Public Document Pack

ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on, **14 September 2015 at 7.30 pm.**

John Lynch
Head of Democratic Services

Enquiries to : Peter Moore
Tel : 020 7527 3252
E-mail : democracy@islington.gov.uk
Despatched : 4 September 2015

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury (Vice-Chair)
Councillor Raphael Andrews
Councillor Osh Gantly
Councillor Mouna Hamitouche MBE
Councillor Gary Heather
Councillor Nurullah Turan
Councillor Tim Nicholls

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Donovan
Councillor Alex Diner
Councillor Jean Roger Kaseki
Councillor Jenny Kay
Councillor Una O'Halloran
Councillor Alice Perry
Councillor Dave Poyser
Councillor Clare Jeapes

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have
a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to **all** members present at the meeting.

3.	Apologies for Absence	
4.	Declaration of Substitute Members	
5.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 6
7.	Chair's Report	

	The Chair will update the Committee on recent events.	
8.	Public Questions	
9.	Health and Wellbeing Board Update - Verbal	
B.	**Items for Decision/Discussion**	**Page**
10.	NHS Trust - Whittington Hospital - Quality Accounts -Presentation	
11.	Hospital Discharges - Presentation	7 - 14
12.	111/Out of Hours Service specification	15 - 36
13.	Scrutiny Review - Health Implications of Damp Properties - Presentation/SID	37 - 48
14.	Work Programme 2015/16	49 - 52

The next meeting of the Health and Care Scrutiny Committee will be on 19 October 2015

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

This page is intentionally left blank

London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 2 July 2015

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Thursday, 2 July 2015 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Andrews, Gantly, Heather, Turan and Nicholls
Also Present:	**Councillors**	Kay and Burgess

Councillor Martin Klute in the Chair

109 **INTRODUCTIONS (ITEM NO. 1)**

The Chair introduced Members and offficers to the Committee

110 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**

Councillors Hamitouche, Chowdhury and Bob Dowd

111 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**

Councillor O'Halloran stated that she was substituting for Councillor Chowdhury

112 **DECLARATIONS OF INTEREST (ITEM NO. 4)**

None

113 **ORDER OF BUSINESS (ITEM NO. 5)**

The Chair stated the items would be dealt with in agenda order

114 **MINUTES (ITEM NO. 6)**

RESOLVED:

That, subject to the following amendments –

Minute 106 – bullet point 10 delete the first sentence and replace with –Islington is the most densely populated UK borough and the 4th. most deprived in the country and has the second highest rate of child poverty

the minutes of the meeting of the Committee held on 19 May be confirmed and the Chair be authorised to sign them

115 **CHAIR'S REPORT (ITEM NO. 7)**

The Chair stated that he had attended the JOHSC meeting that had been held at Islington the previous week. He added that Councillor Alison Kelly of L.B.Camden had been appointed Chair of the JOHSC and that Councillor Pippa Connor of L.B.Haringey and himself had been appointed Vice Chair of the Committee.

Discussion has taken place at the JOHSC on the 111/Out of Hours service retendering and it was agreed that the revised specification should be submitted to the JOHSC as well as the Health and Care Scrutiny Committee.

There had also been a presentation on the Cancer/Cardiology service at UCLH and Barts and that the operations performed had increased by 50%.

The Chair also reported that there is a shortage of DCG vaccines however it had been agreed that 11/12 year olds not vaccinated would receive the vaccine when it became available again.

In addition it had been agreed that Councillor Kaseki would continue as the Council's other representative on the JOHSC rather than Councillor Turan as discussed at the last meeting of the Committee.

The Chair added that he was pleased to report that after lobbying to NHS England he had been able to get them to agree to not closing the Mitchison Road GP practice and that this would now remain open.

The Chair also stated that he had been surprised to learn that some of the GP appointment recommendations had been rejected and he would be discussing the reasons for that and report thereon to the next meeting of the Committee.

116 PUBLIC QUESTIONS (ITEM NO. 8)

The Chair outlined the procedure for public questions and filming and recording of meetings

117 HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)

Councillor Janet Burgess, Executive Member for Health and Social Care was in attendance for this item.

During consideration of the verbal report the following main points were made –

- It was stated that the Mitchison Road practice would stay open as reported earlier and that it would be staffed by interim GP' until April next year when permanent GP' s would hopefully be in place
- There had been £2m funding awarded from the Locality Development Funding
- Commissioning is taking place currently in relation to the Healthwatch contract, the carers contract and housing support services, however it was noted that Care UK had decided not to bid again for the carers contract

The Chair thanked Councillor Burgess for her attendance

118 WHITTINGTON HOSPITAL DEFECIT - VERBAL (ITEM NO. 10)

Simon Pleydell, Chief Executive Whittington NHS Trust and Steve HItchins, Chair of Whittington Trust were present for this item.

During discussion the following main points were made –

- Simon Pleydell stated that he had briefed the Council on the defecit position and that Councillor Convery is a member of the Board
- The position is that there were cost improvements imposed by the Government for 2013/14 and 2014/15 and these targets had not been met
- The cost pressures on the Trust were significant and there was a recurring defecit of £13M and there had been a reduction in income of £9.2M
- There had also been a non-recurring cash income of in excess of £4M and funding had reduced from NHS England
- There had been a reduction in funding for substance misuse and the Trust had lost the contract for Pentonville Prison and the sexual health contract with L,B,Haringey had had its funding reduced by £250000
- A cost improvement plan had been put in place to reduce the defecit and in 2015/16 cost improvements of £15M needed to be made to get to a balanced position in year 3
- The Trust stated that there were also reductions to public health budgets and when bidding for contracts the Trust wished to maintain quality and safety and this must be paramount when determining the viability of bidding for services

- The Trust were now confident that they had in place a senior management team to deal effectively with the cost improvement strategy and all were now permanent members of staff with a vision to make the Trust succeed and be financially sustainable
- The focus was to maintain the repertoire of services currently provided by the Trust and in the community in the face of the cost improvement plans that had to be implemented, however there were risks and work is being carried out with GP's to have more local care
- Whittington has spare capacity to provide more treatment in a number of surgical specialities and it was hoped to attract more women to use the maternity services
- In response to a question it was stated that the annual budget of the Trust is £300M and the underlying defecit problem accounted for approximately 10% of the budget and a target of roughly 5% per cent per year had been set to reduce the defecit and in the longer term a reduction of 2% in the following years
- It was stated that discussions had been held with the Trust Development Agency recognised that there is now a strong management team in place but the Trust needed time to deliver
- The Trust stated that there will need to be redundancies of administrative and clerical staff to make the Trust viable in future, however these would not impact on clinical safety
- In response to a question as to the proposed expansion of the maternity services unit it was stated that a meeting had taken place with the TDA and they wished reassurance that the year 1 cost improvements can be delivered but it was a positive meeting and the Trust continue to be optimistic
- It was stated that opportunities for savings had been identified and in the past it was felt such opportunities had been missed. There is a need to work in partnership with other health colleagues in view also of the reductions in public health budgets in order to enable residents to access services in a different way
- Islington has a relatively young population and there is a need to identify and deliver services needed in a different way and match the Local Authority ambition to focus on prevention and early intervention
- It was stated that discussions had taken place with the Mental Health Trust and the Council as to how mental health services could be delivered more effectively
- The Executive Member Health and Wellbeing stated that the Council were committed to working in partnership with the Whittington Trust despite the reductions from the Government in public health funding
- The Whittington Trust stated that the instability of the 3 year tendering service made it difficult for them to plan long term and it could not continue to deliver cost reductions in these contracts and maintain the quality of service required
- In response to a question it was stated that the turnover rate of staff at the Whittington is 14% compared to 6% in Middlesbrough and this was a reflection of high costs of living and working in London. However a recent recruitment day for nurses had been positive
- Councillor Nicholls stated that the would e mail his questions to the Whittington Trust for response due to shortage of time

The Chair thanked Simon Pleydell and Steve Hitchins for their attendance

119 **CAMDEN AND ISLINGTON NHS QUALITY ACCOUNT REPORT 2015/16 (ITEM NO. 11)**

Clare Johnson and Zoe Fyffe, Camden and Islington Mental Health Trust and David Barry, Lead Governor Camden and Islington Mental Health Trust were present for discussion of this item.

During discussion of the report the following main points were made –

- The Trust had appointed a local security management specialist, work is taking place with the Police and the use of drug search teams and with support staff to look at the lifestyles of patients at risk and significant progress is being made
- The Trust exceeded the target of less than 20% of all patients having an admission over 100 days
- The Lead Governor stated that Governors were satisfied that items identified previously were being addressed. Governors were also satisfied that there is no causal link between the Trust and suicides and progress had been made on service users experience and on having a smoke free environment
- There were however difficulties in getting patients who were under stress to give up smoking but the connection between mental health problems and smoking did need to be addressed. In addition it was time consuming for staff to have to take patients out to smoke
- In response to a question it was stated that there is still work to do with regard to readmissions. Part of the problem is the need to support patients with their medication as patients are often readmitted as they had failed to take their medication or not taken it properly
- There is a follow up on patient discharge within 72 hours and at 7 days and it is important to ensure plans were in place with support services
- The Chair of the Trust is focusing on any gaps in response times to complaints
- The Trust had met with the CQC as regards to their proposals for ligature assessment and these had been accepted. There had been significant investment by the Trust of £4.5M although space was limited as a part of the site had been sold off
- There had been two in patient suicides in the last 12 months
- There had been a Care Academy established with Middlesex University to provide training for nursing staff and the employment of practice development in order to help assess risks
- The priorities for 2014/15 were patient safety and clinical effectiveness, working with other providers, stopping smoking and substance misuse and patient experiences

The Chair thanked Clare Johnson, David Barry and Zoe Fyffe for attending

120 **QUALITY ACCOUNTS PRESENTATION V1 (ITEM NO. 12)**

121 **DRUG AND ALCOHOL MISUSE ANNUAL UPDATE (ITEM NO. 13)**

Charlotte Ashton and Emma Stubbs, Islington Public Health were present and outlined the report and made a presentation thereon.

