TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 26 October 2010 at 6.30 p.m.

A G E N D A

VENUE
Room M72, 7th Floor Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Tim Archer **Vice-Chair: Councillor Rania Khan**	
Councillor Shelina Aktar **Councillor Abdul Asad** **Councillor Alibor Choudhury** **Councillor Lutfur Rahman** **Councillor Kosru Uddin**	Councillor Dr. Emma Jones, (Designated Deputy representing Councillor Tim Archer) Councillor Mohammed Abdul Mukit MBE, (Designated Deputy representing Councillors Shelina Akhtar, Abdul Asad, Alibor Choudhury, Rania Khan, Lutfur Rahman and Kosru Uddin) Councillor Anna Lynch, (Designated Deputy representing Councillors Rania Khan, Shelina Aktar, Abdul Asad, Alibor Choudhury, Lutfur Rahman and Kosru Uddin) Councillor Lesley Pavitt, (Designated Deputy representing Councillors Rania Khan, Shelina Aktar, Abdul Asad, Alibor Choudhury, 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, 26 October 2010

6.30 p.m.

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**	**3 - 8**	
	To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 27th July 2010.		
4.	**REPORTS FOR CONSIDERATION**		
4.1	**Access to GP services – the Ocean Estate - NHS Tower Hamlets - Verbal Update.**		
4.2	**Joint Report on Complaints across the three local Trusts - NHS Tower Hamlets**	**9 - 22**	
4.3	**East London and City Alliance Commissioning Strategy Plan Update - NHS Tower Hamlets**	**23 - 44**	
4.4	**THINk Patient and User Comments Report and Recommendations 2010 - Presentation**		
4.5	**Update on Joint Strategic Needs Assessment - Briefing and Presentation**	**45 - 66**	
4.6	**Health Scrutiny Panel Work Programme**	**67 - 76**	
5.	**ANY OTHER BUSINESS**		
5.1	**Update on:1) INEL JOSC 2) Polysystems Challenge Session Report**		

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 6.30 P.M. ON TUESDAY, 27 JULY 2010

GROUND FLOOR MEETING ROOM OF BURDETT HOUSE, MILE END HOSPITAL.

Members Present:

Councillor Tim Archer (Chair)

Councillor Shelina Aktar
Councillor Abdul Asad
Councillor Kosru Uddin
Myra Garrett

Other Councillors Present:
Nil

Co-opted Members Present:

Myra Garrett	–	(THINk)

Guests Present:

Paul James	–	(East London NHS Foundation Trust)
Graham Simpson	–	(Barts & the London NHS Trust)
Ben Vinter	–	Head of Corporate Affairs, NHS Tower Hamlets
John Wilkins	–	East London NHS Foundation Trust
Jane McClean	–	(Associate Director Commissioning, NHS Tower Hamlets)

Officers Present:

Rachael Chapman	–	(Strategy & Policy Officer)
Deborah Cohen	–	(Service Head, Commissioning and Strategy, Adults Health and Wellbeing)
Katie McDonald	–	(Scrutiny Policy Officer, Scrutiny & Equalities , Chief Executive's)
Hafsha Ali	–	(Acting Joint Service Head Scrutiny & Equalities, Chief Executive's)
Alan Ingram	–	(Democratic Services)

COUNCILLOR TIM ARCHER (CHAIR) IN THE CHAIR

1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillors Alibor Choudhury, Rania Khan and Lutfur Rahman and Dr Amjad Rahi, Co-opted Member.

The Chair added that he would have to leave after consideration of the first agenda item, owing to other meeting commitments, following which Councillor Abdul Asad would chair the Panel for the remainder of the meeting.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. UNRESTRICTED MINUTES

The minutes of the meeting of the Panel held on 22 June 2010 were agreed as a correct record, subject to the inclusion of Dr Ian Basnett, Director of Public Health, Tower Hamlets, and Mr John Wilkins, East London NHS Foundation Trust, in the list of those present.

4. REPORTS FOR CONSIDERATION

5.1 NHS White Paper

Mr Ben Vinter, Head of Corporate Affairs, NHS Tower Hamlets, provided a brief to Members including a tabled update document summarising the new Government's White Paper and some of its key proposals. These included measures to improve outcomes to the level of the best in the world; giving patients increased choice about where and how they are treated; improvements to the commissioning of healthcare services; the development of all NHS trusts to foundation status by 2014; new roles for local authorities. Mr Vinter added that Panel Members were invited to consider the changes proposed and an in-depth presentation would be made in October.

Ms M. Garrett referred to the Department of Health Document "Liberating the NHS" and it was **agreed** that Ms Katie McDonald, Scrutiny Policy Officer, provide copies for all Panel Members.

At 6.45 p.m. Councillor Tim Archer left the meeting.

COUNCILLOR ABDUL ASAD IN THE CHAIR

Discussion ensued on how local links could feed into the consultation programme on the White Paper and Mr Vinter expressed support for the Chair's suggestion that the matter could be addressed through the Council's LAP programme.

It was **agreed** that Ms Hafsha Ali, Acting Joint Service Head Scrutiny & Equalities, would consider how her service might assist in facilitating the White Paper consultation processes locally.

5.2 Six Lives Panel Project - NHS London Health Self-Assessment

Ms Jane McClean, Associate Director Commissioning, NHS Tower Hamlets, introduced her report relating to both the Six Lives Panel Project and the subsequent NHS London health self-assessment for learning difficulties. She indicated that the Rix Centre had been commissioned to produce a DVD in response to the Ombudsman's recommendations following the Mencap's *Death by* Indifference report (also known as Six Lives). This process enabled service users with learning difficulties and carers to recount their experiences in accessing relevant services. This was aimed at identifying gaps in service provision. The Panel then proceeded to view a DVD showing excerpts of the project.

Ms McClean also tabled documents regarding the Rating At A Glance (RAG) assessment that had also been submitted as part of the NHS London health self-assessment, and an action plan which had subsequently been developed in order to ensure people with learning difficulties were able to access mainstream health services. This work was being taken forward by the Healthy Lives Sub Group of the Borough's Learning Disabilities Partnership Board.

Discussion ensued on the tabled information, which was broadly felt too detailed for immediate comments to be made. Ms Katie McDonald, Scrutiny Policy Officer, commented that the information had not been available in time to distribute with the meeting agenda. It was **agreed** that Ms McDonald pass on to Ms McClean any comments that Members may wish to make on the RAG plans.

5.3 Health Scrutiny Evaluation - Summary and Action Plan

Ms Katie McDonald, Scrutiny Policy Officer, introduced the report containing the Summary and Action Plan in response to the Health Scrutiny Evaluation conducted by Mr Tim Young in January and February 2010, the Final Evaluation Report having been considered by the Panel in March 2010. She added that many of the action plan points would be ongoing throughout the year.

Ms Hafsha Ali, Acting Joint Service Head Scrutiny & Equalities, commented that it was recognised that Health Scrutiny had a powerful role to play for health issues in Tower Hamlets and there were many practical actions to be taken. However, the Panel's functions were very broad in nature and there needed to be a closer focus on particular issues and change the culture of meetings, so as to be able to maximise the potential of the Panel.

The Action Plan was **agreed** as put forward.

5.4 Health Scrutiny Panel Work Programme 2010/11 - 2011- 2012

Ms Katie McDonald, Scrutiny Policy Officer, introduced the report outlining the draft two year work programme for the Health Scrutiny Panel for municipal years 2010/11 and 2011/12. She pointed out that some updating of the draft would be required, with particular reference to maternity services and facilities for adults with learning difficulties. Challenge sessions would be held later in the year in connection with Polysystems and Reconfiguration of Local Services (November); also the development of cancer preventative services (December).

Mr Ben Vinter, Head of Corporate Affairs, NHS Tower Hamlets, welcomed the dialogue with Councillors and indicated that the PCT found the challenge sessions helpful and supported this approach. They were also investigating how best to be able to spread dialogue to include local communities.

Members referred to possible problems caused by language barriers between GPs and patients and the fundamental changes that were intended for the NHS by the new Government.

It was **agreed**:

(1) that options for managing the work programme be approved;
(2) that the work programme be reviewed every quarter.

5.5 Health for North East London - Response to INEL JOSC recommendations

Ms Katie McDonald, Scrutiny Policy Officer, indicated that the circulated reports were intended as information and a reference for Members, comprising:

- The response from Health for North East London (Programme Team) to the Inner North East London Joint Overview and Scrutiny Committee Report.
- The independent Integrated Impact Assessment undertaken by Mott MacDonald and Public Health Action Support Team.

She added that these would be the subject of more work by the Panel later in the year.

In response to queries Mr Ben Vinter, Head of Corporate Affairs, NHS Tower Hamlets, stated that consultation responses and evidence base contributing towards the programme's recommendations were to be retested over the summer due to requirements set by the new Government and outcomes were expected in the autumn.

The report was noted.

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

6.1 Improving Physical Access

Mr Brian Harvey, a Trust Member of the East London NHS Foundation Trust, circulated a document promoting the provision of mixed forms of seating in public buildings to meet the needs of individuals with particular needs and also information produced by RNIB Access Consultancy Services concerning colour schemes designed to assist people with visual problems.

Following discussion of the issues involved, it was **agreed** that the matter be included on the Panel agenda for 26 October 2010 and that, in the meantime, liaison take place between Ms Hafsha Ali's service, the Corporate Equality Group and Equalities Officer to explore possible action that might be taken.

The meeting ended at 8.00 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	**26 October 2010**	**Unrestricted**		**2**

Report of:	**Title:**
NHS Tower Hamlets Community Health Services East London Foundation Trust Barts and the London NHS Trust **Presenting Officers:** Caroline Alexander - Director of Quality Development (NHS TH) Anneliese Weichart – Associate Director for Clinical Governance and Workforce (Community Health Services) Judith Bottriell – Associate Director of Quality Improvement (BLT) Christine Bevan-Davies, Quality and Effectiveness Manager (BLT) Paul James - Acting Borough Director (ELFT)	Joint Report on Complaints across the three local Trusts **Ward(s) affected:** All

1. Summary

This presentation covers the key complaints issues at the three local health Trusts and has been put together jointly with BLT, ELFT and CHS. The presentation puts the number of complaints received into context and discusses the changes that have been made as a result.

2. Recommendations

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

This page is intentionally left blank

Joint report on complaints – 09/10

Health Scrutiny panel

26th October 2010

Barts and The London NHS Trust

NHS Tower Hamlets

NHS Tower Hamlets Community Health Services

East London NHS Foundation Trust

Complaints in context

Complaints received 09/10

	Numbers	Patient contacts	Complaints as %
Barts and The London	950↓	864,610	0.1%
Community Health Services	100↑	832,530	0.01%
East London Foundation Trust	77↑	149,478	0.05%

	Top issues
Barts and The London	Communication and attitude (32)↑ 12% fertility services 4% end of life care and deceased Diagnosis and clinical treatment (23%)↓ Appointments/clinics (19%)↓
Community Health Services	Attitude 23% (08/09) ↓ Clinical care/assessments 21% (08/09) ↑ Appointments 11% (08/09) ↓
East London Foundation Trust	Medication (21%)↑ Staff attitude (18%)↓ Patient property and expenses (9%)↓ Privacy and dignity (9%)↑ Communication (9%)↑

Changes made as a result of (BLT):

•**‘Excellence in Care Strategy’ (**Barts and The London NHS Trust’s Nursing, Midwifery and Allied Health Professionals in partnership with NHS Tower Hamlets, Community Health Services, School of Community & Health Sciences, City University, Barts and The London School of Medicine and Dentistry)

a 12-month development programme focussing on **compassionate care, in all patient services,** as part of enhancing the overall patient experience, involving four clinical teams/wards/departments.

