the "do minimum" scenario through patients being treated closer to home and increasingly efficient building use.

# Potential Positive Impacts and Opportunities

- **Impact:** Improved health and clinical outcomes
- **Impact:** Access to more specialist care

  **Opportunity:** To ensure that the new arrangements are well communicated to residents, GPs and health care workers. Consistent and sustained communication will be necessary to build a 'culture of confidence' amongst patients and earn their trust in the new service model.

  **Opportunity:** Improved clinical outcomes and health benefits would only be derived through the effective implementation of the reconfiguration proposals. It is recognised that this provides Health for north east London with the opportunity to develop a systematic and comprehensive strategic delivery plan underpinned by a proactive change management process.

# Potential Positive Impacts and Opportunities

- **Impact:** Benefits of more community-based care

  **Opportunity:** With the development of new polysystems, need to ensure encouragement of interfaces between health and social care and provide a total care package in one setting.

- **Impact:** Reduced carbon emissions

  **Opportunity:** Development of carbon reduction plans for each of the hospitals affected by the proposals, focussing on such issues as: energy and carbon management; procurement and food; water; travel, transport and access; waste; and finance.

# Potential Negative Impacts and Mitigations

- **Impact:** Confusion for patients and their relatives regarding where to go to access the health care services that they need

  **Mitigation:** Good communication between hospitals, GPs and primary care and local communities. Protocols and transfer arrangements will also need to be developed across NEL with the London Ambulance Service.

- **Impact:** More complicated discharge and after care arrangements

  **Mitigation:** To establish protocols for patient transfer, discharge and rehabilitation. This will need to be across Boroughs and across PCTs. This is necessary during both the transitional phase, and the period following full implementation.

- **Impact:** Negative travel impacts are likely to be felt by carers, relatives and visitors more than patients . In many cases, journey times will increase and travel may be less familiar to different hospitals, with some hospitals being subject to car parking capacity difficulties. Particularly affected Wards fall within the Boroughs of Redbridge, Havering and Waltham Forest.

  **Mitigation:** Provision of comprehensive travel information; provision of clear public signage to each hospital; ensuring that providers have high quality travel plans in place for patients, staff and visitors; development of a fare concession scheme subsidising public transport, taxi trips, or parking charges; to improve/provide accommodation arrangements and facilities on-site; and to address available car parks, their inconsistencies in prices.

# Potential Negative Impacts and Mitigations

- **Impact:** Extra pressure on existing sites and services, maternity units in particular

  **Mitigation**: Review and redesign of existing clinical and operational processes to maximise patient flow and demand management and achieve optimal length of stay for high volume conditions.

  **Mitigation:** Development of alternative models of care for the management of long term conditions to avoid unnecessary admissions, including the use of nurse led community based clinics and 'Expert Patient' self management programmes.

  **Mitigation:** To develop well-integrated services with the majority of ante-natal and post-natal care located in the community, which offers the possibility of having co-located low risk units run by midwives to assist with the quality of care.

- **Impact:** Anxiety expressed about the potential for reduced sensitivity to equality group needs

  **Mitigation:** Whilst some providers have recognised expertise in meeting the needs of their local populations and equalities groups (e.g. Homerton, Newham) others need to work to ensure that, in context of NELs diverse population, they continuously review how well they do this, taking into account their current / new patient populations. In particular in the light of these proposals BLT and Queens will need to demonstrate how they will ensure needs of 'new' patients will be met.

- **Impact:** Reduction in patient choice

  **Mitigation:** To ensure effective communication as to why the concentration of services is taking place and where choice remains.

# Key Implementation Factors

Successful implementation will require an integrated approach including:

- Effective clinical networks including across primary, secondary and community care
- Good clinical leadership
- Better links between all health sectors and social services
- Integrated commissioning across north east London
- Targeted organisational support
- Appropriate use of milestones

# In Summary…

- The proposals have positive impacts:
  - improving health and clinical outcomes
  - access to more specialist and community based services
  - reduced carbon emissions
- The negative impacts include:
  - confusion for patients and their relatives and carers about what service to access where,
  - more complicated discharge and after care arrangements
  - slightly more difficult access to services for some people
  - reduced sensitivity for some equality groups
  - extra pressure on existing sites and services.
- In our opinion, the positive impacts outweigh the negative impacts and with appropriate actions by Health4NEL and others, any negative impacts can be substantially mitigated.

# Transport Methodology

- Journey times are from the Health Services Travel Analysis Toolkit (HSTAT) created for London Health Accessibility analysis. Journey times are for the AM peak.
- Average journey times calculated from each ward to each hospital.
- During the modelling phase the nearest suitable hospital by travel time is considered the most suitable hospital for that Ward before and after reconfiguration.
- Wards have been used instead of Output areas because they match the patient flow data and are more comprehensible/familiar to the general public.
- People's personal experience may differ, e.g. congestion.
- Flows recorded as well as population - to provide an indication of the likely demand.
- Journey times for both public and private transport have been mapped and calculated in ten minute intervals.
- For the 'longest journey time' and 'highest increase in journey time' the worst three electoral wards in each model have been identified.