During consideration of the report the following main points were made –

- The total public health budget is £6.5M and approximately 20-25% is spent on substance misuse
- Consideration is being given as to how to improve services with a reduced budget
- In response to a question it was stated that 16% of drug users successfully completed treatment however there is a higher percentage of users who are functioning normally on methadone or opiate substitutes

- It was stated that work is being undertaken to target early intervention with schools and youth clubs
- A Member enquired the levels of safe drinking and that the public health message given out is often confusing. It was stated that there is a risk of hospitalisation as a result of binge drinking where accidents and fights occur as a result and lower levels of drinking do present an increased risk
- Work is being carried out with GP's and other organisations to deliver an effective substance misuse message and there were discussions taking place with the Whittington and GP's in relation to the effect of drinking and sexual health

The Chair thanked Charlotte Ashton and Emma Stubbs for attending

122 **ISLINGTON HEALTHWATCH ANNUAL REPORT (ITEM NO. 14)**

Emma Whitby, Islington Healthwatch, was present and outlined the report. The final version of the report was laid round for Members.

During consideration of the report the following main points were made –

- It was noted that there is a 2 page summary of the report now available and that Healthwatch would provide copies for Members of the Committee
- The Healthwatch tendering process will shortly take place – this will be a 2 year contract with a possible extension for a third year and the contract is funded by the Department of Health through the Local Authority
- Outreach work had taken place at Chapel Market and whilst there had been attempts to engage residents at different venues this had so far not proved very successful, however consideration is being given to using other venues such as the Whittington Hospital or Health Centres
- Members expressed the view that consideration should be given to engaging residents at ward partnership meetings and Healthwatch indicated that if details were sent to them they would consider this
- Healthwatch indicated that it was important that they worked with the Council and the co-option of Bob Dowd on the Committee assisted this
- Healthwatch stated that they had a good retention of volunteers with a good local knowledge of health services
- A copy of the leaflet detailing recent work Healthwatch had undertaken on complaints was circulated to Members

The Chair thanked Emma Whitby for attending

123 **SCRUTINY REVIEW HEALTH IMPACT OF DAMP HOUSING CONDITIONS - APPROVAL OF SID - TO FOLLOW (ITEM NO. 15)**

A copy of the draft SID was circulated for Members approval.

RESOLVED:

That, subject to the following amendments –

124 **WORK PROGRAMME 2015/16 (ITEM NO. 16)**

RESOLVED:

That the report be noted

The meeting ended at 10.10p.m.

Chair

University College London Hospitals NHS
NHS Foundation Trust

uclh

UCLH

Dr Jonathan Fielden *Medical Director (Medicine)*
UCLH

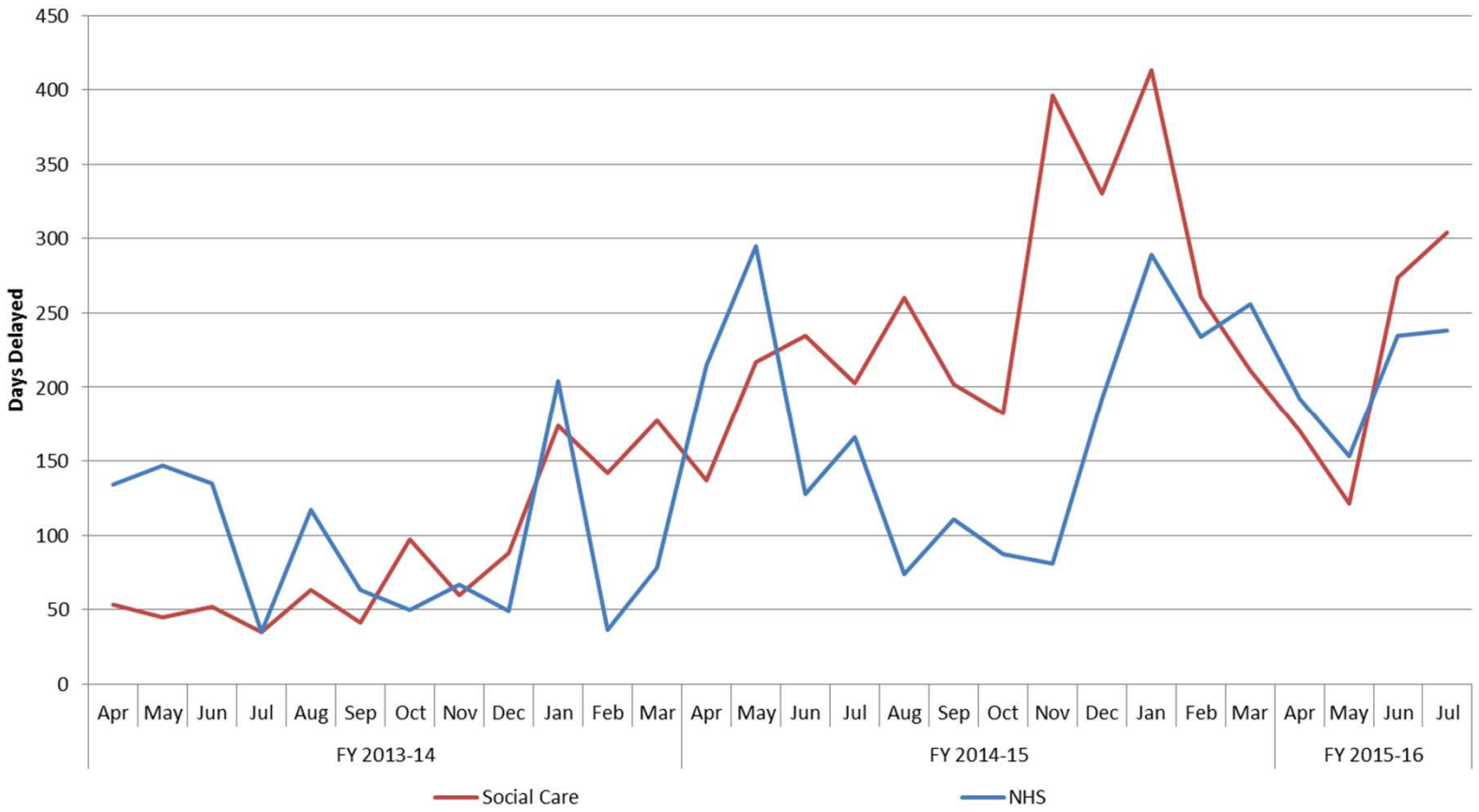
Hospital discharges

– focus on Islington Delayed Transfers of Care

Summary

- **Purpose:**
  - to highlight the trend and issues related to delayed hospital discharges
- **Recommendations:**
  - Islington review and implement agreed changes to their social care support to reverse current trends in increasing delays
  - UCLH and Islington continue positive working relationships to further eliminate delays for patients
- **What success looks like:**
  - no patient stays in an acute hospital bed awaiting social care support/placement

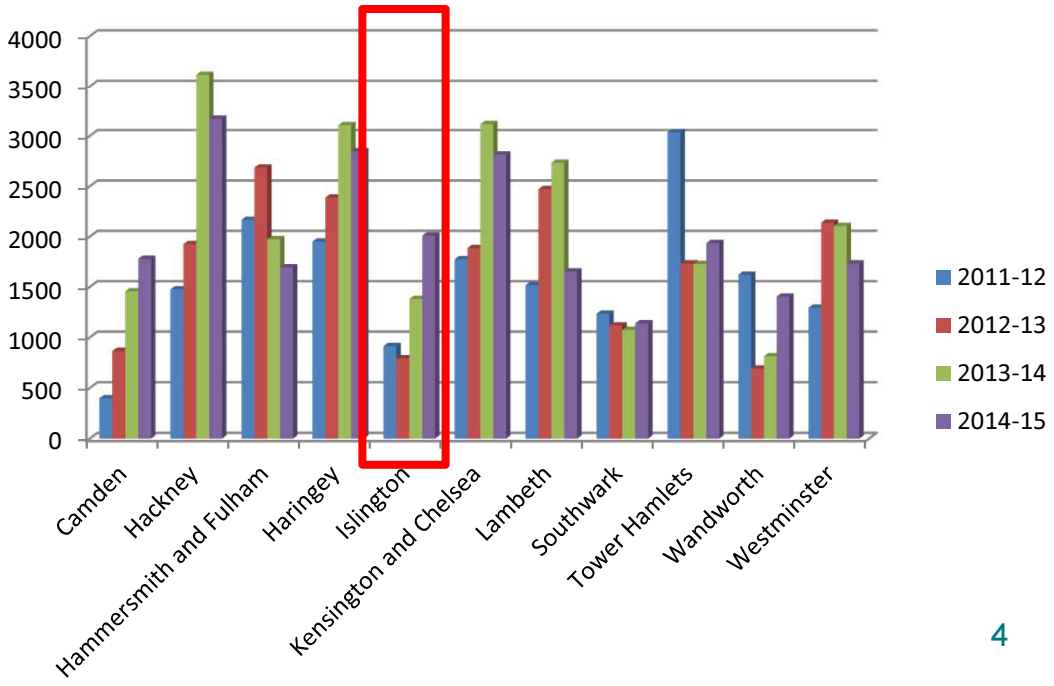
Delayed Transfers of Care – NHS and Social Care Delays