Fertility Services

Poor customer service with top complaints: i) contacting the Unit ii) Communication iii) Appointment availability

Complaints were the driver for the LEAN pathway for staff who wish to provide a good service, with a review of the service and actions, including:

- Computerisation – currently introducing electronic systems of diaries and message boards
- Phones – discovery of patients phoning incorrect telephone number instead of dedicated queuing system phone (extra admin. member of staff recruited). Reduction from 85% to 43% “hang-up” rate.
- Secretarial backlog addressed and quicker turnaround
- Reduction in IVF treatment waiting times with a new system for direct referral from the clinic (still working with GP patients towards 18-week pathway)
- Semen Analysis backlog and times reduced
- No longer a referrals backlog and a new process for follow-up appointments

Changes as a result of CHS:

- Baby changing facilities on the Mile end site
- Awareness sessions about Bengali culture for nurses
- In depth communication training and customer awareness training for frontline staff

Changes as a result of (ELFT):

- Review of Trust's administrative processes by the Head of Administration identified need for patients to be informed in a timely way of all cancelled appointments, both by telephone and by letter, and also by text message.

- The Trust's "sleep over" protocol amended to include local procedures for staff, so that service users being received on a ward, are welcomed and orientated to the new environment.

- Gap in service provision in terms of policies, procedures and guidelines on transgender issues being addressed.

	Barts and The London	East London Foundation Trust	Community Health Services
White British	31%	32%	Information not available
Not stated	34%	34%	
Other Asian	8% (or Asian British Bangladesh)	10%	
Other Black	3%	6.5%	
White – other/Irish	7%	5%	
Other mixed	6%	2.5%	
Bangladeshi	See above	2.5%	
Other ethnic category	2%	2.5%	

Opening up the complaints process

Barts and The London	Community health services	East London Foundation Trust
•"tell us what you think" leaflet •Easy read version of leaflet •Lean review of service •Email •Fax •internet •Website •Proactive engagement with regular ward rounds •GP link project •Links with community organisations and groups	•Email •Internet •4 telephone lines •Call back for mobile users •Fax •Freepost address •"tell us what you think" leaflet •Targeted community events •Home visits •DVD for users with learning disabilities	•Freephone •Freepost •Leaflets and posters on all wards/depts (audited) •Meetings with service users as part of the resolution of their complaint

Ombudsman cases

	Number of cases	Those upheld
Barts and The London	51	1
Community Health Services	5	1
East London Foundation Trust	9	0

Overall themes

Complaints becoming more complex
Support in the community
Appropriate route via A&E
Discharge planning and liaison

Monitoring via commissioning

This page is intentionally left blank

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**26 October 2010**	**Unrestricted**		**3**
Reports of: NHS Tower Hamlets **Presenting Officer:** Alan Steward Deputy Director Delivery Directorate		**Title:** East London and City Alliance Commissioning Strategy Plan Update **Ward(s) affected:** All		

1. Summary

The attached presentation provides a summary of the progress in developing NHS Tower Hamlets' contribution towards the East London and City Alliance Commissioning Strategic Plan (CSP). It updates on the financial and activity modelling, the QIPP (Quality, Innovation, Prevention and Productivity) assessment and the impact of our current CSP initiatives to both address the QIPP and financial gap.

The financial and activity modelling identifies a gap of £30.4m in 12/11 with a cumulative gap of £72.0m by 14/15.

The QIPP assessment highlights key issues around:
- Improving primary care quality and access
- Improved delivery of integrated care outside hospital
- Cancer
- Acute performance and productivity
- Improving Mental Health
- Maternity/obstetrics
- Patient Experience/involvement

Our review of our current initiatives demonstrates that with redesign on some initiatives, they are tackling the identified QIPP gaps and contributing to closing the financial gap.

A substantial financial gap remains however and further work is proposed to bridge this gap.

2. Recommendations

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

This page is intentionally left blank

NHS
Tower Hamlets

Commissioning Strategic Plan 2011/12 – 2014/15 Update

Health Scrutiny Panel

26 October 2010

This presentation outlines

- **Our existing Commissioning Strategic Plan (CSP)**
- **The changes facing the NHS and the need to refresh the CSP**
- **The financial and quality gaps that face Tower Hamlets and Inner North East London**
- **The initiatives we will use to close those gaps**
- **Options and proposals to close the financial gap**
- **Our consultation and engagement plans and feedback to date**
- **Our next steps**

We developed last year's Commissioning Strategic Plan (CSP) to deliver our Joint Improving Health and Wellbeing Strategy

Our Vision

"is to improve the quality of life for everyone who lives and works in the borough by building One Tower Hamlets."

Our Strategic Aims

- Reducing inequalities in health
- Improving the experience of those who use services
- Developing excellent integrated and more localised services
- Promoting independence, choice and control by service users
- Investing resources effectively

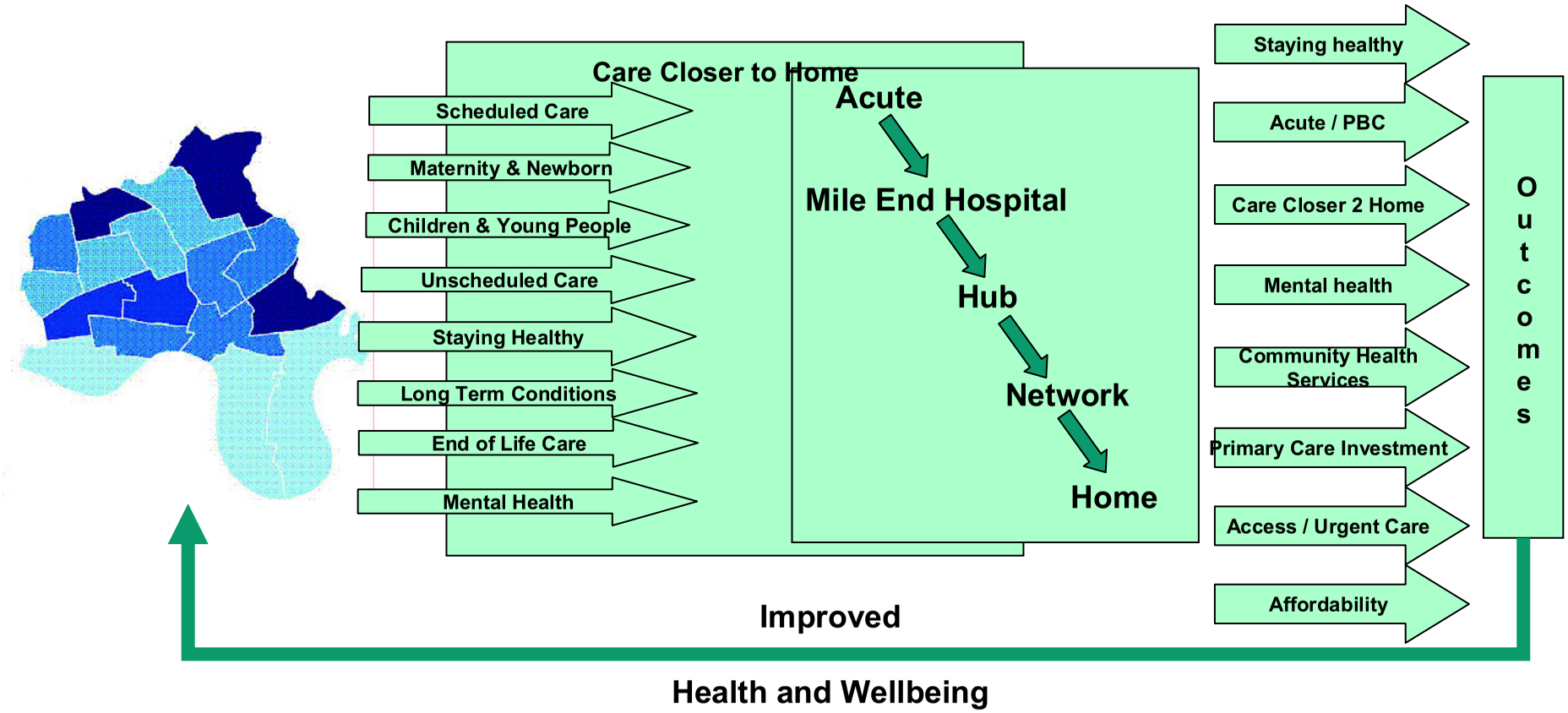
Key issues and drivers

- health inequalities and variations of care exist
- Rely on the high-cost hospital setting for outpatient activities and consultations
- Underdeveloped primary care
- Affordability gap

Overview of our Five Year strategy

NHS Tower Hamlets

Our Health Needs + Clinical Pathways + System Reconfigured + Programmes = Impact



Significant changes have affected the implementation of our CSP so that we reprioritised our investment programme and controlled our cost pressures

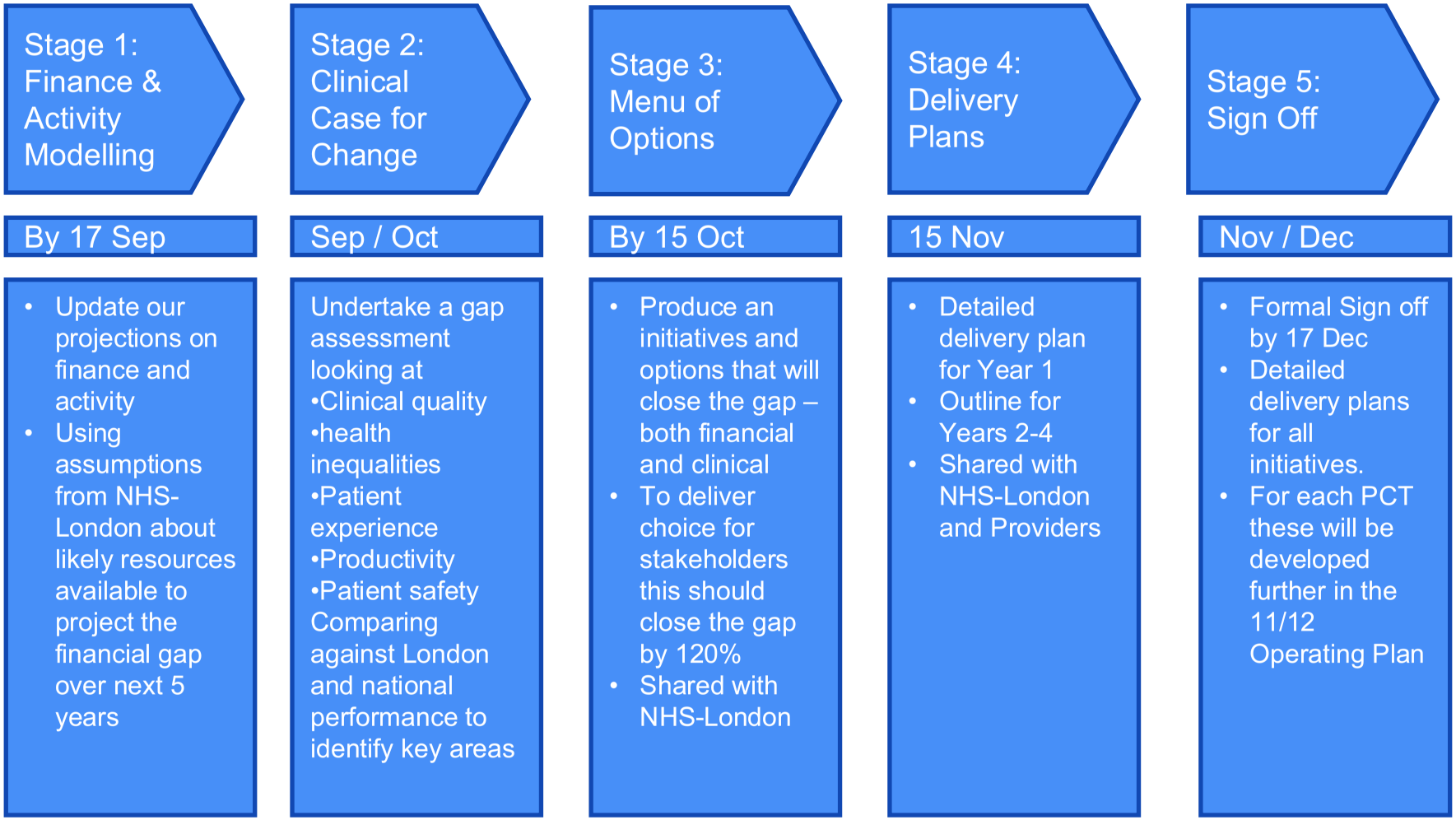
Changing priorities and context

- Coalition Government
  - White Paper
  - GP Commissioning and Transition
  - CHS Endstate
  - Wider public spending reductions
- Cost pressures
  - Hospital activity and cost greater than planned
  - Community Health Services not at full efficiency
  - Increased Management Cost savings target of 53%

