MEETING

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

FRIDAY 3RD FEBRUARY, 2017

AT 10.30 AM

VENUE

TO: MEMBERS OF JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)
Councillor Pippa Connor (LB Harringey) (Vice-Chair)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Richard Olszewski (LB Camden)
Councillor Abdul Abdullah (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Harringey)
Councillor Jean-Roger Kasek (LB Islington)

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance
Enquiries to Vinothan Sangarapillai, Committee Services (London Borough of Camden)
Telephone 020 7974 4071 (text phone prefix 18001)

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
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AGENDA ITEM 1

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 3 FEBRUARY 2017 AT 10.00 AM
CONFERENCE ROOM, ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD EN1 3XA

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
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MEMBERS

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Richard Olszewski (LB Camden)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Jean-Roger Kaseki (LB Islington)

Issued on: Wednesday, 25th January 2017

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 3 FEBRUARY 2017

THERE ARE NO PART II REPORTS

AGENDA

1. APOLOGIES

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

3. ANNOUNCEMENTS (IF ANY)

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THAT THE CHAIR DECIDES TO TAKE AS URGENT

5. MINUTES (Pages 5 - 24)

To consider the minutes of the meetings held on 25th November, 9th December and 14th December 2016.

6. SUSTAINABILITY AND TRANSFORMATION PLAN - RESPONSE TO JHOSC RECOMMENDATIONS (Pages 25 - 44)

To consider a response from the Transformation Board to the NCL JHOSC's recommendations on the STP.

7. ROYAL FREE - RELATIONSHIP WITH NORTH MIDDLESEX

To consider a presentation from Councillor Abdul Abdullahi on the plans for the North Middlesex Hospital to join the Royal Free London Group as discussed at the 5th January 2017 Enfield Health Scrutiny Standing Workstream meeting.

The minutes of that meeting can be seen here:
https://governance.enfield.gov.uk/mgAi.aspx?ID=38616

8. REVIEW OF ADULT IMMUNISATION AND SCREENING PROGRAMMES (Pages 45 - 92)

To consider a report on Adult Immunisation and Screening

Programmes.

9. LONDON AMBULANCE SERVICE REPORT ON HOSPITAL HANDOVER TIMES IN NC LONDON

(Pages 93 - 98)

To consider a report on hospital handover times from the London Ambulance Service.

10. WORK PROGRAMME

(Pages 99 - 102)

To consider the JHOSC work plan for 2016-17.

11. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

12. DATES OF FUTURE MEETINGS

The dates of future meetings for the rest of this municipal year and for the municipal year 2017-18 are:

- Friday, 17th March 2017
- Friday, 21st April 2017
- Friday, 9th June 2017
- Friday, 22nd September 2017
- Friday, 24th November 2017
- Friday, 26th January 2018
- Friday, 23rd March 2018

AGENDA ENDS

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 25TH NOVEMBER, 2016** at 10.00 am in the Committee Room 1, Hendon Town Hall, The Burroughs, London NW4 4AX

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Jean-Roger Kaseki (LB Islington)

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the. North Central London Joint Health Overview and Scrutiny Committee.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Abdul Abdullahi (LB Enfield) and Councillor Richard Olszewski (LB Camden).

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Alison Cornelius (LB Barnet) reported that she was a trustee of a care home in Barnet. Councillor Pippa Connor (LB Haringey) declared that she was a member of the RCN and her sister was a GP in Tottenham.

3. ANNOUNCEMENTS

The Chair reported the following dates had been set for special meetings of the Committee to consider the draft Sustainability and Transformation Plan for North Central London:

- Friday, 9th December 2016 at 9.30am at Camden Town Hall; and
- Wednesday, 14th December 2016 at 5pm at Camden Town Hall.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There were no notifications of any items of urgent business.

5. MINUTES

Subject to the correction on page 1 of the minutes, under section 2 to read 'Councillor Cornelius reported that she was a trustee of a care home in Barnet' – the Committee **RESOLVED** that the minutes of the previous meeting held on 30th September 2016 be approved as a correct record.

6. SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

The Chair introduced the item and noted the Committee's responsibility to review whether the STP was realistic and practical in order to deliver its desired outcomes. The Committee had discussed the STP at its last meeting and that, through discussion, it had become evident that further time would need to be spent reviewing the priority areas in further detail.

The Chair welcomed the following guests in connection with this item:

- Dr Jo Sauvage, co-chair NCL Clinical Cabinet, Clinical Chair Islington CCG
- David Sloman, NCL STP convenor, Chief Executive, Royal Free London NHS Foundation Trust
- Mike Cooke, local authority lead for the STP, Chief Executive, LB Camden
- David Stout, Senior Programme Director, NCL STP
- Sue Richards, member of NCL STP Watch
- Siobhan Harrington, Deputy Chief Executive and Director of Strategy at Whittington Hospital

The Chair stated that focus of the meeting would be on transparency, finance, estates and governance.

Mr Sloman presented the item and briefed the Committee about the overall aims of the STP. These were to ensure best value for money and improved productivity, with overall benefits for the local population. There were pronounced health inequalities within the north central London area, which the plan aimed to address. It aimed to provide communities with the optimum opportunity to stay healthy whilst ensuring that the best possible provision of health and social care was available. There was a clear need to switch the focus from illness to prevention. He acknowledged that there had been a lack of public and patient voice within the plans to date.

Dr Sauvage also set out the principles behind the development of the Plan. She highlighted that there was intense clinical scrutiny of them. Demand for health services continued to increase and there was a key role for social care in addressing them. She welcomed discussion on how the STP could begin to address the issues around health and social care, particularly in light of increasing demand and costs.

Transparency

Following a query about engagement from the Committee, Mr Cooke stated that the Plan was at its early stages and noted the limited engagement in the production of the draft plan that there had been so far with elected Members and residents, due to the national process. He also stated that the post of Engagement and Communications Manager had been created and that a candidate had been recruited for the post. Discussions would follow to develop a comprehensive stakeholder engagement plan.

The Chair welcomed the comments and highlighted the need for effective engagement with residents, service users, communities and Members. The following comments were raised by Members of the Committee:

- The need to issue an informative statement in a clear and concise way on what the STP is, and how communities can engage and comment on plans. The Committee also felt that improved consultation would enhance efficiency at the implementation stage.
- The need to draw a distinction between public engagement and statutory consultation.
- Given the diversity of communities within the NCL area and the statutory duty to have regard to protected characteristics under the Equalities Act 2010, Cllr Jean-Roger Kaseki asked whether consideration had been given to the way the plans will affect this duty.
- Councillor Anne Marie Pearce requested further information about plans for care in the community and possible closures of hospitals within NCL.
- Councillor Alison Cornelius made a suggestion to approach local newspapers, local Healthwatch websites for publication of regular informative STP articles with links for further information on a weekly basis.
- The Committee made a request for information on the timelines for engaging with local authorities and Councillors – Councillor Pippa Connor noted the need for clarity on a detailed public consultation plan, involving not just patients but also populations and community groups.

Mr Sloman reiterated the commitment towards engagement using language which was clear, particularly as Members had commented that the language used was often challenging for lay people. There would be various engagement stages and that a statutory consultation might also need to take place although there were currently no plans. Mr Cooke also acknowledged the need for further partnership work on how to best engage, which would in turn inform future consultation and engagement initiatives.

Dr Sauvage stated that the development of the plans had been progressed with attention being given towards equalities across the system. As part of this, national evidence was considered to note what was working well, particularly for local areas and to take lessons forward. There was an issue with inconsistency as different areas were undertaking different processes. This would be of particular importance

when considering support for GP practices in relation to how the 'care closer to home' model could be delivered.

Mr Sloman noted that the process for communication, consultation and engagement would be a long term process for the next 2-3 years. There were currently a number of work streams in place which were progressing through various working groups and work on engagement plans would continue.

Finance

The Chair noted that this was a critical aspect to the working of the STP and reiterated the message around the extra costs facing councils' social care budgets. It was noted that this message could be emphasised more strongly collectively.

Mr Stout reported that there was a potential funding gap of around £900 million in health care funding should no action be taken to address it by partners. Although funding had been increased, the growth in this had been slower than the increase in demand and costs. In addition there was the potential for a gap in social care funding of £300 million in 2021. Taking in account the proposals in the STP, there still remained a gap of £75 million that still needed to be filled. The financial assumptions were based on the reduction in demand for acute care. There was a strategic transformation fund of £105 million to assist with the implementation of the STP by 2020/21 but only around £50 million of this was as yet guaranteed for 2017/18. Further work was needed to balance the plan and it would continue to be progressed as far as possible, along with discussions with partners, until the end of the year.

The Committee expressed concerns over the inherent reliance made in the plans on social care, which was currently facing funding challenges. Mr Stout noted that the proposals had not been specifically modelled around pressures from social care budget savings but that cost growth modelling had been based on pressures faced in previous years which included the impact of social care budgets' reductions. He also stated that there was recognition of the scale of the significant financial problem facing local authorities. He noted the need for addressing the issues by considering different ways in which services could be delivered and to reduce unnecessary costs.

Committee Members raised the following queries:

- Councillor Jean-Roger Kaseki asked that as part of the proposals how much time was being committed towards considering mental as well as physical health services.
- Given the possible structural changes to CCGs, Councillor Graham Old asked whether the increased administrative and financial burden had been taken into account as part of the proposals.

Mr Sloman stated that there was a need for serious consideration of the productivity agenda and a different and more efficient way of working – by, for example, avoiding

duplication of back office work. In relation to the issue of the workforce, Sue Richards noted that the proposed investment was crucial to up-skilling people and the development of the current workforce. Dr Sauvage informed the Committee about the Workforce Advisory Board and the planning it was doing to try to ensure that the workforce the NHS had in NCL would reflect its needs.

Mr Sloman thanked the Committee for the comments and noted the challenges facing NCL and the development of the STP. He also noted the financial gap set out within the plans. He also emphasised the need to consider the system as a whole and the importance of the proposals for integrated care outside of the hospital setting. The plan had targeted those areas with the potential for delivering the most immediate impact. There was a particular need to reduce demand for acute care, which was very expensive.

Mr Cooke also welcomed the comments from Members. Time and investment were needed to ensure that robust plans were in place for implementation, in light of the pressures facing adult social care over the next five years. The Chair also requested that partners consider other routes for voicing the concerns facing NCL as a system, particularly social care budget pressures.

Estates

Following a query from the Chair about proposals for Whittington Health and its sites, it was suggested that a separate session be held for detailed discussion on Whittington Health, sites and hospital infrastructure.

Siobhan Harrington, Deputy Chief Executive and Director of Strategy at Whittington Hospital stated that, at the end of the six month period, there would be a business case for Whittington Health which would go through the NHS approval process and inform the STP. It was agreed that this topic would be considered in further detail at a future session.

Governance

In relation to governance, the Chair commended the partnership work undertaken by local authorities and CCGs and the good progress achieved. She stressed the need for a linkage with communities and acute providers. In terms of the delivery of the plan, the Chair queried whether an oversight group including lay people and non-executive directors of trusts should be put together to ensure there was transparency and oversight of the plans.

Mr Cooke noted that current governance proposals which were being discussed through the relevant organisations included the setting up of a joint committee with representation from local authorities, public and participation groups. The Committee noted that, despite the closer co-operation between commissioners and providers of NHS health services that had taken place in putting the STP together,

the CCGs nevertheless had a statutory role in respect of the commissioning of services.

The Chair thanked the Committee for the discussion and requested that reports be brought back to the Committee setting out the:

- Estates strategy
- Governance system proposals

RESOLVED:

That the comments above be noted and specific consideration be given by the Committee in further discussions on the STP to the Estates Strategy and proposals for the governance system.

7. LUTS CLINIC UPDATE

Councillor Martin Klute (Vice Chair) introduced the report noting the background to the service at the LUTS Clinic.

Ms Siobhan Harrington, Deputy Chief Executive and Director of Strategy at Whittington Hospital reported on the recommendations aimed at patient safety within the recent report on the LUTS service that had been undertaken by the Royal College of Physicians (RCP). The Committee noted that services were still not fully functional but that good progress had taken place.

The Chair also noted the importance of including children and young people in provision of services. Ms Harrington noted that, as soon as the evidence had been reviewed, the clinic would be reopened and this might take up to May next year.

Councillor Charles Wright requested clear communication on timelines so that any potential funding or commissioning issues were addressed and clarified. Ms Harrington informed the Committee of the plans to consult with the commissioners early next year about funding and transitional issues.

The Committee requested that a one page summary be circulated to them by the patients' group on the response that they were working on to the RCP report.

RESOLVED

That the report be noted.

8. WORK PLAN

The Committee agreed that for its meeting on 3rd February 2017, the STP item would consider the Governance and Transparency aspects. It was also agreed that the item on Dementia Pathways be moved to the 24th March 2017 agenda. The

Committee agreed to move the UCLH item from its March meeting to a later date in order to consider the STP item in more detail.

The Committee wished to consider the item on the interaction of the London Ambulance Service and East of England Ambulance Service at a future session.

RESOLVED:

That, subject to the comments and amendments above, the work plan be approved.

9. DATES OF FUTURE MEETINGS

The Committee noted that future meetings of the JHOSC would be held on:

- Friday, 9th December 2016 at 9.30am at Camden Town Hall (Special meeting to consider the STP);
- Wednesday, 14th December 2016 at 5pm at Camden Town Hall (Special meeting to consider the STP);
- Friday, 3rd February 2017 at 10am at Enfield Civic Centre;
- Friday, 24th March 2017 at 10am at Camden Town Hall

The meeting ended at 1pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
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MINUTES END

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 9TH DECEMBER, 2016** at 9.30 am in the Council Chamber, Town Hall, Judd Street, London WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne-Marie Pearce (LB Enfield)
Councillor Jean-Roger Kaseki (LB Islington)

MEMBERS OF THE COMMITTEE ABSENT

Councillors Richard Olszewski, Charles Wright and Martin Klute

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the. North Central London Joint Health Overview and Scrutiny Committee.

MINUTES

1. APOLOGIES

Apologies were received from Councillors Martin Klute, Richard Olszewski and Charles Wright.

2. DECLARATIONS OF PEUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Pippa Connor declared that she was a member of the RCN and that her sister worked as a GP in Tottenham.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATIONS OF ANY ITEMS OF URGENT BUSINESS

There were no notifications of any items of urgent business.

5. SUBMISSIONS FROM STAKEHOLDERS REGARDING THE SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

Consideration was given to the written submissions supplied in the supplementary agenda and to verbal submissions from six speakers (Councillor Georgia Gould, Jeanelle de Gruchy, Frances Hasler, Paul Jenkins, Dawn Wakeling and Gordon Peters).

Councillor Gould, who was the Cabinet Member with responsibility for health at Camden Council, addressed the Committee first. She welcomed the attention the JHOSC were giving to the STP.

Councillor Gould said she shared some of the concerns that people had expressed about the STP process. There had not been transparency at an early stage. She wanted to see political accountability, as elected representatives were the guardians of their constituents' interests.

She welcomed the greater focus on mental health services in the STP. She also welcomed the mention of investing in community-based care. However, she said that it needed to be appreciated by all concerned that there was a funding crisis in the social care sector and this needed to be addressed by central government.

In response to questions, Councillor Gould confirmed that the STP had emerged outside of the normal governance processes. However, the Council remained open to working with the other organisations involved in order to shape integrated services for the North-Central London (NCL) area and a report on the STP would be considered by the Cabinet at its meeting on 14th December.

In terms of governance, final decision-making would sit with the statutory bodies not with the STP Board.

Jeanelle de Gruchy, Haringey's Director of Public Health, spoke to the Committee. She highlighted the STP's focus on prevention. It was estimated that 20% of disease was preventable. By prevention and early intervention, the need for acute care could be reduced.

Ms de Gruchy indicated that the Board wanted to see where good practice was taking place and to spread it throughout the NCL area. They wanted to support residents to make healthier choices.

Members asked about examples of current joint working. She said that sexual health was a current example of joint working and there was also joint working on smoking cessation services.

A member asked about diabetes services. She informed the meeting that a tranche of funding had been received from NHS England to use for identifying those at risk

from diabetes and on early intervention to help them. It also tied in with the weight management interventions that professionals were attempting to make.

Councillor Cohen (Barnet) asked what the added value of the STP was, and what the service would be doing if there was not an STP. Ms de Gruchy said that the STP helped the public health function which had transferred to local authorities stay in touch with the NHS and it encouraged co-operation between boroughs.

The Chair asked what the key recommendation Ms de Gruchy would like members to make was. She said that she would like to see members recommending the allocation of more money to prevention. Currently only 3% of the NHS budget went towards prevention.

Frances Hasler, the Director of Healthwatch Camden, addressed the meeting. She expressed concern that it was difficult for members of the public to engage with a large document such as the STP. She said that many members of the public had not heard of the document; let alone how to express their views on it. She said that there needed to be improvements in the accessibility of public consultation meetings that were held on this, and signers and speech-to-text interpreters needed to be present.

She expressed concern about what she saw as the opaque financial assumptions within the Plan and the lack of citizen involvement in it. She added that she was disappointed at the lack in focus on adult social care.

Members heard from Dawn Wakeling, the Director of Adult Social Services in Barnet. She was the STP lead for estates. Ms Wakeling highlighted that the NCL sub-region was the subject of an estates devolution pilot. The devolution pilot meant that some decisions could be taken locally regarding NHS property and capital expenditure/receipts, and did not have to be taken nationally as was the normal situation.

She mentioned that one-third of the NHS estate pre-dated the creation of the NHS in 1948. Furthermore, a significant number of GP practices were not in a satisfactory condition. The spending on the estate was estimated at £400m, but a lot of buildings did not meet the “Carter efficiency” levels.

She said that it was estimated that 15% of the estate was surplus to requirements, and that they were trying to release surplus capital from this to rebuild. She said that she was looking for co-location between health services/organisations and to see whether care could be delivered closer to people’s homes. There was also a need for key worker housing, which could be located on surplus estate.

Ms Wakeling estimated that £111m of funding was needed to develop the community estate, which would enable more care to be provided closer to home.

Members queried who kept capital receipts from sales. She said that receipts could be kept by the selling organisation if it was a foundation trust or linked to a

redevelopment scheme. In terms of non-foundation trust organisations, money was normally returned to the Treasury but they could keep some receipts if they were below £5m. The estates devolution pilot enabled greater retention of sales revenue from non-foundation trust properties and NHS Property Services sales.

The Barnet councillors noted the finding that many health service properties were not operating at "Carter efficiency" levels and said that inefficiencies occurred when organisations were not directly picking up the tab for underused properties. The example of Finchley Memorial Hospital was cited, where space was lying vacant and the CCG was picking up the cost rather than the LIFT firm or NHS Property Services.

Councillor Connor said she was frustrated at the 'stop' on development at St Ann's Hospital. She wanted to know if estates devolution could speed matters up. Ms Wakeling said she was not able to give a timescale for St Ann's, but would do her best to push for the redevelopment to resume.

The Chair asked Ms Wakeling what she felt the key risks were. She said that the key risks were the complexity of the system and not being able to fund the development of the community estate.

The STP lead for mental health, Paul Jenkins, was the next speaker who addressed the Committee. Mr Jenkins said that he wanted to work with patients, families and carers to co-design services. He wanted to focus on strengthening the provision of services in the community with primary care based teams.

There were people who presented ostensibly with physical health problems but who had underlying mental health issues. The aim was to try and pick these cases up at an early stage.

Mr Jenkins said that mental health was not a sector that was being asked to make net savings in the plan. However, he highlighted that this was a sector with rising demand and demographic pressures.

He highlighted good work being done by Barnet, Enfield and Haringey Mental Health Trust on the 'recovery home' model and 'crisis cafes'. Perinatal mental health was a sector with unmet needs and so they were arranging access to a specialist mother & baby unit at the Homerton Hospital.

He said that about £44m of investment was required for mental health. This investment would in turn save about £24m.

Councillor Connor expressed concern that the model was community-based at a time when councils had to cut back on day centres and other social services provision. The NHS might be relying on local authority services to help people in the community that no longer existed.

Councillor Kaseki noted the co-morbidities between mental and physical health and hoped that the health service would be able to tackle this.

Mr Jenkins agreed with the observation that there was a significant degree of co-morbidity. He said that about one-quarter of patients with serious physical health problems also had mental health issues; and that people suffering from serious mental illnesses themselves had a life expectancy that was 15 years lower than the average.

Councillor Kelly asked Mr Jenkins what he felt the key risks on the horizon were. He said that he welcomed the fact that mental health was higher up the political agenda than in the past, but that there was a danger that good intentions would be overwhelmed by other pressures.

Gordon Peters, who was the Chair of the Older People's Reference Group in Haringey, spoke about his concerns as someone who was active in the voluntary sector on behalf of older people.

Mr Peters was concerned about the lack of mention of older people in the document. A number of problems in the health and social care sector, such as delayed discharge, were mainly due to older people who did not have social care support to return home after a stay in hospital.

He highlighted the demographics pressures facing the health and social care sector due to an aging population. He said that he wanted to see the restoration of lost social care funding, and a social framework of care for long-term patients. He wanted the Better Care Fund to be more transparent. He said that there needed to be an appreciation of the importance of community hubs, such as GP surgeries.

He added that he felt that more detail was needed in the STP about how services would change in the next few years. He also said that he felt the timetable was too short and that councils should ask for more time to consider it before they signed it off.

The Chair thanked the speakers for their contributions. She said that the next meeting of the JHOSC would consider recommendations to make regarding the STP. She asked that, following that meeting, when she circulated her suggested recommendations, other members feed back within 48 hours.

She noted that finance and governance matters had been raised in the submissions and she felt that this was something that the Committee could examine in its February or March meetings.

6. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

There was no other business.

7. DATE OF NEXT MEETING

The next special meeting of the Committee would be on 14th December at 5pm in Committee Room 1 in Camden Town Hall.

The meeting ended at 12.30pm.

CHAIR

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MINUTES END

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **WEDNESDAY, 14TH DECEMBER, 2016** at 5.00 pm in the Committee Room 1, Town Hall, Judd Street, London WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)
Councillor Alison Cornelius(LB Barnet)
Councillor Graham Old(LB Barnet)
Councillor Richard Olszewski(LB Camden)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne-Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Jean Roger Kaseki (LB Islington)

ALSO PRESENT

Councillor Richard Cornelius (Leader, LB Barnet)
Councillor Phil Cohen (LB Barnet)

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the. North Central London Joint Health Overview and Scrutiny Committee.

MINUTES

1. APOLOGIES

There were no apologies.

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

There were no declarations of interest.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATIONS OF ANY ITEMS OF URGENT BUSINESS

There were no notifications of urgent business.

5. SUBMISSIONS FROM STAKEHOLDERS REGARDING THE SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

Consideration was given to the supplementary agenda pack of submissions received from stakeholders.

Members received verbal presentations from Dr Vicky Weeks, Alex Bax, Anne Gray, Viv Sharma and Professor Sue Richards.

Dr Weeks was the Medical Director of the Londonwide Local Medical Committees (LMCs) for North Central London. She informed the Committee the LMCs had written to STP chairs as they were concerned that the STPs were being led by acute trusts without local GP involvement. There had been a lack of engagement between the STP board and GPs. The LMC had now been given a seat on the board, but this was only one person. She felt that the priority of STPs was the acute trusts.