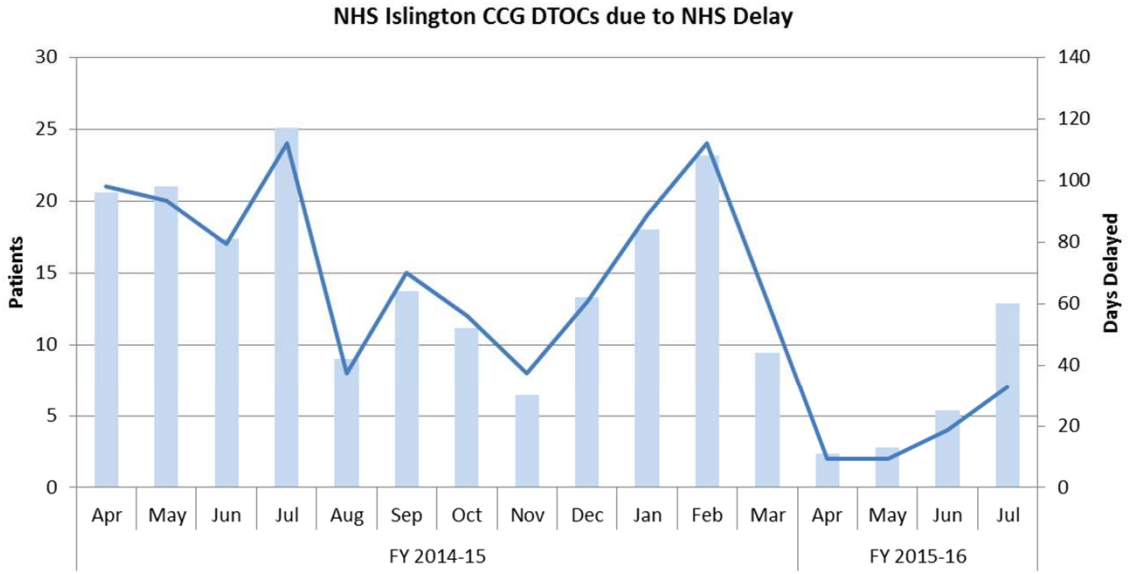


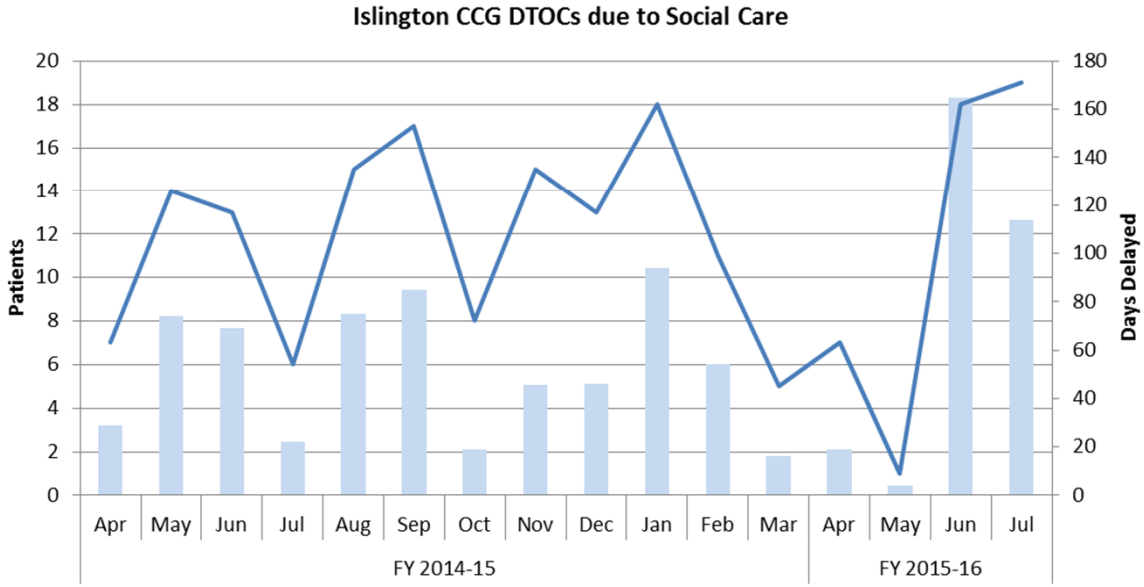
uclh

Delayed Transfer of Care per 100,000 population cf demographic neighbours

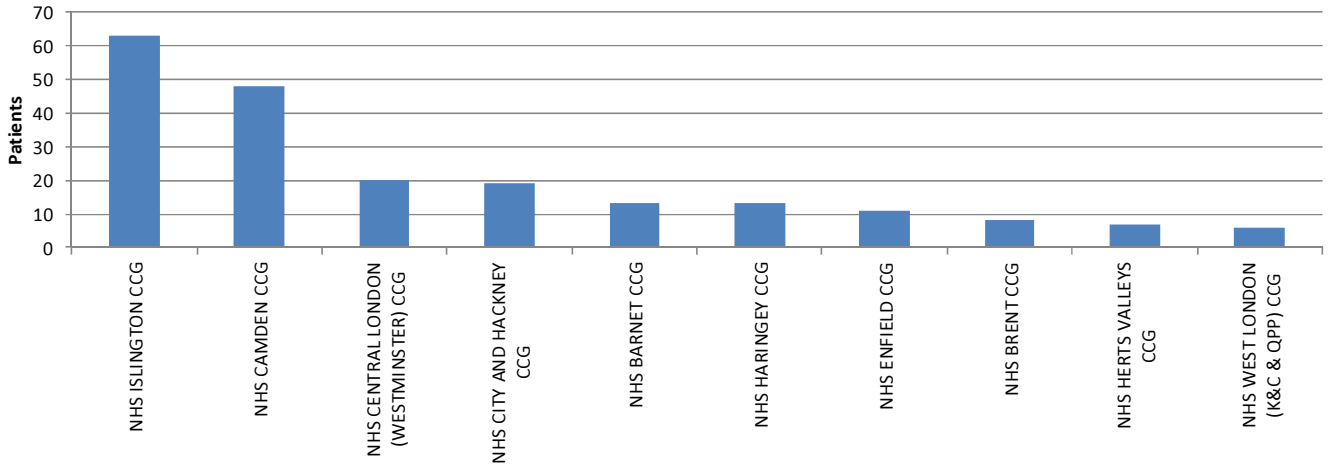
FY	CAMDEN	HACKNEY	HAMMERSMITH AND FULHAM	HARINGEY	ISLINGTON	KENSINGTON AND CHELSEA	LAMBETH	SOUTHWARK	TOWER HAMLETS	WANDSWORTH	WESTMINSTER
2011-12	398.9	1476	2166	1952	914.5	1775	1518	1235	3038	1622	1293
2012-13	866.7	1925	2685	2388	793.3	1887	2472	1118	1733	692.5	2138
2013-14	1457	3616	1974	3106	1380	3117	2734	1074	1728	813.9	2106
2014-15	1779	3171	1696	2849	2010	2816	1653	1140	1936	1405	1733
4 year Average	1126	2547	2130	2574	1275	2399	2094	1142	2109	1134	1818

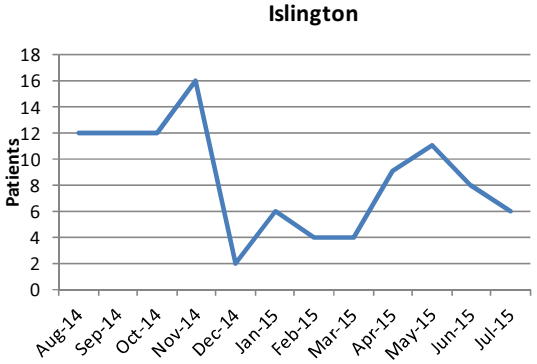


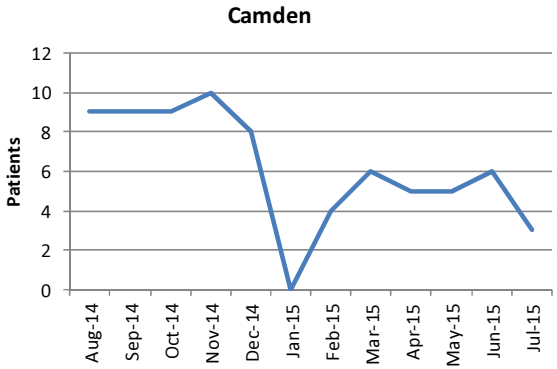

NHS Islington CCG DTOCs due to NHS Delay
Patients
Days Delayed
0
5
10
15
20
25
30
0
20
40
60
80
100
120
140
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
FY 2014-15
FY 2015-16

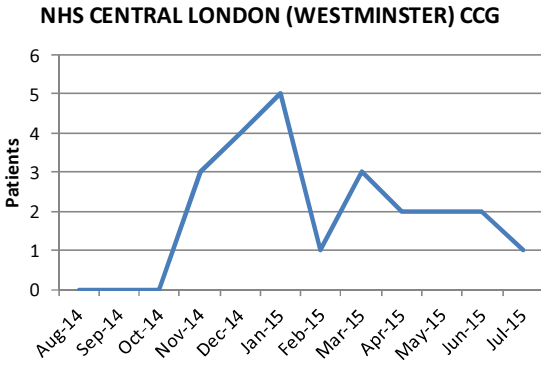

Islington CCG DTOCs due to Social Care
Patients
Days Delayed
0
2
4
6
8
10
12
14
16
18
20
0
20
40
60
80
100
120
140
160
180
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
FY 2014-15
FY 2015-16

UCLH@Home - Top 10 CCG's Since Service Start (August 2014)









Work so far

- Clinical team and “pathway” work to expedite patient care and discharge at the earliest safe point for patients.
- Utilising ambulatory care models to avoid admission and facilitate discharge.
- UCLH@Home
- Development of Integrated Discharge Service to support the discharge planning
- Daily reports sent to Adult Social Care of all admitted patients to provide earlier knowledge than Section 2
- Daily reports with a Section 5 in place to provide information on potential discharges
- Early escalation of any delays (process agreed)
- Initial Islington DTOC meeting
- 7 day Social work cover is provided at weekends by Camden BCF
- Social Workers are attending ward MDTs

Areas to improve

- Increase re-ablement capacity for weekend discharges
- Prompt assessment by Community Social Workers
- Intermediate bed capacity
  - Jubilee Ward currently run by UCLH
- Increased capacity of Home Care providers (covered by UCLH@Home)
- Whole system coordinator
  - (Camden have this in place with good effect)
- Out of panel agreement for NHS delays (continuing care)
  - Currently have to wait for weekly panel, unlike Camden

NHS
Islington
Clinical Commissioning Group

MEETING:	Islington Health and Scrutiny Committee
DATE:	14 September 2015
TITLE:	NHS111/GP Out of Hours procurement update
AUTHOR:	Kath McClinton
CONTACT DETAILS:	kathmcclinton@nhs.net 020 3688 2921

1. Purpose of the report

This report provides the Committee with an update on the procurement of an integrated NHS111/GP out of hours service across the North Central London area; an update on national developments and sets out the next key steps in the procurement process

2. Recommendations to the Scrutiny Committee

The Scrutiny Committee is asked to NOTE this update and continues to be invited to comment on the procurement process.