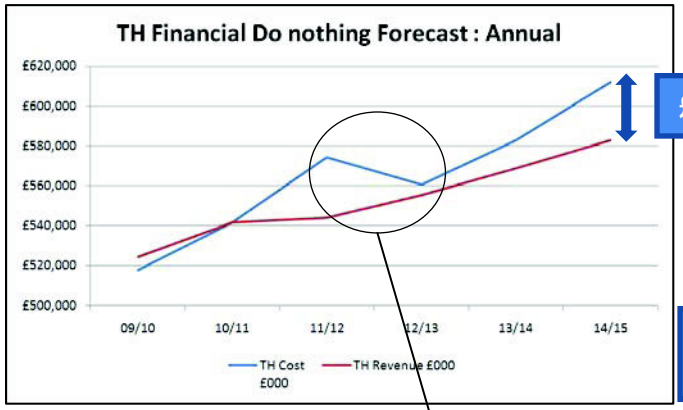
Reprioritisation Board May / June 2010

- Public Health - no additional investment
- Primary Care – Maintain agreed care packages, release investment for new care packages and to support Networks
- Mental Health - Priority to a dementia liaison service to reduce time in hospital
- Support transformation of primary care estate – Harford Street
- Budget Review Group to achieve in year savings of £3m
- Better information and monitoring of hospital activity with GPs

We are now refreshing the Commissioning Strategic Plan (CSP) to 2014/15



Stage1: The latest projection shows a cumulative TH gap of £72.0m by 14/15

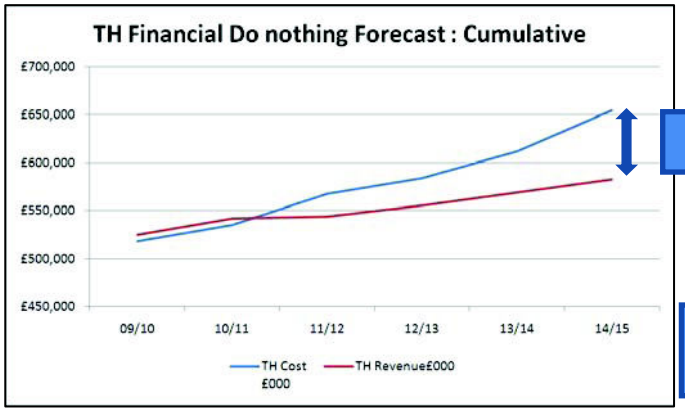


£30.4m

The gap across Inner North East London is £72.5m

Impact of decline of house completions - recession and picks up from 12/13

Year	TH Cost £000	TH Revenue £000	Diff £000
09/10	£517,693	£524,446	£6,753
10/11	£541,478	£541,566	£88
11/12	£574,295	£543,889	-£30,407
12/13	£560,602	£555,335	-£5,267
13/14	£582,898	£568,846	-£14,052
14/15	£612,016	£582,870	-£29,146



£72.0m

The gap across Inner North East London is £260.3m

Year	TH Cost £000	TH Revenue £000	Diff £000
09/10	£517,693	£524,446	£6,753
10/11	£534,725	£541,566	£6,840
11/12	£567,455	£543,889	-£23,566
12/13	£584,168	£555,335	-£28,833
13/14	£611,731	£568,846	-£42,884
14/15	£654,901	£582,870	-£72,030

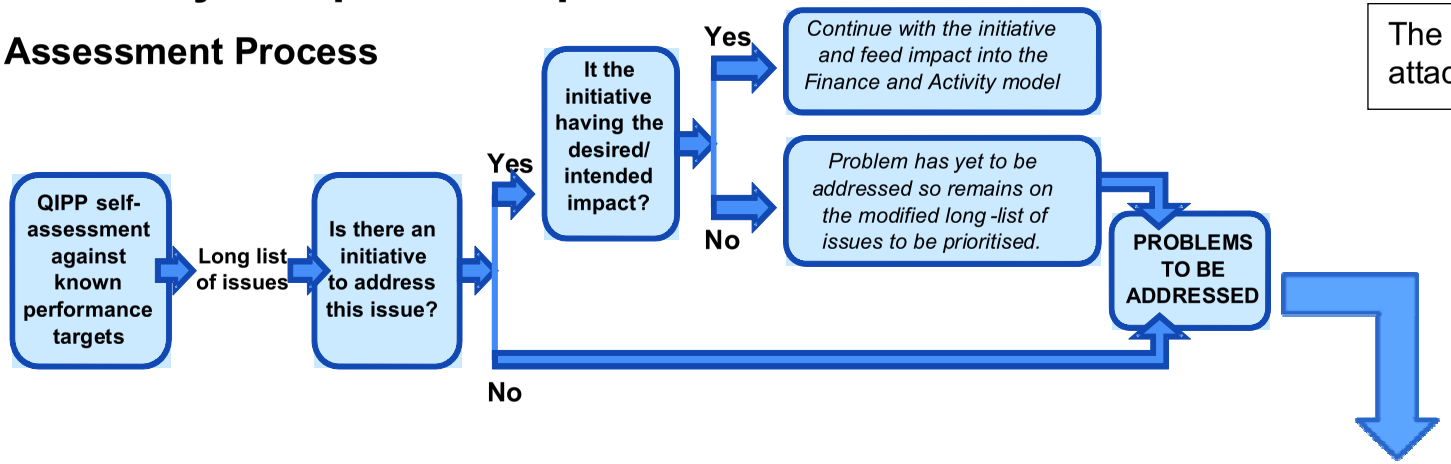
Key Assumptions

- Demographic growth
- Inflation and hospital tariffs
- Clinical changes
- Hospital Length of Stay – providers in top quartile by 2017
- Reducing demand for services in hospitals
- London topslices

These are set by NHS-London and are liable to change

Stage 2: We've compared performance on efficiency, quality and needs to highlight the areas of greatest gain. This has highlighted issues around acute over performance, mental health, access and quality of primary care, cancer, maternity and patient experience

Assessment Process



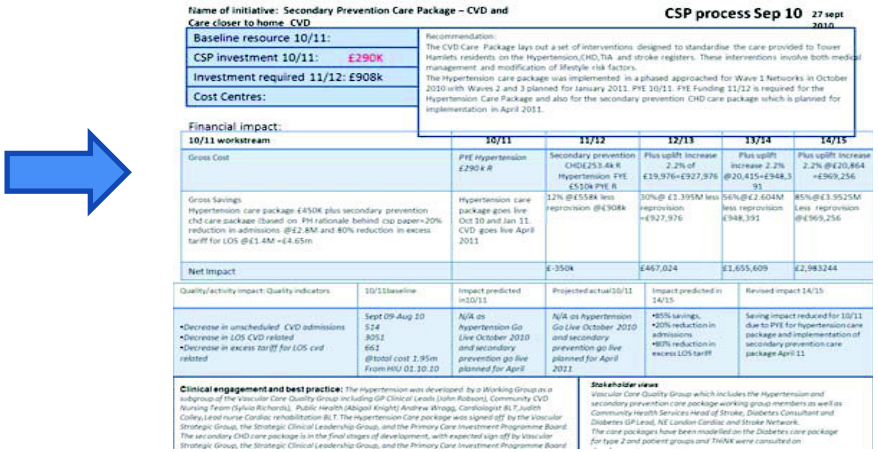
The final Sector assessment is attached as Appendix 1.

Primary Care	Secondary Care	Mental Health
• **Improving primary care quality and access**, including better management of LTCs, reduced variability & improved service quality • **Improved delivery of integrated care outside hospital** – Primary and Community Services better aligned to deliver high quality care in non-acute settings • **Improved screening**, public awareness and early detection of Cancer (e.g. CONTRACT LEVERS, PROCUREMENT, IMPROVED INTEGRATED CARE PATHWAYS, IT SOLUTIONS, PUBLIC & PATIENT INVOLVEMENT & SOCIAL MARKETING)	• **Acute performance and productivity** e.g. demand management, redesign of Urgent Care and improved clinical pathways (e.g. CONTRACT LEVERS, PRODUCTIVITY THROUGH PATHWAY REDESIGN & DEVELOPMENT OF ADMISSIONS AVIODANCE STRATEGIES)	• **Improving Mental Health** - planning for the ELFT contract (e.g. CONTRACT LEVERS & PRODUCTIVITY THROUGH PATHWAY REDESIGN)
• **Maternity/obstetrics** – patient experience and improved service quality; (e.g. CONTRACT LEVERS, AGREED RISK STRATIFICATION, IMPROVED INTEGRATED CARE PATHWAYS);		
• **Patient Experience/involvement** – need to build confidence in new service models and improve effective involvement in care planning. (e.g. LINk & WIDER PUBLIC & PATIENT INVOLVEMENT, PARTNERSHIP WORKING WITH LAs & SOCIAL MARKETING		

Stage 3: We have developed initiatives to meet the financial and quality gaps

Public Health	Primary Care	Mental Health	Enablers
•Reducing Adult Obesity •Promoting Healthy Workplace •Reducing Child Obesity •Tobacco Control •Improving Maternity •Child Death Panel •Safeguarding children •Reducing Alcohol •Community Health trainers •Cancer •Promoting Health in schools •Reducing Teenage Pregnancy •TB Control	•Shifting care outside of hospital and closer to home by speciality •Investing in care packages to manage Long Term Conditions better eg diabetes •Improving the productivity of Community Health Services •Improving access to primary care and reducing demand for Urgent Care	•Reducing the use of Out of Borough Accommodation •Dementia Liaison to reduce stays in hospital •Healthchecks for people with mental health problems •Reducing smoking for people with mental health problems	•Project Management of major capital schemes •Newby Place investment •IT to support Networks and GPs

We've collected information for all initiatives that sets out:
•Financial impact - costs and saving – over next five years
•What clinicians and other stakeholders think
•The impact on quality, patient choice, access and patient experience
•High level milestones
•Risk and mitigation


Name of initiative: Secondary Prevention Care Package – CVD and Care closer to home CVD

CSP process Sep 10 27 sept 2010

Baseline resource 10/11:	
CSP investment 10/11:	£290K
Investment required 11/12: £908k	
Cost Centres:	

Recommendation:
The CVD Care Package lays out a set of interventions designed to standardise the care provided to Tower Hamlets residents on the Hypertension,CHD,TIA and stroke registers. These interventions involve both medical management and modification of lifestyle risk factors.
The Hypertension care package was implemented in a phased approached for Wave 1 Networks in October 2010 with Waves 2 and 3 planned for January 2011. PYE 10/11. FYE Funding 11/12 is required for the Hypertension Care Package and also for the secondary prevention CHD care package which is planned for implementation in April 2011.