She said she wanted to see holistic care and this required funding that followed patients if they were to be treated in the community rather than in an acute setting. Members made reference to problems there had been with the "care in the community" model when psychiatric hospitals were closed and did not want to see this recur.

Dr Weeks was asked about the relationship between CCGs and the LMCs. She said that they had monthly or two-monthly meetings and their relationship was developing.

Members asked about premises plans. Dr Weeks replied that each borough was supposed to have a premises strategy, but a large number of GPs had not seen them.

There was a concern among the LMCs about GP practice closures and the patients being dispersed to other practices that were already busy. It was noted that if a new practice was being created it would have to go out to tender under the APMS model (alternative provider of medical services).

Alex Bax, from Pathways, addressed the Committee. He explained that Pathways was a charity which focused on homeless people admitted to hospital. He said that they defined homelessness as people who did not have a safe home to be discharged to, so the client group was wider than rough sleepers.

Mr Bax highlighted that homelessness was a major factor in morbidity and premature death. Health providers needed to address this to comply with their statutory duty to have regard to health inequalities.

He highlighted that homeless people were not receiving help that more suitably-housed residents were. He cited the example of smoking cessation services. A

majority of homeless people who smoked wanted to have help with smoking cessation but they were not receiving this support.

Mr Bax praised the CHIP (Camden Health Improvement Practice) services which provided primary care for homeless people in Camden. This was an example of good practice, but he was concerned that in other places there was poor provision of primary care to homeless people.

He noted that many homeless people had a multiplicity of problems and conditions which affected their mental health. Mental health services would need to be configured in such a way that they were able to deliver a much-needed service to them.

The Chair asked what Mr Bax would like the Committee to recommend. He said that he would like homelessness to be seen as a health issue and for prevention to be key in local authorities' approach to this. He said that about 60-70% of UK-born homeless people had been in local authority care. He felt that a greater focus on preventing illness amongst homeless people through provision of such things as influenza and hepatitis vaccinations had the potential to deliver significant savings.

Anne Gray and Viv Sharma from the Haringey Social Care Alliance addressed the Committee.

They highlighted that social care cuts were causing suffering, stress and anxiety for service users and carers. They had concerns about the poor quality of care and the low rates of pay in the care sector. There were concerns in Haringey that some operators had been paying below the minimum wage.

They noted that there was talk of the government allowing councils to levy a social care precept again next year to provide more funds for social care. They said that this might cause difficulties for low-income residents given the reductions there had been in Council Tax Benefit. They suggested that people's council tax could be reduced for those who were doing voluntary work.

They wanted to see collective self-care and support for volunteering. They also saw a role for non-profit social enterprises providing care, rather than private firms.

Members asked if they wanted the Committee to say that transformation in services required initial investment. They said they did.

Ms Gray and Ms Sharma highlighted that housing for disabled people was a problem. There were long delays in getting aids and adaptations fitted, and this contributed to delayed discharge. Local authorities also did not have adequate supplies of homes that were suitable for disabled people, and sometimes those homes were occupied by able-bodied tenants. There also needed to be a recognition that people's needs could increase over time.

Sue Richards spoke to the Committee on behalf of NCL STP Watch and thanked the JHOSC for raising the profile of the STP.

Professor Richards said the matter of the STPs was a politicised issue. She said that people should not lose sight of the fact that the decision to cut health spending as a percentage of GDP had been made by central government. She said that service changes could not be divorced from the cuts in spending. In order for service changes to work well, there needed to be investment and dual-running of some facilities.

She said that NCL STP Watch did not want councils to agree with or take ownership of the plan. She asked that the five NCL boroughs instead use their collective voice to ask Whitehall for more money. She wanted local authorities to be clear that they were not condoning reductions in services.

Professor Richards drew attention to a lack of transparency in the process. She also highlighted that there was a contradiction between the approach of the STP, which was a collaborative process, and the purchaser/provider split in the Health & Social Care Act.

John Lipetz added that if local authorities refused to agree with to the Plan they could prevent local authority staff being involved, as NHS England could not impose changes on local authority staff without the consent of that local authority.

Councillor Richard Cornelius, the Leader of Barnet Council, spoke to the Committee. He said that he shared some of the concerns that people had expressed. He said that the approach NHS officials had taken had not gone down well with local authorities.

He welcomed the principle of joining up health and social care but said there were a number of practical difficulties. There needed to be a stronger voice for local authorities and greater accountability. He said there was a difference between local authority budgeting and NHS budgeting, and this had been demonstrated when public health functions were transferred to local authorities.

Councillor Richard Cornelius observed that there were differences within the sub-region, and he drew attention to the fact that Enfield and Barnet had rapidly growing populations. Funding and the provision of services needed to reflect this.

The Chair asked if he had one point he wanted to emphasise. He said that it was that primary care needed to be ‘geared up’ for the change beforehand with sufficient funding and the IT infrastructure to support it.

Members asked about joint working between the five boroughs’ Leaders. Councillor Cornelius said that he had signed a joint letter with the other four Leaders outlining their common concerns.

Councillors Phil Cohen and Graham Old brought to the attention of other members that a Barnet Council meeting last night had made eight recommendations about the STP. They hoped these would feed into the views of the JHOSC as a whole.

6. CONSIDERATION OF SCRUTINY RECOMMENDATIONS FOR THE STP

Members gave consideration to the recommendations they would be making as a Committee concerning the STP.

Councillor Kelly said that a draft report would be circulated in Word format on Thursday (15th December) and asked that members reply by Monday (19th December) morning. A second draft would then be created, incorporating member comments, and this would go to members for approval. She asked that members reply with their agreement or any further comments within 48 hours of the second draft being created, so it could then be forwarded to the relevant people and organisations promptly.

Members agreed that there should be a recommendation that Local Authority Leaders do not endorse the STP unless they and clinicians were convinced that there was enough money available to implement the Plan.

It was noted that the clinicians involved had good intentions to improve health outcomes for residents, but that it would not be possible to deliver it without the necessary funding and resources.

Councillor Klute commented that the tone of the report needed to be critical and should not assume that the Plan would be agreed and go ahead.

Members thought that their report should go to the STP Board, the Secretary of State, the Leaders of the five Councils, the King's Fund, the London Health Board and Simon Stevens.

RESOLVED –

THAT the Committee's report and recommendations be drawn up by the process detailed above.

7. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

There was no urgent business.

8. DATES OF FUTURE MEETINGS

Future meetings will be on:

- Friday, 3rd February 2017 at 10am at Enfield Civic Centre;

- Friday, 24th March 2017 at 10am at Camden Town Hall

The meeting ended at 6.45pm

CHAIR

Contact Officer: **Vinothan Sangarapillai**
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MINUTES END

North Central London Sustainability and Transformation Plan

Response to North Central London Joint Health Overview and Scrutiny Committee report – December 2016

Introduction

The North Central London (NCL) Joint Health Overview and Scrutiny Committee (JHOSC) issued a report in December 2016 on the current status of the NCL Sustainability & Transformation Plan (STP). This followed three evidence gathering sessions held during November and December 2016.

The JHOSC report sets out a number of recommendations for the STP Transformation Board to consider. Our initial response to these recommendations is set out below.

Overview

The NCL Transformation Board welcomes the JHOSC review of the STP and the recommendations which are set out in the report. The leadership of the STP were actively engaged in the JHOSC process and welcomed the positive and constructive approach that has been taken throughout.

The NCL STP is very much a work in progress and we are committed to continuing to work with the JHOSC and the wider NCL community as we develop our plans in the months and years ahead.

The JHOSC report set out recommendations against eight key themes. Our preliminary response to the recommendations made by the committee, follow the headings provided in the report.

Recommended principles

We agree to adopt the recommended principles to guide NCL's approach to developing the STP set out on page 2 of the JHOSC report:

- *Put the needs of individual patients, carers, residents and communities truly at the centre;*
- *Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;*
- *Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;*
- *Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;*
- *Focus on building resilient patients, carers, residents and communities -and on where resources can have the biggest sustainable impact.*

Transparency

We understand the concerns raised about transparency, although we do emphasise that there has been more engagement in the development of the content of the draft STP than has been acknowledged. The draft plan builds on many years of engagement work which has been undertaken by the Clinical Commissioning Groups, NHS providers and local authorities across NCL. This information and research has informed many of the areas of work being proposed. As a consequence, the ideas set out in the draft plan have generally been welcomed.

However we acknowledge the need to address the concerns that have been raised about transparency and set out our initial response to the recommendations below.

Transparency recommendations from the JHOSC:

1. *Ensure future development of the STP includes greater transparency, political accountability, inclusive and open engagement with residents, including with the most vulnerable, frontline staff, clinicians, GPs and council and political leadership.* *Transformation Board response:* Agreed. We are committed to working in a fully transparent, inclusive and open way as the STP develops.
2. *Ensure there is meaningful public engagement once details of the plans are available, using a range of communication methods, including but not limited to, the existing engagement processes used by partner agencies.* *Transformation Board response:* Agreed. We will ensure that public engagement is built into each of the STP workstreams as they develop the plans in more detail.
3. *Set out clearly what the impacts and implications of the changes will be in a language and format accessible to all residents regardless of age, disability and ethnicity.* *Transformation Board response:* Agreed.
4. *Events must be in accessible locations.* *Transformation Board response:* Agreed.
5. *Engage with people from a range of backgrounds including those disadvantaged by language barriers, physical disabilities, mental health, physical health, social and other inequalities.* *Transformation Board response:* Agreed. We make a commitment that equalities assessments will be developed as part of the next phase of planning.
6. *Outputs from meetings held in public must be publically available.* *Transformation Board response:* Agreed. We will create a NCL website that allows material from meetings to be available and accessible to the public.
7. *Commit to demonstrating where engagement activity has influenced STP planning and be transparent when it has not.* *Transformation Board response:* Agreed.
8. *Provide the evidence base for key decisions. Undertake 'stress-testing' to ensure assumptions underpinning the STP are credible and the changes can be delivered.* *Transformation Board response:* The draft plans have been based on an assessment of evidence. The evidence base which has been

used will be shared as part of engagement on the plans as they are worked up in more detail.

Governance

We have recognised that there has been a lack of engagement of local politicians and chairs of health organisations in the governance of the STP to date. We are currently developing our ideas on how to address this.

There has been significant social care input into the STP. All local authorities are represented on the current *Transformation Board* and there are lead officers for both adult social care and children's social care who sit on the current *Transformation Group* and on the *Clinical Cabinet.* There is also social care input into the workstreams.

Our initial response to the governance recommendations from the JHOSC is set out below:

1. *To adopt the 'Principles to guide NCL's approach to the STP' outlined in page 2 of this report.* *Transformation Board response:* Agreed.
2. *Align with the principle of the NHS Constitution and in particular that 'patients should be at the heart of everything the NHS does' and that 'the NHE is accountable to the public, communities and patients that it services' i.e. demonstrate how/where the local voice is involved in decision making.* 3. *To provide full details of anticipated governance arrangements so soon as possible for public consultation.* 4. *Develop governance arrangements that allow organisations to make collective decisions and share accountability, and that allow for scrutiny and assurance.* 5. *Include staff representation on the STP Oversight group.* 6. *Ensure accountability is maintained at both sub-regional and local level, and that accountability is clear.* *Transformation Board response:* The new governance arrangements that are being developed will set out how this will be achieved. We expect to be able to put new arrangements in place by the end of March 2017.
7. *Work with ASC professionals so that they consider that they are appropriately represented on the Transformation Board and STP work streams.* *Transformation Board response:* Adult social care is well represented throughout the STP as described above. However we are currently working to review whether the focus on social care within the STP could be strengthened.
8. *Consider establishing an NCL Health & Wellbeing Board building on good practice across the five boroughs and align the STP with Health & Wellbeing strategies* *Transformation Board response:* This recommendation should be considered by the Health & Wellbeing Boards.

Finance

We recognise that further work is necessary on the financial elements of the draft STP. The draft STP submitted in October did not achieve financial balance and lacks detail in relation to social care. The

draft STP does include significant investment in out of hospital services, but that investment is indicative to date.

Our initial response to the finance recommendations from the JHOSC are set out below:

1. *Recognise that major investment in adult social care, community services, third sector organisations and in prevention is needed to deliver the plans.* 2. *Recognise that as services are transferred from acute to the community so must the funding.* 3. *Provide clarity on where the level of investment required will come from.* 4. *Provide the evidence base and detailed financial assumptions for detailed savings within in the STP e.g. a properly staffed and resourced more primary-care led NHS will be cheaper than the current model of service.* 5. *Provide further detail of the intended spending on public health interventions for the next five years and what measurable benefits are expected to be achieved from this investment.* 6. *Provide detail of intended investment in the voluntary and community sector to support delivery of the plan locally.* 7. *Provide detail on how resources will be shared and what financial management processes are being developed.* *Transformation Board response:* Agreed. The draft STP includes indicative investment in community based services and public health interventions, but the financial and workforce implications will need to be worked through as we develop the plans in more detail.
8. *Increase the focus on mental health, homelessness, prevention and the development of integrated community services and to support residents closer to home.* *Transformation Board response:* These areas are a major focus of the current draft plan, although further consideration may be needed on homelessness. The more detailed plans as they are developed will demonstrate how these issues are being addressed.

Digital Services

We believe the digital technology offers opportunities to both improve the quality of care and to drive improved productivity. We therefore see the digital workstream as one of our key enabling areas of work.

Our initial response to the digital services recommendations from the JHOSC are set out below:

1. *Provide further information about how the digital transformation will be paid for.* *Transformation Board response:* The draft STP sets out the scale of capital investment required to deliver our ambitions. Speed of implementation will depend on the availability of capital funding which has not yet been confirmed.
2. *Explore options to integrate the Accessible Information standard across all systems.* *Transformation Board response:* We aim to utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for local people.
3. *Provide further detail about key planning assumptions and risks around delivery and integration of the digital transformation across all provides.*

4. *Provide further detail on the approaches that will embed technology to support people to remain independent for longer.* *Transformation Board response:* More detailed plans will be developed over the coming months.
5. *Learn from elsewhere, including from abroad.* *Transformation Board response:* Agreed.

Adult Social Care (integrated working)

We recognise the challenges we face in relation to social care funding and we support the development of more integrated working between health and social care.

Our initial response to the adult social care recommendations from the JHOSC is set out below:

1. *Work with ASC professionals so that they consider they are appropriately represented on the Transformation Board.* *Transformation Board response:* Adult social care is well represented throughout the STP as described in the governance section above. However we are currently working to review how the focus on social care within the STP could be strengthened.
2. *Continue to support localised plans currently in progress to develop integrated health and care services for residents, including using the voluntary and community sectors as the sector of preference. Continue to ensure local control.* *Transformation Board response:* Agreed. This is a key element of the care closer to home workstream.
3. *Be more explicit in detailing, in plain English, how the proposed plan will benefit local residents and the sustainability of the health and care system.* *Transformation Board response:* Agreed. As the details of the plan are further developed we will produce plain English versions of the plans.
4. *Consider the creation of maternity hubs within the Care Closer to Home Integrated Networks and the inclusion of maternity outcomes e.g. choice added to the care closer to home outcomes listed in the STP.* *Transformation Board response:* To be considered as part of the care closer to home workstream and the work in the NCL of our early adopter programme for the national Better Births which will be our maternity workstream in the STP.
5. *Consider and promote non-profit model options for home care as a sustainable model for fair care wages.* *Transformation Board response:* We will consider the recommendation as we move forward to developing the STP, particularly around the development of CHINs and the UEC stream

Outcomes including better public and mental health

The draft STP puts an emphasis on increasing our efforts on prevention and early intervention to improve the health and wellbeing outcomes for our whole population.

Our initial response to the outcomes recommendations from the JHOSC is set out below:

1. *Ensure NCL is the best place for health and wellbeing where: no one gets left behind; in times of need, good quality and safe health and social care is available; people can access services in the right place and at the right time; tax payers money is used to the maximum value; there is maximum opportunity for people to reach full recovery.* *Transformation Board response:* Agreed. This is in line with the vision set out in the draft STP
2. *Commit that no acute services will be cut until the 'replacement' community services are proven to work. Provide further details about plans to consolidate services.* *Transformation Board response:* The draft STP sets out our ambition to reduce demand on acute services. There are no plans to 'cut' acute services and any capacity reduction would be linked to reduction in demand. There are currently no plans to consolidate services but we will keep this under review as our detailed plans develop. Any consolidation would be subject to public consultation.

Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population. Our initial response to the estates recommendations from the JHOSC is set out below:

1. *Integrate estates planning with the rest of the STP process so it focuses on delivering better health and wellbeing outcomes and full staffing and VFM.* *Transformation Board response:* Agreed.
2. *Put pressure on Central Government so all decisions about NHS estates in London are taken by London NHS commissioners, providers and London councils working together, with devolved powers, for the good of local people.* *Transformation Board response:* We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate.
3. *Provide assurance that no estates disposals will take place unless the full benefit goes to the NCL community or is retained for their future use.* *Transformation Board response:* This is one of the expectations of the London devolution programme.
4. *Explore options to maximise the potential of community hubs e.g. expanding GP settings with Keeping Well facilities, the voluntary and community sector, council services and funding mobile clinics.* *Transformation Board response:* This will be considered as part of the care closer to home workstream.

Workforce

We aim to ensure that NCL becomes the place of choice to train, work and live healthy lives. This includes working together to create and deliver a compelling offer that will attract, develop, retain and sustain a community of people who work in health and care in NCL. Our staff need to move towards a more person-centred approach to care and this will mean developing new skills, training modalities and new roles.

Our initial response to the workforce recommendations from the JHOSC:

1. *Adopt a policy of redeployment rather than redundancies as a result of any STP implementation.* *Transformation Board response:* We would always seek to redeploy staff to avoid redundancies wherever possible.
2. *Detail how they plan to embed positive working cultures (supportive and open workplaces where staff are supported to learn from mistakes, where leaders are open and honest and where people can speak up when things go wrong) and ensure that services are appropriately staffed, across health and social care, as they are transformed.* 3. *Detail how they plan to reduce agency spending.* 4. *Detail the intended investment in developing skills and qualifications for the part of the workforce who will need to work differently in the future.* *Transformation Board response:* The next stage of the workforce workstream will be to develop more detailed plans. We will ensure there is broad stakeholder engagement in the work as it progresses.

Next steps

We are keen to continue to work constructively with the JHOSC as our plans develop.

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North Central London
Joint Health Overview Scrutiny Committee (JHOSC)
December 2016

Sustainability and Transformation Plan (STP)

Recommendations to ***Secretary of State for Health Rt. Hon Jeremy Hunt MP***
In light of the severe cuts to the Social Care budget of the Councils represented by this Joint Health Overview Scrutiny Committee, we ask for the Chair to write to the Secretary of State for Health to highlight our deep concerns about the current level of transformation money and the need to ensure the safe redesign of all services. ***We recommend that the extra money required should be determined and agreed by NCL's Transformation Board, the CCGs and the Leaders of Barnet, Camden, Enfield, Haringey and Islington Councils.***

Recommendation to NCL Council Leaders and David Sloman Chair NCL Transformation Board – see also pages 2 to 11
We believe that the Leaders of Barnet, Camden, Enfield, Haringey and Islington Councils must not endorse NCL's STP until sufficient funding for local clinical and social care services has been agreed.

The JHOSC will take the response of the Transformation Board to our recommendations at a future meeting of the JHOSC.

Chair of NCL JHOSC Cllr Alison Kelly, vice –chairs Cllrs Martin Klute and Pippa Connor. Members: Cllrs Abdul Abdullahi, Alison Cornelius, Jean-Roger Kaseki, Graham Old, Richard Olszewski, Anne-Marie Pearce, Charles Wright.

Contact Sarah Moyies sarah.moyies@Camden.gov.uk Tel: 0207 974 4129

Introduction

This report presents the combined response of residents, stakeholders, health service professionals, officers, Council Cabinet and Leaders, and elected scrutiny members to the current status of the NCL STP.

The document presents considered critical challenge to the plans where it is felt to be necessary, and is based on verbal and written evidence taken during November and December 2016 at specially convened meetings of the Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London, in response to the very short timescales for submission imposed on the sector by Central Government.

The committee heard evidence that was passionate, supportive and concerned about our local health services, and what those services might look like following implementation of the STP, and deep concerns about whether the STP as it currently stands contains sufficient detail for all interested parties to understand what it does in fact propose.

The JHOSC review has generated a number of key principles and recommendations across eight key themes to help inform and challenge the development and delivery of the NCL STP.

RECOMMENDED PRINCIPLES
to guide NCL's approach to developing the STP

- ***Put the needs of individual patients, carers, residents and communities truly at the centre;***
- ***Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;***
- ***Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;***
- ***Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;***
- ***Focus on building resilient patients, carers, residents and communities - and on where resources can have the biggest sustainable impact.***

Transparency

People told us:

- There is a need to ensure clinical scrutiny of everything across the whole system and to ensure we maintain good and safe clinical and social care.
- Engagement is key
    - There has been little to no engagement so far. Many people, including those who are vulnerable, homeless unwell or elderly, are unaware of the STP.
    - There is a need to clearly explain what the STP plan means (translate the technicality and language of the plan)
    - Local people who know of the STP are often concerned it implies major cuts;
    - There is a need to produce a short simple statement about what the STP plans are (sent to every household) and that there will be public consultation on them as they are developed
    - There is a need to produce weekly digests and engagement meetings for each part with a range of stakeholders
    - There is a need for investment of resources in on-going public engagement including the political accountability process. Elected political representatives are guardians of our residents; they engage with and champion the needs of residents. They embrace public scrutiny and understand how to challenge where plans fail to meet the needs of our residents
- Co-production should be serious
    - There has been very little collaborative while developing the plans so far.
    - There has been no dialogue or attempt at any co-design or co-production.

Transparency recommendations: The Transformation Board needs to:

• Ensure future development of the STP includes greater transparency, political accountability, inclusive and open engagement with residents, including with the most vulnerable, frontline staff, clinicians, GPs and council and political leadership;
• Ensure there is meaningful public engagement once details of the plans are available, using a range of communication methods, including but not limited to, the existing engagement processes used by partner agencies;
• Set out clearly what the impacts and implications of the changes will be in a language and format accessible to all residents regardless of age, disability and ethnicity.
  ○ Events must be in accessible locations
  ○ Engage with people from a range of backgrounds including those disadvantaged by language barriers, physical disabilities, mental health, physical health, social and other inequalities
  ○ Outputs from meetings held in public must be publically available
• Commit to demonstrating where engagement activity has influenced STP planning and be transparent when it has not.
• Provide the evidence base for key decisions. Undertake ‘stress-testing’ to ensure assumptions underpinning the STP are credible and the changes can be delivered.