This page is intentionally left blank

# What will happen next

Helen Brown, Programme Director

# Next steps

- Decision making paper
  - Clinical review including GP commissioners
  - Further stakeholder engagement
  - Further work with Joint Overview and Scrutiny Committees and local authorities
  - Review governance and decision making structures to take account of the Secretary of State's 'four tests'
  - Implementation planning and gateways

- Issues raised during the consultation
  - How do these feed into decision making?
  - What information is already available?
  - What further work are we doing? e.g. model capacity and activity, review population projections, preparation for implementation

# Travel

- Recognise the importance of access and concerns about the potential impact of the proposals on travel times, particularly in relation to King George Hospital

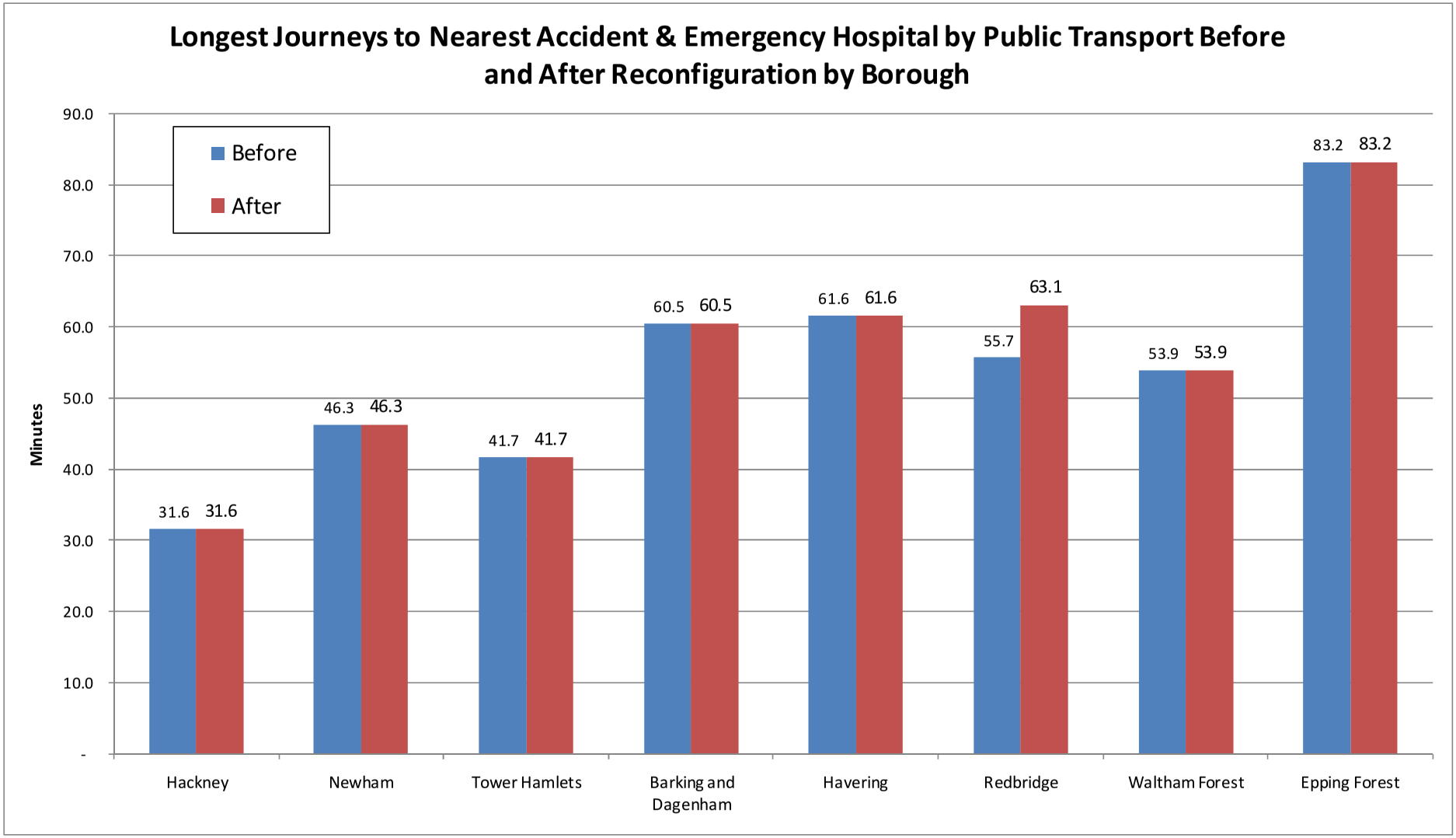
- Understand concerns regarding accuracy of Health for north east London travel analysis, however it is based on Transport for London's approved model