Financial impact:

10/11 workstream	10/11	11/12	12/13	13/14	14/15
Gross Cost	PYE Hypertension £290k R	Secondary prevention CHD£253.4k R Hypertension FYE £510k PYE R	Plus uplift increase 2.2% of £19,976=£927,976	Plus uplift increase 2.2% @20,415=£948,391	Plus uplift increase 2.2% @£20,864 =£969,256
Gross Savings Hypertension care package £450K plus secondary prevention chd care package (based on PH rationale behind cop paper=20% reduction in admissions @£2.8M and 80% reduction in excess tariff for LOS @£1.4M =£4.65m	Hypertension care package goes live Oct 10 and Jan 11 CVD goes live April 2011	12% @£558k less reprovision @£908k	30%@ £1.395M less reprovision =£927,976	56%@£2.604M less reprovision £948,391	85%@£3.9525M less reprovision @£969,256
Net Impact		£-350k	£467,024	£1,655,609	£2,983244

Quality/activity impact: Quality indicators	10/11baseline	Impact predicted in10/11	Projected actual10/11	Impact predicted in 14/15	Revised impact 14/15
•Decrease in unscheduled CVD admissions •Decrease in LOS CVD related •Decrease in excess tariff for LOS cvd related	Sept 09-Aug 10 514 3051 661 @total cost 1.95m From HIU 01.10.10	N/A as hypertension Go Live October 2010 and secondary prevention go live planned for April 2011	N/A as Hypertension Go Live October 2010 and secondary prevention go live planned for April 2011	•85% savings, •20% reduction in admissions •80% reduction in excess LOS tariff	Saving impact reduced for 10/11 due to PYE for hypertension care package and implementation of secondary prevention care package April 11

Clinical engagement and best practice: The Hypertension was developed by a Working Group as a subgroup of the Vascular Care Quality Group including GP Clinical Leads (John Robson), Community CVD Nursing Team (Sylvia Richards), Public Health (Abigail Knight) Andrew Wragg, Cardiologist BLT, Judith Colley,Lead nurse Cardiac rehabilitation BLT. The Hypertension Care package was signed off by the Vascular Strategic Group, the Strategic Clinical Leadership Group, and the Primary Care Investment Programme Board. The secondary CHD care package is in the final stages of development, with expected sign off by Vascular Strategic Group, the Strategic Clinical Leadership Group, and the Primary Care Investment Programme Board

Stakeholder views
Vascular Care Quality Group which includes the Hypertension and secondary prevention care package working group members as well as Community Health Services Head of Stroke, Diabetes Consultant and Diabetes GP Lead, NE London Cardiac and Stroke Network.
The care packages have been modelled on the Diabetes care package for type 2 and patient groups and THINK were consulted on

Our initiatives build on our successes so far and the lessons learnt

Successful
Limited

Impact

Staying Healthy	• Child Imms is approaching herd immunity • Meeting targets on stopping smoking, obesity and breast screening	
Hospital Services	• Hospital activity is greater than planned • Some reductions in low clinical value activity but within hospital referrals still high	
Primary Care Investment Programme	• All networks showing positive impact on diabetes – with more care planning and patients with controlled diabetes • NHS Healthchecks and Hypertension gone live	
Care Closer to Home	• Primary care activity has reduced • Secondary care not reduced – possibly new demand • Good progress for some specialities such as diabetes but more limited for others such as Urology	
Community Health Services	• Timetable shortened for End State to 1 Apr 11 (was 1 Apr 13) • Review of Bancroft Unit at Mile End Hospital to reduce use and length of hospital stay	
Urgent Care and GP Access	• GP streaming away from A&E is effective • New Urgent Care Centre at Royal London on track • Access to GPs sustained despite London / national decline	
Mental Health	• Base line review across Sector delayed • Dementia service from 1 Jan 10 • Residential care on track and delivering	
Affordability	• Cost pressures including more activity in hospitals than planned • Budget review has released £3m	

The eight programmes with enablers help close the financial gap in 11/12 …

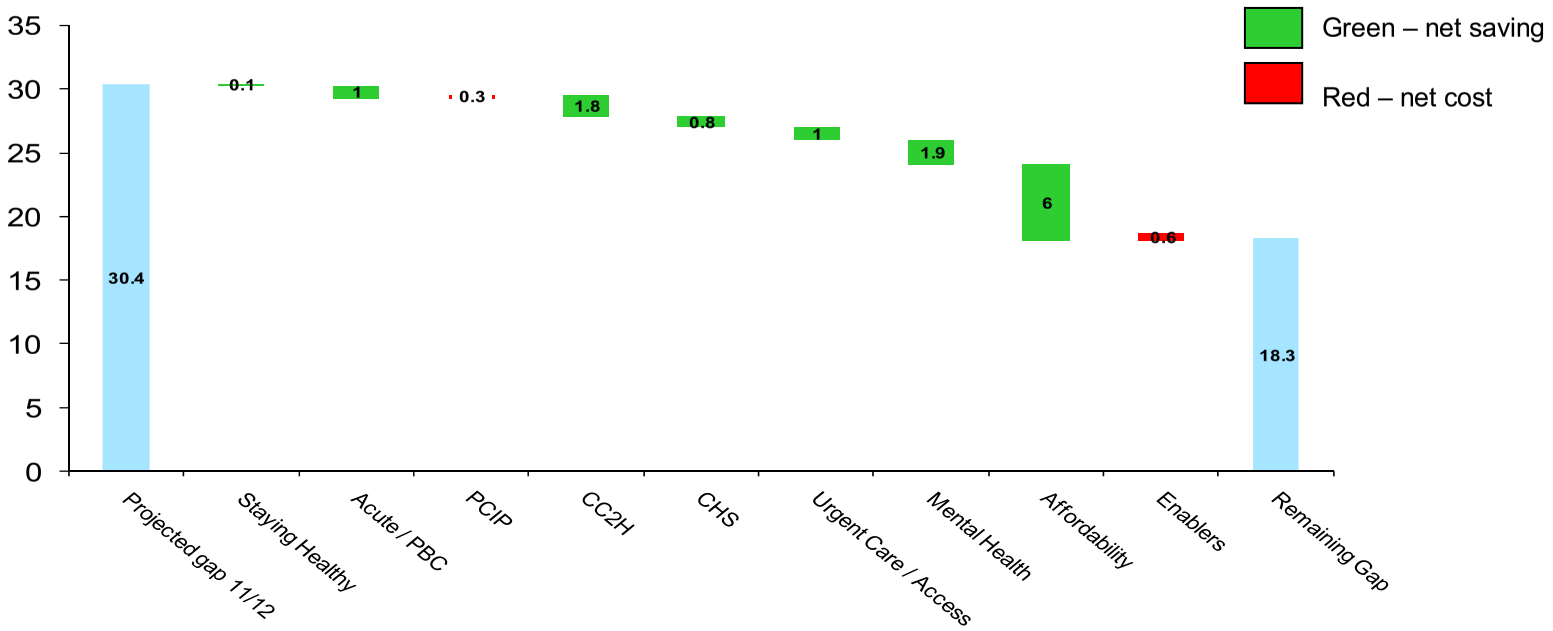
All numbers are latest estimates and subject to change

Full five year projections are attached in the appendix for all initiatives

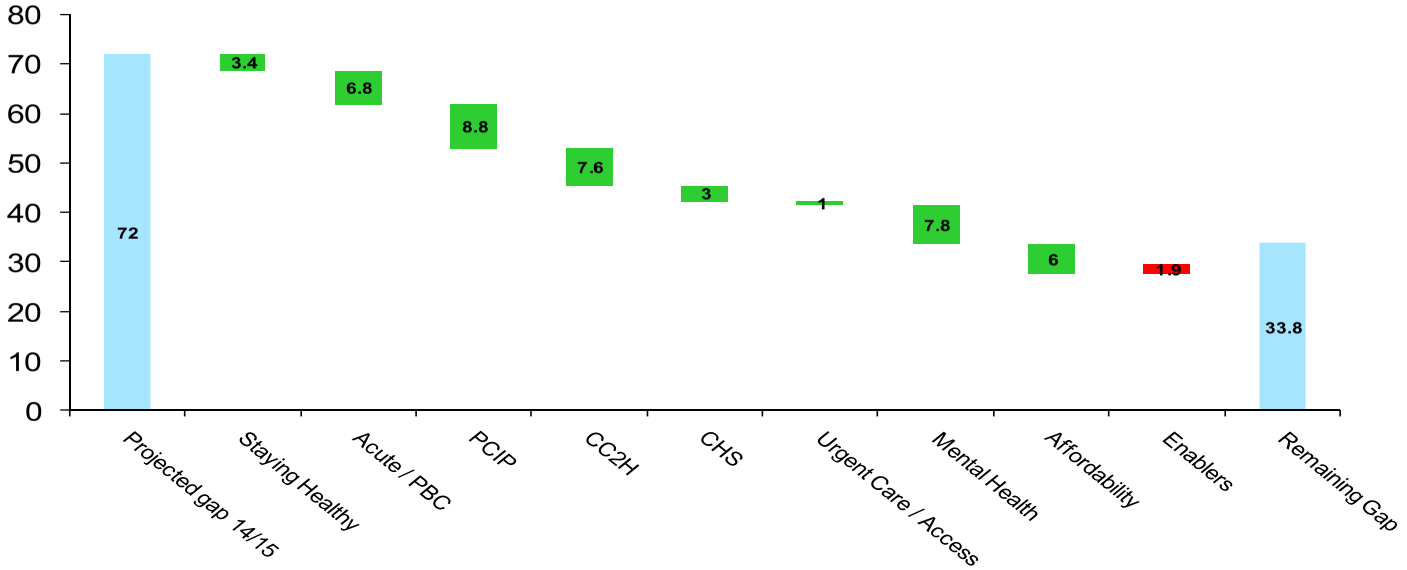
		11/12	
Staying Healthy	Cost	-72.1	• Cancer Strategy • Reduced Teenage Pregnancy budget • Continue success initiatives – smoking, obesity, breast screening
	Savings	0.0	
	Net	-72.1	
Hospital Services	Savings	-1000.0	• Improved contract and monitoring focus on hospital referrals and stopping Procedures of Low Clinical Value • Increased role and control for GPs
Primary Care Investment Programme	Cost	2473.2	• Improved Long Term Conditions management • Develop four new care packages: vulnerable adults, children (0-5), Cardiovascular Disease (CVD), COPD (lungs, breathing)
	Savings	2158.9	
	Net	314.3	
Care Closer to Home	Cost	2717.6	• Programme redesigned with focus on four specialities with increased volume • Aim for capitated pathways: where an annual contract value is agreed and all providers work within that sharing any surplus or loss
	Savings	4552.9	
	Net	-1835.3	
Community Health Services	Cost	240.0	• Contract and productivity levers • More efficient use of Bancroft Unit
	Savings	1000.0	
	Net	-760.0	
Urgent Care and GP Access	Cost	0.0	• Urgent Care Centre at front of A&E at Royal London Hospital • Continued focus on improving GP access and reducing A&E attendances • Aim for capitated pathway
	Savings	1000.0	
	Net	-1000.0	
Mental Health	Cost	0.0	• Reduced LOS through dementia liaison • Reduced high cost out of borough accommodation • Review of Mental Health services across Sector
	Savings	1916.0	
	Net	-1916.0	
Affordability	Cost	0.0	• Sector – City and Hackney, Newham and Tower Hamlets – shared services and common approaches – (ELCA) • Further work for 12/13 onwards
	Savings	6000.0	
	Net	-6000.0	
Enablers	Cost	652.0	• Estate improvements to primary care facilities • IT to help support move of Care Closer to Home and Network and GP development
	Savings	5.0	
	Net	647.0	

but the current initiatives leave a potential financial gap ….