Governance

People told us:

- There is a lack of Adult Social Care representation on the Transformation Board
- There is a lack of clarity over the governance arrangements / structure of the STP Board
- The JHOSC should consider recommending the delay of signing off to enable consultation, provision of financial modelling information and to address the political engagement deficit.
- There is a need to link into community interest groups, CCGs and elected Councillors
- There is a need to establish a Joint Committee to allow organisations to make collective and public decisions and share accountability

Governance recommendations: The Transformation Board needs to:
• To adopt the 'Principles to guide NCL's approach to the STP' outlined in page 2 of this report. • Align with the principle of the NHS Constitution and in particular that 'patients should be at the heart of everything the NHS does' and that 'the NHE is accountable to the public, communities and patients that it services' i.e. demonstrate how/ where the local voice is involved in decision making • To provide full details of anticipated governance arrangements so soon as possible for public consultation • Develop governance arrangements that allow organisations to make collective decisions and share accountability, and that allow for scrutiny and assurance • Ensure accountability is maintained at both sub-regional and local level, and that accountability is clear • Include staff representation on the STP Oversight group • Work with ASC professionals so that they consider that they are appropriately represented on the Transformation Board and STP work streams. • Consider establishing an NCL Health & Wellbeing Board building on good practice across the five boroughs and align the STP with Health & Wellbeing strategies

Finance

People told us:

- No funded plan for the transformation. The STP makes assumptions about council services which cannot be met due to funding pressures. If there is no further investment in social care the aims of the STP are undeliverable.
    - Need to recognise the significant funding pressures are also being felt by voluntary sector groups that support vulnerable people across the boroughs.
    - Solutions must be developed to fund adult social care services beyond the introduction of the precept, avoiding the disproportionate impact on lower income households that increasing council tax in the long-run would cause.
    - There is a need to prioritise spending to addressing health inequalities e.g. mental and physical health and homelessness
    - A shift to prevention should not involve a reduction of resources – integration requires running costs to fund targeted peer support and capacity building
- There is a need to understand the impact is of detailed financial assumptions / cuts to social and public health care funding. E.g. What is the future of Better Care Fund and how will this be transferred to ASC
    - It will take time and investment to deliver the kind of systemic change required to move to a prevention based approach.
    - Facing an aging population, more complex morbidity, increasing demand, patient expectations and cost and more expensive innovative technology; issues seen internationally
    - Concerns whether care closer to home will reduce unnecessary costs.
    - Concern that plans to deliver more services in pharmacies may be affected by national plans to reduce pharmacy funding.
    - The STP seeks to fund health promotion and sickness prevention However, there is concern that many factors influencing ill-health lie outside the scope of local interventions and the potential expected gains of keeping people well longer is not achievable within this footprint.
    - Concern where innovative projects are working, there are no funds to upscale.
- The money originally promised for transformation of services is steadily being removed to fund the deficits being incurred by under-funding of the NHS. It will not be available in the original amounts to fund integration between health and social care**.**

Finance recommendations: The Transformation Board needs to:
• Recognise that major investment in adult social care, community services, third sector organisations and in prevention is needed to deliver the plans • Increase the focus on mental health, homelessness, prevention and the development of integrated community services and to support residents closer to home. • Recognise that as services are transferred from acute to the community so must the funding. • Provide clarity on where the level of investment required will come from. • Provide the evidence base and detailed financial assumptions for detailed savings within in the STP e.g. a properly staffed and resourced more primary-care led NHS will be cheaper than the current model of service. • Provide further detail of the intended spending on public health interventions for the next five years and what measurable benefits are excepted to be achieved from this investment • Provide detail of intended investment in the voluntary and community sector to support delivery of the plan locally. • Provide detail on how resources will be shared and what financial management processes are being developed.

Digital Services

People told us:

- Digital technology to provide major savings requires significant investment.
- Health and care providers are not ready to meet the Accessible Information Standard for people with disabilities
- The digital transformation described within the plan cannot be delivered and integrated effectively across all provides given the anticipated deficit and historic problems with and overspend on IT systems in the NHS
- Potential to develop approaches that will embed technology to support people to remain independent for longer. Can be used at all stages of the care pathway from early prevention to supporting complex needs.

Digital services recommendations: The Transformation Board needs to:
• Provide further information about how the digital transformation will be paid for • Explore options to integrate the Accessible Information standard across all systems • Provide further detail about key planning assumptions and risks around delivery and integration of the digital transformation across all provides. • Learn from elsewhere, including from abroad. • Provide further detail on the approaches that will embed technology to support people to remain independent for longer.

Adult Social Care (integrated working):

People told us:

- Concerns about the critical challenges faced in providing ASC, given the impact of funding reductions, including the financial gap of local ASC services and increasing demand pressures on the whole health and care system both locally and nationally.
- The challenges around the workforce instability in terms of recruitment and retention, market sustainability for areas such as home care and care/nursing home sector, meeting the needs of an aging population and pressures presented by the National and London Living Wage all require an ASC perspective.
- Health and care systems are closely linked. Addressing the challenges and proposing changes in one part of the system without considering the other risks severely limits the progress that can be made.
- There needs to be a strategic rethink of the delivery of services to develop new integrated target operating models that promote and support individual independence, dignity and choice, that are financially sustainable.
    - They support the Care closer to Home Integrated Networks (CHINs), to also encompass Maternity Hubs and to ensure that models of care closer to home are funded and transparent
    - There is a need for collaboration that focuses on prevention and early intervention
    - There is a need to ensure inpatient care and secondary care in an acute setting is improved with a focus on strengthening the population and community based model.
    - There is a need to integrate services across health, social care and housing regardless of service or borough boundaries.
- There is a need for stronger recognition of integration through for example, a focus on a more integrated workforce and for pathways that promote independence and that keep people in the community.
    - Getting integrated care right can have a range of benefits for carers, including reduced use of mental health services and increasing of peer support networks.
- Local people are worried about the future of essential community services and the STP does not offer a solution.
    - Concern that a lot of the community based services detailed within the STP rely on community centres e.g. children's centres, day care centres, which are being closed = people left in a community setting without proper support. The community is being asked to provide but it is already so overstretched.
    - There is a need to invest and strengthen community services otherwise there will need to be more acute beds.

Adult Social Care recommendations: The Transformation Board needs to:
• Work with ASC professionals so that they consider they are appropriately represented on the Transformation Board. • Continue to support localised plans currently in progress to develop integrated health and care services for residents, including using the voluntary and community sectors as the sector of preference. Continue to ensure local control. • Be more explicit in detailing, in plain English,, how the proposed plan will benefit local residents and the sustainability of the health and care system • Consider the creation of maternity hubs within the Care Closer to Home Integrated Networks and the inclusion of maternity outcomes e.g. choice added to the care closer to home outcomes listed in the STP • Consider and promote non-profit model options for home care as a sustainable model for fair care wages

Outcomes including better public and mental health

People told us:

- We want NCL to be the best place for health and wellbeing and where: no one gets left behind; in times of need, good quality and safe health and social care is available; tax payers money is used to the maximum value; there is maximum opportunity for people to reach full recovery
- There is a need to start talking about people / residents / citizens - not patients
- Need to ensure a shift from a model based on sickness to a model focusing on prevention – enable people to stay healthy and live to the best of their potential
    - Need to direct services towards early intervention and integration to ensure people have healthy long and fulfilling lives and prevent the need for more costly services like avoidable hospital admissions and long term residential care.
    - Only 3% of NHS funding goes into prevention – needs a step change = more money to go on prevention.
- There is a need to improve access for deaf and non-English speakers needing interpreters at GP and hospital appointments.
- Concerns about local health and social care outcomes:
    - Need to invest in mental health crisis services in A&E, homelessness, psychiatric intensive care for women and strengthen peri-natal mental health and intervention around dementia
    - Commend the STP for ensuring the implementation of the findings of the national Maternity review: Better Births.
    - NCL have high rates of homelessness – there is no mention of any systematic focus on response to the problem in the STP. The STP process could help to join up and integrate services for homeless patients, as an

exemplar to how the system works with other complex groups with multiple morbidities
    - Investment in adaptions and adapted housing is needed to prevent people having accidents and to enhance people's lives in the long-term; ensure adapted housing is targeted to those with need.
    - Public health activity in relation to women (e.g. caring for women with substance abuse problems, obesity issues) and families may benefit from joined-up working in LAs and the core NHS workforce
    - Consider the introduction of therapeutic audits by pharmacists to overview prescribed medications
- Concerns about clinical services being consolidated into fewer hospitals, making them less geographically accessible to local people – Accessibility is a key factor in overcoming health inequality.

Outcomes recommendations: The Transformation Board needs to:
• Ensure NCL is the best place for health and wellbeing where: ○ no one gets left behind; in times of need, good quality and safe health and social care is available; people can access services in the right place and at the right time; tax payers money is used to the maximum value; there is maximum opportunity for people to reach full recovery • Commit that no acute services will be cut until the 'replacement' community services are proven to work. Provide further details about plans to consolidate services.

Estates

People told us:

- There is a need a fit for purpose estate that matches the overall strategy
    - Opportunity for estate, hospital environment and workplace environment to be part of the solution.
    - Need to consider dementia friendly building design during any remodelling.; more efficient use of estates; shrink back office accommodation; NHS Property must take risks of void space in their buildings not CCGs as under current arrangements; greater flexibility around rent setting and facilities management costs in community health and primary care properties to ensure best use of properties and facilities.
- Insufficient funding to develop estate and remodel for care closer to home.
- NCL NHS estate has high land values. It is not clear who owns the estates and who would get the proceeds of disposals (Central Government?.) This must be fully clarified. Any disposals must only be made in the long term interests of NCL residents, patients and staff.

- The estates devolution agreement aims to release capital and land for housing and modernising the NHS estate - to better deliver services. The STP focuses on how to release surplus property to remodel, repurpose and modernise the estate to move care out of hospitals and closer to home.

Estates recommendations: The Transformation Board needs to:
• Integrate estates planning with the rest of the STP process so it focuses on delivering better health and wellbeing outcomes and full staffing and VFM • Put pressure on Central Government so all decisions about NHS estates in London are taken by London NHS commissioners, providers and London councils working together, with devolved powers, for the good of local people • Provide assurance that no estates disposals will take place unless the full benefit goes to the NCL community or is retained for their future use. • Explore options to maximise the potential of community hubs e.g. expanding GP settings with Keeping Well facilities, the voluntary and community sector, council services and funding mobile clinics.

Workforce

People told us:

- There is a shortage of staff :
    - The best way to improve productivity is to use the existing workforce to eliminate staff shortages, making the work place positive and supportive place, incentivising staff to work overtime, encouraging those who have left to return or to become bank staff - thereby reducing agency spend
    - Need a more versatile workforce and give people new skills to work differently in an integrated health and social care sector
        - requires significant investment; and
        - requires strong strategic innovation capacity in a system which is actually a collection of large and small entities
- Concerns about the capacity of the current workforce to go through the transformation programme;
- The ability to recruit and retain high calibre, well-trained operational staff remains a substantial issue and one that has impact for the whole system – the STP has not had strong input from councils and does not provide details how these issues will be addressed for ASC;
- Concerns that the STP does not address how to develop a positive workplace culture, transparency or development of safe spaces where clinicians can learn when things go wrong or right;
- Concerns about amount of investment in professional development pathways at a time when bursaries and funding have been reduced/removed;
- Concerns that Making every contact count (MECC) is a challenge (staff frequently lack the time, training and resources to meet the demands of a public

health agenda) but can be overcome if contacts are long enough and if appointments are consistently with the same clinician.

Workforce recommendations: The Transformation Board needs to:
• Adopt a policy of redeployment rather than redundancies as a result of any STP implementation. • Detail how they plan to embed positive working cultures (supportive and open workplaces where staff are supported to learn from mistakes, where leaders are open and honest and where people can speak up when things go wrong) and ensure that services are appropriately staffed, across health and social care, as they are transformed. • Detail how they plan to reduce agency spending. • Detail the intended investment in developing skills and qualifications for the part of the workforce who will need to work differently in the future

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NCL Joint Health and Overview & Scrutiny Committee

Review of Adult Immunisation and 7a Screening Programmes

3rd February 2017

Review of Adult Immunisations in NCL- Barnet, Camden, Enfield, Haringey and Islington

1 Summary

- The purpose of this paper is to provide the Health and Oversight Scrutiny Committee with an overview of immunisation programmes delivered to adults in the boroughs of North Central London.

- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and comprise of:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - **Adult vaccinations such as the annual seasonal influenza vaccination**

- The Health and Oversight Scrutiny Committee are asked to note and support the work NHS England (London) are doing to increase vaccination coverage and immunisation uptake in adults across North Central London.

Background:

Immunisation is the most effective method of preventing disease and maintaining the public health of the local population and vaccination and immunisation services exist to ensure the safe and effective delivery of all vaccine programmes. The NHS England Immunisation Plan sets out actions to be undertaken by all key stakeholders in support of coordinated immunisation activities thereby ensuring that vaccines are available and given to the eligible groups at the recommended times.
NHS England, Public Health England, Clinical Commissioning Groups (CCG) and Local Authorities all have a defined role to play, with NHS England assuming the lead commissioning role in line with the Section 7A mandate.

The roles and responsibilities of the partners are:

NHS England (NHSE):

- Commissioning of all national immunisation and screening programmes described in Section 7A of the mandate
- Commission immunisation and vaccination services from primary care, community providers (e.g. school nursing teams) and other providers which are specific to national standards
- Monitoring of provider's performance and for supporting providers in delivering improvements in quality and changes in the programmes when required
- Accountable for ensuring local providers meet agreed population uptake and coverage levels against the national service specification and as specified in the Public Health Outcome Indicators
- Work with the Department of Health and Public Health England in national planning and implementation of immunisation programmes and in quality assurance
- Emergency Planning Responses and Resilience (EPRR) where this involves vaccine preventable diseases.

Public Health England (PHE):

- Lead the response to outbreaks of vaccine preventable disease and provide expert advice to NHS England in cases of immunisation incidents. PHE will provide access to national expertise on vaccination and immunisation queries.

- Professional support to the PHE staff embedded in the NHSE Area Teams including access to continuing professional appraisal and revalidation system
- Provide information to support the monitoring of immunisation programmes
- Publishes Cohort of Vaccination Evaluated Rapidly (COVER) data

Clinical Commissioning Groups (CCGs):

- Have a duty of quality improvement and this extends to primary medical care services delivered by GP practices (such as immunisation and screening) – as such, they should be able to provide support where NHSE need to liaise or contact specific primary care facilities.
- CCGs have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen positive patients and meet quality standards
- CCGs hold the contracts for maternity services, and are providers of antenatal and new-born screening (neonatal BCG and infant Hepatitis B).

Local Authorities:

- Leader of the local public health system and is responsible for improving and protecting the health of local population and communities.
- Provide information and advice to relevant bodies within its areas to protect the population's health (whilst not explicitly stated in the regulations, this can reasonably be assumed to include immunisation)
- Provide local intelligence information on population health requirements e.g. JSNA
- Independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.
- Local authorities will need to work closely with Area Teams including arrangements for the NHS response to the need for surge capacity in the cases of outbreaks.

General Practitioners (GPs):

- General practices are contracted by NHSE to deliver the Childhood Routine Immunisation Schedule to their registered child population. They are the main mode of delivery in England.

Community Services Providers:

- Child Health Information System (CHIS) is housed within community service providers and holds clinical records on all children and young people. COVER data is submitted from CHIS to PHE quarterly.
- The community provider may have an immunisation team that provides outreach or 'catch-up' for childhood immunisations (e.g. for unregistered populations) and for BCG.
- Health visitors have a role to play in promoting the importance of vaccinations to parents and 'making every contact count.'
- Some community service providers have immunisation clinical leads or coordinators who provide clinical advice and input into immunisation services locally.

Aim:

- Achieving high levels of immunisation coverage in London remains challenging.

- The NHS England immunisation strategy and local borough action plans have been developed as part of NHS England's ongoing work to improve immunisation coverage in London and outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in NCL. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service.

- The 2016/17 Immunisation Action Plans is underpinned by NHS England's immunisation strategic objectives which are:

    1. To achieve improved immunisation coverage across London.
    2. To reduce inequalities in immunisation uptake between GP Practices and populations.
    3. To improve patient choice and access to immunisations across London.

Improving patient choice and widening access

Feedback from community groups and patients indicates that, whilst the majority go to their GP practice for routine immunisations, some would prefer access in other settings closer to where they work, learn, shop and socialise.

Building on some of the previously commissioned (former PCT) schemes, we commissioned a pan-London scheme for community pharmacies to deliver the targeted seasonal flu vaccination. Two-thirds of community pharmacies in London offered the flu vaccine to over 65s and those in clinical 'at risk' groups.

We have assessed the evidence for using community pharmacies and evaluated the impact that they had on last year's seasonal flu uptake.

In NCL 23,485 seasonal flu vaccinations have been delivered via pharmacies already this year. We aim to commission community pharmacies to deliver selected targeted vaccinations – seasonal flu and pertussis – to at-risk groups that are currently under-immunised.

Challenges common to the majority of immunisation programmes

- Improving immunisation information so that we have a robust and accurate baseline.
- Targeting specific individuals and communities who are vulnerable or who are at risk of not being fully immunised.
- Contribution of nurseries, schools, colleges of further education:
- Effective co-ordination of immunisation programmes (provision, access and support) and provider recovery plans.
- Training for immunisers – basic immunisation training and updates:
    - Budgets for training immunisers in theory sits with Local Education and Training Boards, which are part of Health Education England.
    - On-line training is available, but the PHE immunisation minimum standards[1] require that the basic immunisation training for new immunisers is a two day formal taught course.
- Governance and assurance.
- Budgets are not easy to set, as immunisations tend be a variable cost. The higher the coverage, the higher the bill.
- Vaccine supply:
    - Newer vaccines, such as Fluenz©, shingles and PPV have been in short supply; although the JCVI (Joint Committee on Vaccinations and Immunisations) has recommended that these are effective and cost-effective.

[1] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1196942164323

- Some pharmaceutical companies no longer supply directly to private providers, such as community pharmacies or private GPs. ImmForm (the national system for ordering vaccines and for reporting surveillance data) has a limited number of licenses and this is acting as a potential barrier to NHS England (London region's) commissioning plans for alternative provision.

Adult vaccinations	
Expected outcomes:	• >75% uptake of seasonal flu vaccination across all at-risk groups • >70% uptake of seasonal flu vaccination for health care workers • >75% uptake of shingles (aspirational target is 100%) • >75% uptake of PPV in over 65s (cumulative total of programme to March 2019) with an annual uptake rate of 4-5%
Evidence:	• Effective co-ordination of immunisation programme • Accessibility and acceptability of immunisation programme and service • Effective community engagement • One to one structured behaviour change interventions
High level timeline:	Year 1: • Use evaluation of seasonal flu plan 2015/16 to implement 'lessons learned' and rollout of seasonal flu vaccination programme in September 2016; implement a more robust long-term approach to flu vaccination planning that commences in April • Develop and implement a plan to improve uptake of shingles using the lessons learned from 2014/15 • Establish a baseline for social care workers in local authorities with direct patient contact • Develop a trajectory for improving uptake across all 'at risk' groups for flu and for shingles for years 1-5 • Develop a system for capturing patient feedback and public views on how to improve access to flu vaccination and to encourage better uptake • Use PPV data when available to assess uptake and use to scope out why uptake is low (if that is the case); a project to be undertaken on how to improve uptake across London Years 2- 5: • These years will continue to build upon Year 1's plans and lessons learned to develop a stepped approach to achieving the expected outcomes by 2020

Enablers:	• Winter Vaccinations Planning Sub-Group of the London Immunisation Programme Board for seasonal flu, PPV and shingles (although shingles is a yearlong programme) • Partnership work with CCGs (for community services and improving quality of performance in GP practices) and community pharmacies • Partnership work PHE and CCGs for increasing flu vaccination uptake in health care workers • Targets for flu vaccination rates in contracts with acute and community providers trusts • Undertake public engagement to ascertain how to increase uptake in the at risk groups, especially the clinically at risk 18-64 year olds and in Health Care Workers with direct patient contact
Barriers to success?	• Complacency about flu vaccination in health care workers – London has lower than England average • Traditionally low uptake in the clinical at-risk 18-64 year olds and pregnant women in London
Investment costs: (financial and non-financial)	• Cost neutral.

Table 1

Adult Vaccinations

1.1 PPV (PNEMOCOCCAL) PPV

- Pneumococcal Polysaccharide Vaccine (PPV) is offered to all those aged 65 and older to protect against 23 strains of pneumococcal bacterium. It is a one off vaccine which protects for life.
- Vaccine uptake and reporting coverage is published cumulatively. The latest published data is for 2015/16.

01/04/15-31/03/2016	
CCG	PPV % uptake
NHS BARNET	68
NHS CAMDEN	63.4
NHS ENFIELD	69.6
NHS HARINGEY	60.9
NHS ISLINGTON	60.9
London	65.3

Table 2

1.2 Shingles

The Shingles vaccination programme commenced in September 2013.
Shingles vaccine is now offered to people who are 70, 78 and 79 years old on 1st September 2016.

The shingles action plan was designed and implemented in June 2016 to promote the London Shingles Awareness Week (LSAW). LSAW's goal was to increase the uptake of the shingles vaccine in London, because the uptake was as low as 30%. The action plan contained three major tasks to promote London Shingles Awareness Week (LSAW):

- Radio campaign
- Communication (with partners including GPs, the media, a social media campaign, promoting the campaign on the My Health London Website and to the London office of CCGs)
- Distributing resources to London Partners

This document evaluates this action plan with the aim to improve the plan and provide recommendations for the next implementation.

Another shingles campaign will be implemented in 2017 which will have a more targeted approach per London borough.

Shingles uptake 2013-2015

CCG	2013/14	2014/15	2014/15	2013/14	2014/15
	Age 70	Age 70	Age 78	Age 79	Age 79
Barnet	56.1	55.9	54.9	55.3	57.5
Camden	50.3	47.6	43.5	52.6	47.3
Enfield	52	51.2	53.6	51.7	52.8
Haringey	47.7	47.5	43.6	49.4	46.8
Islington	51.2	48	47.6	45.9	51.8
London	51.3	48.8	48	50.9	49.7
England	61.8	59	57.8	59.6	58.5

Table 3

1.3 Pertussis in pregnant women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. Pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt the increase of confirmed pertussis (whooping cough) cases. This programme has since been extended for another 5 years by the Department of Health (DH). Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.

- Statistics for pertussis vaccine uptake are reported monthly and by region/area. They now cover those women who delivered a baby within the survey month at more than 20 weeks gestational age and who are registered on the general practitioner (GP) systems.

Pertussis in Enfield October 2015-March 2016

CCG Name	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
BARNET	39.6	37.7	44.3	44.6	41.1	41.4

CAMDEN	47.1	45.1	49.1	42.8	47.6	46.4
ENFIELD	32.6	28.8	30.6	29.1	34.1	36.7
HARINGEY	40.8	34.4	44.0	39.8	46.0	36.6
ISLINGTON	42.1	48.1	50.0	58.1	51.5	54.4
LONDON	**47.7**	**50.6**	**52**	**48.9**	**49.8**	**49.8**
ENGLAND	**59.3**	**61.6**	**61.4**	**59.7**	**59.4**	**60.7**

Table 4

- In England, pertussis vaccine coverage in pregnant women reached 62.6% in December 2014 – the highest recorded since the start of the programme. Nationally, the uptake of pertussis vaccine is increasing year on year.

- NHS England has a pan-London action plan to increase uptake amongst pregnant women. A maternity service level agreement (SLA) has been implemented to enable all maternity services to administer seasonal influenza and pertussis to all pregnant women. In NCL London hospitals are successfully delivering these vaccinations to increase uptake and offer improved access.

1.4 Seasonal Influenza

- Table 4 illustrates the uptake of seasonal influenza vaccine for each of the adult groups for NCL CCG compared to London and England averages for the winter 2015 (September 1st 2015 to January 31st 2016
- London, England and NCL all performed below the recommended 75% uptake level for all at risk groups.
- All five boroughs in NCL are currently performing above last year's achievement in all cohorts. Intensive work has been done with Local Authorities, CCG's and GP practices to increase uptake this season. Commissioners have visited the lowest performing practices in all boroughs to offer support and ensure call and re-call processes are being followed.