3. Intended impact of the report

The intention of the report is to keep one of the CCG's key stakeholders informed and engaged throughout this complex procurement process and continue to maintain transparency on the work of the CCG.

4. Contribution by community partners to the report

There has been extensive engagement and discussion with community groups and partners over the last two and a half years, initially through the urgent care review and subsequently through the local engagement undertaken on the clinical model for integrating NHS111 with GP Out of Hours. Most of this work has been reported to the Committee already, most recently in May this year.

The Patient Reference Group, which was established in April 2015, continues to meet regularly and has provided comments and input into the service specification development. Members of the group will take a full part in the procurement process through evaluating bids and contributing to the decision making in selecting the new service provider. Four Islington residents sit on this group.

5. Contribution by professional partners to the report

The development of the service specification has been led by clinical leaders across the five CCGs. Locally the draft service specification has been reviewed and commented on by primary care clinical leads across the borough, led by Dr Jo

Sauvage and Dr David Davies; both local GPs in Islington. Final approval of the service specification will be through the Governing Body of the CCG.

6. Key issues, challenges and risks and their management

There has been a delay to the timetable as set out to the Committee earlier in the year which has meant that we are not yet in a position to bring the final service specification to the Committee, as intended, at this stage.

All CCGs received a letter from Dame Barbara Hakin, Director of Commissioning Development at NHS England in early July 2016 setting out the national expectations for NHS111 and GP Out of Hours services. The letter is appended to this report (Appendix 1). The direction of travel indicated in the letter is that services should be commissioned as an integrated model; that they should be commissioned across a wider geographical footprint than single CCGs and that collaboration between providers within a lead provider arrangement is encouraged. This national guidance is in line with the preferred approach being taken by the five CCGs in north central London. All NHS111 and GP Out of Hours procurements nationally have been suspended pending the release of revised commissioning standards for integrated services. These are expected at the end of September although we do not anticipate this to significantly alter our intentions or plans as they are already congruent with national thinking.

A further period of engagement was undertaken during July, restating the CCG's case for commissioning the integrated service across North Central London. There was a low response rate to this engagement with 28 responses received across the five boroughs. There are obvious limitations in the data in view of the sample size but a report outlining the engagement and summarising the responses is attached as Appendix 2 for those Members interested in the detail. It is important to note that this was the latest phase of a long period of engagement on our plans. Committee members will remember receiving a report in May this year, outlining the extensive engagement undertaken in Islington which included open meetings, targeted meetings with specific user groups as well as an on-line survey.

Whilst we await the publication of the national standards the development of the Service Specification continues. The draft specification has been widely circulated for comment. In order to encourage as many responses as possible the period for commenting has been extended to 19 August. The document is available on the CCG website, along with information about how to comment. A further version of the specification will be developed following this engagement period and is likely to be available for final approval later in September, subject to any amendments necessary following the publication of the national guidance.

A second market event was held on 5 August, to talk to interested bidders about the service model and how it will fit in the local system. There is interest from a wide range of providers including GP collaborative organisations, NHS Trusts, social enterprises and the private sector with more than 20 separate organisations attending the event. As the Committee is aware, we are especially looking for potential providers to demonstrate how they would work together to deliver an integrated service and we know that providers are already looking at ways to work together.

7. Intended impact on reducing inequalities and improving health, wellbeing and value for money

As previously reported to the Committee the integrated NHS111 and GP Out of Hours service will have a range of health benefits for individual patients as well as supporting improvements in the wider urgent health care system. Patients accessing the service are more likely to be seen by the right clinician earlier in the process; there will be fewer transfers between services as people progress through the system; there will be improved equity of access to out of hours services across North Central London and individuals should only have to give their information once. The use of different healthcare professionals in the service model, combined with more timely access to a GP will support the urgent care system, individuals will be directed to the most appropriate service that meets their medical needs and should mean that they are less likely to have to wait around at a busy A&E. These changes will significantly benefit families with young children and people living with long term conditions in Islington; two groups we know are regular users of the current NHS111 and GP Out of Hours service.

8. Legal implications

In relation to the procurement for the integrated NHS111/GP Out of Hours Service the CCG is required to abide by the relevant legislations that govern the award of contracts, specifically EU Procurement Regulations and Public Contract Regulations. We continue to take advice on this complex procurement from North East London Commissioning Support Unit.

9. Resource implications

None in relation to this report.

10. What success looks like, measuring success and targets

The finalisation of the service specification will be the successful outcome of this stage of the procurement process. As indicated, we hope this will be later in September although it is partially determined by the release of the national guidance. We will ensure that the Committee receive the final version of the service specification.

11. Next steps, next month, six months and a year

Key dates in the current timetable are as follows:

- September 2016 – service specification finalised
- October 2015 – procurement starts
- March 2016 – procurement ends
- April 2016 – contract awarded to successful provider
- October 2016 – new service starts, allowing 6 months for smooth transition

This page is intentionally left blank

Our Ref: BH/2015/253

Publications Gateway Ref. No. 03568

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

Email : england.nhs111@nhs.net

To:
CCG Accountable Officers
CCG Clinical Leaders

Cc:
Regional Directors
General Practitioner Committee
Royal College of General Practitioners
NHS Alliance
NHS 111 Clinical Leads – Regional and Local
NHS 111 Providers

3 July 2015

Dear Colleague

Commissioning a Functionally Integrated Urgent Care Access, Treatment and Clinical Advice Service

As you will be aware, over last winter local health services responded to the highest ever number of NHS 111 calls, ambulance calls, A&E attendances and emergency admissions in NHS history. The NHS and its staff responded magnificently to these difficult circumstances and worked tirelessly to find solutions.

However, far too often the arrangements for access into urgent and emergency care are confusing for patients and professionals alike. It is clear that we need a fundamental redesign of the NHS urgent care 'front door': A&E; GPs; 999; NHS 111; Primary Medical Care Out of Hours (OOH); community; and social care services, as part of the broader programme of care transformation set out in Sir Bruce Keogh's Urgent and Emergency Care Review and later in the NHS Five Year Forward View. I wrote to NHS 111 commissioners earlier this year [1] to outline how they could begin this redesign by using the work completed as part of the NHS 111 Learning and Development Programme to introduce greater clinical input to managing NHS 111 calls.

[1] Publications Gateway Reference No.02919

The current position

Around the country, commissioners have adopted a range of models for the provision of NHS 111, OOH and urgent care services in the community. In some areas a more comprehensive model of integration has been implemented. More often, however, there are separate working arrangements between NHS 111 and OOH services, and a lack of interconnectivity with community, emergency departments and ambulance services. This position is entirely understandable given the way that primary care, OOH and NHS 111 policy has evolved; but it no longer fully meets the needs of patients or health professionals.

This letter builds on the recommendations in my earlier correspondence and outlines the steps that commissioners should consider in relation to an essential part of this transformation: a functionally integrated 24/7 urgent care access, treatment and clinical advice service (incorporating NHS 111 and OOH services), referred to here as an **integrated service**.

New Commissioning Standards for an Integrated Service

It will be imperative that we work together on the new clinical model and commissioning standards for the integrated service and do so in close collaboration with key stakeholders. We will build upon the existing commissioning standards for NHS 111 by including further important elements from the NHS 111 Learning and Development Programme, the wider Urgent and Emergency Care Review and by taking into account the standards that OOH providers are required to meet.

There will be widespread engagement on these components prior to the publication of a revised set of commissioning standards and associated procurement guidance (with due consideration of Patient Choice and Competition Regulations) by the end of September 2015. NHS England will be holding a number of workshops in each region over the next three months, which will offer an opportunity for you and to your organisation to input into the design of this new service.

Workshops will be held on:

- South: 23 July.
- North: 14 July and 11 August.
- London: 7 August.
- Midlands and East: 24 August, 25 August and 21 September.

Annex One provides some early thoughts on the additional components of the service to be included in the commissioning standards. Clearly, these are important changes to the way services are currently delivered, requiring a significant change management programme.

Further procurements of NHS 111 and OOH services should be suspended (whatever stage of the procurement has been reached) until the end of September, to allow completion of the consultation and the release of the revised commissioning standards and supporting procurement advice for integrated services. If the suspension in service procurement will cause contractual or service difficulties, please discuss this with your local NHS England Director of Commissioning Operations.

Developing a Lead Commissioner arrangement

At present the core NHS 111 Service is specified nationally through published commissioning standards so that a consistent identity and quality of service is maintained across the country. The service is then commissioned locally by CCGs in a way that is most appropriate for a given area. The responsibility for commissioning OOH has been delegated to CCGs since 2013. Where practices remain opted in, CCGs are responsible for assuring the quality of OOH services provided. These arrangements have led to a number of providers holding multiple contracts for NHS 111 and OOH services for different CCGs.

The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service. This has been shown in a number of areas to be an effective model for engaging with providers (particularly those that deliver services over an area covering a number of CCGs) and to effect strategic change. The Urgent and Emergency Care Review envisages that an area covered by an Urgent and Emergency Care Network will, in most cases, be the most appropriate level for agreeing how a service such as an integrated service should be commissioned.[2]

Developing a Collaborative Provider arrangement

The current provider system is characterised by a range of provider organisational types, with a wide range of services provided, across a mix of geographical footprints with variation in investment levels.