11/12 £m



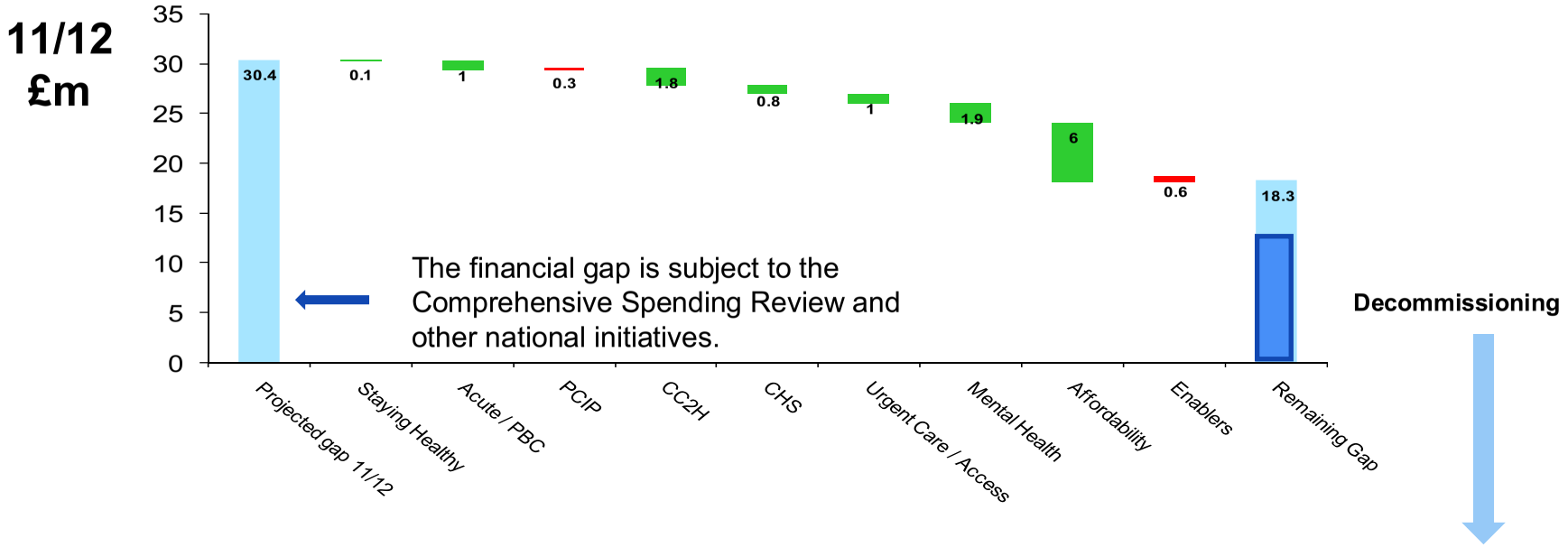
14/15 £m



To close the gap we have a number of options:

- Consider more initiatives to seek savings – but we need to be focused on the initiatives that will produce the biggest savings
- Quicken the pace of initiatives to drive benefits out sooner for example around Long Term Conditions and Urgent Care – but this could put their success to date at risk
- Stop funding some non-mandatory services to develop a pool of resources that can serve as “insurance” so we can deliver the investment needed to provide better, more efficient services
- Reduce spending across all services to close the financial gap

Stopping funding of some lower priority services will help close the financial gap and deliver investment



Decommissioning

- Agree Framework and criteria
- Review all commissioning budgets to identify mandatory and discretionary funding } Over next two weeks
- Aim to deliver £10m in 2011/12
- Long list to be prioritised using the following criteria
  - Quality – minimum impact on patient quality
  - Affordability – delivers savings of >£100k
  - No impact on must-do targets or performance that matters
  - No significant impact on health inequalities
  - Deliverable in 11/12
  - GPs and other stakeholders bought in
- Consultation with all stakeholders before implementation

We are continuing to involve key stakeholders in developing our initiatives

Stakeholders	Discussion	Outcome
Practice Based Executive Committee / GPs	• Discussion on approach and priorities for moving care closer to home with workshop on 12 October to finalise • Clinical Advisory Service discussion paper	• Agree on approach • Boost acute contract management • Agreed 4 specialities to focus on to move Care Closer to Home • Request for meeting of all GPs to consider strategy
PCT Strategic Clinical Leadership Group	• Quality gap discussion on 22 September	• Comments fed into Quality assessment and initiative development
PCT Commissioning Executive Committee	• Outline of process at September meeting • Evaluation and initiatives at 12 October meeting	• Further work on initiatives needed
THINk (steering committee)	• Tower Hamlets Involvement Network (THINk) Steering Committee 20 October • A joint meeting of all three LINKs is planned for November.	
Council	• Health Scrutiny Panel on 26 October	
PCT Board	• Outline of process at September meeting • Evaluation and initiatives at 21 October meeting	

Our Next Steps

- Firm up the financial assumptions and implications after the outcome of the Comprehensive Spending Review (20 Oct)
- Continue to refine our initiatives with particular focus on increasing the pace of change to deliver more savings
- Develop a decommissioning framework and proposals to deliver savings of £10m in 11/12
- Develop initiatives and an integrated programme across Inner North East London to 14/15 with a detailed delivery plan for 11/12
- Update at CEC and Board in November

The eight programmes modelled through to 14/15

All numbers are latest estimates and subject to change

		11/12	12/13	13/14	14/15	Total	
Staying Healthy	Cost	-72.1	-44.1	-114.1	-114.1	-344.4	• Cancer Strategy • Reduced Teenage Pregnancy budget • Continue success initiatives – smoking, obesity, breast screening
	Savings	0.0	0.0	0.0	0.0	0.0	
	Net	-72.1	-44.1	-114.1	-114.1	-344.4	
Hospital Services	Savings	-1000.0	-1500.0	-2000.0	-2333.0	-6833.0	• Improved contract and monitoring focus on First to Followup, Consultant to Consultant, Excess Bed Days and Procedures of Low Clinical Value (ELCA) • Increased GP / PBCE role and power
Primary Care Investment Programme	Cost	2473.2	2259.6	2342.7	2432.5	9508.0	• Improved LTC management • 5 new packages – vulnerable adults, 0-5 , COPD, CVD, Hypertension
	Savings	2158.9	3349.4	5109.9	7715.8	18334.0	
	Net	314.3	-1089.8	-2767.2	-5283.3	-8826.0	
Care Closer to Home	Cost	2717.6	2788.2	2931.3	2996.4	11433.5	• Enhanced programme focusing on 4 specialities with increased volume • Aim for ICO approach / capitated pathways
	Savings	4552.9	4647.1	4889.7	4980.1	19069.8	
	Net	-1835.3	-1858.9	-1958.4	-1983.7	-7636.3	
Community Health Services	Cost	240.0	240.0	240.0	240.0	960.0	• Contract and productivity levers
	Savings	1000.0	1000.0	1000.0	1000.0	4000.0	
	Net	-760.0	-760.0	-760.0	-760.0	-3040.0	
Urgent Care and GP Access	Cost	0.0	0.0	0.0	0.0	0.0	• Urgent Care Centre at RLH • Continued focus on access and reducing A&E • Aim for capitated pathway
	Savings	1000.0	0.0	0.0	0.0	1000.0	
	Net	-1000.0	0.0	0.0	0.0	-1000.0	
Mental Health	Cost	0.0	0.0	0.0	0.0	0.0	• Reduced LOS through dementia liaison • Reduced high cost out of borough accommodation • ELFT MH review (ELCA)
	Savings	1916.0	2083.0	2079.0	1764.0	7842.0	
	Net	-1916.0	-2083.0	-2079.0	-1764.0	-7842.0	
Affordability	Cost	0.0	0.0	0.0	0.0	0.0	• Sectorisation – shared services and common approaches – (ELCA) • Further work for 12/13 onwards
	Savings	6000.0	?	?	?	?	
	Net	6000.0	?	?	?	?	
Enablers	Cost	652.0	436.0	400.0	400.0	1888.0	• IHWB costs • IT to support PCIP, CC2H
	Savings	5.0	6.8	0.0	0.0	11.8	
	Net	647.0	429.2	400.0	400.0	1876.2	

This page is intentionally left blank

Area	Clinical Pathway	Sub-pathway / Topic	Primary / Secondary etc	ELCA in-year assessment 2010/11	Performance gaps	*Existing National / Pan-London initiatives*	*Cross-reference with current sector initiatives*	Deliverability of existing initiatives in 2011/12 (RAG)	*Existing Tower Hamlets PCT Initatives*		*Existing City & Hackney PCT Initiatives*		*Existing Newham PCT Initiatives*		Quantification of Gap for 2010/11
Patient experience	Acute care	**Patient satisfaction**	Secondary	All 3 acute trusts had multiple patient satisfaction scores in the bottom 20% of the country (HUH 29 of 60 qns; NUHT 20; BLT 5). In addition, HUH and NUHT received responses in relation to Nursing Care that were assessed as "worse" than other trusts by CQC, overall.	Low levels of patient satisfaction relative to other trusts across the sector, but especially HUH and NUHT.						The Clinical Quality Review group review patient satisfaction surveys and follow up concerns with the Trust.				All 3 acute trusts had multiple patient satisfaction scores in the bottom 20% of the country (HUH 29 of 60 qns; NUHT 20; BLT 5). In addition, HUH and NUHT received responses in relation to Nursing Care that were assessed as "worse" than other trusts by CQC, overall. Trend improving slightly.
	Multiple / Not Applicable	**GP Patient Experience**	Primary	NPCT and TH performed worse than national and London averages on GP patient survey 09/10, including waiting times, quality of care, cleanliness, relationships. C&H generally better than London average, worse than National.	Poor patient experience for GP visits, particularly in TH and NPCT. GP 48 hour access is lower than national average (S11).		Primary Care Performance	Amber.	Partial - initiative targets Patient Access - aligning to pick up other areas	R	C&H monitors the GPPS results on a quarterly basis. Comparitive information is sent to all practices and poor performing practices receive a diagnostic visit. Local work aims for synergy with sector initiatives.	A			Current 48 hour GP access availability is average 76% for ELCA (74% NPCT, 76% C&H, 78% TH) versus 81% nationally. Contributing to high admission rates (refer Urgent and Emergency Care gap statement.) NPCT and TH performed worse than national and London averages on GP patient survey 09/10, including waiting times, quality of care, cleanliness, relationships. C&H
Productivity	Planned care	**Acute Productivity Measures (Planned Care)**	Secondary	Several measures indicate productivity improvements across the sector are possible, including: consultant-to-consultant referrals (A8), Excess Bed Days (A7), First to followup rates (A4, P2), day case rates (A6), DNA rates (P1).	Several measures indicate productivity improvements across the sector are possible, including: consultant-to-consultant referrals (A8), readmissions (A5), shortstay admissions (A1), LOS (A7), First to followup rates (A4), day case rates (A6).		Drive acute productivity to upper quartile	Red. Sector initiative focussing on C2C & F2FU.	Conducted through SACU with PCC support		CSP and Operating Plan initiatives for 10-11. Performance Monitored through Sector acute performance group and reported back to fortnightly CHPCT Directors meeting and monthly PBCE/CCE	A	First OP shift to community settings and Primary Care. Fup shift to community setting and primary care +20% decommissioned. In 2012/13 we will shift an additional 30,086 OPAs In 2013/14 we will shift an additional 29,183 OPAs In 2014/15 we will shift an additional 15,043 OPAs; Development of Integrated Health and Social Care Teams, Virtual wards, Redesign of the following existing teams: community matrons district nurses continuing care and community nurses specialist nurses home rehabilitation service intermediate care, respite and CC beds OTs, SLT, physiotherapies and psychology day hospital social care Activity reductions are expected in GP care, acute care and A&E Diagnostic wastage should be reduced The number of people dying in hospital should be reduced More self care will take place in the home; health and social care economic gain varying between 1.35 million pounds and 2.55 million pounds PA	G	The following figures are estimates of potential annual savings based on average tarrif costs. **FFU:** Achieving London average = £2.0M **Daycases**: Moving elective daycase rate from 61% to 65% = £1.26M (London av 61% also) [Savings only achieved if total beds reduced] **Excess Bed Days:** Reducing excess bed days by 2% towards London average = £494K **C2C Referrals:** Costed data not yet available. Current performance in line with London average. **DNA Rates:** Data not yet available **Identified potential savings = £3.8M**
Health Inequalities	Cancer	**Cancer Screening / Awareness and Early Diagnosis**	Cross-cutting	2008/9 data shows proportion of eligible population participating in breast cancer screening programme: TH (63.5%), CH (58.38) and NPCT (55.58) all below National (77) and London (65) averages. (PCT breakdown not yet	Low proportion of the population participating in breast cancer screening programmes, though improving. Bowel cancer screening also improving from low base, cervical static. All a contributor to low overall one year survival rates	National Cancer Screening Programmes	Breast screening improvement programme	Red. Initiative covers breast scr only, with 3yr trajectory.	Developing cancer Strategy for Nov 10	G	Operating plan initiaitve 3: Feeling well, staying healthy		Community development approaches to increase screening uptake, developing plans for providing digital mammography services.	G	Improving one-year survival to England average would result in up to 90 people in INEL living 5 years or more beyond their diagnosis. Improving to best in England would result in up to 300 people in INEL living 5 years or more beyond their diagnosis.
		One year survival rates	Cross-cutting	Cancer 1 yr survival 2006 (%): CH 63.8, TH 58.7, N 56.3. Position in London is 19th, 29th and 31st respectively. TH and N are in bottom 10% nationally	One year survival is lower than London average for all three localities. Newham and Tower Hamlets have particularly poor outcomes and are in the bottom 10% nationally.				Developing cancer Strategy for Nov 10		Operating plan initiaitve 3: Feeling well, staying healthy		Engaging with public, patients, community partners to deliver preventative and health improvement services across a wide range of environments Developing prostate cancer clinic in community setting or in conjunction with West Ham Football Club Develop plans for providing digital mammography services in Newham and age extension of breast cancer services. Possibilities for this service are the use of symptomatic breast services at NUHT, or the Polysystem approach		See above.