Uptake of the 'at risk' Groups of Seasonal influenza for NCL CCG compared to London and England for winter 2015 (September 1st 2015 – January 31st 2016)

	Flu Season 2015/16		
CCG	% of uptake 65 +	% of at risk patients (6 months - 64 years)	% of pregnant women
Barnet	68.2	44.2	37.5
Camden	72.4	48.6	43.9
Enfield	68.9	44.6	32.2
Haringey	63.6	41.5	36.6
Islington	64.2	41.8	38
London	**66.2**	**43.6**	**38.5**
England	**71**	**45.1**	**42.3**

Table 5 Source: PHE (2016)

1.5 HPV Vaccination

HPV vaccine coverage data by Local Authority, England, September 2015 to August 2016											
	Cohort 13: 12 - 13 year olds (Year 8) Birth Cohort: 01/09/2002 - 31/08/200						Cohort 12: 13 - 14 year olds (Year 9) Birth Cohort: 01/09/2001 - 31/08/2002				
Local Authority	No. females in Cohort 13 (Year 8)	No. vaccinated with at least one dose by 31/08/16	%	No. vaccinated with two doses by 31/08/16	%	LA offered two dose programme In Year 8?	No. females in Cohort 12 (Year 9)	No. vaccinated with at least one dose by 31/08/16	%	No. vaccinated with two doses by 31/08/16	%
LA coverage range (%)		(68.4 - 100.0)						(71.0 - 100.0)		(43.7 - 99.1)	
Barnet	1,978	1,551	78.4	1,470	74.3	Yes	2,004	1,541	76.9	1,454	72.6
Camden	1,099	900	81.9	717	65.2	Yes	1,078	957	88.8	844	78.3
Enfield	1,791	1,476	82.4	1,176	65.7	Yes	1,748	1,339	76.6	1,293	74
Haringey	1,316	1,013	77	1,013	77	Yes	1,309	1,096	83.7	1,065	81.4
Islington	683	544	79.6	487	71.3	Yes	667	587	88	561	84.1
London	42,666	35,787	83.9	31,922	74.8		43,061	36,475	84.7	34,748	80.7
England	288,536	251,010	87	116,191	n/a		281,640	254,136	90.2	239,735	85.1

Table 6 Source: https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2015-to-2016-by-local-authority-and-area-team

The recent publication of HPV data for 2015/16 shows a decrease from previous years. There are several reasons cited for this-

- Coverage of the completed course may be under-estimated as 'mop-up' vaccinations given in GP practices are not included in the returns for some Las
- Coverage (of one and/or two doses) may be over-estimated in some LAs due to movements of students in and out of schools during the academic year not being accurately reflected in the denominators and/or numerators for some LA returns
- The change from a three to a two-dose schedule has resulted in fewer opportunities to offer in–year mop-ups to those girls who miss out on a vaccine dose
- When delivering the three-dose course (2008/09 to 2013/14) providers returned to all schools approximately one month after the first clinic (to administer the second dose) and were more easily able to 'mop up' any missed first doses promptly. In areas where only the first HPV dose is delivered in Year 8 providers may now only be able to offer HPV mop-up during sessions to deliver the other teenage programmes at the school
- The commitment to deliver on the childhood flu immunisation programme(extended to school years 1, 2 and 3 from 2016/17), school leaver booster programme (Td/IPV vaccine), and the Men ACWY routine and catch-up programme (from 2015/16) may have impacted on the capacity of school immunisation providers to deliver the HPV programme
- Some areas have changed providers during the two academic years (2014/15 and 2015/16) which are covered by this survey. This may have temporarily impacted on the delivery of the HPV programme

Many areas have planned catch-up activities for the 2016/17 academic year to address cancelled school sessions or missed doses in the 2015/16 academic year. It is expected that coverage for the 2015/16 Year 9 cohort will increase during 2016/17 and final coverage for this cohort (Year 10 in 2016/17) will be collected as part of the 2016/17 annual collection

2. Adult Screening Programmes

Purpose

The purpose of this paper is to provide an overview of uptake, coverage and performance of the Adult Screening Programmes, namely Diabetic Eye Screening and Abdominal Aortic Aneurysm Screening Programmes for the North Central London patch.

Diabetic Eye Screening Programme

The paper will present data from the period between 1st of December 2015 and 30th November 2016, for all the five CCGs which make up North Central London (Barnet, Camden, Islington, Enfield and Haringey. However, reference will be made, where applicable, to data before this time period.

The source of data to prepare this report has been OptoMize reporting tools as well as writing specific SQL queries to obtain data from OptoMize. Furthermore QMS GP data extraction information has been used to complement the ethnicity of the invited population where there were no specific data was available on OptoMize.

Estimated Diabetes Prevalence: NCL DESP

Estimates of the number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation.

Region/ CCG	2013	2015	2016	2017	2018	2019	2020
England	TBC	3,921,071 (8.4%)	3,976,419 (8.5%)	4,032,506 (8.5%)	4,089,864 (8.6%)	4,147,109 (8.7%)	4,204,334 (8.7%)
London	TBC	664,041 (8.9%)	677,273 (8.9%)	690,782 (8.7%)	703, 916 (9.0%)	716,906 (9.1%)	730,575 (9.1%)
NHS Barnet	23,364 (8.5%)	27,073 (8.6%)	27,670 (8.6%)	28,300 (8.7%)	28,871 (8.7%)	29,540 (8.8%)	30,140 (8.9%)
NHS Camden	13,757 (6.2%)	14,871 (6.7%)	15,252 (6.7%)	15.565 (6.7%)	15,959 (6.8%)	16,355 (6.8%)	16,693 (6.9%)
NHS Enfield	19,174 (8.4%)	23,480 (9.4%)	23,931 (9.5%)	24,461 (9.5%)	24,867 (9.6%)	25,409 (9.7%)	25,824 (9.7%)
NHS Haringey	13,666 (7.6%)	22 411 (9.3%)	22,950 (9.4%)	23,470 (9.5%)	24,019 (9.6%)	24,484 (9.6%)	24,957 (9.7%)
NHS Islington	10,491 (6.5%)	15,032 (7.6%)	15,419 (7.6%)	15,725 (7.7%)	16,067 (7.7%)	16,422 (7.7%)	16,748 (7.8%)
NCL Total	80,452	80,456	105,222	91,972	109,783	112,210	114,362

Table 7 Source: APHO Diabetes Prevalence Model section of the YHPHO website (www.yhpho.org.uk)

Context

The National DESP screens all diabetic patients aged 12 + annually, with the aim of preventing sight loss from preventable retinopathy.

Following a successful re-procurement of the London Diabetic Eye Screening programmes in London are now delivered by five Provider organisations, to an eligible population of approximately half a million people.

The Programme in NCL is delivered by North Middlesex University Hospital, who are responsible for delivering screening service to approximately people living with diabetes across North Central London. Programmes are contracted to deliver a national service specification, containing nationally agreed Key Performance Indicators and Programme Quality Standards.

In London, commissioners have developed a set of enhanced indicators that Providers will be measured against in subsequent contract years.
The eligible population is identified through data extraction solutions from GP registers that aim to update monthly.

Oversight of performance

NHS England (London) Commissioners deliver the oversight and performance management function for the DESP contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads
- Local Authority Public health strategists
- Clinicians
- Hospital Eye service managers and failsafe leads

NCL-DESP uptake

Below is a table (table 8) summarising uptake of Diabetic Eye Screening Services across NCL between 2012 and 2016

Year	Uptake
2012- 2013	74.5%
2013-2014	78.9%
2014-2015	85.0%
2015-2016	85.1%

Table 8

a. Indian population seem to have the highest rate of uptake and attendance at 91.2%.
b. All known ethnicities have an uptake of 80% or above.
c. As in the previous health equity audit, undertaken in July 2013, uptake skews down in the groups with no ethnicity data, as the programme is less likely to have seen the patient to collect that information. However, the extent of this is now much less as NCL-DESP has collected data on the ethnicity for 90.4% of the invited population within the reporting period.

NCL DESP is currently working with QMS to facilitate a more accurate upload of ethnicity data. However, the programme is continuously trying to improve intake in groups identified through methods like DNA Audits to have a low uptake. Provision of translation services have been proved to increase uptake in the Turkish Community, however the cost of providing such services, makes it difficult for the programme to invest in long term language and geography.

Uptake by Gender (table 9)

Gender	#invited	#screened	uptake
Unknown	39	23	59.0%
F	30681	25916	84.5%
M	36667	31250	85.2%
Total	**67387**	**57189**	**84.9%**

NCL-DESP Uptake by Ethnicity

Table 10 shows uptake by Ethnicity, where this was recorded:

Ethnicity	#Invited	#Screened	Uptake
A: British	18710	16379	87.5%
B: Irish	1277	1088	85.2%
C: Any other White background	10478	8943	85.4%
D: White and Black Caribbean	308	253	82.1%
E: White and Black African	246	198	80.5%
F: White and Asian	205	171	83.4%
G: Any other Mixed background	513	424	82.7%
H: Indian	5237	4776	91.2%
J: Pakistani	997	843	84.6%
K: Bangladeshi	2515	2172	86.4%
L: Any other Asian background	4093	3627	88.6%
M: Caribbean	3834	3298	86.0%
N: African	5255	4235	80.6%
P: Any other Black background	1559	1297	83.2%
R: Chinese	841	752	89.4%
S: Any other Ethnic group	4857	4010	82.6%
Unknown	2269	1459	64.3%
Z: Not stated	4193	3264	77.8%
Total	**67387**	**57189**	**84.9%**

Table 10

Where ethnicity data was not recorded on OptoMize, it was supplemented from QMS; there are still some patients where it's not recorded either with the programme or the GP.

Uptake by Age

Age Group	Invited	Screened	uptake
0-14	113	96	85.0%
15-19	345	287	83.2%
20-24	513	412	80.3%
25-34	1947	1523	78.2%
35-44	4875	4086	83.8%
45-54	11730	9863	84.1%
55-64	16652	14140	84.9%
65-74	15964	13660	85.6%
75+	15248	13122	86.1%
Total	**67387**	**57189**	**84.9%**

Table 11 Source: NCL DESP

a. 88.4% of NCL-DESP diabetic patients (59,594) are over 45 years old and 85.2% of this population has attended screening.
b. Of note is that uptake in the 25-34 age group is78.2%. This might be an area that can receive some focus and may be extra phone call reminders.
c. Previous analysis of DNA data showed lower uptake in the working age population which was vastly improved by an increase in out of hours and weekend clinics.

Uptake by Index of Multiple Deprivations (IMD)

IMD Quintile	Invited	Screened	uptake
Unknown	146	106	72.6%
1 (most deprived)	24652	18634	75.6%
2	19148	15467	80.8%
3	11817	11438	96.8%
4	8378	8325	99.4%
5	3246	3219	99.2%
Total	**67387**	**57189**	**84.9%**
1 (most deprived)	**24652**	**18634**	**75.6%**
Quintiles 2-5	**42589**	**38449**	**90.3%**

Table 12 Source: Official Statistics; English indices of deprivation 2010

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010
http://dclgapps.communities.gov.uk/imd/imd-by-postcode.html
http://www.apho.org.uk/resource/view.aspx?RID=111277

Each patient is mapped via their postcode to the LSOA (local small output area) used in the national dataset. Data from the London Health Observatory was then used to identify which quintile of deprivation each LSOA falls into.

a. IMD has divided the whole country in to five levels in terms of level of deprivation. 1 is the most deprived (20% of the country), then 2 (the next 20%), 3, 4 and 5 (the final 20% which are the most affluent).
b. In the cohort of patients invited for screening in this reporting period, 24,652 (36.6%) live in the most deprived areas of England. The uptake in this cohort is 75.6%.
c. The uptake in the less deprived group (quintiles 2-5) is 90.3%.
d. It is apparent that level of deprivation is directly correlated with uptake.
e. During a HEA conducted by NCL-DESP in July 2013 it was established that uptake of the screening test in the Most Deprived Quintile was 73.8%, compared with 76.6% in the non-deprived group. Therefore whilst we have managed to increase the uptake of the non-deprived group to 90.3% from 76.6%; the deprived Quintile has been increased by a much smaller margin.

Uptake by CCG

NCL-DESP has achieved an uptake of over 80% for all CCGs

CCG	Invited	Screened	Uptake
Barnet	17862	15605	87.4%
Camden	8420	6984	82.9%
Enfield	17410	15080	86.6%
Haringey	14021	11638	83.0%
Islington	9670	7880	81.5%
Total	**67383**	**57187**	**84.9%**

Table 13 Source: OptoMize PPR

DNA rates by CCG

CCG	Total No of Appointments due	Total Number of DNA Appointments	DNA Rate
Barnet	24645	8470	34.4%
Camden	13023	5795	44.5%
Enfield	24534	8857	36.1%
Haringey	20088	8083	40.2%
Islington	14571	6461	44.3%
Total	**96861**	**37666**	**38.9%**

Table 14 Source: RDS Operational Performance Report on OptoMize

a. Booking appointments: The high DNA rate is the result of patients being offered multiple appointments in a year when they DNA (for example, in Barnet, there were 8470 DNAs, relating to 4607 patients: 1011 patients DNAd between 3 and 7 appointments in the

reporting period, 1057 patients DNAd 2 appointments, and the remaining 2539 DNAd a single appointment).

b. Clinic efficiency and slot utilisation: In order to reduce wastage of clinic slot resources, NCL-DESP overbooks the clinic according to the historical DNA analysis of each of the clinics. This has meant that according to a detailed audit conducted in October 2016 looking at a three month data from 1st April 2016 to 30th September 2016, the overall clinic slot utilisation at 13 clinic sites and our Mobile Screening Unit (MSU) is over 95%. This point to a highly efficient usage of available clinic slots.
c. Actual uptake: In terms of uptake and reaching to the "hard to reach" patients, since the overall annualised uptake is around 85%, the proportion of those who were invited and not screened is around 15%.

GP practice

NCL-DESP operates using a single collated list for call and recall. In order to facilitate the maintenance of an accurate Single Collated List, NCL-DESP successfully engaged the 227 GP practices within its catchments to sign up to the QMS Electronic data transfer service. The Electronic Data Transfer service does not nullify the routing referral methods used by GPs to refer diabetic patients into the programme, but it acts as a failsafe mechanism to ensure that all patients with diabetes are referred to the programme. In addition to this, NCL-DESP actively cleanse data every month using the national SOP and also actively compares its data with CQRS although this is only done annually as CQRS is not updated regularly.

In light of learning from incidents, relating to the Single Collated List, an escalation protocol has been developed to support process of ensuring all stakeholders submit lists in a safe and timely manner. The Escalation Protocol is endorsed by PHE and the Medical Directorate provides a clear and standardised escalation process for all to follow and is being implemented successfully across the NCL patch and London.

The NCL-DESP maintains regular contact with GPs through a range of forums, including the

- Programme website
- Routine GP mailing
- Access to GP meetings to raise specific issues or to alert of new developments.

Uptake by GP practice for each CCG in NCL is shown in Appendix 1

Inequities and inequalities in uptake

The retinal screening programme is an important means to reducing eye complications among people with diabetes and consequently, ensuring universal equity of access to the programme is a key government priority.

Uptake in NCL DESP is currently at 55232 over 64872, making it 85.1%. NCL-DESP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups.

Patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. Appendix 2 shows a recent patient satisfaction survey report by the NCL DESP.

NHSE has recommended quarterly Patient Experience Surveys, with findings and analysis shared at Programme Board Meetings. Developing a strategy for public engagement:

Work in Progress

Screening in Prisons and secure units

NHS E L is currently developing protocols for the screening of people with diabetes who are in prison and secure settings, working in conjunction with Prison health officers, NHSE commissioners and DESP programme leads

The programme is trying to establish the numbers and location of 'halfway houses' or hostels run by the Probation Service, for prisoners preparing for release into the community.

London referral pathway for pregnant women with diabetes:

Commissioners for Adult screening and ANNB screening have worked with service providers to design and deliver a pathway that ensures women with diabetes are referred for enhance screening, as per national guidance. The teams are currently trying to identify the right links to support implementation – i.e. diabetes midwives in all London maternity units

An Implementation action plan will be developed by commissioners and to be circulated to wider stakeholders before the end of September

Co-commissioning of Optical Coherence Tomography (OCT)

DESP providers across London are seeking support from CCGs for the development and implementation of OCT within the DESP. This is in response to the ongoing issues with capacity, in many Hospital Eye Services.

OCT is an enhanced form of imaging which can help to cut the amount of patients who are referred into HES to access enhanced imaging where images taken in the programme are deemed unclear for screeners to conclude a safe outcome. It is possible to implement OCT cameras within the Screening Programmes and in programmes where this has been available, it helped to cut the amount of referrals into HES and also improved patient experience, as it meant the enhanced images can be taken on the same day without patient having to make a separate trip to a hospital site.

Diabetic Eye Screening Programme Leads met in October 2014 and developed an OCT Protocol. Most are working towards developing Business Cases in order to present to CCG HES Commissioners and HES Eye Service Managers, in order to gain their support to agree to fund the specialist OCT Cameras. NHS England feels that although the purchase of Cameras involves an initial Capital outlay, this will provide future cost savings by cutting the large amount of referrals into the HES specifically for OCT only.

An equity analysis which describes the differential uptake of adult screening .

This report will look at the data provided by NCL DESP for routine digital screening uptake during the period between 01/12/2015 to 30/11/2016

Abdominal Aortic Aneurysm Screening (NAAASP)

Purpose

The National Aortic Abdominal Aneurysm Screening Programme (NAAASP) aims to reduce deaths from ruptured aneurysms through early detection of men at risk. The UK National Screening Committee (UKNSC) recommended implementation of a systematic population screening programme, in March 2009, following evidence that ultrasound screening of men in their 65th year could reduce the rate of premature death from ruptured AAA by up to 50 per cent.

Context

The North Central London (NCL AAASP) was implemented in 2010. The London AAA Programmes are aligned to the Strategic Planning Groups structure. Currently, the five London AAA screening programmes are delivered by NHS Trusts that are also vascular network centres or hubs. All aspects of the service, both clinical and administrative, are coordinated by these Trusts.

All London programmes use the nationally commissioned IT system, Surveillance Management and Referral Tracking (SMaRT), to manage the eligible cohort population. Each local service coordinates screening for the population in its area and organises invitation letters, screening and surveillance clinics, results letters and referrals to the appropriate vascular network. The local screening services ensure GPs are informed when men from their practice have been screened and of the outcomes of their screening test.

Men with a screen detected aneurysm of 5.5 cm and above are referred into the vascular centre for surgery, whilst those with aneurysms measuring between 4.5 and 5.4 cm are put on quarterly surveillance; those with aneurysms measuring between 3.0 and 4.4 cm are recalled for surveillance on an annual basis.

Throughout England, each commissioned Provider is responsible for delivering a service to the local population that delivers against the Public Health England (PHE) Service Specification (No.23), Ref[1], and other agreed national quality requirements.

Oversight of performance

NHS England (London) commissioners deliver the oversight and performance management function for the AAA contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Local Authority Public health strategists
- Clinicians
- Vascular Service Managers
- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads

Health Equity Audit

A Health Equity Audit which was recently conducted by NHS England (2016) to support the London AAA Re-procurement process, had limitations due to poor data to facilitate some analyses. The Head of Screening at NHS England is cited as stating that, whilst it is not possible to form a comprehensive picture of all factors that influence AAA screening uptake or to comment on the relative influence of demographic and programme factors, there is a clear variation in screening uptake that is associated with deprivation and geography. Recommendation is that, Programmes should consider the clear variation by location and deprivation in their plans for improving uptake and implications for future service provision (NHSE, 2016).

Gender and age

The AAA Screening Programme in the UK is restricted to men aged 65years old within the year of screening. Men over the age of 65, who missed out on screening at 65, can attend for screening as a self- referral. There are currently no plans to screen women.

Ethnicity

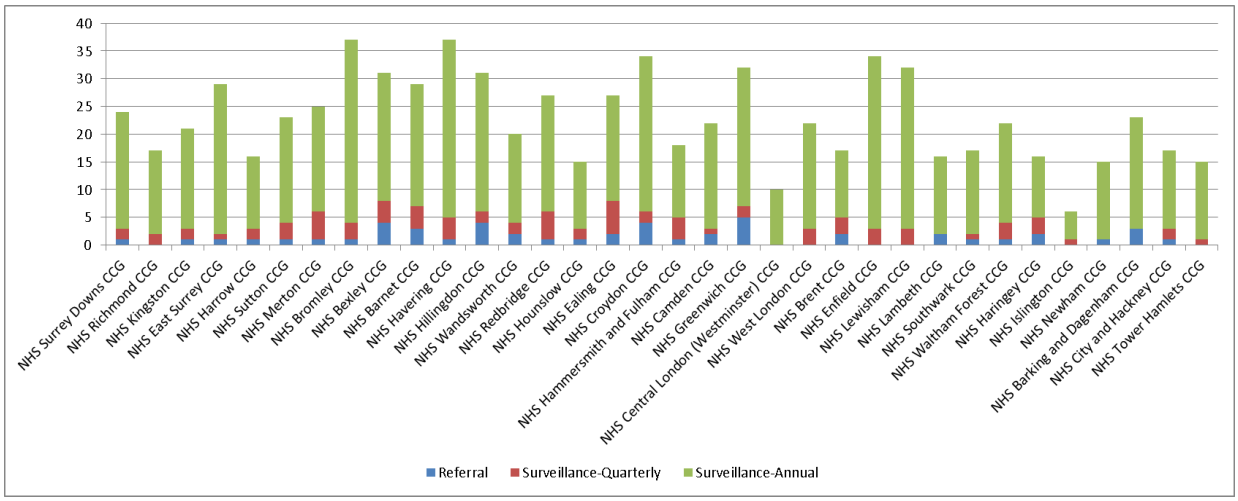
The health equity audit conducted by NHSE (2016) for the procurement, shows differences in uptake by ethnicity are also presented, this data needs to treated with caution because of concerns about data quality. Ethnicity was only available for those who attended as it is only requested and recorded at the point that men attend. Therefore for all who did not attend and some people who attended, ethnicity was not stated.

Ethnicity was estimated by using the ethnicity breakdown of the local authority from the 2011 Census and comparing that to the proportion of the same ethnic group in those who attended. The North Central London programme had a particularly high proportion of people who did not state their ethnicity (72%).

Deprivation

There is an established link between uptake of AAA Screening and deprivation and also the incidences of AAA in relation to deprivation, with deprived communities bearing an increased burden of abdominal aortic aneurysms in association with high rates of DNAs. The geographical variations in uptake of AAA screening across London that, are similar to those seen in other screening programmes. It also shows the association between uptake and deprivation scores.

Screening outcome (referral and surveillance) ordered by CCG average deprivation score (least deprived to most deprived) for years 2013/14 to 2015/16



Graph 1

Ward of residence

There is currently only CCG level data rather than Ward of residence level data. Islington is the lowest performing CCG. Factors contributing to this include:

- low GP engagement
- high level of homeless people in the borough. Suggestions have been made for the programme to look at issues affecting uptake in Islington and the NCL AAA propose, amongst other actions:
    - Mapping of locations with high % of patients with no fixed abode to see if this accounts for lower performance in a particular borough (Islington).
    - Mapping non-attendance in Islington by geography, to identify if there are areas with poor access to the Kings Cross screening venue that show higher rates of non-attendance.