- Local where possible / care outside of hospital is the key principle

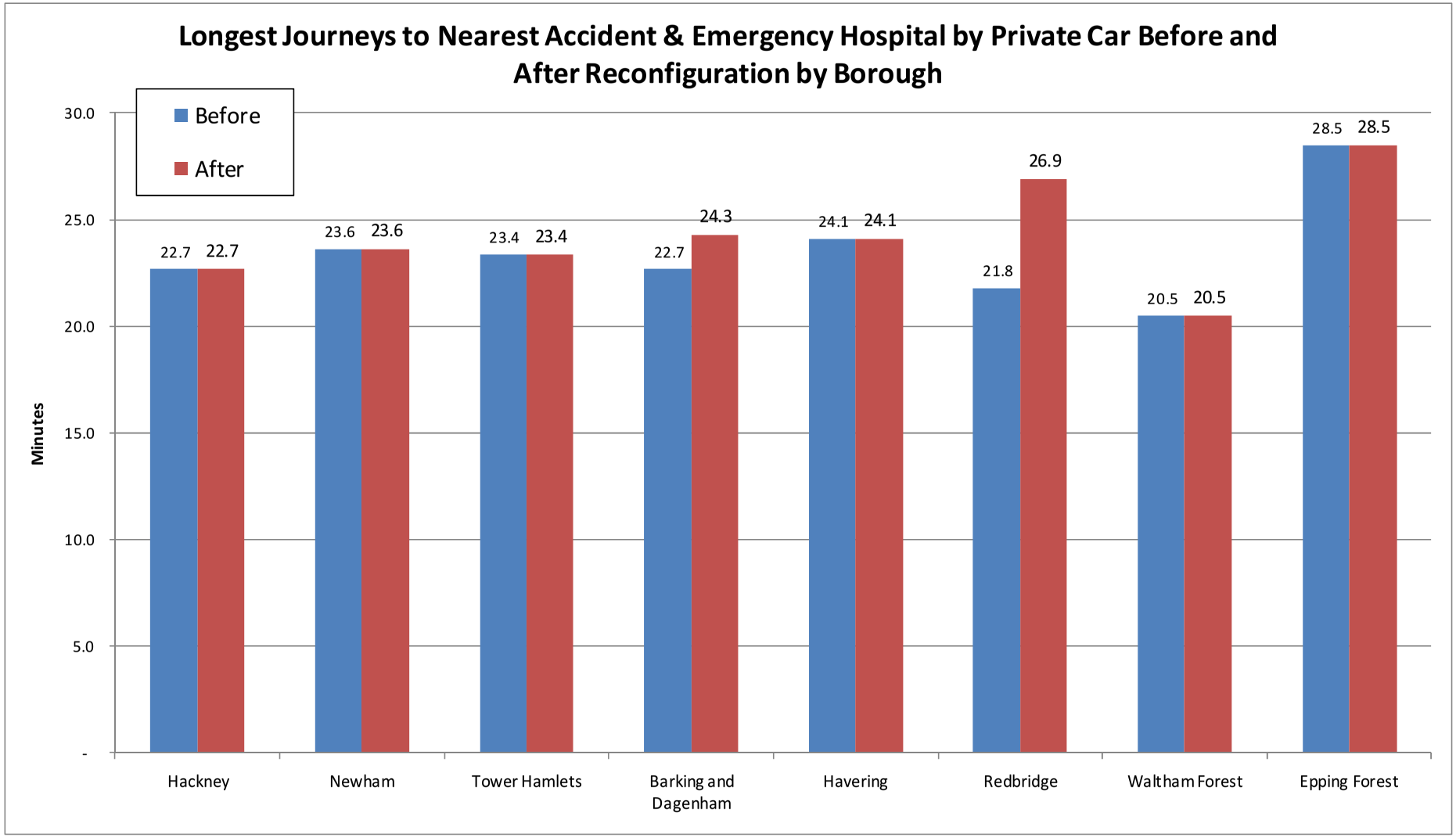
- Travel advisory group to address current concerns and to look at ways to mitigate impact of any future changes

- Relative start and finish points important to understand not just absolute travel time impacts for affected areas…

# Travel


Longest Journeys to Nearest Accident & Emergency Hospital by Public Transport Before and After Reconfiguration by Borough
Before
After
Minutes
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
-
31.6 31.6
46.3 46.3
41.7 41.7
60.5 60.5
61.6 61.6
55.7 63.1
53.9 53.9
83.2 83.2
Hackney
Newham
Tower Hamlets
Barking and Dagenham
Havering
Redbridge
Waltham Forest
Epping Forest

# Travel


Longest Journeys to Nearest Accident & Emergency Hospital by Private Car Before and After Reconfiguration by Borough
Before
After
Minutes
30.0
25.0
20.0
15.0
10.0
5.0
-
22.7 22.7
23.6 23.6
23.4 23.4
22.7 24.3
24.1 24.1
21.8 26.9
20.5 20.5
28.5 28.5
Hackney
Newham
Tower Hamlets
Barking and Dagenham
Havering
Redbridge
Waltham Forest
Epping Forest

# Meeting of the Joint Committees of PCTs

13 July 2010