Area	Clinical Pathway	Sub-pathway / Topic	Primary / Secondary etc	ELCA in-year assessment 2010/11	Performance gaps	*Existing National / Pan-London initiatives*	*Cross-reference with current sector initiatives*	Deliverability of existing initiatives in 2011/12 (RAG)	*Existing Tower Hamlets PCT Initatives*		*Existing City & Hackney PCT Initiatives*		*Existing Newham PCT Initiatives*		Quantification of Gap for 2010/11
Clinical Quality	Long-term conditions	**Variable management of vascular conditions**	Cross-cutting	Directly Age Standardised mortality rates for circulatory diseases 2006-8: (<75) CH 112.49, TH 120.52, N 118.84, L 79.38, Eng 74.8. Variable management of risk factors such as cholesterol (L3, L7, L13), blood pressure (L10, L12), HbA1C (L8). Also poor diet across sector a contributor (S3).	Management of vascular risk factors in primary care shows a mixed picture when benchmarked against London with examples of performance on indicators well above average, average and below average. Higher mortality in vascular conditions compared to London and England. Trends indicate that mortality rates falling at similar rate to elsewhere which means that the gap persists.		Shift setting of care for OP activity	Red. Scope does not address gap exactly - progress slow.	PCIP - Care Package	G			- Developing the existing vascular risk assessment service to deliver health checks to target populations Engaging with public, patients and community partners to deliver preventative and health improvement services across a wide range of environments Systematically assessing the target population to manage and reduce risk of cardiovascular disease Using point of care testing services during the assessment and supporting the outcome with a range of interventions suited to reduce and manage individual risk. - 15,000 checks each year. Creation of a Integrated multidisciplinary diabetes team that is consultant led and GP championed , Increase to 70% for patients with diabetes in whom the last HbA1C is 7.5 or less in the previous 15 months 50% reduction in emergency admissions with primary care diagnosis of diabetes by 2012 20% reduction in amputation rates by 2012 50% reduction in non-elective admissions with primary diagnosis of diabetes by 2012 50 % reduction in CVD events by 2012 Reduction in mortality rate to 70 per 100,000 by 2015	G	Application of best practice interventions across 100% of eligible population with CVD could reduce All Age All Cause Mortality (AAACM) rate per 100,000 by 75. (DH Modelling, 2006-8 data)
		Variability in management of COPD	Cross-cutting	COPD 12 % with COPD diagnosed and spirometry confirmed: CH 88.1, TH 92, N 81.6, L 89.2, Eng 90.5. COPD mortality rate also high (L4). **More evidence required.**	Performance on spirometry confirmed diagnosis in top quadrant for TH, below average for CH and bottom quadrant for N. COPD mortality rates high across the sector.		QIPP COPD Initiative		PCIP - Care Package	G					Application of best practice interventions across 100% of eligible population with COPD could reduce All Age All Cause Mortality (AAACM) rate per 100,000 by 21.69. (DH Modelling, 2006-8 data)
Productivity	Maternity and newborn care	**Maternity pathway**	Cross-cutting	Variable or poor outcomes across the sector relating to maternity pathway, including: c-section rates (N6, N3), 12+6 (N2), breastfeeding at 6 weeks (N1), patient experience (N9).	Variable or poor outcomes across the sector relating to maternity pathway.	H4NEL	Antenatal care pathway	Red - progress slow, exact scope tbc.	Contributions around early access (amber), breastfeeding (green)	A			Delivering maternity care in the community reduction of 50% of N1 attendances by 2013	G	- Homerton (27.2), NUHT (29.3) and BLT (24.7) all significantly above National (23.5) average C-Section rates. Achieving England average c-section rate = £150K saving for C&H alone. - Newham PCT breastfeeding rates half the national average (15.9%). - Low proportion of pregnant woment seeing midwife within 12 weeks at Homerton (43.5 % vs London 53.7 , England 61.9).
Clinical Quality	Mental health	**Quality of mental health care**	Mental Health	Recent SUI reviews highlighted shortfalls in performance at ELFT. Hospital admissions for mental health/100,000: CH - 678.45, TH - 516.22, N - 438.33, L 332.49, E 305.82.	Best practice mental health approaches not used consistently at ELFT. High rates of acute hospital admissions where mental health is a key contributor.		MH commissioning unit / Whole system review	Red- whole system review not yet commenced.			This area is covered under CQUIN and monitored as part of contract review process.				Whole system review in progress.
Productivity	Multiple / Not Applicable	**Community services**	Cross-cutting	Poor alignment of community services with primary/secondary care clinicians, contributing to poor outcomes, including high readmission rates. **[FURTHER EVIDENCE REQUIRED]**	Poor alignment of community services with primary/secondary care clinicians, contributing to poor outcomes, including high readmission rates.		Sector tariff for community services	Red- current scope unlikely to solve perceived gaps.							
Productivity	Unplanned Care	**Urgent and Emergency Care**	Cross-cutting	Poor performance in urgent and emergency care across various measures: UCC diversion rates (U1), GP Access (NA10),)A&E attendance and admissions (U3, U4), growth in ambulance activity (U5), shortstay admissions (A1), Readmission rate (A5)).	Poor sector wide performance and growth in urgent and emergency care.		Shift 40% of A&E activity to UCCs	Amber.	Urgent Care Strategy and programme - aligned with access and showing v good results eg A&E VO8 attendances reduced through increased GP Access	G	Key CSP initiatives are to Increase UCC diversion rate to 40%, the GP in CDU pilot and to align UCC model with sector approach		Developing a 24 hour primary care led centre delivering urgent care services on the existing A&E site at NUHT and operating a „see and treat" model The interim UCC is now treating 52% of patients attending A&E services. It is expected that increased hours, improved effectiveness and increased skills of practitioners will increase that to 60%	G	**0 LOS:** INEL currently near London average. 10% reduction = £1.6M **Emergency Admissions:** 85% INEL admissions are non-elective. Achieving London av (80%) = £2.3M **Readmissions:** 2010/11 rate 11.5%. Achieving 09/10 rate (10.55%) = £465K [Excluding effect of operating F/W changes] **Minor Attendances:** Transfer of 10% of "Minor" A&E attendances into UCC = £300K **Ambulance:** Potential savings 2011/12 through diverting 10% more to non-A&E settings, treating 5% more patients at scene, and referring 7% more without conveying = £465K. **Identified potential savings = £5M**

Committee	Date	Classification	Report No.	Agenda Item No. 5
Health Scrutiny Panel	**26 October 2010**	**Unrestricted**		
Report of: **NHS Tower Hamlets** **London Borough of Tower Hamlets** **Presenting Officer:** Dr Somen Banerjee Co-Director Public Health NHS Tower Hamlets and LBTH Clare Skidmore Policy and Strategy Manager, Strategy and Policy Adults Health and Wellbeing London Borough of Tower Hamlets		**Title:** Update on Joint Strategic Needs Assessment **Ward(s) affected:** All		

1. Summary

The briefing and presentation set out the borough profile, health headlines and needs assessment for Tower Hamlets in 2010.

The Joint Strategic Needs Assessment is the process that identifies the current and future health and wellbeing needs of a local population. It informs the priorities and targets set by local area agreements between the NHS and the Council and its partners which lead to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

It takes in to account the wider determinants of income, unemployment, housing and homelessness, education, crime, road safety and unemployment. As well as the following health issues: maternity and early years, children and young people, staying healthy, long term conditions and disability, cancer, mental health, end of life care, planned care, unplanned care and cross cutting issues

2. Recommendations

The purpose of the presentation is to:

a) Introduce HSP to JSNA and the joint approach of the Council and NHS
b) Summarise 09/10 findings and recommendations.
c) Summarise feedback from 09/10 and set out approach to 10/11

The Health Scrutiny Panel is asked to:

a) Comment on the content and approach for 10/11
b) Consider how the Health Scrutiny Panel can be involved in the process.

Tower Hamlets Borough Profile 2010

Needs Summary

Population
The Tower Hamlets population in 2010 is estimated to be 242,000. It is a population characterised by diversity (50% of the population are non white and 34% Bangladeshi), mobility (19% move in or out of the borough per year), high growth (although this uneven across the borough) and a significantly higher proportion of young people than elsewhere (37% are aged 25-39 compared to 27% across London). Growth is predicted through a local planning model that links population growth with residential development and this suggests that the population will reach 264,000 by 2016.

Health headlines
Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Male life expectancy is 75.3 years compare to 77.82 nationally and female life expectancy is 80.4 compare to 81.95 (2006-8). The Borough has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). Trends indicate year on year improvement but with limited reduction in the gap.

Socioeconomic determinants of health
The most important factor accounting for health inequalities between Tower Hamlets and elsewhere is socioeconomic deprivation. The borough is ranked the third most deprived ward nationally. 78.5% of Tower Hamlets residents live in the 20% most deprived areas in England compared to around 26% of London residents. This is reflected in statistics indicating the highest levels of child poverty in the country, amongst the high unemployment rates in London, a high proportion of people with no qualifications, lower educational attainment compared to the rest of the country (but improving), higher levels of overcrowding and significant levels of housing classified as 'non decent' (in 2008 52% council housing fell below the decent homes standard compared to 32% in London).

Early years
The birth rate in Tower Hamlets is similar to the London average. 45% of births are to Bangladesh mothers. Although a higher proportion of newborns have lower birth weight (<2500g), infant mortality rates are not significantly different to London. Breast feeding initiation rates are higher than London. Tooth decay rates in five year olds have been improving but remain higher than London. Childhood obesity in 4-5 year olds is the 5th highest in London.

Children and Young People
60% of under 19s are Bangladeshi. Two thirds of under 16s live in low income households (the highest levels of child poverty in the country). 1 in 5 children under 15 have tried a cigarette (similar to national averages) and 4 out 10 retailers are selling cigarettes to under 18s.. Tower Hamlets has the 2nd highest prevalence of obesity in year 6 in the country. 3 in 10 children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim community in the borough). Teenage pregnancy rates are lower than England and London averages following a recent downward trend although recent data indicates that rates are expected to increase for 2009. Childhood immunisation uptake is higher than London and MMR uptake at 24 months and 5 years has increased significantly over the past year (most recent data indicates over 92% uptake of second MMR). The number of children on the Child Protection Register has increased sharply over recent years. This primarily reflects increases in ascertainment Prevalence of mental health disorders in children is similar to national averages (around 1 in 10)

Staying Healthy and Health Protection
27% of adults in Tower Hamlets smoke compared to 21% nationally with particularly high smoking prevalence in Bangladeshi males. 9 out of 10 adults eat less than five a day compared to 7 out of 10 nationally. A lower proportion of adults participate in sport and active recreation (15.5% compared to 21.2% nationally). 1 in 2 adults have not had an alcoholic drink in the past year but in the White population, 4 in 10 are classified as harmful drinkers compared to 2 in 10 nationally. Incidence of sexually transmitted infections (STIs) has increased significantly in the past few years. Tower Hamlets has the 8th highest rates of STIs per 100 000 population in the country (50% higher than the London rate). Prevalence rates of HIV have increased by 34% since 2005. 23% of HIV infections

were diagnosed late in 2009 compared to 31% in London. Prevalence rates for tuberculosis have been rising slowly over the past few years and reached 65.3 per 100 000 population in 2009, significantly higher than the London average of 45.1. Seasonal flu immunisation uptake is adequate in over 65s (76%) but lower in under 65s with long term conditions (55%) although this is above the national average (52%).