Commissioners should continue to promote a healthy and diverse provider market. Both larger and smaller providers will have an important part to play in delivering a successful and integrated service. However, to achieve integration and the revised commissioning standards, providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage NHS 111 and OOH organisations to collaborate or work within a lead provider arrangement, to deliver the specification for the integrated service.

[2] Urgent and Emergency Care Networks will improve the consistency and quality of urgent and emergency care by bringing together System Resilience Groups (SRGs) and other stakeholders to address challenges in the urgent and emergency care system that are difficult for single SRGs to address in isolation. This will include co-ordinating, integrating and overseeing care, and setting shared objectives for the Network where there is clear advantage in achieving commonality for delivery of efficient patient care. Again we will test this through our engagement process, as is understood that there are a range of local factors that will need to be taken into account.

In doing so, commissioners will need to ensure that the current provider market continues to be developed and is not destabilised in any way. There should be ample opportunity for any willing provider to meet the new service specification in collaboration with other providers. To be clear, NHS England has no expectation that any organisation should merge.

In some localities OOH services are retained or sub-contracted directly by general practice. Commissioners will need to engage with those practices as part of this process in order to best achieve the aims of an integrated service.

Elements of the contractual change

The 2015/16 NHS Standard Contract has been adapted for use for NHS 111 services and must be used for any NHS 111 contracts resulting from current or future procurements. Where NHS 111 and OOH services are being procured from the same provider, this may be contractually accommodated by inclusion of Schedule 2L of the NHS Standard Contract (Provisions Applicable to Primary Care Services), which has the effect of making the contract compliant with the APMS Directions. We will consider with the NHS Standard Contract Team whether any further amendments are needed to the Contract for 2016/17, to ensure that it remains fit for purpose for use in NHS 111/ OOH procurements.

In undertaking this work, we will also ensure that local NHS standard contracts reflect the aspiration for a co-ordinated and consistent payment approach across all parts of the urgent and emergency care system. This will ensure providers are incentivised in three ways to deliver the best possible services:

- Capacity: core (to cover fixed in-year costs to reflect the “always on” nature of urgent care services);
- Volume: variable demand; and
- Quality: core.

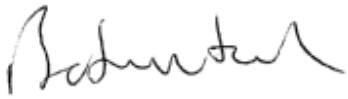
An Integrated Service - action by all NHS 111 and OOH commissioners

It is acknowledged that moving to this new position from where we are now will be complex. However, commissioners should, over a period of time, be able to move all existing contracts towards the new model and to improve patient care and service efficiency as a consequence.

Given this complexity, and acknowledging that there is more work to be done together on the detailed design of an integrated service, the necessary contractual changes and financial modelling, it is important that commissioners and providers have the opportunity to consider these changes and to attend the regional workshops. This time can also be used to develop local plans for achieving integrated services.

The changes outlined in this letter are complex, requiring organisational and cultural change. However, it is an important step that we need to take, working together to achieve consistently high standards for patients across the country.

Yours faithfully



Dame Barbara Hakin
National Director: Commissioning Operations

Annex One – A new service specification for an Integrated Service

Sir Bruce Keogh's Urgent Care Review, and more recently, the Five Year Forward View, both advocate a fundamental redesign of the urgent care 'front door' - including a more coherent 'all hours' telephone, 'consult and treatment' and clinical advice service for patients and health professionals alike. We now have an opportunity to begin the implementation of this vision and the first step is to set out, or 'specify' the key components of such a service.

At present, the NHS 111 Commissioning Standards (available at http://www.england.nhs.uk/wp-content/uploads/2014/06/nhs111-coms-stand.pdf) describes the core requirements and standards for the NHS 111 service and repeats that commissioners may wish to enhance and add to these requirements to ensure that local specifications for NHS 111 are comprehensive and appropriate for their local area.

In addition the National Quality Requirements (NQRs) specify how local OOH services should be performance assessed by local commissioners (available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271

This annex does not rehearse the current commissioning standards again for NHS 111 or OOH but instead proposes components of a new service specification that should be applied by local commissioners to initially provide a fully integrated service. This new service specification for call handling and 'consult and treatment' services would also allow commissioners to specify a further enhancement – namely a 24/7urgent care clinical advice service - 'hub'. If the service is commissioned in this way it would move us away from the rather outdated notion of 'in' and 'out-of-hours' services.

In addition to the current, core components of the commissioning standards, as part of the review of those standards we will be consulting on the appropriateness of the following enhancements:

- At the heart of the integrated urgent care system will be a 24/7 NHS 111 access line working together with 'all hours' primary care services;
- Patients will normally speak first to a call advisor who will use the clinical decision support system to triage symptoms. Complex patients needing to speak to a clinician will be identified quickly and receive a clinical assessment following direct "warm" transfer;
- To ensure a more comprehensive 24/7urgent care access, treatment and clinical advice service, commissioners should also provide access to a wider range of clinical expertise. This will include GPs, pharmacists, mental health workers and dental nurses. Clinical expertise may be available within NHS111 call centres, or accessed by direct transfer to a 'clinical hub'. Patient experience will be enhanced by the early identification of calls that would benefit from access to this level of clinical expertise e.g. dental pain.
- All providers, or combination of providers, must commit to adherence with the Commissioning Standards and contractual framework.
- Special Patient Notes, including End-of-Life Care Plans, will be available at the point in the patient pathway which ensures appropriate care. In addition, patient records including the Summary Care Record will be available to all clinicians.

- Patients who are assessed as needing to see a GP will, in time, be directly booked into the patient's own surgery, or, increasingly as networks and federations of GP practices develop, be offered an alternative practice-based appointment within the GP network. Alternative options include home visit or appointment at an urgent care centre. Clinicians will have access to the Summary Care Record and any Special Patient Notes relating to the patient.
- For other, more minor ailments, patients will be able to be signposted to community pharmacists or optometrists for advice and treatment depending on local commissioning arrangements.
- Red ambulance dispositions will be despatched without re-triage. Green ambulance dispositions will be subject to early clinical assessment within NHS 111 before an ambulance is despatched, but there will be no further re-triage.
- Emergency Department (ED) dispositions will be subject to early clinical assessment within NHS 111. The facilities for NHS 111 to book patients directly into an ED clinic will be a priority enhancement.
- The facility for NHS 111 to book patients directly into a comprehensive range of community services e.g. Urgent Care Centres and Community Services will be a priority enhancement. This should include ability to warm transfer patients who need urgent community nursing support to a 'fast response' multi-professional community team. Patients may also receive visits from community staff e.g. district nurses, falls assessment team and health visitor routinely booked directly by NHS 111.
- It will be an essential requirement that all providers working with NHS 111 demonstrate integration by working jointly to plan and manage patient pathways and capacity. They will also need to show their commitment to integrated clinical governance. Urgent and Emergency Care Networks, working with SRGs and CCGs, will provide assurance that joint planning is effective, and that, for example, there is sufficient GP and primary care service availability and call handling capacity commissioned to meet demand 24/7 and in particular on national bank holidays.
- The Directory of Services will hold accurate information across all acute, primary care and community services and to be expanded to include social care. The functionality to contact social care support through NHS 111 will offer significant benefit, specifically in relation to home support / carers etc.

This page is intentionally left blank

Report of the outcomes of the July engagement activity on the north central London CCGs' commissioning intentions to procure an integrated NHS 111 and out-of-hours service

Since January, the five north central London (NCL) clinical commissioning groups (Barnet, Camden, Enfield, Haringey and Islington CCGs) have been engaging extensively with local service users and residents on a proposal to commission an integrated NHS 111 and GP out-of-hours (OOH) services.

The CCGs engaged with hundreds of people, face to face or through an online survey, particularly with those who would be most likely to use the proposed service, those who face particular barriers to accessing services or are vulnerable.

This NCL-wide engagement has included:

- Discussions about the proposed NHS 111 and OOH model at local engagement events, including meeting with individual service users and with targeted groups such as disabled service users and refugees
- Focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which allowed for in-depth discussion of the proposed model
- Presentations at GP locality meetings across NCL to ensure local doctors understand what is planned and how they could be involved
- Presentations to the NCL joint health overview and scrutiny committee and local health overview and scrutiny committees
- Publication of an online survey to find out the views of stakeholders and service users on the proposed model
- The setting-up of a Patient and Public Reference Group (PPRG), involving service users and Healthwatch representation from each of the five boroughs. The PPRG was set up to support the procurement process and to ensure that the views and experience of local patients and carers are reflected in the decisions about the NHS 111/OOH service planning and delivery of care by the new service. Members have greatly inputted to the service specification, had fact-finding visits to the current NHS 111 provider and are participating in the procurement evaluation panel
- Two market-testing events to ensure potential providers are fully informed of the proposals and to encourage them to collaborate in developing bids.

A considerable amount of support has been received for the idea of combining NHS 111 and OOH. However, it became clear that more needed to be done to make the case for commissioning these as an integrated service across NCL.

The decision was therefore taken to undertake a further period of engagement during July 2015, specifically focused on the intention to commission the integrated service across five boroughs. This included:

- Publishing and widely circulating an engagement document, outlining the case for NCL-wide commissioning and encouraging residents and stakeholders to submit their views
- Sharing an online and postal questionnaire - and gathering feedback
- Meeting with clinicians and key stakeholder groups to discuss and develop further the clinical case for change
- Holding an additional 'market-testing' event for providers to ensure that all those who might want to bid for the new service had the fullest possible information about the proposed service.

The engagement document was distributed widely across CCGs through GP practice patient participation groups (PPGs), local patient groups and communities, voluntary organisations, Healthwatch, key stakeholders, providers, local councils, GP practices and staff. It was also emailed, posted and published online on all five CCG websites.