Issues affecting service delivery

Towards the end of 2014-15, the NCL AAA Programme was experiencing difficulties with it's screening workforce. This led to concerns over their ability to screen the cohort during that year. The matter was escalated to NHS England and the Trust Governance Team, resulting in an Action Plan being drafted and being put in place to address the issues that were identified.

Commissioners' tight monitoring of performance along with the Trust's and Programme's commitment to addressing the identified issues has led to a transformation in how the service is delivered resulting in an increase in the uptake. NCL AAA is now a more stable and a well performing service. Uptake for 2015-16 is 77%, above the acceptable level of 75%.

Performance

Table 15 shows performance during 2016-17, against the only National Key Performance Indicator for the NAAASP. Quarterly figures are aggregated from Q1 with approximately 25% of the cohort expected to be offered screening per quarter although this will vary between local screening programmes, depending on the screening model

Regional Summary	Numerator	Denominator	Performance (%) Acceptable =/ >90% Achievable =/ > 99%
North Central London	5,224	5,267	99.2
England	281,989	285,287	98.8
London	33,631	34,406	97.7

Table 15

Patient satisfaction

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. No recent reports on patient satisfaction surveys by NCL AAA. However, moving forward, the NHS England Commissioners have recommended that Programmes carry out Patients Experience Surveys on a Quarterly basis and share findings with the Programme Board.

Inequities and inequalities in uptake

Breakdown of performance by CCG area is shown in table 16

CCG	PERFORMANCE =/> 85%	PERFORMANCE =/>75% AND <85%	PERFORMANCE < 75%	OVERALL UPTAKE PER CCG 2015-16	NON-PATICIPATING PRACTICES
BARNET	18	13	27	79.32%	9
CAMDEN	6	9	19	75.91%	2
ENFIELD	13	10	23	79.73%	3
HARINGEY	17	7	16	79.14%	6
ISLINGTON	5	4	23	71.28%	2

Table 16

Whilst overall uptake for the NCL AAA Programme 2015-16 Cohort was 77%, it is clear from the data presented in the table above that, the CCG with the lowest uptake also contains the largest number of poorly performing GPs. Below is work in progress to try and tackle some of the inequalities and inequities that still exist.

Work in progress

Re-procurement and reconfiguration of the London AAAA

NHSEL commissioning intentions in 2016/17 included the intention to re-procure London NAAASP to improve the resilience of administrative functions and the screening workforce. Following a lengthy options appraisal, it was agreed that two new services, for south and North London, would be commissioned against the national specification and a London wrap-around to ensure appropriate levels of cross border cover, and the capacity to screen in any convenient location, the Re-Procurement is currently underway. Invitation To Tender will go live in February 2017, with contracts awarded in May with a four month mobilisation period beginning on 1st June 2017 and the new contracts in place by October 2017. Contracts for all current London programmes have been extended by 6 months due to some inevitable delays.

All prospective bidders will be kept up to date about the Re-Procurement Process via the designated portal.

Promoting GP Engagement

There is an appreciation within the NCL Programme that, achieving any response to an invite for screening was reliant on strong relationships with the GP practices and support from them in engaging the patients. This is something the service is trying to develop. There is ongoing work in the Programme around engagement with GPs using a range of strategies including:

- Identify poorly performing practices and investigate possible reasons as to why they may not be performing well.
- Sending pre-invitation letters in advance of drop in clinics. Based on findings so far, GP endorsement of letters seems to encourage uptake of screening.
- Ad-hoc clinics at GP Practices with historical low attendance. Recently, the programme ran 4 clinics at Faversham Practice and 7 out of the 99 patients who attended tested positive to an abdominal aortic aneurysm. They will continue to engage practices with low uptake.
- Looking at the feasibility of using use the television screens in GP premises where other to publicise the NAAASP. This would provide an opportunity to capture patients' attention whilst they are in the practice for other reasons.
- Accessing educational or training forums for doctors, for instance those arranged by the Royal College of Medicine and discuss AAA screening.
- Working with Pharmacy and GPs to raise awareness of the screening Programme and support improved uptake NCL AAA.
- Discussions with EMIS about generating alerts on eligible men's records, when they attend for GP appointments, so GPs can promote attendance.

Promoting Career Development of Clinical Skills Trainers (CST)

The programme intends to host CST workshops, as well as reviewing a programme of audits which they are looking to deliver across London.

Screening in prisons and secure units

There are a small number of patients that have been identified as eligible for screening across two secure units in North Central London. NHSE has developed some guidance for Programmes and will be appointing a Commissioning Lead for Prison screening who will help the Programmes to establish a way of working with the cohort.

Targeted work in areas of low uptake

The NCL AAA Programme has an ongoing action plan to increase uptake in areas with low uptake by using a range of strategies including:

- Identify weak spots and look at possible new clinic locations.
- Look at required versus actual capacity at clinic sites
- Increase the number of Hospital screening clinics.
- Contact Chase Farm, Barnet and Edgware hospitals and Identify contacts for hiring treatment rooms at each hospital site.
- The Programme had held a promotional event in the RFH main hospital, with 10 eligible men agreeing to be screened on the day (self-referrals)
- Maintain Saturday clinics as they are doing well with a reduced number of DNAs.
- A Men's Health Initiative, working in collaboration with Spurs Football Club to raise awareness of the AAA Screening Programme. The programme has also contacted men's clubs and societies and next step will be to arrange drop in clinics to offering opportunity to screen men in places where they socialise.
- The clinical lead for the AAA Screening Programme is planning to target marginalised communities such as, the Turkish community to promote uptake. Related to this is information that has come to light, regarding the fact that, National AAA Programme Literature does not routinely get translated into Turkish.

External Quality Assurance Visit

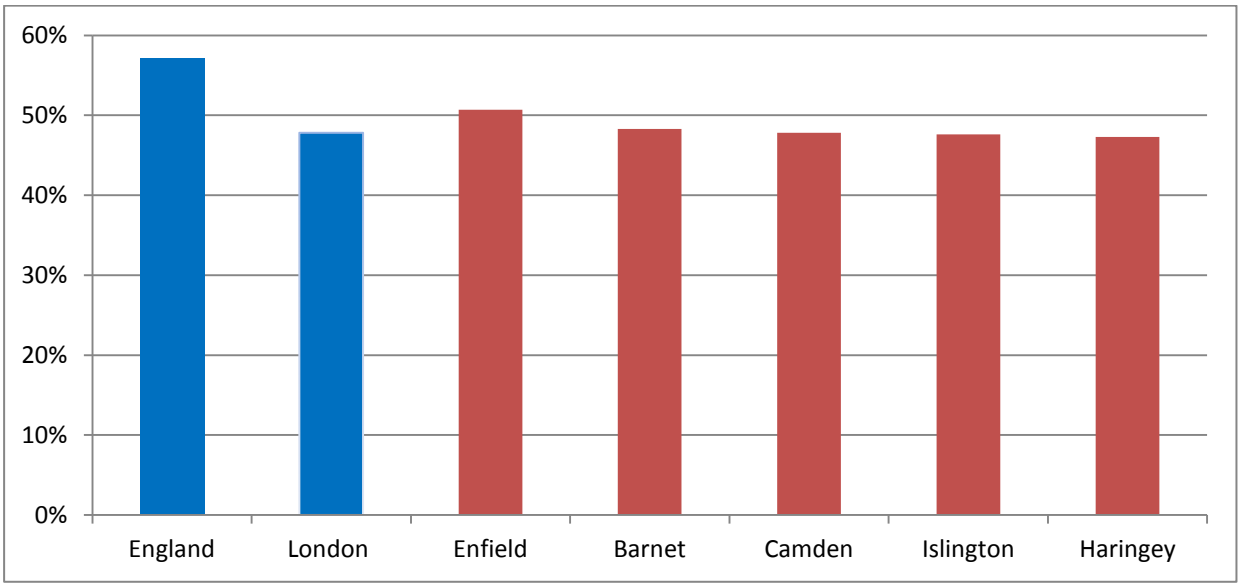
The Proposed date for the NCL AAA Screening Programme External Quality Assurance Visit is 22nd of February 2016.

Bowel Cancer Screening Programme

Coverage

Coverage is the percentage of people adequately screened in the last 2.5 years out of those who are eligible for gFOBt screening. Latest published data (up to end of March 2015) shows North Central London performs significantly below the national average for this measure; 48.34% compared to 57.1%. Performance is slightly better when compared to the London average of 47.8%. Variation in coverage across North Central London CCGs is minimal, ranging from 47.3% in Haringey to 50.7% in Enfield.

Cancer Screening –Bowel Cancer Coverage March 2015 (60-74 years) across NCL CCGs



Graph 2 Data from Public Health Profiles available at http://fingertips.phe.org.uk/profile/health-profiles

2.20iii - Cancer screening coverage - bowel cancer 2015

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	4,406,923	57.1	57.1	57.1
London region	407,429	47.8	47.7	47.9
Barking and Dagenham	6,481	39.7	38.9	40.4
Barnet	20,934	48.3	47.9	48.8
Bexley	15,566	51.8	51.2	52.3
Brent	15,339	47.4	46.8	47.9
Bromley	23,103	53.5	53.0	54.0
Camden	10,234	47.8	47.1	48.5
City of London	415	46.1	42.8	49.3
Croydon	22,073	51.1	50.6	51.5
Ealing	17,648	47.8	47.3	48.3
Enfield	17,967	50.7	50.2	51.2
Greenwich	11,421	46.2	45.6	46.8
Hackney	7,285	39.1	38.4	39.8
Hammersmith and Fulham	7,549	43.9	43.2	44.7
Haringey	11,195	47.3	46.7	47.9
Harrow	16,304	52.5	51.9	53.1
Havering	17,182	50.6	50.1	51.2
Hillingdon	16,929	52.1	51.5	52.6
Hounslow	13,039	46.9	46.3	47.5
Islington	8,692	47.6	46.9	48.4
Kensington and Chelsea	7,565	42.5	41.8	43.2
Kingston upon Thames	10,893	55.5	54.8	56.2
Lambeth	9,742	39.8	39.1	40.4
Lewisham	10,536	43.3	42.7	43.9
Merton	11,329	51.0	50.3	51.6
Newham	8,694	38.2	37.6	38.8
Redbridge	13,383	44.0	43.4	44.5
Richmond upon Thames	14,235	57.2	56.6	57.8
Southwark	9,109	39.8	39.1	40.4
Sutton	13,680	56.2	55.6	56.8
Tower Hamlets	5,698	37.3	36.6	38.1
Waltham Forest	10,835	44.5	43.9	45.2
Wandsworth	13,034	49.4	48.8	50.0
Westminster	9,340	41.8	41.2	42.5

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Table 17

Published data is only available at Practice level for the age range 60-69 years. There is significant variation for coverage between practices across the North Central London footprint, ranging from 27.4% to 62% as seen in the table below. NHSE are working with Primary Care Commissioners and CCGs to address variations in coverage at a practice level.

CCG	Lowest	Highest	Percentage of Practices ≥ England Average (57.8%)
Barnet	31.7% (Alder JS (The Surgery	61.9% (Oakleigh Road Health Centre)	1.34%
Camden	36.8% (Somers Town Medical Centre	56.5% (West Hampstead Medical Centre)	0%
Enfield	33.5% (East Enfield Practice)	62% (Abernethy House)	3.43%
Haringey	27.4% (West Green Road Surgery)	61.7% (The Muswell Hill Practice)	1.8%
Islington	33.4% (Archway Medical Centre)	57.8% (The Miller Practice)	0.36%

Table 18 Data extracted from National General Practice Profiles available at ***https://fingertips.phe.org.uk/profile/general-practice***

Bowel Cancer Screening Service for NCL

NHSE commissions UCLH to deliver bowel cancer screening to the NCL population. Performance against KPIs (national standards) is monitored on an ongoing basis with reports submitted quarterly to the London Bowel Cancer Screening Programme Board. KPIs are generally met by UCLH with a minimal numbers of breaches. In line with all London Screening Centres, uptake continues to fall significantly below the national average for the NCL population. Additionally UCLH, along with the majority of London centres, regularly breaches the target for colonoscopy uptake (the percentage of participants with an abnormal gFOBt who then go on to have a colonoscopy). The majority of breaches are for patients who do not attend an initial SSP assessment. For those who do, according to an internal audit conducted by UCLH, co morbidities are the most significant reason for declining colonoscopy.

The national Bowel Cancer Screening System facilitates a service user questionnaire completed 30 days post screening. In addition the centre provides a service user feedback report to the quarterly London Bowel Cancer Screening Programme Board. The majority of feedback is positive with minimal numbers of complaints. Feedback is discussed at the quarterly Programme Board meetings providing an opportunity for learning across the London programme.

Bowel Scope

University College London Hospitals NHS Trust is currently rolling out bowel scope screening to the populations of North Central London. Bowel scope is offered as a one off screen at 55 years when participants are invited to attend an accredited screening centre for a flexible sigmoidoscopy. Roll

out is being implemented in a phased approach that includes delivery at satellite sites to improve accessibility for those invited to attend. Roll out for UCLH has been slow with only Haringey currently live for bowel scope. Within Haringey 18 practices out of 45 are currently live. This population is served by a satellite service at the Whittington Hospital. Delay to roll out has largely been as a result of the loss of JAG (Joint Advisory Group) accreditation at UCLH, which has prevented this site from going live with bowel scope in line with national standards. Additionally failure to recruit further accredited scopists to operate at the Whittington site has prevented faster roll out for the population of Haringey. JAG accreditation was reinstated at UCLH at end of November 2016 and revised plans for roll out for this site are now being developed with the aim of starting invitations to the Islington population by Spring 2017.

Coverage and Uptake

Data on ethnicity and socio economic status is not routinely collected as part of the national bowel cancer screening system. However in line with other screening programmes uptake tends to be lower in those from more deprived backgrounds along with those from particular minority ethnic groups. In addition there is evidence that uptake tends to be higher in those who attended a previous screening episode. The likelihood of uptake in those who have completed one previous screening episode for bowel cancer screening is almost double than for those who have received an invitation for the first time (prevalent round).

NHSE hosts a Task and Finish Group, which includes Transforming Cancer Services Team, Researchers at UCL, Screening Centres and the London Hub. This group works on a Pan London level to plan the delivery of evidence-based activities across the bowel cancer screening pathway

- to increase the uptake of bowel cancer screening in London
- to reduce inequalities in bowel cancer screening uptake between and within London boroughs, and by different communities

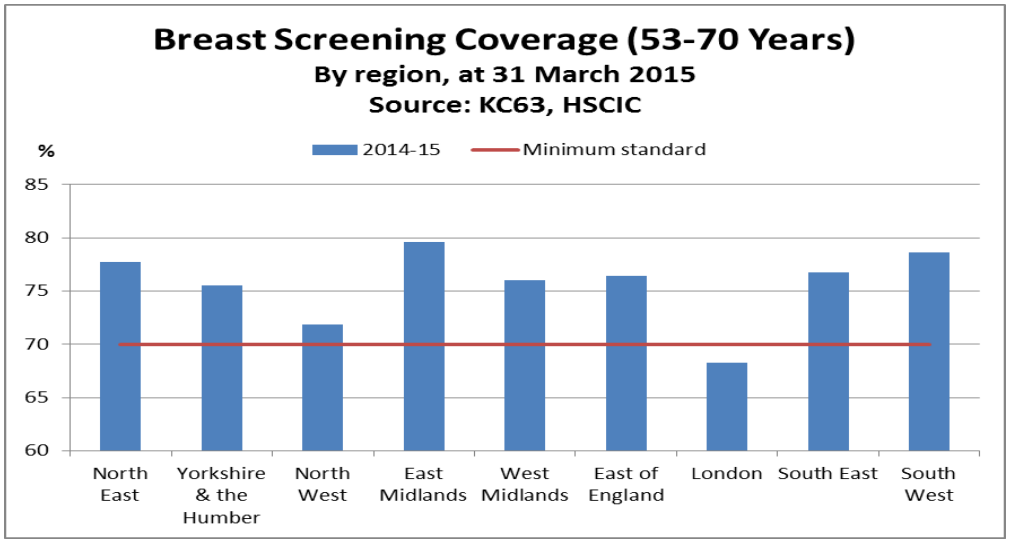
Current initiatives include General Practice Endorsement of pre invitation letters along with enhanced reminder letters. A randomised controlled trial by University College London highlighted the effect of GP endorsement of bowel cancer screening in improving uptake.[2] The addition of GP endorsement to the standard bowel cancer screening invitation letter increased the odds of participation in the gFOBt screening programme by 7%. This translates into a 1.7% relative increase in the probability of screening and a 1% absolute increase. Although the intervention significantly affected uptake overall, no effect was seen between socio-demographic groups.

A recent London Trial of FIT (Faecal Immunochemical Test) demonstrated an increase in uptake of 8.3% overall and this was across all population groups with a greater increase seen in the most deprived compared to the least deprived. Following a ministerial announcement in Spring 2016 FIT will replace the current gFOBt as the primary test for bowel cancer screening in Spring 2018.

[2] Raine R, Duffy SW, Wardle J, Solmi F, Morris S, Howe R, Kralj-Hans I, Snowball J, Counsell N, Moss S, Hackshaw A, von Wagner C, Vart G, M McGregor L, Smith SG, Halloran S, Handley G, Logan R F, Rainbow S, Smith S, Thomas M C and Atkin W *Impact of general practice endorsement on the social gradient in uptake in bowel cancer screening* British Journal of Cancer 114, 321-326 (02 February 2016) | doi:10.1038/bjc.2015.413

Breast Cancer Screening Programme

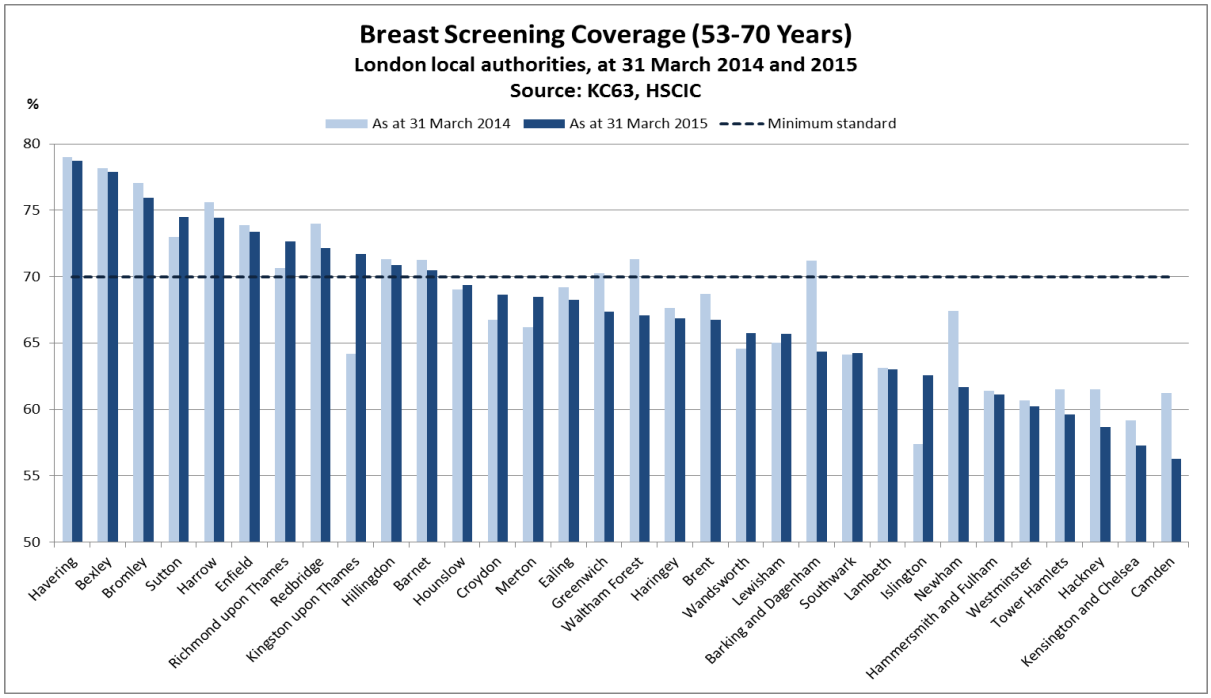
Coverage



Graph 3

Breast screening coverage in London was 68.3% (at 31 March 2015) the lowest of the regions in England. From 2010/11 the coverage in London is fairly stable, closely matching the overall trend in England.

Breast screening coverage nationally has fallen for the last four years. Barnet and Enfield have coverage over the minimum standard



Graph 4

Comparative Coverage by CCG 2013 - 2015

	2013-2014			*2014-2015*			
Local authority	**Eligible pop**	**Women screened**	***Coverage***	**Eligible pop**	**Women screened**	***Coverage***	***Difference***
Barnet	**32,764**	**23,349**	***71.3***	**33,991**	**23,963**	***70.5***	***-0.8***
Camden	**16,131**	**9,880**	***61.2***	**16,728**	**9,416**	***56.3***	***-4.9***
Enfield	**27,879**	**20,600**	***73.9***	**28,790**	**21,119**	***73.4***	***-0.5***
Haringey	**19,566**	**13,234**	***67.6***	**20,534**	**13,727**	***66.9***	***-0.7***
Islington	**14,182**	**8,140**	***57.4***	**15,156**	**9,484**	***62.6***	***5.2***
Source KC63, HSCIC							

Table 19

Table 19 above shows that apart from Islington all other authorities have experienced a decline in coverage.

Improving Uptake

The breast screening units in North London (NLBSS) hosted by Royal Free Hospital and Central and East London (CELBSS) hosted by Bart's Health are responsible for screening women in North Central London. Table two below shows the uptake for each breast screening service. Uptake looks at the percentage of women who attended for breast screening from the total of women invited to attend.

Uptake	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Barking, Havering, Redbridge & Brentwood	75.4	70.4	73.3	73.0	66.6	75.3	72.9	66.0	73.3	67.0	63.3	
Central & East London	48.4	52.8	52.5	52.5	55.6	53.1	61.1	60.6	56.7	57.3	58.0	
North London	61.6	62.7	59.3	59.0	59.9	62.2	64.6	65.2	66.7	66.4	64.7	
South East London	..	..	..	..	..	..	..	64.1	62.9	61.2	65.8	
South East London (Kings College Hospital)	59.3	62.2	61.6	59.3	60.9	60.5	59.8	..	..	..	..	
South East London (Queen Mary's Sidcup)	67.1	65.6	70.8	67.7	64.9	69.5	64.6	..	..	..	..	
South West London	67.4	65.4	61.7	64.5	64.5	62.2	66.4	64.9	64.4	66.7	61.6	
West of London	56.1	58.4	53.9	56.0	56.5	56.4	58.9	58.4	57.4	58.4	61.5	
Whipps Cross	70.2	..	..	..	..	..	..	..	..	..	..	

Table 20 Source: KC62, NHS Digital

.Both breast screening services have implemented 3 uptake initiatives to improve uptake and these have been mainstreamed into regular practice.