Long Term Conditions
Tower Hamlets has the highest or second highest mortality rates in London for the major long term conditions: coronary heart disease (CHD), stroke and chronic respiratory disease. Diabetes prevalence is higher than London and this is particularly linked with the high proportions of Bangladeshis in the population. Analysis of observed prevalence against expected for long term conditions indicates levels of underdiagnosis for most conditions but particularly hypertension, CHD, chronic kidney disease and COPD. In primary care, quality and outcome indicators are generally relatively good compared to London. Management of blood pressure and cholesterol in CHD and diabetic patients is generally well above the London average. Conversely, HbA1C has been in the bottom quadrant in London and for this reason, diabetes was the first priority for the care packages. Despite generally good outcomes overall there remain significant variations between practices and this has been a major driver to standardise care through the primary care investment programme. Secondary care admission rates (age standardised) for CHD, stroke, heart failure and COPD are the highest in London.

Cancer
Tower Hamlets has the highest cancer mortality in London. This is driven to a significant extent by high incidence and mortality from lung cancer and reflects the high prevalence of smoking in the Borough. However, one year survival from cancer is in the bottom 10% nationally and this is particularly poor for breast, colorectal and prostate cancer. Cancer screening uptake is lower than national averages (breast, cervical and bowel). Evidence indicates that late diagnosis is a significant contributor to poorer survival. Increasing screening uptake, early awareness of symptoms and early diagnosis of cancer are major priorities to improve survival.

Mental Health
Suicide is a high level indicator of mental health need in a population and Tower Hamlets has the fourth highest rate in London. Schizophrenia prevalence is just under three times the national average reflecting factors such as homelessness and substance misuse. Overall prevalence of dementia is lower than London due to the younger population. However, 7% of over 65s are estimated to suffer from dementia and there is evidence of significantly levels of underreporting or underdiagnosis in primary care.

End of Life Care
Around 1140 Tower Hamlets residents will die per year. It is estimated that around 870 will need some form of palliative care. Based on national findings, most people when asked, state a preference for dying at home. However, Tower Hamlets has a higher hospital death rate compared to national (68% compared to 58%) and a significantly lower home death rate (17% compared to 19%). The percentage of deaths in hospitals has been slowly falling with a corresponding increase in hospice deaths. The percentage dying at home has remained relatively static.

Planned and Unscheduled Care
Tower Hamlets has amongst the lowest standardised first attendance rates in London. However, a lower percentage of outpatients are discharged at first appointment and the percentage of those not attending is amongst the highest in London. Elective admission rates are the lowest in London. Conversely, Tower Hamlets has amongst the highest emergency admission rates in London (particularly heart attacks, stroke, falls, accidents and fracture neck of femur). Local analysis has indicated a significant relationship between the ratio of elective to non elective admissions and deprivation. This ratio is substantially lower in higher deprivation deciles.

Internal inequalities within Tower Hamlets.

Although there are significant health inequalities between Tower Hamlets and the rest of the country, there are also substantial inequalities within the borough. Life expectancy at ward level varies by around 8 years in males and 6 years for females and variation is strongly correlated with deprivation (more strongly for males than females). These differences are also reflected in deprivation related patterns of prevalence of and mortality from cardiovascular disease, chronic respiratory disease and, to a lesser extent, cancer across the borough. Disease prevalence and mortality also varies significantly by ethnicity. Observed diabetes prevalence is higher in Bangladeshis compared to the white population (7% compared to 5%). Conversely, crude prevalence of hypertension and COPD is higher in the white population (reflecting the older age profile of the white population). Primary care quality and outcome indicators also vary by ethnicity. Age adjusted mortality rates are significantly higher in the White population compared to the Bangladeshi population for deaths from all causes, cardiovascular disease (under 75) and cancer (under 75). Health inequalities between men and women are frequently overlooked. However, it is striking that the life expectancy gap between men and women is 5 years compared to 4 years nationally. This is consistent with a higher gap in areas of high deprivation.

Recent analysis to understand local health inequalities in greater depth has focussed on analysis of health and wellbeing data by deprivation deciles. This has highlighted that the secondary care costs of those living in the most deprived deciles in Tower Hamlets are almost twice those living in the least deprived (£227 per head compared to £117 per head). Furthermore, the ratio between elective and non elective admissions is around three times higher in the least deprived decile compared to the most deprived. The analysis has identified the importance of understanding health inequalities at below ward level (e.g. lower super output area) to inform locality and LAP level clinical commissioning as well as service integration a very local level (e.g. estate, neighbourhood).

Community Perspectives

Findings from the Place Survey and Annual Residents Survey highlight Tower Hamlets as a place where residents feel less satisfied with their local area, have less of a sense of community cohesion and perceive higher levels of crime. Social marketing qualitative research has provided insights into resident perceptions of services and has identified strong cultural differences between ethnic groups in relation to knowledge, attitudes and belief that lead to differences in how services are used. The Tower Hamlets Involvement Network have identified the following priorities issues from a patient/public perspective: quality of patient consultation with GPs, links between GPs and acute care, staff attitude at Royal London Hospital, integration of community care services, integrating mental health care and use of personal budgets by social care users. The Improving Health and Wellbeing consultation in 2009 and other local surveys suggest that residents have seen improvement in services over the past three years. Integration of services through health centres is welcomed, although there is a concern about ensuring that local access is not lost.

This page is intentionally left blank

Joint Strategic Needs Assessment Update

Presentation to Tower Hamlets Health Scrutiny
26th October, 2010
Dr Somen Banerjee, Co-Director Public Health
Clare Skidmore, JSNA Programme Manager

Overview

- JSNA – what is it?
- Last year
- This year

What is Joint Strategic Needs Assessment?

‘ a process that identifies the current and future health and wellbeing needs of a local population, informing the priorities and targets set by local area agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities’

DH Guidance on JSNA 2007

Overview of JSNA

Background	• Local Government and Public Involvement in Health Act 2007(Section 116) • Introduced in 2008
Requirement	• Assessment of relevant needs must be prepared for LA area • Must involve local authority and partner PCT (s) • Covers need that can be met by LA and PCT functions
What it involves	• What is the local picture (JSNA core data set)? • What should we be doing (evidence)? • What are we doing and what are priorities to meet needs?
New Policy Context	• Abolition of PCT means SNA rather than JSNA? • Will be central to scrutiny function of Health and Wellbeing Boards in assessment of extent to which needs being addressed

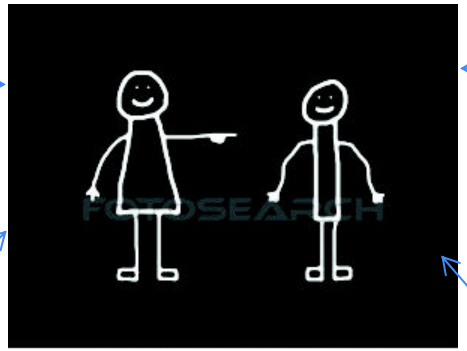
Approach

- What is x?
  - Definition of x
- What is the local picture?
  - Prevalence statement
  - Incidence statement
  - Mortality statement
  - Geography statement
  - Equalities statement
- What are the effective interventions?
  - National strategy statement
  - National guidelines statement
  - Systematic review statement
  - Peer reviewed literature statement
  - Grey literature statement – if nothing else
  - Impact statement – clinical outcomes
  - Impact statement – cost and activity
- What are we doing locally to address this issue?
  - Prevention statement
  - Primary care statement
  - Secondary care statement
  - Community services statement
  - Social care statement
- What evidence is there that we are making a difference?
  - Prevention statement
  - Primary care statement
  - Secondary care statement
  - Community services statement
  - Social care statement
- What is the perspective of the public on services?
  - THInK statement
  - Research statement (discovery interviews, social marketing qualitative research etc)
- What are the priorities for improvement over the next 5 years?
  - Commissioner/Strategic Lead/Clinical lead joint statement
- What more do we need to know?
  - Pending intelligence work statement
  - Gaps statement

Data (Core JSNA dataset)

Demography
Age
Gender
Ethnicity

Socioeconomic
Income
Employment
Housing
Marital Status
Education



Lifestyle
Smoking
Diet
Physical Activity
Alcohol
Substance Misuse
Sexual behaviour

Services
Income
Education
Housing
Community safety
Social Services
Healthy Lifestyles
Healthcare

Health Status
Disease prevalence
Self reported health
Mortality

World Class Commissioning!!

Improved health status and reduction in inequalities

Last Year

JSNA 09/10 – Findings at a glance

Health Headlines
- High population growth but uneven across borough
- 3rd most deprived LA areas
- Life expectancy improving but no reduction in gap

Health Inequalities
- Variation in life expectancy across Borough linked to deprivation
- Mortality rates higher in white population
- 5 years lower life expectancy in males
- Secondary care costs in most deprived decile twice those in least deprived (due to higher emergency admissions)

Children and Young People
- High rates of tooth decay in under 5s
- Obesity in 4-5 yr olds 5th highest in London
- Teenage pregancy has declined
- Sharp improvement childhood imms

Health Lifestyles
- High smoking prevalence (esp Bangladeshi males)
- Lower levels of physical activity
- High levels of harmful drinking in white population
- 8th highest STI rate in country
- Increases in HIV and TB prevalence

Long Term Conditions and Cancer
- Highest or second highest mortality in three major killers: Cardiovascular disease, Cancer, Respiratory disease
- Generally good and improving outcomes in management of vascular disease in primary care although variations between practices
- Poor one year survival from cancer linked to late diagnosis

Mental Health
- Fourth highest suicide rate in London and high prevalence of severe mental illness
- Evidence of underdiagnosis of dementia

End of Life Care
- Lower home death rates than national

Planned and unscheduled care
- Highest emergency admission rates in London
- High DNA (did not attend rates) to outpatients

Detailed needs assessments conducted
- Carers
- Learning disabilities
- Older people and mental health
- Alcohol use in young people
- Mental health in BME children
- Physical disablity in children

JSNA 09/10 Key Recommendations

Evidence from factors influencing health

- The success of the Community Plan is fundamental to improving health in the long term (through impact onf wider determinants)
- Get populations projections right
- Continue to integrate benefits and health services (18% of working age population on benefits)
- Prepare for impact of recession (evidence base indicates MH, alcohol problems)
- Integrate and target approaches around healthy lifestyles

Evidence from indicators of health

- Maintain focus on CVD (2nd highest mortality rate in London)
- Intensify focus on Cancer (highest mortality rate in London)
- Maintain focus on integration of services (comorbidity evidence)
- Explore further targeting of white population (higher mortality rates)
- Ensure that equality impact assessment embedded to ensure programmes are not widening inequalities (health inequalities proofing)