Responses to the engagement

Although the engagement was publicised widely, the level of response has been very low. It is worth noting that this was the final phase of a long period of engagement.

Online questionnaire responses	**21**
Questionnaire responses by post	5
Other responses	2
Total responses	**28**

Who responded to the questionnaire?

As this was not a full public consultation, the survey did not collect a full set of demographic data. However respondents were asked for their age (within a range), gender and the capacity in which they were responding. Specific to this exercise, they were asked which borough they lived in and in which borough they worked.

28 responses to the questionnaire were received, with more responses from women than men (18 of the 22 responses where this was indicated), more from those aged 65+ (14 respondents) or 41-65 (10 respondents) and more responses from people who lived in Camden and Haringey.

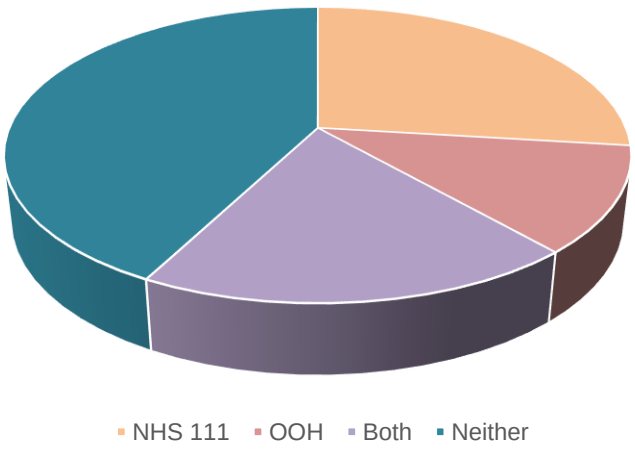
Respondents were invited to leave a comment to clarify or explain the answer which they had given to the question. These comments have been examined in some detail as they provide valuable additional information about the views of patients and public.

Common themes have been identified and are highlighted within the report for each section where qualitative data was collected. A sample selection of quotes from respondents has also been included in order to give some indication of the range and diversity of views. Two responses did not reply to the specific questions but gave a narrative response. These have been included as they provided helpful feedback.

It should also be noted that respondents had the option not to complete some of these questions by either choosing the 'don't know' or 'prefer not to say' categories, or by skipping the question completely. A count of how many respondents answered each question has therefore been included alongside each graph as there are variations in the number of responses to each question. The two narrative responses will not appear in the following analysis.

Analysis of the questions

Q: Have you used NHS 111 or a GP out-of-hours service in the past two years?



NHS 111	7
OOH	3
Both	5
Neither	11
Total responses	**26**

The majority of respondents (15 out of 26) stated that they had used one or both of the NHS 111 and OOH services in the past two years. One of the narrative (non-questionnaire) responses received also alluded to using NHS 111. The question did not ask where they were in the country when they used the service(s), and did not specify whether the respondent had accessed telephone consultation only or an out-of-hours base/home visit.

This indicates quite a large proportion of respondents (close to two-thirds) with experience of the services in question.

Q: We are considering a proposal to commission an integrated NHS 111 and GP out-of-hours service across north central London. What factors are most important for you when using these services? (Please select your top five)

Selected factors	Chosen by	As %age of respondents
Out-of-hours sites being easy to get to by public transport	19	73.1%
Being able to speak with someone with access to your medical records	17	65.4%
Being able to speak to a nurse or other health professional	15	57.7%

Selected factors	Chosen by	As %age of respondents
Getting useful advice about your condition quickly	14	53.8%
Being able to speak to a doctor	14	53.8%
Being able to speak with someone with good knowledge of local services	12	46.2%
Being able to speak with a local doctor	11	42.3%
The service being accessible for people who don't speak English as a first language	5	19.2%
The service being able to book an appointment with your GP practice (inside practice working hours)	4	15.4%
The service being accessible for people with a physical disability	3	11.5%
The service being accessible for people with a hearing or visual disability	2	7.7%
Other	3	11.5%

The most important factors for respondents were:

- **Out-of-hours sites being easy to get to by public transport.** It is important to note that the procurement proposals do not include any plans to reduce or change the locations of the current out-of-hours bases. Further, if the decision is taken to procure these services across all five CCGs, it is hoped that this would improve access to more local services for some patients by **removing artificial service boundaries** within north central London.

> "I wouldn't wish to have to go all the way to Barnet/Haringey/ Enfield. I live south of Euston Road, and I am nearing 80 and don't travel well these days – osteo-arthritis etc."

- **Being able to speak to someone with access to your medical records.** By developing an integrated NHS 111 and out-of-hours service we would **improve record-sharing** between urgent care services.
- **Being able to speak to a nurse or other health professional.** The plans for procuring an integrated NHS 111 and out-of-hours service include **investment to fund additional clinical support** – doctors, nurses and paramedics working closely with the call advisers to make sure that those service users who need clinical advice are put through to the most suitable clinician.

> "Being able to register serious life-threatening conditions so that you are flagged as being a high priority. I have a rare life threatening condition called Addison's disease. If I'm really not feeling well I don't want to have to battle with someone trying to get them to understand I need advice or help quickly."

- **Being able to speak to a doctor**. As above, the proposal is to use a range of clinical support. However, by integrating NHS 111 with the out-of-hours service, we hope also to be able **to increase access to GPs**, where that is the clinician with the right skill-set to give the advice required
- **Getting useful advice about your condition quickly.** NHS 111 is designed to be a **rapid response service**. NHS 111 provider organisations have challenging performance indicators measuring how quickly they answer calls and how quickly they transfer callers to clinicians if clinical advice is required. The NCL CCGs' proposals should increase the access to this clinical support.

The statements relating to localisation – '*Being able to speak to a local doctor'* and '*Being able to speak with someone with good knowledge of local services'* – were selected by 11 and 12 respondents respectively, although a number of these people had not previously used either service.

It may be worth noting that these options were disproportionately selected by respondents who had not used NHS 111 or OOH services recently, as set out below:

	Used NHS 111 or OOH recently (15 in total)		Have not used the services recently (11 in total)	
Being able to speak to a local doctor	4	26.7%	7	63.6%
Being able to speak with someone with good knowledge of local services	4	26.7%	8	72.7%

The NHS 111 service works by giving call advisers access to a comprehensive directory of services, designed to make sure callers who need further support are directed to the most appropriate local service. As such, it doesn't not depend on the local knowledge of the individual, but on their ability to use the system and their communication skills.

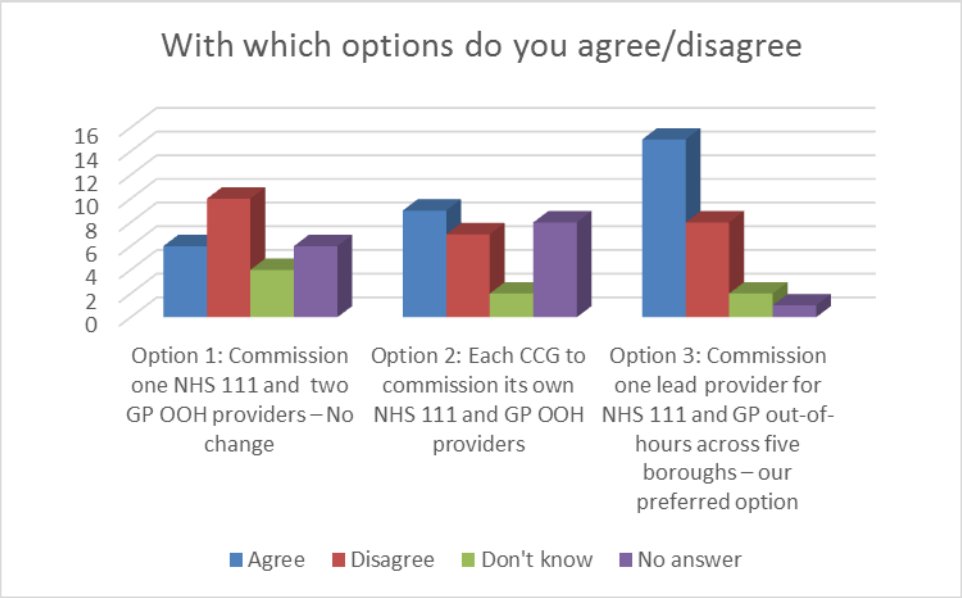
From the evidence above, it suggests that there is work needed to communicate more widely how NHS 111 works, and to give local people the confidence that they would be given access to the right services.

Q: Our preferred option is to commission an integrated NHS 111 and GP out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington. With which options do you agree/disagree?

		Agree	Disagree	Don't know	No answer
Option 1:	Commission one NHS 111 and two GP OOH providers – No change	6	**10**	4	6
Option 2:	Each CCG to commission its own NHS 111 and GP OOH providers	**9**	7	2	8

Option 3:	Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – *our preferred option*	**15**	8	2	1

As these figures indicate, the overwhelmingly preferred option (selected by 15 out of the 25 people who expressed a preference) is **Option 3: *Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs***. Option 1 – no change: *Commission one NHS 111 and two GP OOH providers* – was the least preferred option, with only six out of 25 selecting this.



Option 1 was also the most disliked option (10 respondents out of 25), though the least disliked option was Option 2: *Each CCG to commission its own NHS 111 and GP OOH providers*.

Option 3 was marginally more popular with those who have used the NHS 111 or OOH service recently, than with those who have not used it recently, as shown below:

	Used NHS 111 or OOH recently (14 in total who expressed a view)		Have not used the services recently (11 in total)	
Agree	9	64.3%	6	54.5%
Disagree	4	28.6%	4	36.4%
Don't know	1	7.1%	1	9.1%

This question invited respondents to give the reasons for their choices. These give considerably more nuance to the choices made – for example, some people chose Option 3 for pragmatic reasons, because they felt it would save money for the NHS.