- Pre-invitation letters
- Text message reminders
- Second timed appointments

Over the last 10 years, the administration of the breast screening service had been identified as a weakness, both through QA processes and clinical incidents/SIs. As a result, there have been discussions about how the configuration of the breast screening programme in London could be changed to strengthen the administrative function and ensure equity across the service. As part of the new model of service for breast screening across London from March 2017, the administration for the service has transferred to the London Breast Screening Hub hosted by the Royal Free Hospital. This means a centralised administration unit for the whole of London. It also means a single point of contact for women and better access through extended opening hours. Women may not realise any change in the service as the screening will remain provided by CELBSS and NLBSS. What they may notice is a new telephone number and the opportunity to make an appointment outside of

NC London more easily than had previously been the case. The Breast Screening Hub is also looking at other opportunities to increase the uptake. There are planned initiatives with the hub to improve uptake through extending opening times of the call centre. The Hub will be working closely with GP practices, reintroducing information packs for GPs and creating a website.

In 2015/16 NHSE commissioned Community Links, a voluntary organisation, to promote uptake through community engagement in 3 boroughs in London. The work involved telephoning women who had received an invitation to attend for breast screening. One of the boroughs included was Camden. The work has seen an increase in uptake for Camden during 2016/2017. This can be seen below in table 21 and table 22.

Overview of Coverage and Uptake in April2015

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	25	10	12	40
Camden	39	0	35	3	26
Enfield	55	24	5	17	20
Haringey	54	7	15	1	31
Islington	38	0	21	0	26

Table 21 Source Open Exeter via NHS England cube

Overview of Coverage and Uptake in March 2016

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	19	10	1	41
Camden	39	0	21	0	19
Enfield	55	23	7	14	17
Haringey	54	2	17	2	29
Islington	38	0	31	2	24

Table 22 Source Open Exeter via NHS England cube

A feasibility study will be undertaken shortly to determine whether extending the work telephoning women invited for mammography across London to improve uptake

Performance

In July 2013 CELBSS were instructed by NHS England (London) Head of Screening and the Director of Quality Assurance, London, to implement a managed slow-down of invitations to 50% to redress issues of quality within the service. It was also recommended that the Trust commissioned a management team from the North London Breast Screening Service to improve administrative functions within the breast screening service. There was a managed slowdown of the round length and monthly assurance meeting to monitor performance. There was a need to recruit locum radiologists and for substantive posts to be advertised. By October 2015 2016 the minimum standard for round length had been achieved.

In quarter two, three and four of 2015/2016 CELBSS did not meet the screen to assessment KPI. This was due to a large volume of women pulled back to meet the round length target. This was addressed by balancing screening activity with assessment capacity and putting a demand and capacity model in place.

Failure to meet the minimum standards has meant that CELBSS has not taken part in the age extension trial. This is taking place in NLBSS where women aged 47-49 and women aged 71-73 are invited within a randomised trial

In quarter two NLBSS also did not meet the minimum standard for screen to assessment. This was due to staff capacity issues and an increase in workload due to an increase in women screened. This was resolved by optimising clinic slots and filling radiography and radiology posts.

Patient Surveys

Each breast screening services submits a quarterly report of how many complaints and compliments they have received. A comment form is available to clients when attending for a mammogram. These can be completed anonymously if the client prefers to not complete her personal details. The client can also submit a comment independently and through the local PALS department. Each service also offers the opportunity of communication from clients via their websites. On an annual basis each service runs a patient survey.

The compliments far outweigh the complaints that are submitted. The common themes with the complaints were the manner and negative attitude of the staff, customer care, and availability of appointments, the painful experience of mammogram, unclear signage, unhygienic changing rooms and problems parking. Each complaint was looked into and addressed and where necessary an apology was given. All were discussed at team meeting so there was shared learning. The common themes with the compliments were friendly and helpful staff and an excellent service provided.

There is no analysis available which looks at the differential uptake by age, ethnicity learning disabilities deprivation or ward of residence.

Future actions

At the moment women are invited in NLBSS by GP practice and in CELBSS by area and GP practice. In July 2016 the computer system used to produce breast screening batches was replaced with a new system called BS Select. The introduction of BS-Select has had an unanticipated (negative) impact on the Round plans of both breast screening services in North Central London. It is anticipated that in one of the London breast screening services 9-25% of the cohort will be called/recalled either early or late (reduced or increased Round length for the affected cohort by a few months or up to two years or more in some cases). This has been raised with the National Office and guidance has been sought to determine what action can be taken to mitigate the effects. An independent consultant is working with the breast screening units to quantify the impact.

There is a desire to move to delivering the breast screening programme using the next test due date, this would reduce the negative impact of BS Select it would also result in women being called at the correct time exactly three years form their last test. For services involved in the age extension trial it would not be possible to transfer to next test due date without using further software. For NLBSS

using mobile breast screening units there would have to be a move to static sites before transferring to next test due date.

Cervical Screening

Overview

The NHS Cervical Screening Programme invites women between the ages of 25 and 64 are invited for regular cervical screening under the NHS Cervical Screening Programme. Women aged 25 to 49 are invited every 3 years. After that, women are invited every 5 years until the age of 64. This is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

Coverage

Coverage of cervical screening is an effective indicator of judging the success of the Cervical Screening Programme. It measures the percentage of women in the target age group (25–64 years) who have been screened. Nationally there has been a downward trend in coverage from 2013/14 which is reflected across London. North Central London coverage is in line with the London average but lower than the national minimum standard of 80% coverage (Table 23).

NHS Cervical Screening Programme: Age appropriate coverage by age band and NC London Boroughs, 2015-16

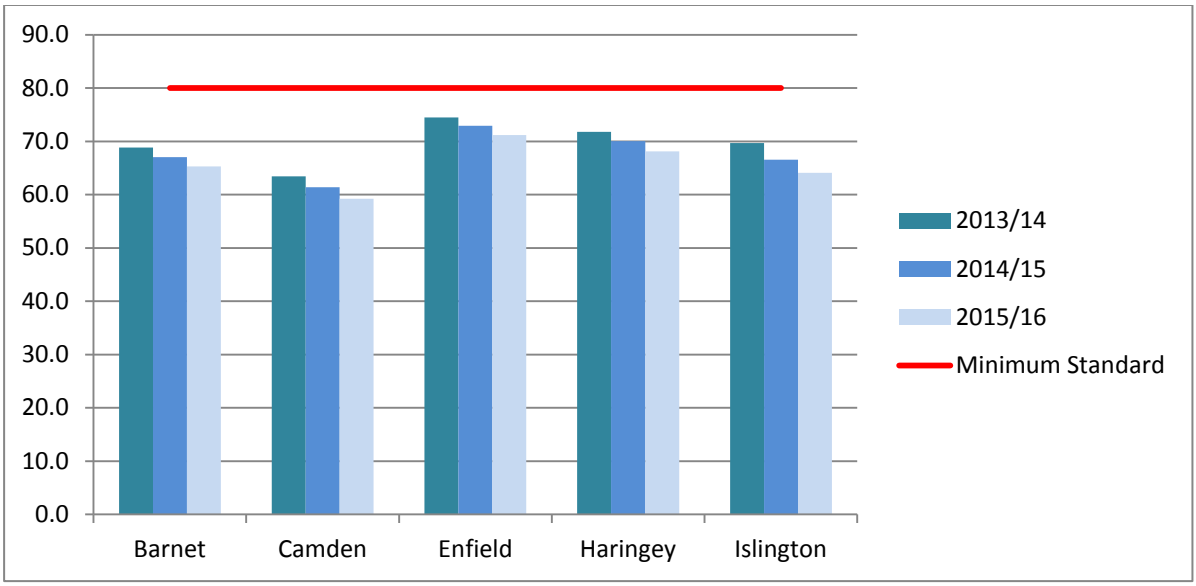
Region & Local Authority		2015-16						
		Eligible population [1]				Age appropriate coverage		
		Thousands				Percentages		
		25-49	50-64	25-64		25-49 (less than 3.5 yrs since last adequate test)	50-64 (less than 5.5 yrs since last adequate test)	25-64
	ONS Code	(000's)	(000's)	(000's)		*(%)*	*(%)*	*(%)*
London	**E12000007**	**2,002.8**	**652.8**	**2,675.3**		***63.7***	***76.3***	***66.7***
Barnet	E09000003	81.6	30.9	112.5		*61.9*	*74.4*	*65.3*
Camden	E09000007	59.6	15.6	75.1		*56.1*	*71.3*	*59.2*
Enfield	E09000010	67.4	27.4	94.8		*68.0*	*79.2*	*71.2*
Haringey	E09000014	69.2	21.0	90.2		*65.0*	*78.1*	*68.1*
Islington	E09000019	62.7	15.1	77.8		*61.5*	*74.9*	*64.1*

[1] This is the number of women in the resident population less those with recall ceased for clinical

Table 23: Source: Open Exeter system (Health and Social Care Information Centre), PHOF report.

Cervical screening coverage has worsened for all Local authorities in North Central London from 2013/14 to 2015/16 (Graph 1). There are no Boroughs in North Central London that are achieving the minimum standard of 80%. In NC London, Enfield has the highest uptake (71.2%) which is higher than London average (66.39%) with Camden having the lowest (59.2%); trends in coverage figures reflect a similar pattern across London with a slight drop in coverage rate of 1.7% from 2014/15 to 2015/16 and remain lower than the national minimum standard of 80% coverage.

Cervical Screening Age Appropriate Coverage: 25-64 Age Cohort (3.5 years for 25-49 and 5.5 years for 50-64)



Graph 5: Source: Health and Social Care Information Centre

Although coverage shows a downwards trend since March 2014, both Enfield and Haringey have performed above the London average but both have also shown a reduction from March 2015 to March 2016 (1.7%) and (1.9%) respectively.

There are no Boroughs in London that are achieving the national minimum standard of 80% for coverage. However, Enfield (71.2%) and Haringey (68.1%) coverage remains higher than the London average (66.7%) in March 2016.

- Boroughs in NC London continue to not to meet the standard for cervical screening coverage and all show some deterioration in 2015/16.
- NC London coverage is in line with London's performance but shows a downward trend in 2015/16

NC London Boroughs receive their colposcopy service from six providers namely; Barnet Hospital, Chase Farm Hospital, North Middlesex Hospital, The Royal Free Hospital, Whittington Hospital and University College London Hospital. All six providers are meeting the following targets: high grade waiting times, DNAs for new patients and communication of results letters within 8 weeks.

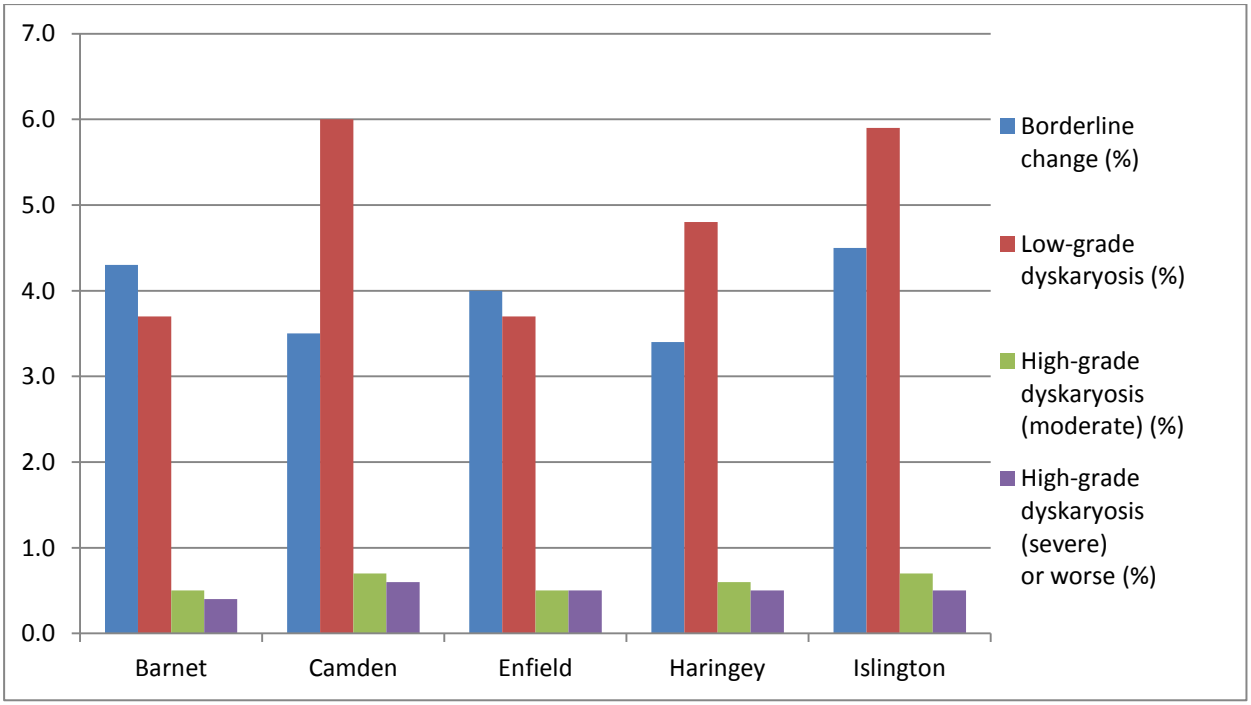
Table 24 below includes data for NC London Boroughs on the screening samples examined by the Health Services Laboratory (HSL) and Chase Farm Hospital on referrals to colposcopy units. Of samples submitted by GPs and NHS Community Clinics across NC London, the percentage of test results returned Negative ranged between 88.3% and 91.4%, the London average is 92.8% of test results returned Negative. Test results returned as High-grade dyskaryosis (severe or worse) and or High-grade (moderate) were less than 0.7%, Low-grade dyskaryosis results are highest in Camden (6.0%) and Borderline change results are highest in Islington (4.5%) see Graph 6 below.

NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16

	Negative	Borderline change	Low-grade dyskaryosis	High-grade dyskaryosis (moderate)	High-grade dyskaryosis (severe) or worse
	(%)	*(%)*	*(%)*	*(%)*	*(%)*
London	***92.8***	***2.9***	***3.3***	***0.5***	***0.5***
Barnet	*91.1*	*4.3*	*3.7*	*0.5*	*0.4*
Camden	*89.2*	*3.5*	*6.0*	*0.7*	*0.6*
Enfield	*91.4*	*4.0*	*3.7*	*0.5*	*0.5*
Haringey	*90.8*	*3.4*	*4.8*	*0.6*	*0.5*
Islington	*88.3*	*4.5*	*5.9*	*0.7*	*0.5*

Table 24: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

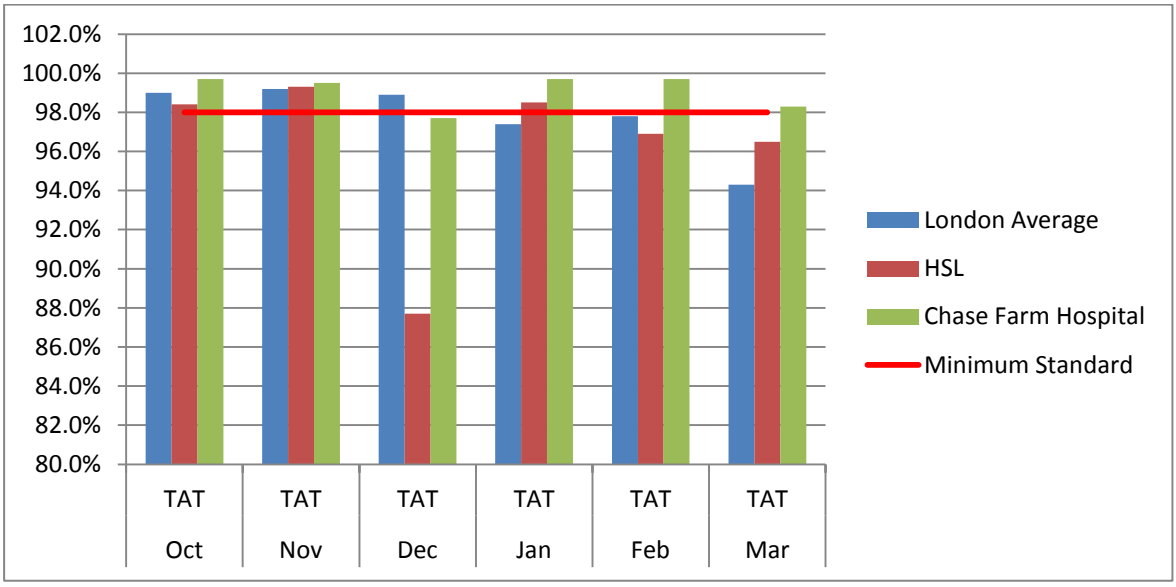
NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16



Graph 6: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

Cervical screening Turnaround Times (TATs) the national minimum standard is 98% of women receive their cytology result within 14 days from the date of primary screen. The cytology laboratories covering NC London Boroughs regularly achieve the minimum standard, however, in November 2016 HSL breached the target (97.7%) but the London average remained at 99% see Graph 7 below.

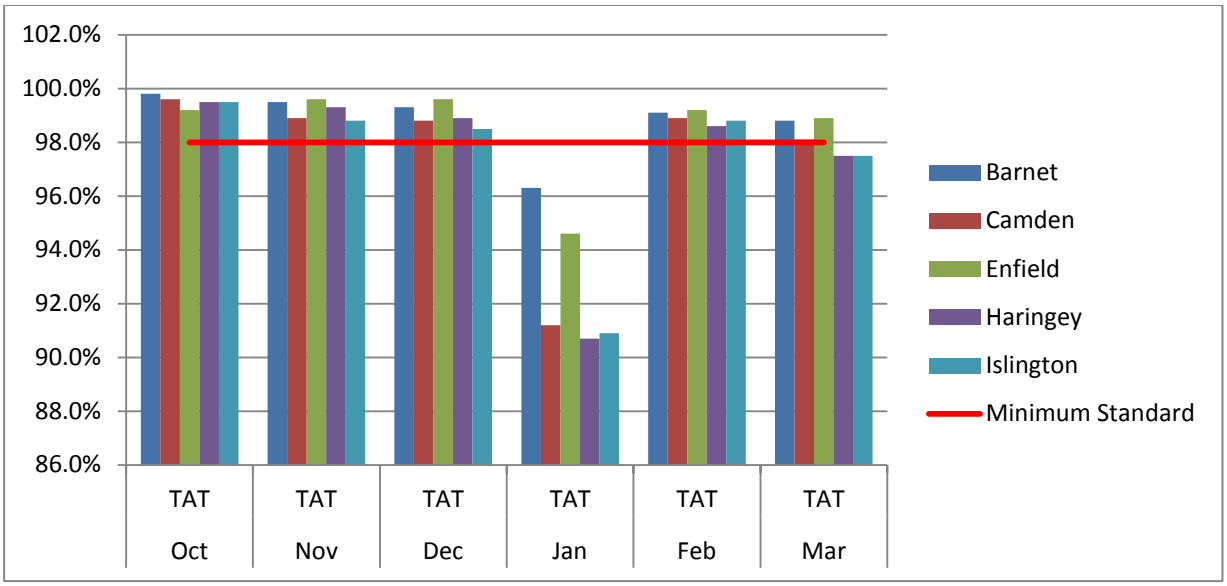
NHS Cervical Screening Programme: Turn Around Times (TATS) by Cytology Laboratory, October – March 2015-16



Graph 7: Source**:** Open Exeter

The performance in cervical screening Turnaround Times (TATs) at Borough level has seen a decline in performance since December 2015 (98.7%) of results were estimated to be delivered within 14 days achieving the national standard (98%). In March 2016 the overall TATs for London had dropped to 95.7% with only 3 of the NC London Boroughs meeting the national standard of 98% see Graph 8 and Table 25 below.

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16



Graph 8: Source: Open Exeter

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16

	Oct	Nov	Dec	Jan	Feb	Mar
London	99.0%	99.2%	98.9%	97.4%	97.8%	95.7%
Barnet	99.8%	99.5%	99.3%	96.3%	99.1%	98.8%
Camden	99.6%	98.9%	98.8%	91.2%	98.9%	98.1%
Enfield	99.2%	99.6%	99.6%	94.6%	99.2%	98.9%
Haringey	99.5%	99.3%	98.9%	90.7%	98.6%	97.5%
Islington	99.5%	98.8%	98.5%	90.9%	98.8%	97.5%

Table 25: Source: Open Exeter

From April 2016, Primary Care Support England (PCSE) has taken over the responsibility for the primary care support services delivered by NHS England. PCSE's priority is to ensure the safe and secure delivery of existing services, whilst introducing new arrangements to help create a national easy to use service for all customers. The closure of the support services based in London has resulted in an increase in the number of both laboratories and CCGs failing to meet the minimum standard.

HSL are currently conducting an audit to understand delays with results to Primary Care Support England (PCSE) since centralisation of services in Leeds. Initial investigations show that files sent at 8am and should be received and posted on that day are not being processed (i.e. results letters sent) until the following day so adding an extra day to our TATs.

Learning disabilities

Unfortunately, the screening programmes do not routinely collect data regarding numbers of patients with learning disabilities accessing the services due to the software not being programmed to collect such data.

Deprivation

The screening programmes do not routinely collect data for deprivation; this data is held by Local Authorities

GP practice

NHS England will engage with CCG commissioners to develop actions to support GP practices with low uptake of service. We will also actively participate in Strategic Transformation Plan working groups looking at cancer commissioning and prevention

Females 25- 64 yrs, attending Cervical Screening within target period 3.5 or 5.5 year coverage % (2014-15)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.4	41.5	78.3
Camden	59.4	27.7	73.2
Enfield	72.8	62.3	82.2
Haringey	70.8	54.2	80.5
Islington	67.1	61.3	74.4

Table 26: Source: QOF

Ward of residence

There is currently only CCG level data rather than Ward of residence level data.
Camden is the lowest performing Borough

Service delivery issues

All services breaching national performance targets are asked to provide an exception report highlighting the reasons for the breach and remedial actions taken to prevent reoccurrence. At the Cervical Screening Programme Boards the Hospital Based Programme Coordinators (HBPC) provide an exception report on performance and alert NHSE to any issues concerning performance. When a trust breaches the same target in two consecutive quarters NHSE commissioners review the exception reports and make a decision on the issuing of contract performance notices.

North Middlesex Hospital (January 2016)

Contract performance letter sent to Chief Executive

- Consistently failed to meet the target DNA rate for follow up patients. Performance data for Quarter 2 2015/16 shows the DNA rate for follow up patients to be well above the recommended 15% at 32.38%, we note this is a rise of 12.3% on the previous quarter which is a real cause for concern and which needs to be addressed immediately.

The Trust has implemented a number of changes to address the poor performance. Reminder letters and phone calls were implemented early December 2015. Text reminders have also been reintroduced; the implementation of phone calls and letters has already had an impact on performance and DNA rates are significantly reduced.

Data validation issues caused by the interface between Medway and Compuscope, impacted on indicators reported via Cyres. There were discrepancies between the two systems which meant KPIs could not be tracked and figures reported via KC65 (extracted from Cyres) were inaccurate. The trust have now implemented a new computer system for the colposcopy department to resolve this issue

Barnet and Chase Farm (December 2015)

Despite initiatives in place to reduce follow up DNA, including texts and reminder letters, rates at Barnet and Chase Farm Hospitals breached the standard (<15%) for quarter 3

Following the acquirement of BCFH by RFH in July 2015, the PAS systems at Hampstead site and at Barnet & Chase Farm site were merged on 1st November 2015. This involved allocating new hospital numbers to most of Barnet & Chase Farm patients. As a result of the merge, old appointment history on PAS and appointments for direct referrals booked on the system for patients that had not been seen prior to the merge (approx 6 weeks) were lost.