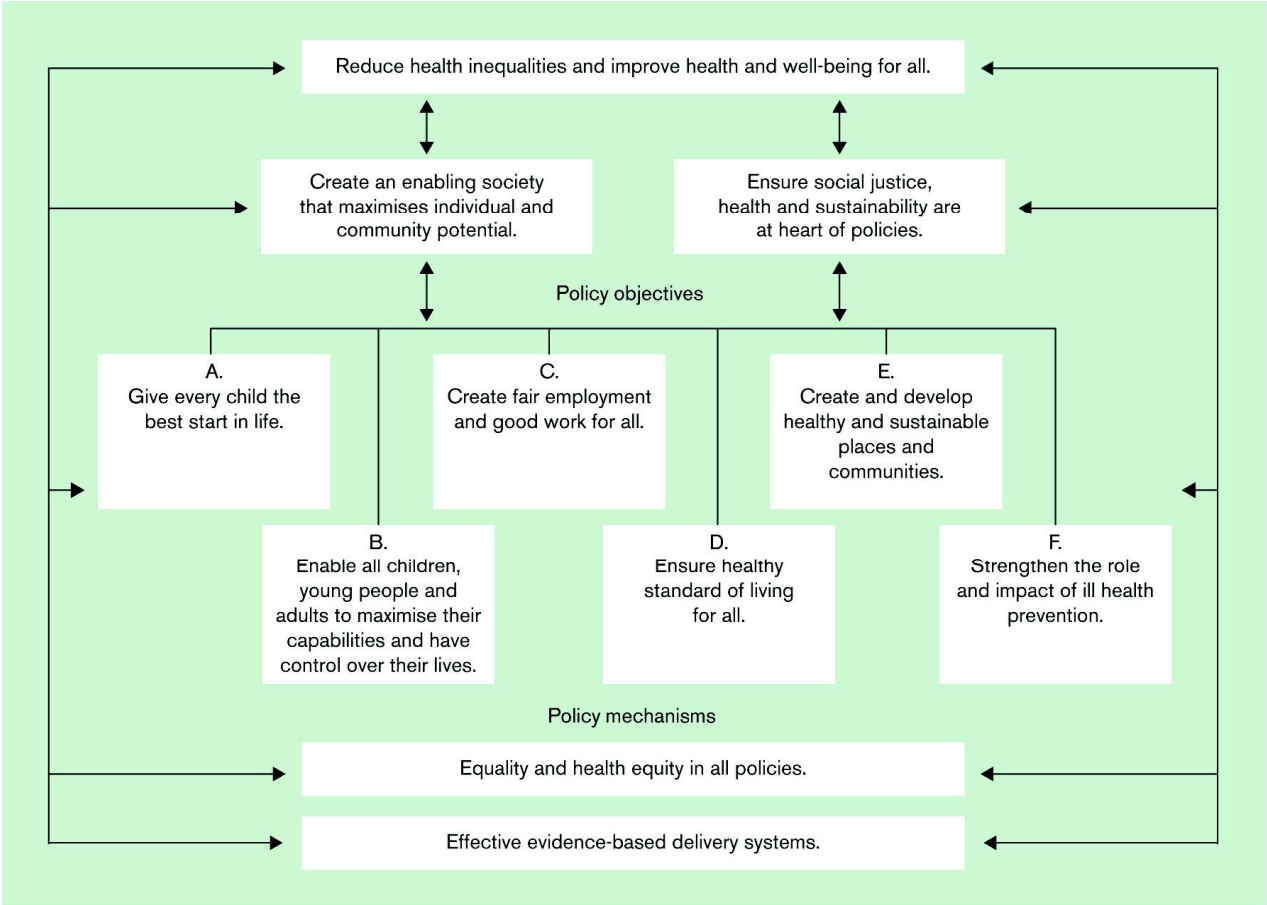
Evidence from service data

- Target underdiagnosis HT, CKD, HF, COPD, MH, dementia
- Refocus social marketing and develop a strategic approach to behavioural change
- Ensure processes are in place for feedback from PPI
- Further analysis of programme budgeting (eg lower relative expenditure Cancer, CVD)

This Year

Since last year we have had the Marmot Review on Health Inequalities (Fair Society, Healthy Lives – The Marmot Review) and this informs our approach..

Figure 4 The Conceptual framework

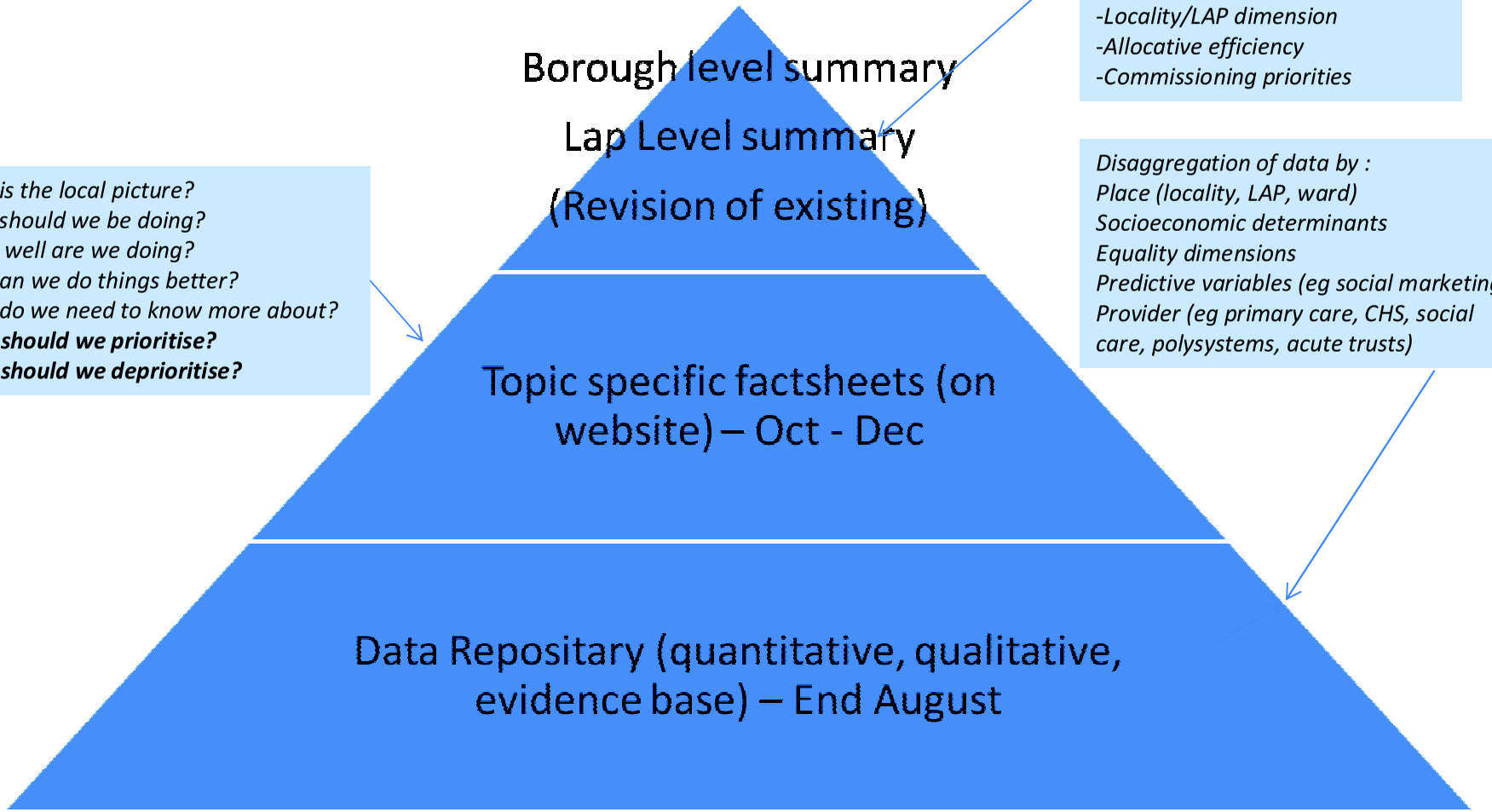


New White Paper: Local Authority Health and Wellbeing Boards as Borough oversight body to drive this?

Feedback from public, commissioners and providers

- Great but we don't want to have to wade through a massive document
- Would like to get the key issues in a way that is easily accessible
- Need more locality level analysis
- Need to address different audiences (eg commissioners, public etc)
- So….

JSNA Products



Summmary
-Demography
-Wider determinants
-Healthy Lifestyles
-Community perspectives
-Health headlines
-Locality/LAP dimension
-Allocative efficiency
-Commissioning priorities

What is the local picture?
What should we be doing?
What well are we doing?
How can we do things better?
What do we need to know more about?
What should we prioritise?
What should we deprioritise?

Disaggregation of data by :
Place (locality, LAP, ward)
Socioeconomic determinants
Equality dimensions
Predictive variables (eg social marketing)
Provider (eg primary care, CHS, social care, polysystems, acute trusts)

Delivery through joint LA/PCT PMO – Team consists of AD Public Health, PH strategist, LA programme manager and 2 LA research officers

Topic Areas for Fact Sheets – For Discussion

Wider Determinants	Income, unemployment, housing and homelessness, education, crime, road safety
Maternity and early years	Antenatal care, infant and early years nutrition
Children and young people	Oral health, children with disabilities, safeguarding children (see also Staying Health and Long Term conditions)
Staying Healthy	Tobacco, physical activity, diet, alcohol, obesity, sexual health, teenage preganancy, HIV/AIDs, TB, immunisation
Long Term Conditions and Disability	Vascular disease (CHD, Stroke), diabetes, chronic obstructive pulmonary disease, asthma, long term neuro, learning disablities, physical disablities
Cancer	All cancers, lung, breast, bowel, cervical, prostate, stomach, other (less detail)
Mental Health	Child and adolescent, adult (mild, moderate, severe), dementia
End of Life Care	Palliative care, dying at home
Planned Care	GP access, outpatient care, elective care, care closer to home
Unplanned Care	Emergency admissions
Cross cutting	Older People, Safeguarding adults, Programme Budgeting Also: Locality-based needs assessments, Promoting Independence, Carers, Falls

Principle – read across to Marmot Framework

Questions for discussion

- Thoughts on process?
- Involvement in process?
- Thoughts on content? Suggestions for factsheets?
- Link to 09/10
  - http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

This page is intentionally left blank

Committee	Date	Classification	Report No.	Agenda Item No. 4
Health Scrutiny Panel	**26 October 2010**	**Unrestricted**		

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

1. Summary

1.1 This report outlines the 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** **020 7364 0941**

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 reducing 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 <u>The review had a number of key objectives</u>.

- 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 <u>Key Recommendations from the report were</u>:

- That the Children, Schools and Families Directorate find additional resources to provide free school meals for all pupils in Tower Hamlets (although it is realised in the current economic climate that this recommendation will not be implemented).
- 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.

<u>Impact:</u>

- The report is due to go to Cabinet in December 2010.

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 improve 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 later in the year.

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 is quoted "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 requested to feedback on possible areas to evaluate and where possible 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 2010/2011 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:

- Examine the local picture and what reconfiguration of local primary care and social care services will mean for residents.
- Increase Member's understanding around the key issues to enable them to use their community leadership role to communicate change to residents
- Listen to local GPs and hear their opinions on the re-provision of local healthcare services.
- Make recommendations on how we can better engage residents in this process and communicate change.

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.

This session took place on 29th September 2010, the recommendations will be discussed at the Committee meeting in October.

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

This session will aim to:

- To support the improvement of 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
- Address the important role Councillors and residents have to play in their communities to prompt early diagnosis and treatment

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 has 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 put 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 • Update on THINk • Work Programme discussion	Presentation Meeting & Verbal updates
July 2010	• The NHS White Paper • Six Lives Panel Project • 2010/2011 Draft Work Programme • Health Scrutiny Evaluation Report - Action Plan • Health4nel response to INEL JOSC	Verbal Update Report and Presentation Draft Report Report Report and Verbal update
October 2010	• Access to GP services – the Ocean Estate • Joint Reporting of Complaints across all Three Trusts • East London and City Alliance Commissioning Strategy Plan Update • THINk Patient and User Comments Report and Recommendations 2010 • Update on Joint Strategic Needs Assessment • HSP Work Programme	Briefing Presentation Presentation/Briefing Presentation Report/presentation Report
January 2011	• Public Health White Paper • NHS Tower Hamlets – Operating and Commissioning Priorities 2010-2012 • Update on Maternity Services at BLT • Transformation of Adult Social Care and the Personalisation Agenda • Update on Challenge Session	Briefing/Presentation Report/Presentation Briefing Presentation Report
March 2011	• Excellence in Quality Strategy Report and Presentation, Barts and the London NHS Trust • Focus on Dementia (Adults Health and Wellbeing Directorate) • Update on Review and Challenge Session	Report and Presentation Report and Presentation Briefing

Appendix 2 – Health Scrutiny Panel Meetings

2011/12

Panel Date	Reports / Topic	Method
June 2011	• Induction Programme • Update on THINk • Work Programme discussion • Mental Health Review	Presentation Meeting & Verbal updates
July 2011	• 2011/2012 Draft Work Programme • Barts and London – Service Provision for Adults with Learning Disabilities.	Verbal Update Report/presentations
October 2011	• HSP Work Programme • Joint reporting of complaints from all three Trusts • East London NHS Foundation Annual Plan • Mental Health Review	Report Presentation Report/presentation
January 2012	• NHS Tower Hamlets – Operating and Commissioning Priorities 2011/12 • Update on Review and Challenge Session Work	Report/Presentation Report
March 2012	• Excellence in Quality Strategy Report and Presentation, Barts and the London NHS Trust • Update on Review and Challenge Session	Report and Presentation Report and Presentation Briefing

This page is intentionally left blank