Comments from people who **agreed** with Option 3 include:

- I would hope that a five borough wide service would mean that users would get the best possible advice and access to services available. However I do also think that we need access to local services and would not support this proposal if I thought that, for example, an out of hours service was not available within the borough where I live
- Economy of scale. Access to the services from a wide area in NCL
- Boundaries between boroughs can be arbitrary from an individual's point of view i.e. you may live in Barnet but it might be easier to get to the Whittington
- Integrating 2 services makes sense across 5 boroughs not a problem as long as the service responds to local need
- Financially a better option; should be more cost effective. Wider range of accessible medical services and health care professionals should be available with this option.

People who **disagreed** with Option 3 gave the following reasons:

- Local knowledge of what services are available is very important
- I think the best option is for each contract to be as small as possible so that there is more of an opportunity for the existing local service providers to be able to bid for the contracts. If the contracts are too large the local service suppliers won't be able to bid because they won't be able to afford it
- I think that the service needs to reflect the local community and therefore having one that is specific to the area you live will be better (Camden and Islington). Camden and Islington have very different needs than Barnet, Enfield and Haringey, and the services should reflect this. People want a local service and having services connected with Barnet, Enfield and Haringey isn't local for Camden and Islington residents
- I think a GP-led consortium is preferable and by keeping to the existing model that is more likely. Bigger integrated contract means private providers are more likely to bid. Private contracts have in the past been harder for CCGs to monitor
- I have concerns about too many people having access to confidential medical records. It sounds unwieldy and I am not confident that I'd be referred to the appropriate service with the necessary clinical skills.

Q: Is there anything particular you would like us to consider in our plans to commission an integrated NHS 111/out-of-hours service?

These can be grouped into themes:

- **The ability to speak to a local doctor when they call the GP out-of-hours service.**
  - Clinicians recruited should ideally be local practitioners. If not possible then they must be assessed on their command of intelligible spoken English, and their comprehension of English spoken by patients with a range of accents.
  - How will non-local clinicians be recruited?
  - OOH based in health centres in Haringey. Could be a split service with some centres having nurses only. This could provide some A+ E services.
- **Access to medical records**
  - I think potentially serious medical conditions should be flagged on any electronic patient record system to help assist triage
  - When I have had a doctor out of hours, they did not bring any notes on my medication and once one doctor asked me what I think I needed!

- **The increased involvement of private companies in delivering these services.**

  - That this service be supplied by a not for profit organisation and not by any part of the private sector
  - Check that the profit level is not more than 5% or use non-profit making organisations. Profits equate to less services
  - I think that the concept of breaking up the National Health Service under public ownership and then reuniting it under a private ownership is one that is politically motivated rather than evidence based.
- **Supporting people who need access to mental health services, with learning disabilities, hearing impairment or other disability, who do not speak English as a first language**
  - Mental health services and emergency care needs to be a highlighted facility to ease pressure on A&E
  - The interface or front of house needs to be more coherent. At the moment it is confusing for patients who have a range of options from walk-in centres, A&E and so-called Urgent Care centres, which give the impression they are not part of A&E when they are and OOH.

Many of these comments reflect views that have been expressed throughout the wide engagement on these proposals.

Conclusion

From the wide engagement undertaken since January (see Appendix 1), very useful feedback from many service users and local campaign groups has been received, with support for joining up NHS 111 with the GP out-of-hours service to improve patients' experience.

That a future service would mean fewer handoffs between services has been particularly welcomed, as have the improvements proposed in the clinical model such as the opportunity to talk to other NHS services (dentists, pharmacists, mental health workers), earlier access to services, eg pharmacy, repeat prescriptions and direct access into GP appointments.

Despite wide communications highlighting the engagement document and its survey, there was a very small response to this phase of the engagement; of those that did respond **Option 3 was the most favoured option, supporting our proposals to integrate the two services.**

In parallel with engagement on the proposal to commission an integrated NHS 111/OOH service, the development of the draft service specification for the proposed integrated service has been taking place, with input from the clinical leads from Barnet, Camden, Enfield, Haringey and Islington CCGs. The Patient and Public Reference Group and Healthwatch organisations across NCL have had the opportunity to discuss the service specification and make line-by-line comments. Additionally, the draft specification was published on the websites of all five CCGs from 21 July to 19 August, and circulated to the same stakeholder list as the engagement document, inviting comments which will be fed back to the drafting team before the final specification is produced for discussion by the CCG governing bodies in September.

We will continue to engage, inform and involve service users and residents in the progress and process of the proposed procurement of an integrated NHS 111/out-of-hours service across north central London.

Further information can be found at:

Barnet	www.barnetccg.nhs.uk/nhs-111-out-of-hours-service.htm
Camden	www.camdenccg.nhs.uk/about/nhs-111-and-gp-out-of-hours-services.htm
Enfield	www.enfieldccg.nhs.uk/about-us/nhs-111-and-out-of-hours-gp-services.htm
Haringey	www.haringeyccg.nhs.uk/about-us/nhs-111-and-out-of-hours-gp-services.htm
Islington	www.islingtonccg.nhs.uk/111%20and%20OOH.htm

Via email at feedback@nelcsu.nhs.uk

By phone at 020 3688 1615

This page is intentionally left blank

Review of the health impacts of damp housing conditions
September 2015

1.0 Purpose of the report

The aim of this report is to provide an overview to the Islington health scrutiny committee on the impact of damp housing. It provides a summary of the best available evidence relating to the impact on health of damp housing; what is known about the extent of damp housing in Islington; and what measures are being taken by Islington Council and its partners to tackle damp housing and the attendant health related impacts.

2.0 Recommendations to the scrutiny committee

The committee are asked to note the contents of the report

3.0 Intended impact of the report

The report is intended to provide an impartial summary of the evidence base about the impact of damp housing on health for the committee's review.

4.0 Contribution by community partners to the report

This health evidence section of this report was compiled as a desk-based exercise and involved an extensive literature review of studies relating to health, wellbeing and housing and national and international guidance concerning damp.

5.0 Contribution by professional partners to the report

The report was completed by Camden and Islington's Public Health team with input from partners across the council.

6.0 Key issues, challenges and risks and their management - focusing on prevention, partnership working and reducing inequalities

None identified.

7.0 Intended impact on reducing inequalities and improving health, wellbeing and value for money

Tackling cold and damp housing is important because of its association with a range of health conditions, from common colds and asthma through to respiratory and heart conditions that can lead to early death. Cold and

damp homes are also associated with poor mental health and poor social and economic outcomes as well as fuel poverty.

8.0 Comments of the Borough Solicitor

"The Health and Social Care Act 2012 ("the 2012 Act") provides the legal framework for the councils duties in respect of public health functions.

Section 12 of the 2012 Act inserted a new section 2B into the National Health Services Act 2006 , which imposes a duty on each local authority to take such steps as it considers to improve the health of people in its area. In addition the 20 12 Act places a duty on local authorities to reduce health inequalities in its area"

9.0 Comments of the Director of Finance

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The total funding for 2015/16 is £25.4m however an in-year cut is expected circa £1.7m, with a future reduction in grant also expected.

There are no direct financial implications from this report. The cost of the review will be met from existing Council resources however any findings or recommendations from the report will need to be considered at a later date, and financial implications may result from implementation of the findings.

10.0 What success looks like, measuring success and targets

N/A

11.0 Next steps, next month, six months and a year

Next steps will be dependent on the report and recommendations of the scrutiny review panel.

REPORT ENDS

SCRUTINY REVIEW INTITATION DOCUMENT

Review: The health impacts of damp housing conditions

Scrutiny Committee: Health Scrutiny Committee

Lead Officers: Julie Billett. Joint Director of Public Health and Simon Kwong, Director of Housing Property Services

Overall aim: To understand the scale and nature of the negative health and wellbeing impacts of damp housing conditions in Islington, and the effectiveness of current arrangements and measures for tackling damp and its adverse impacts on health.

Objectives of the review:-

- To understand the relationship between damp housing conditions and health and wellbeing in general, and specifically the impact of damp housing on Islington residents' health and wellbeing.
- To understand the extent of damp housing across all tenure types in Islington, and the current arrangements and mechanisms that exist for preventing, identifying, addressing and mitigating its impacts?
- To assess the effectiveness of current approaches to tackling both the structural and behavioural causes of damp, with a particular focus on health-related outcomes, and to make recommendations for increasing the impact of local measures, as appropriate.
- To particularly assess the impact of dampness on children and how it affects absence from school.

Duration: Approx. 6 months

How the review will be conducted

Scope: The review will look at the issue of damp and its impact on health across all tenure types in Islington, and at the measures taken by the council, RSLs, Housing Associations and private landlords to address damp housing and its health-related impacts.

Types of evidence to be assessed:

- National and local data on
    a. Health and wellbeing impacts of damp housing (particularly on older people and children), including understanding evidence of causation and association.
    b. Scale and location of damp properties in Islington, including information on the type/cause, severity etc, as well as the limitations of what is known regarding damp housing conditions.
    c. Overview of local programmes and interventions to prevent, identify, diagnose and address damp, and information on their impact and effectiveness.
    d. Islington's housing transfer policy, its operation in practice and how it takes into account the interaction between residents' health and housing conditions.

- Witness evidence from a range of relevant individuals and organisations

    a. LBI
        i. Housing
        ii. Public Health
        iii. Residential Environemtnal Health
    b. External partners

i. Partners for Improvement
ii. Registered providers eg Family Mosaic, Circle, etc
iii. Islington Registered Landlords Forum
iv. Islington CCG - impact on health/addressing damp housing in care pathways; impact on primary care
v. Help on Your Doorstep

c. Residents
i. Residents – identified via members' casework?
ii. Tenants/residents associations
iii. Islington HealthWatch

- Site visits to see:-
  a. housing / housing estates with known damp conditions
  b. housing where remedial action is or has been taken to address damp
  c. Any out of borough schemes/programmes offering learning for Islington

Additional information:
May want to also consider hearing from national organisations regarding innovative practice such as Shelter, National Housing Federation, etc.