The issue was declared a serious screening incident to ensure the Trust had taken the appropriate actions to resolve the incident and have escalated to the highest level within the organisation. Following assurance that all data had been restored on the PAS system and submission of a concise Root Cause Analysis, the incident was closed.

The Whittington Hospital (November 2016)

A Contract Performance Notice issued because the Trust had consistently failed to meet Colposcopy performance targets in Q1and Q2 2016/17. A meeting between NHSE and the Trust has taken place and a number of recommendations with timescales have been agreed to improve performance. NHSE will continue to monitor performance and take appropriate action if performance breaches continue.

Information on patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board (NC London vacancy)
- routine monitoring of compliments and complaints
- to implement required improvements patients

Adverts for Patient Public Voice (PPV) representatives for Cervical Screening Programme boards have been sent out.

NC London-wide and borough specific action plan to address:

- **non-achievement of national minimum standards in the programme**
    - breaches will be managed through NHS performance frameworks

- **inequities and inequalities in uptake**

- NHSE/PHE Uptake and Coverage Manager to be appointed (social marketing)
- Commissioning CASH clinics to provide cervical screening for women who do not respond to invitation
- NC London CSP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups
- Engagement with pharmacies
- Integration of screening and/or screening awareness raising in other community settings
- NHSE/PHE working with Local authorities and CCG commissioners to develop a joint understanding of local population needs leading to a shared set of priorities

Table 5: Female patients (25 – 64yrs) on the Mental Health register who had cervical screening test in the preceding 5 years (2015-16)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.6	27.3	100
Camden	69.2	45.5	95.5
Enfield	70.4	47.1	100
Haringey	72.5	42.9	100
Islington	68.2	41.7	100

Source: QOF

- **identified issues with service delivery**
  - monthly delayed sample reports by CCG and GP practice
  - monthly sample handling errors reports by CCG and GP practice

- **identified issues with patient experience**
  - management cervical screening incidents affecting patient or service delivery

Other actions to improve uptake and coverage:

- Introduction of Primary HPV screening
  - HPV self-testing subject to National approval
- Working with Primary care commissioning to develop action plans and ensure that private and overseas samples are recorded appropriately
- Working with Sustainable Transformation Plans (STPs) planning groups

Appendix 1: Uptake by Practice NCL DESP

Barnet CCG

GP Code	Invited	Screened	uptake
Y03664	238	186	78.20%
E83027	327	257	78.60%
E83042	113	90	79.60%
E83649	108	87	80.60%
E83041	218	176	80.70%
Y02986	63	51	81.00%
E83657	108	88	81.50%
E83009	294	240	81.60%
E83026	192	157	81.80%
E83600	143	117	81.80%
Y03663	373	308	82.60%
E83011	413	342	82.80%
E83633	154	128	83.10%
E83021	505	420	83.20%
E83046	361	303	83.90%
E83006	243	205	84.40%
E83631	96	81	84.40%
E83036	189	160	84.70%
E83032	842	718	85.30%
E83638	153	131	85.60%
E83031	155	133	85.80%
Y00316	177	152	85.90%
E83039	168	145	86.30%
E83013	237	205	86.50%
E83037	240	208	86.70%
E83025	380	330	86.80%
E83008	259	225	86.90%
E83658	123	107	87.00%
E83637	286	250	87.40%
E83653	316	277	87.70%
E83050	179	157	87.70%
E83639	294	258	87.80%

GP Code	Invited	Screened	uptake
E83005	214	188	87.90%
E83038	537	472	87.90%
E83632	191	168	88.00%
E83622	225	198	88.00%
E83034	238	210	88.20%
E83020	358	317	88.50%
E83045	378	335	88.60%
E83028	360	320	88.90%
E83640	18	16	88.90%
E83035	577	514	89.10%
E83012	298	266	89.30%
E83629	152	136	89.50%
E83016	698	625	89.50%
E83010	431	386	89.60%
E83017	405	364	89.90%
E83018	741	666	89.90%
E83049	290	261	90.00%
Y00105	208	188	90.40%
E83024	417	377	90.40%
E83053	612	554	90.50%
E83613	138	125	90.60%
E83030	367	333	90.70%
E83656	79	72	91.10%
E83644	113	103	91.20%
E83668	210	192	91.40%
E83003	368	337	91.60%
E83621	444	408	91.90%
E83650	74	68	91.90%
E83007	324	299	92.30%
E83044	341	316	92.70%
E83624	104	99	95.20%

Camden CCG

GP Code	#invited	#screened	uptake
Y02674	34	19	55.9%
F83672	47	28	59.6%
F83632	164	125	76.2%
F83682	52	40	76.9%
F83059	614	476	77.5%
F83050	134	106	79.1%
F83677	48	38	79.2%
F83683	207	165	79.7%
F83043	80	64	80.0%
F83061	146	117	80.1%
F83665	265	213	80.4%
F83658	165	133	80.6%
F83635	191	155	81.2%
F83020	367	303	82.6%
F83058	226	187	82.7%
F83017	468	388	82.9%
F83023	801	666	83.1%
F83019	461	384	83.3%
F83005	84	70	83.3%
F83011	180	150	83.3%
F83030	120	100	83.3%
F83006	506	422	83.4%
F83623	229	191	83.4%
F83057	148	124	83.8%
F83042	179	150	83.8%
F83048	241	204	84.6%
F83633	62	53	85.5%
F83003	180	154	85.6%
F83022	506	433	85.6%
F83018	389	335	86.1%
F83055	276	238	86.2%
F83025	360	317	88.1%
F83044	202	178	88.1%
F83052	124	110	88.7%
F83615	159	144	90.6%

Enfield CCG

GP Code	Invited	Screened	uptake
F85011 (1)	83	39	47.00%
F85039	280	218	77.90%
F85701	433	347	80.10%
Y03402	1176	956	81.30%
F85666	280	229	81.80%
Y00612	348	285	81.90%
F85678	218	182	83.50%
F85703	285	239	83.90%
F85002	757	637	84.10%
F85043	247	209	84.60%
F85023	281	238	84.70%
F85682	282	239	84.80%
F85687	360	306	85.00%
F85652	202	172	85.10%
F85015	293	251	85.70%
F85686	127	109	85.80%
F85010	333	286	85.90%
F85650	379	327	86.30%
F85048	208	180	86.50%
F85036	175	152	86.90%
F85024	137	119	86.90%
F85700	183	159	86.90%
F85634	270	235	87.00%
F85033	739	645	87.30%
Y00057	237	207	87.30%

GP Code	Invited	Screened	uptake
F85003	581	508	87.40%
F85004	833	729	87.50%
F85053	327	287	87.80%
F85654	271	239	88.20%
F85663	340	300	88.20%
F85676	363	321	88.40%
F85044	273	242	88.60%
F85035	415	368	88.70%
F85625	284	252	88.70%
F85684	318	283	89.00%
F85020	310	276	89.00%
F85076	698	624	89.40%
F85642	315	282	89.50%
F85029	536	480	89.60%
F85058	403	361	89.60%
F85027	480	431	89.80%
F85072	552	496	89.90%
F85025	452	408	90.30%
F85032	409	370	90.50%
F85707	120	109	90.80%
F85055	332	305	91.90%
F85016	285	262	91.90%
F85681	92	85	92.40%
F85656	101	94	93.10%

(1) Merged with another practice

Haringey CCG

GP Code	Invited	Screened	uptake
F85708	22	13	59.10%
F85632	19	12	63.20%
F85059	64	46	71.90%
F85669	493	376	76.30%
Y03506	247	190	76.90%
F85697	141	111	78.70%
Y01655	146	115	78.80%
F85060	304	240	78.90%
F85030	899	713	79.30%
Y02117	527	419	79.50%
F85017	552	439	79.50%
F85643	49	39	79.60%
F85679	35	28	80.00%
F85028	492	397	80.70%
Y03135	390	316	81.00%
F85615	305	250	82.00%
F85645	146	120	82.20%
F85067	270	222	82.20%
F85705	522	430	82.40%
F85008	826	682	82.60%
F85007	928	771	83.10%
F85046	202	168	83.20%

GP Code	Invited	Screened	uptake
Y03035	638	531	83.20%
F85065	157	131	83.40%
F85675	324	271	83.60%
F85064	225	189	84.00%
F85623	199	169	84.90%
F85071	339	288	85.00%
F85013	478	407	85.10%
F85019	696	593	85.20%
F85014	353	303	85.80%
F85026	157	135	86.00%
F85688	202	175	86.60%
F85031	457	397	86.90%
F85049	173	151	87.30%
F85628	235	206	87.70%
F85052	99	87	87.90%
F85069	192	169	88.00%
F85034	244	216	88.50%
F85061	96	85	88.50%
F85063	257	228	88.70%
F85066	541	481	88.90%
F85640	262	233	88.90%
F85045	101	92	91.10%

Islington CCG

GP Code	#invited	#screened	uptake
Y03254 (HMP)	66	41	62.1%
F83033	219	157	71.7%
F83056	167	125	74.9%
F83652	256	192	75.0%
Y03253 (HMP)	17	13	76.5%
F83004	255	197	77.3%
F83674	353	274	77.6%
F83063	459	357	77.8%
F83021	452	352	77.9%
F83686	213	166	77.9%
F83680	195	153	78.5%
F83624	230	181	78.7%
Y01066	292	233	79.8%
F83064	278	224	80.6%
F83664	326	263	80.7%
F83034	68	55	80.9%
F83053	294	238	81.0%
F83032	298	243	81.5%
F83060	327	270	82.6%
F83027	307	254	82.7%
F83678	128	106	82.8%
F83015	519	430	82.9%
F83671	161	134	83.2%
F83002	435	363	83.4%
F83660	358	299	83.5%
F83681	146	122	83.6%
F83008	594	500	84.2%
F83666	283	239	84.5%
F83051	140	119	85.0%
F83012	283	241	85.2%
F83010	414	355	85.7%
F83045	301	259	86.0%
F83039	257	223	86.8%
F83007	308	269	87.3%
F83673	262	229	87.4%

Appendix 2: Patient Satisfaction Report

Survey_W5-S_B6-September 2016.pdf

Appendix 2: Action Plan

Action	Responsibility	Timescale
Shingles campaign will be implemented with a targeted approach per London borough	NHSE, PH teams in LA, CCGs, STPs	2017
Agree maternity service level agreement (SLA to enable all maternity services to administer seasonal influenza and pertussis to all pregnant women	CCG commissioners, NHSE, Maternity Services	Ongoing
Ensure delivery of bowel cancer, Diabetic Eye Screening and Aortic Aneurysm screening in prisons and secure facilities	NHSE, Providers Prison Healthcare Services	March 2018
Implementation of referral pathway to DESP for pregnant women with diabetes	NHSE, CCG commissioners, Maternity Services	June 2017
Promoting GP engagement in NAAASP: • Identify poorly performing practices • Sending pre-invitation letters in advance of drop in clinics. • Ad-hoc clinics at GP Practices with historical low attendance. • Looking at the feasibility of using use the television screens in GP premises where other to publicise the NAAASP. • Accessing educational or training forums for doctors, and discuss AAA screening. • Working with Pharmacy and GPs to raise awareness of the screening Programme and support improved uptake NCL AAA.	Screening Provider, GP practices, Pharmacies	March 2018
Implementation of Faecal Immunochemical Testing in the NHS bowel cancer screening programme, ensuring capacity within endoscopy services	NHSE, London Hub, CCG Commissioners, STPs, endoscopy providers	Spring 2018
Ensure full roll-out of bowel scope screening through development of capacity plans, training of endoscopists and JAG accreditation	NHSE, screening providers, London Hub, HEE	March 2019
Embed recommendations of bowel screening task and finish group (text messaging, GP endorsement, Pre-invitation letters)	NHSE, London Hub, PHE, TCST	March 2018
Scope the feasibility of commissioning DNA contact service for breast screening across London	NHSE, STPs	March 2018
Establish effective GP communications via Hub and clinical services to ensure practices are informed of dates of screening for registered patients, provide promotional resources for use in local practices and provide timely screening reports following completion of screening round	London Hub, Clinical screening services	June 2017
Scope the feasibility of change of invitations for the	NHSE, PHE, London	June 2017

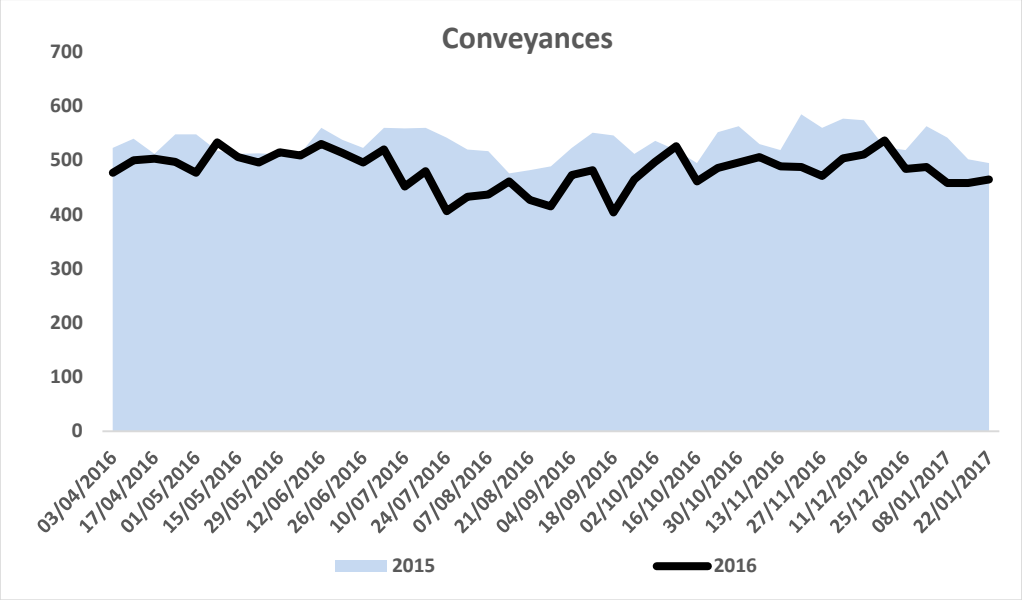
NHS breast screening programme to Next Test Due Date to smooth round planning and reduce early and delayed invitation	Hub, Clinical services	
Reduce inequalities in coverage for the NHS Cervical Screening Programme through: • Appointment of NHSE/PHE Uptake and Coverage Manager to be appointed (social marketing) • Commissioning CASH clinics to provide cervical screening for women who do not respond to invitation (non-recurrent funding) • Work closely with GPs and other stakeholder to improve uptake in the hard to reach groups • Promotion of cervical screening through pharmacies • Integration of screening and/or screening awareness raising in other community settings • NHSE/PHE working with Local authorities and CCG commissioners and STPs to develop a joint understanding of local population needs leading to a shared set of priorities	NHSE, GP practices, Pharmacies, Jo's Cervical Cancer Charity, CCG Commissioners, STPs CASH providers	March 2018
Implementation of Primary HPV screening following review and rationalisation of laboratory and colposcopy services in line with national guidance	NHSE, PHE, STPs, CCG commissioners, providers	March 2019

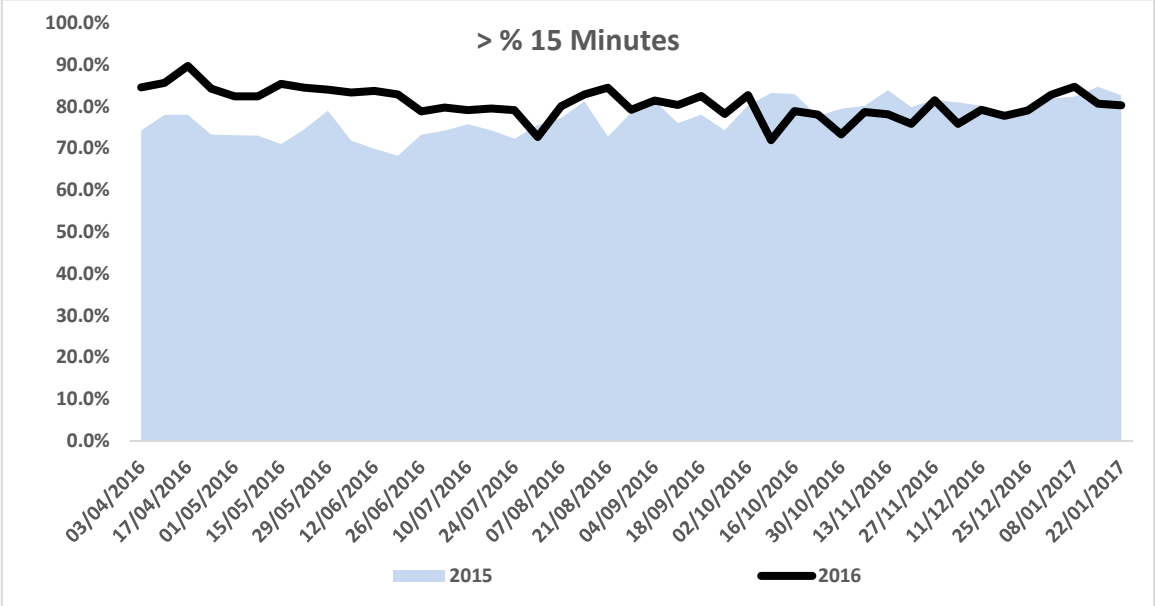
Hospital Handovers in North Central London

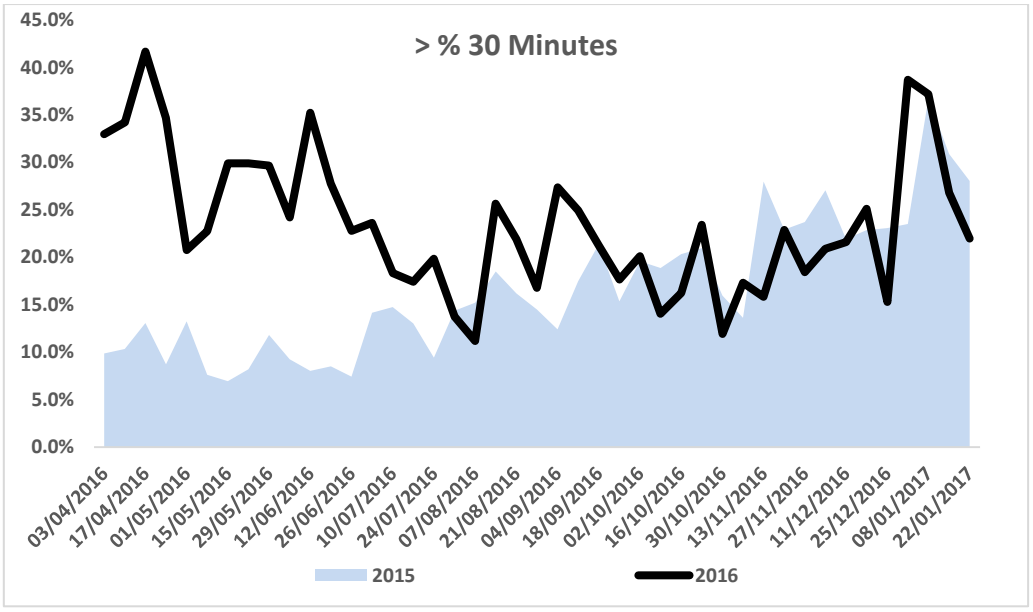
Context: This paper is provided by the London Ambulance Service (LAS) to inform the NCL HOSC of the current position in regard to hospital handover times in North Central London.

Scope: Data is provided for the 2016/17 financial year. The 'target' is that all handovers from ambulance to ED staff be within 15 minutes to allow the release of ambulances to respond to 999 calls.

1) **Barnet General Hospital**



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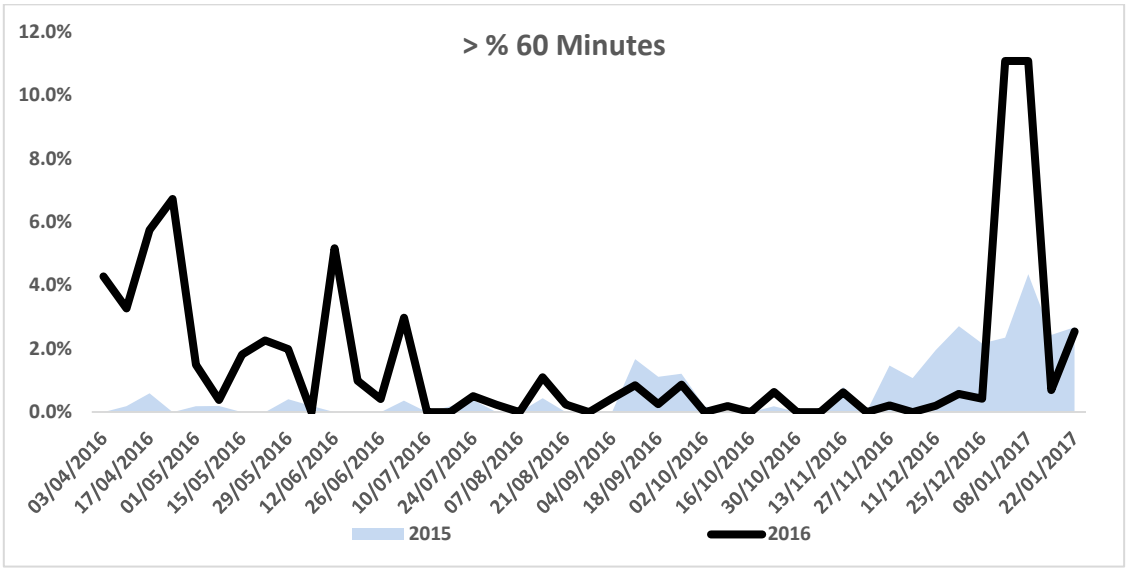
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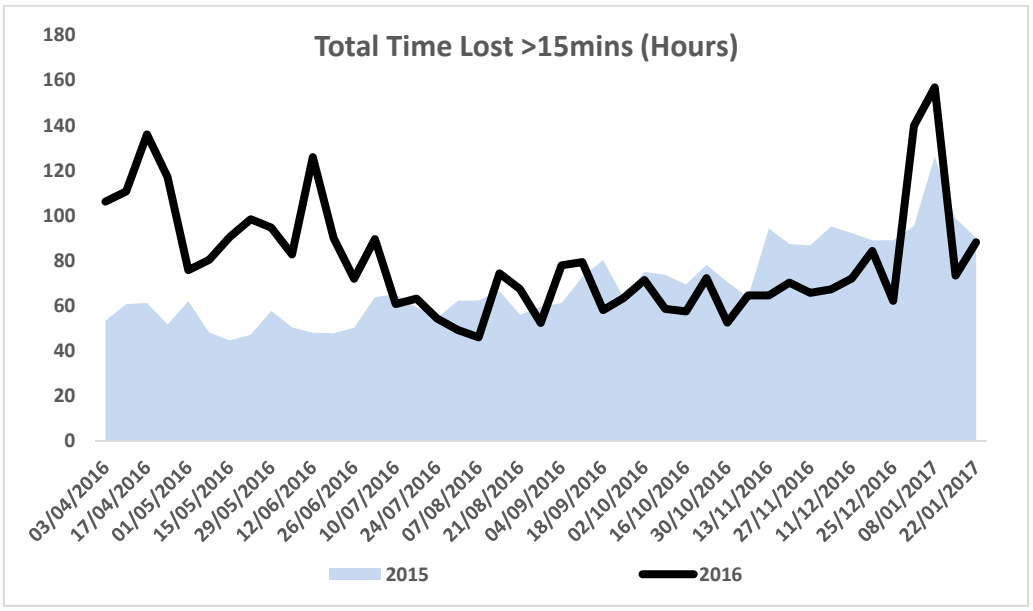
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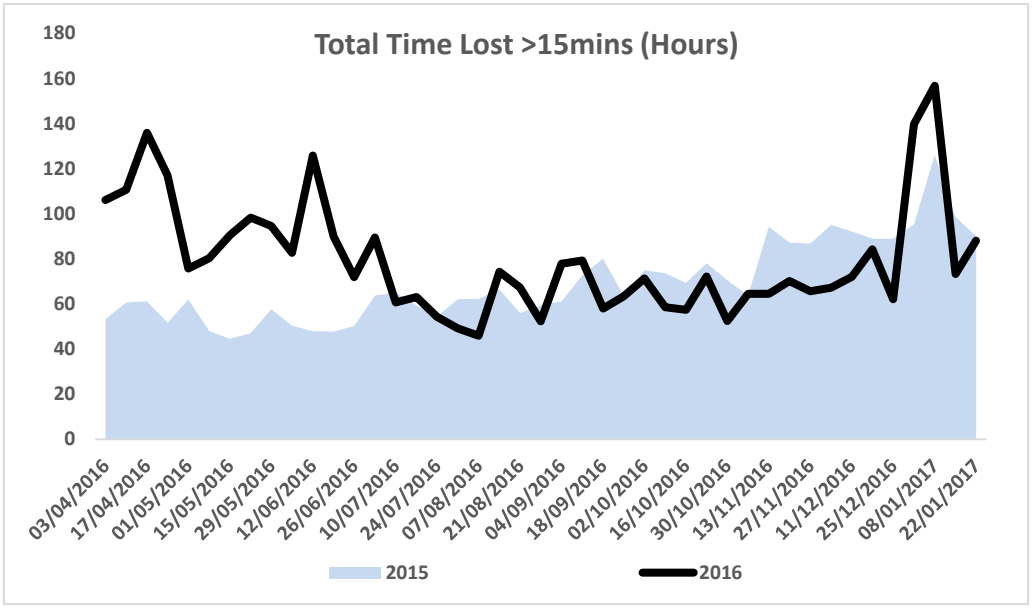
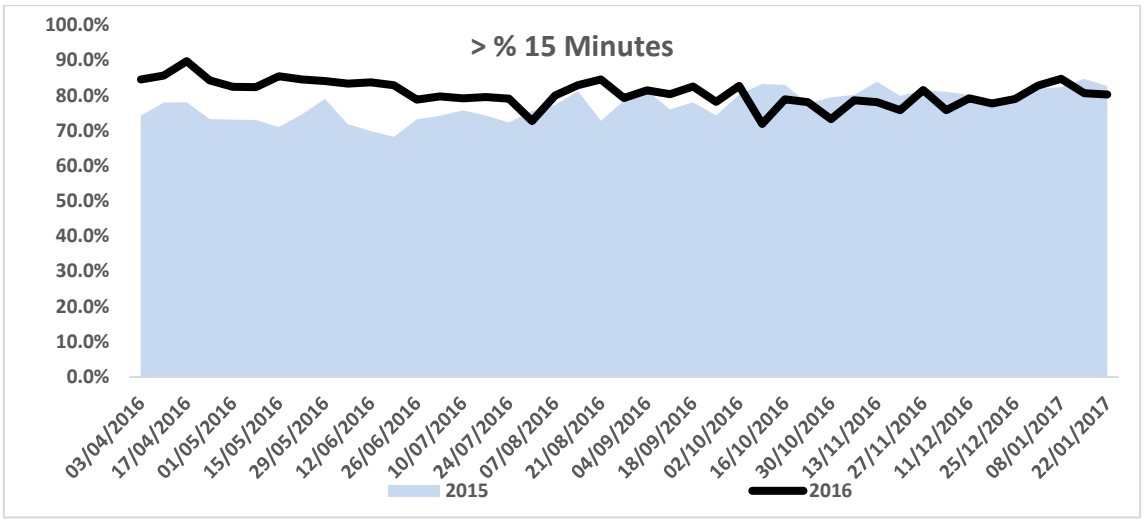
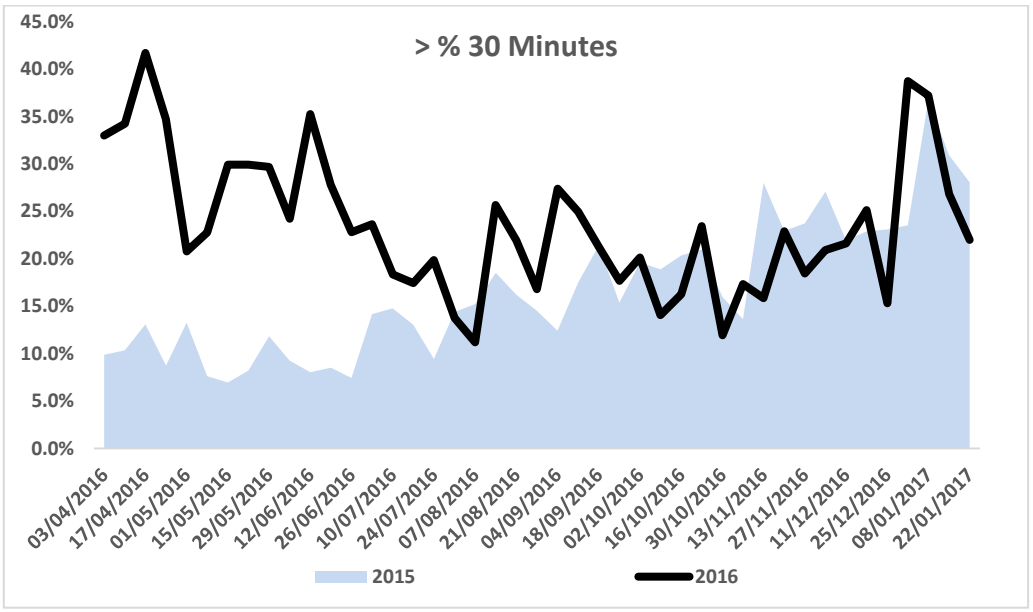
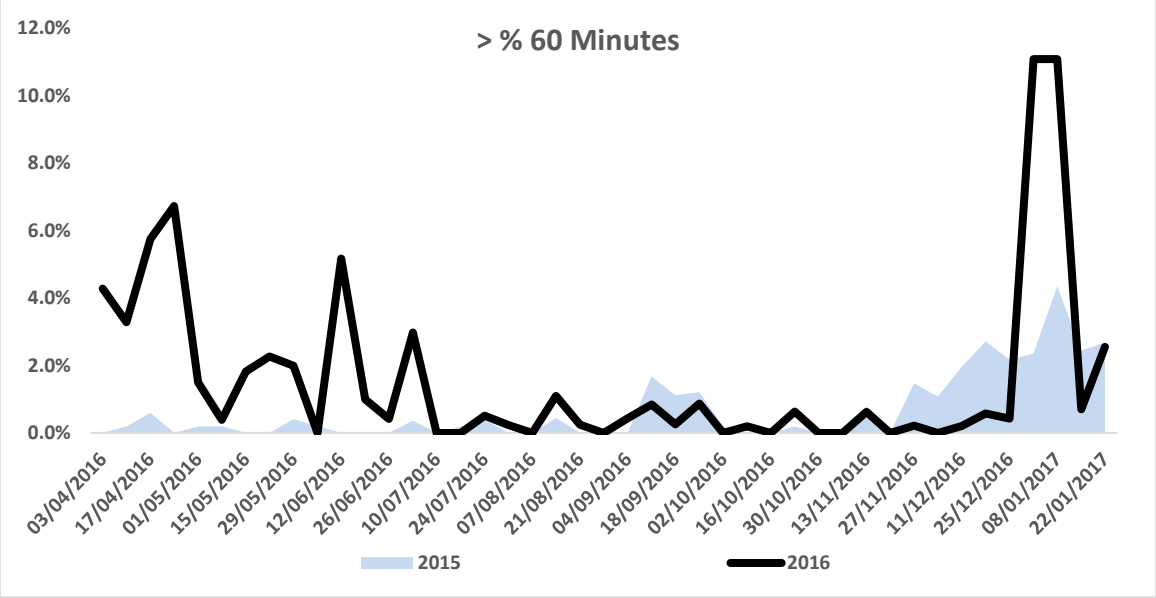
2) The Royal Free Hospital





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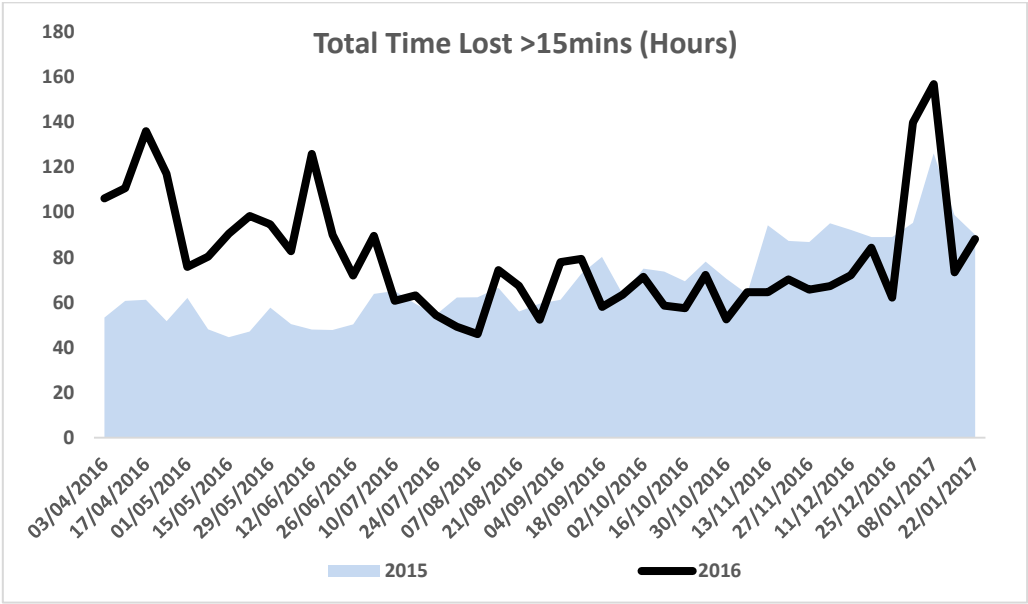
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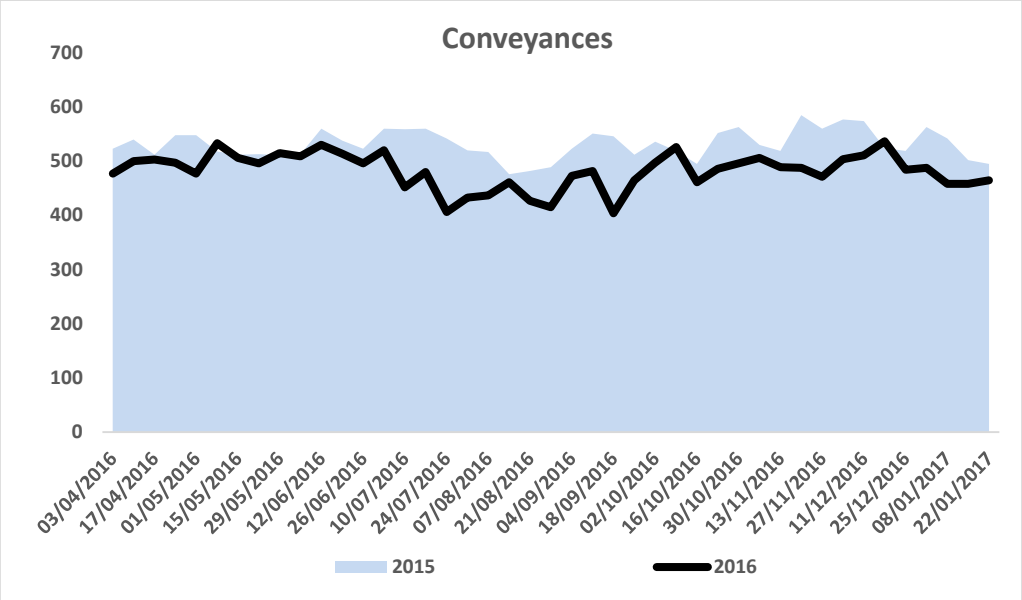
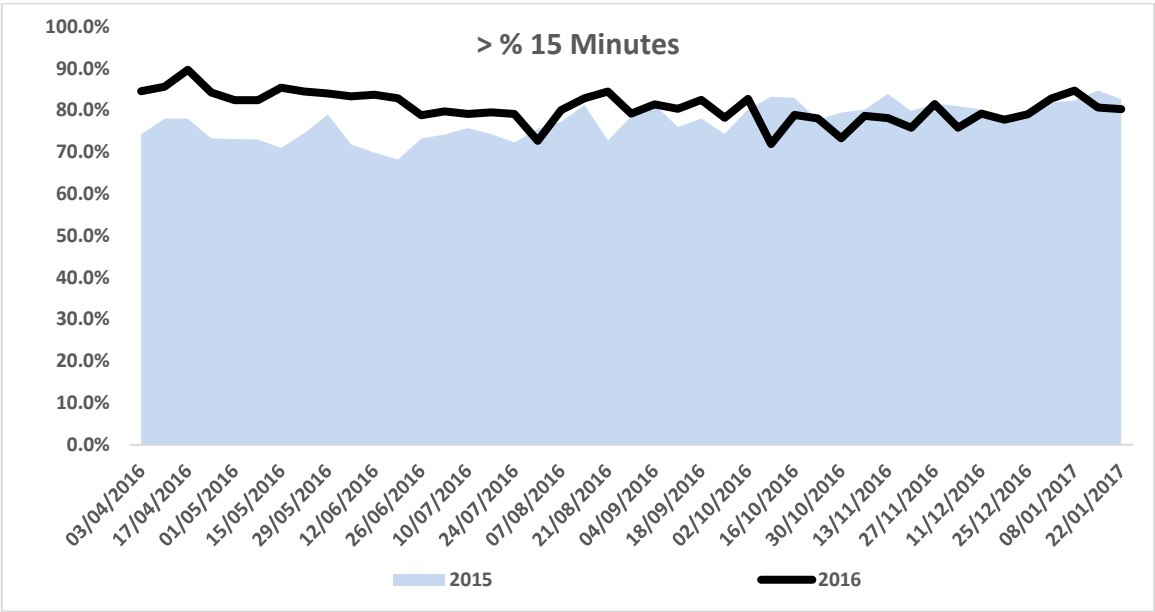
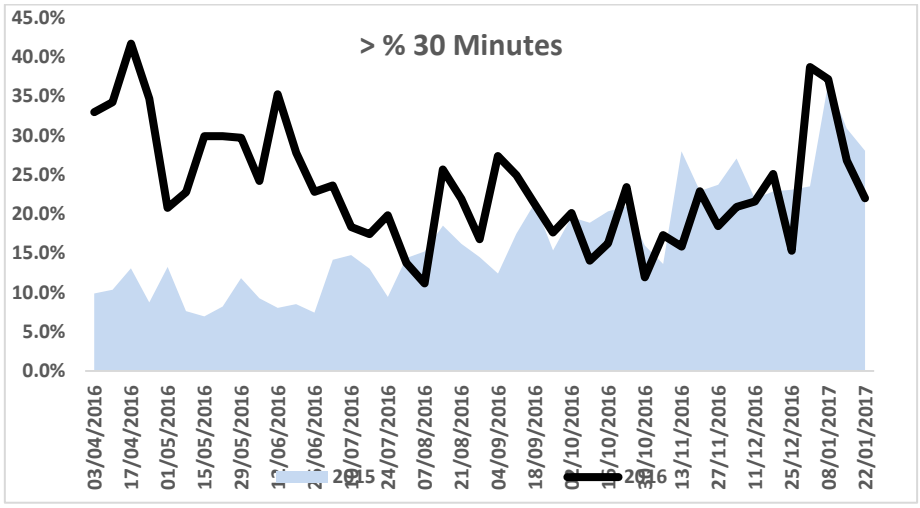
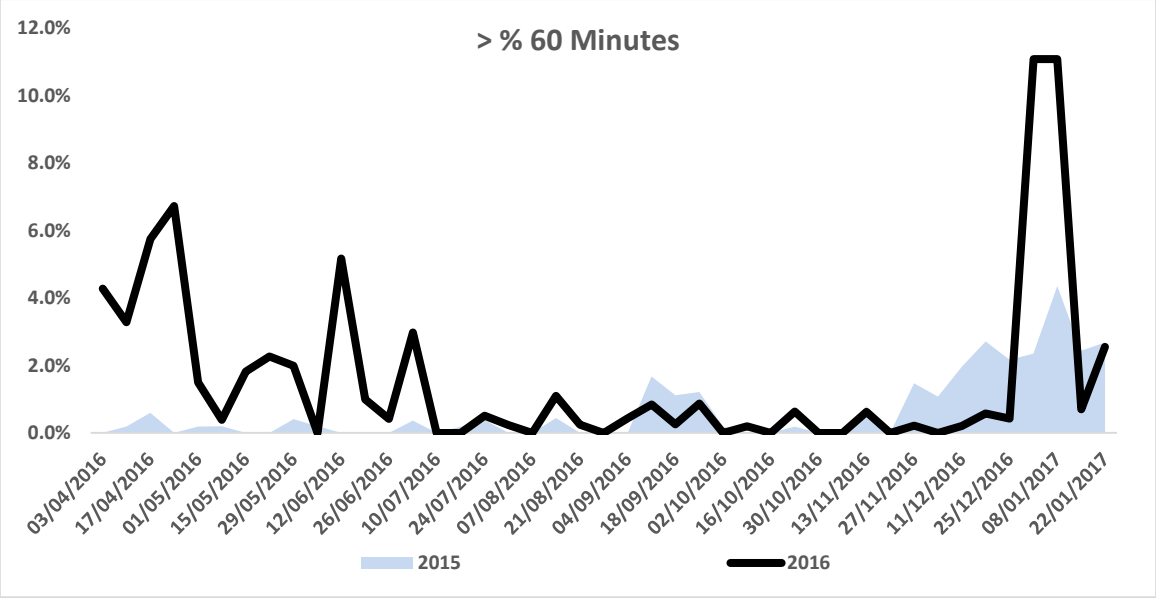
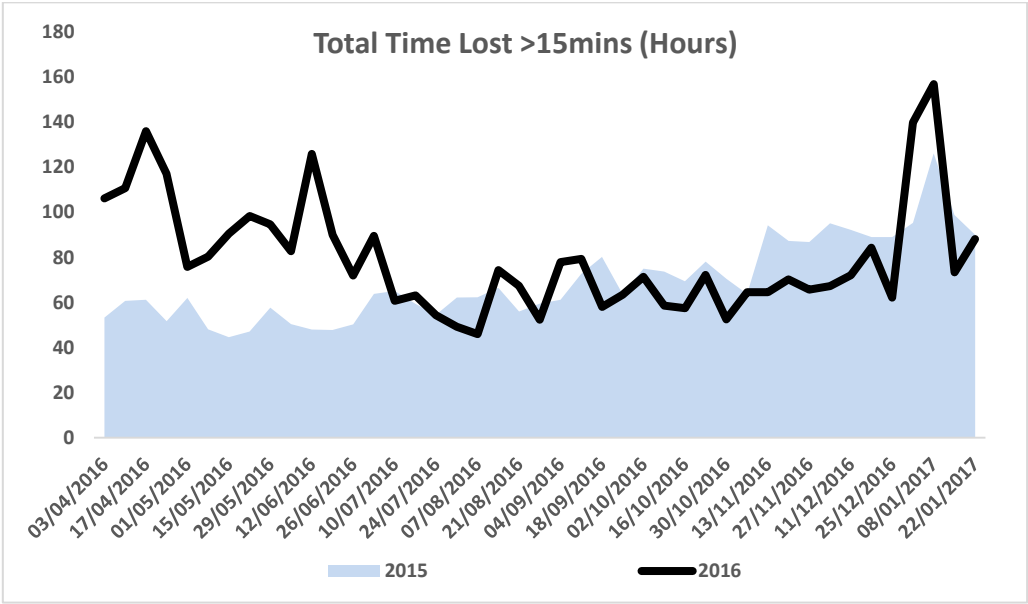
3) North Middlesex Hospital











The LAS are commissioned to provide an 'Intelligent Conveyance' service which aims to smooth flow across Emergency Departments. This system only applies to hospitals in London, and only to the London Ambulance Service, although inbound ambulance numbers from the East of England Ambulance Service (EEAST) are used when moving ambulances away from Barnet General and North Middlesex Hospitals. The net outcome of this may be the disproportionate movement of the LAS ambulances into the Whittington and Royal Free Hospitals.

From Tuesday 24/1/17, the LAS has been providing a Hospital Support Team, made up of five clinicians working to support Barnet General and North Middlesex Hospitals. This team aims to further smooth inbound flow, provide 'cohorting' capacity where needed and provide support to the two Acute Trusts during times of extreme pressure.

Peter Rhodes > 25/1/17

North Central London Joint Health Overview and Scrutiny Committee

Work Planning 2016-17

Future Items

Date of meeting	Potential Items	Lead Organisation
30 September 2016	• Lower Urinary Tract Clinic; Lead – Councillor Martin Klute	Whittington Hospital
	• NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly	CCGs/Local authorities
	• GP provision in Care Homes; Lead – Councillor Abdul Abdullahi	CCGs
	• Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute	Whittington Hospital
25 November 2016	• NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly	CCGs/Local authorities
9 December 2016 *(Special meeting)*	• NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly	CCGs/Local authorities

14 December 2016 *(Special meeting)*	• NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly	CCGs/Local authorities
3 February 2017	• NCL Strategic Transformation Plan Response to Committee's Recommendations	STP PMO
	• Royal Free – Relationship with North Middlesex	Update from Enfield HOSC
	• NHS England Adult Immunising and Screening Annual Report	NHS England
	• LAS Handover procedures and times report	London Ambulance Service
17 March 2017	• Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute	Whittington Hospital
	• Health Tourism at the Royal Free; Lead – Councillor Alison Cornelius	Royal Free
	• Dementia Pathway; Lead – Councillor Graham Old *To report on provision within each borough including relevant statistics and work with acute providers*	CCGs
	• CAMHS; Lead - Councillor Pippa Connor	CCGs

	• NCL Strategic Transformation Programme; Lead – Councillor Alison Kelly *To include governance and transparency*	CCGs/Local authorities
21 April 2017	• Quality Accounts a. Royal Free b. UCLH c. Whittington	Royal Free/UCLH/Whittington

To be arranged:

- Patient safety
- NMUH – Achievement of Foundation Status
- 7 day NHS
- Stop Gap Services (Maternity)
- Sexual Health Services
- UCLH (Lead – Councillor Alison Kelly)

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