WORLD HEALTH ORGANIZATION
EUROPE

DAMP AND MOULD

Health risks, prevention and remedial actions

Information brochure

Abstract

This information brochure has been developed in collaboration with WHO and the Health and Environment Alliance, and was co-funded by the European Commission (DG Sanco, grant agreement 2005156).

The brochure summarizes key messages that the public needs to know in order to prevent and reduce the exposure to dampness and mould, and to remove potential mould once it occurs. Emphasis is put on the problem of excessive moisture, which is the root cause for problems with dampness and mould in indoor built environments. Further references and user guides on actions against dampness and mould in several languages are provided, and reference is made to an international list of agencies providing more detailed damp and mould support functions to the public. This information brochure has also been produced in response to the WHO Indoor Air Quality Guidelines on Dampness and Mould.

This brochure was developed following the advice of the EU Indoor Air Quality expert group, and makes available to the public some main conclusions derived in the WHO project on policy implications of actions against indoor air pollution with biological agents.

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (http://www.euro.who.int/pubrequest).

Acknowledgments

This brochure was co-written by the Health and Environment Alliance (HEAL). HEAL aims to raise awareness of how environmental protection improves health. Based in Brussels, it brings together 60 organisations working at the international, European and national level. Further information can be found at www.env-health.org

Scientific advice by project advisory group members (Dr Kelly, UK; Dr Kurnitski, Finland; Dr Szewzyk, Germany) during the production phase of this brochure is gratefully acknowledged.

Photo credits: Braubach (page 3; 4; 6 middle and lower picture); Kurnitski (page 6 upper picture); Moriske (page 5)

Damp and mould: why you should care!

In Europe, an estimated 10–50% (depending on the country) of the indoor environments where human beings live, work and play are damp. Too much moisture makes a home stuffy and gives it a faint odour. Humid walls create a coldness that makes more heating necessary and increases energy bills.

WHO is concerned about this situation because excessive dampness and mould are a threat to health. Occupants of damp or mouldy buildings are at increased risk of experiencing health problems such as respiratory symptoms, respiratory infections, allergic rhinitis and asthma.

Some people are more sensitive to mould than others, and some groups are especially vulnerable. Additional effort should be made to keep away from damp and mould babies and children, elderly people, those with existing skin problems, such as eczema, or respiratory problems, such as allergies and asthma, and anyone who is immuno-compromised (e.g., chemotherapy patients).

On the other hand, WHO has demonstrated that remedial action works. For example, research shows that people living in well-insulated and adequately ventilated accommodation are less likely to visit their doctor or be admitted to hospital due to respiratory conditions than those living in damp homes.

This brochure provides practical tips for the public on how to tackle the core problem of excessive moisture (which can take the form of damp air, condensation on surfaces and increased humidity levels in materials) and how to prevent mould growth, as well as on how to clean up mould safely.

➔ If you have concerns about a health problem that may be related to humidity in your home, always contact your general practitioner.

Practical tips on getting rid of damp and mould

Key message: Measures to prevent or reduce moisture are the main way to limit the development of mould (and any microbial) growth: **Without water – no mould!**

The three main actions are:

1. Detecting and locating the source of the moisture problem;
2. Removing the mould; and
3. Taking action to control excessive moisture and condensation.

This brochure begins with an introduction to measures to detect and locate a mould problem, and then provides advice on the adequate measures to take if you are to tackle the mould damage yourself (do-it-yourself work).

The important final section informs you about appropriate measures to prevent or reduce excessive moisture. It assesses causes of moisture, defines condensation and what to do to prevent it, and outlines what to do if problems persist.

1. Detecting and locating the source of the moisture problem

Key message: Moulds only grow when there is sufficient moisture. When mould appears, the first task is to try to establish where the moisture is coming from.

If your home is damp and possibly mouldy, you need to find out why. The question to answer, therefore, is:

What is causing the moisture?

Major causes for excessive moisture are:

- Leaking pipes, wastes or overflows;
- Rain seeping through the roof where a tile or slate is missing, spilling from a blocked gutter, penetrating around window frames, or leaking through a cracked pipe; and
- Rising damp due to a defective damp-course or because there is no damp-course.

These causes of damp often leave a "tidemark" and you should have the necessary repairs carried out to remove the source of damp.

If your house is newly-built it may be damp because the water used during its construction (e.g., plaster) is still drying out.

If your home is damp for any of these reasons, it may take weeks of heating and ventilating (see section below: how to prevent condensation) to dry out. Hiring a dehumidifier may also help.

When the source of moisture does not appear to be related to structural faults, leaks or rising damp or the newness of the property, it is probably due to condensation (see below).

2. Removing the mould

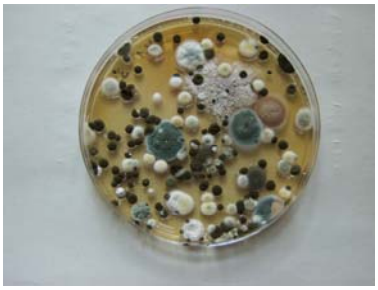
Key message: After identifying and reducing/removing the moisture sources, the next step is to decide whether removing the mould from the affected areas is something that can be managed without professional help.

When the cause of the mould is related to building faults (leakages etc.) and/or the mould is also present in the building structure and material, it is recommended to get professional help. In this case, it may be useful to consult a national or local source of information to guide you in your selection of a suitable contractor.

If mould growth is due to condensation and the mould area is less than 1 m^2 (i.e., 1 metre high by 1 metre wide or roughly 3 feet high by 3 feet wide) and is not caused by sewage or other contaminated water, you can probably manage the job yourself following these guidelines or some of those listed in the references, such as the guidelines of the US Environment Protection Agency (EPA). Many national institutes have also published guidance documents in national languages (see examples in French, German and Spanish under “Further reading”).

Whether the job is undertaken by a contractor or yourself, care has to be taken to avoid personal exposure to microscopic mould spores and the spread of spores within the building. If you yourself are undertaking the task of the mould removal, use a protective mask which covers your nose and mouth, wear goggles (without ventilation holes) to avoid getting mould or mould spores in your eyes, and protect your hands by wearing rubber gloves, preferably long ones.

Chemical disinfection and the use of biocides are not recommended as a routine practice for mould control as it may be toxic for the occupants. The application of disinfecting substances also does not solve the cause of the problem, and therefore may provide more health risks than benefits.



Removal of mould-contaminated materials: a checklist

- ✓ Have a big plastic bag ready to take away mildewed clothes, curtains, rugs and carpets for cleaning. Consider replacing a mattress or soft toy that smells and feels damp.
- ✓ The process of cleaning will release mould spores into the air. Open any windows but close doors tightly to help prevent the spores being spread to other areas of the house. Leave the windows open during and after the clean up activity.
- ✓ Prepare a bucket of water, some mild detergent, such as washing up liquid or a soap used for hand-washing clothes, and some rags that can be thrown away after removing the mould.
- ✓ Carefully wipe the mould off the wall surface with the soapy rag. Take a dry rag to wipe down and remove the moisture following the cleaning process. Put the rags in a plastic bag prior to disposal.
- ✓ After mould removal, all surfaces in the room should be thoroughly cleaned either by wet wiping or by vacuum cleaning preferably with a HEPA filter[1] to remove spores that have spread during mould removal.

Once the work of removing the mould is completed, your energies should turn to preventing it from reappearing. The following section provides advice on preventing dampness and condensation.

[1] HEPA is an acronym for High Efficiency Particulate Air. A HEPA filter can trap a large amount of very small particles that other vacuum cleaners would simply re-circulate back into the air of your home.

3. Taking action to control excessive moisture and condensation

Key message: If your problem is not from a leak or a faulty or non-existent damp-course, it is probably caused by condensation.

What is condensation?

Three factors contribute to the condensation of water on building surfaces: high humidity of indoor air, low temperature of the walls/surfaces, and poor ventilation.

***1) Humidity of indoor air**:* Condensation appears when the indoor air in a room cannot hold the level of moisture. Warm air can hold more moisture than cold air. For example, running a bath causes steam. As the air in the bathroom fills up with water vapour, it can no longer hold all the moisture that it contains. As a result, tiny drops of water appear, and develop first on cold surfaces such as mirrors and window sills.

***2) Low temperature**:* Condensation can be worse when it is cold. The humid air comes into contact with cold indoor surfaces, transforms into surface mist and then into water that runs down the window causing wooden frames to rot and wallpaper and painted walls to blister. The tell-tale signs of dampness are often found on north-facing walls, the cooler side of any home, and especially in corners of rooms.

3) Poor ventilation: Humidity of indoor air can be reduced by ventilation. If air exchange is inadequate, then humidity accumulates indoors and leads to increased condensation. In addition, walls remain cool when a lack of free movement of indoor air prevents warm air from reaching them. Mould may therefore form where there is little movement of air, for example, in a windowless basement, or behind wardrobes and cupboards. In places where low ventilation comes together with cold surfaces (e.g. outside walls), they become the priority risk areas for mould growth.

After cleaning up mould due to condensation, stopping the dampness from coming back means understanding and dealing with each of the causes of condensation.

How to prevent condensation

a. Produce less moisture

- ✓ Put a lid on saucepans to keep the steam inside.
- ✓ Do not leave kettles boiling.
- ✓ Dry washing outside if possible. Otherwise, hang it up in the bathroom, close the door and have the window open or a fan working continuously while it dries.
- ✓ Try to avoid using paraffin or bottled-gas heaters that do not have an exhaust pipe to the outside. Burning paraffin or gas produces considerable amounts of water.

b. Ventilate to remove moisture

- ✓ Ventilate all rooms at regular intervals to remove humid air. Note that tight buildings require more active ventilation!
- ✓ Mechanical ventilation systems should not be stopped.
- ✓ Cooking, bathing and showering all produce steam. Open the window or put on the fan, and close the door to prevent the damp air circulating into other rooms.
- ✓ At other times, leave all the doors to different rooms open to allow the air to circulate.
- ✓ To avoid condensation in bedrooms, open the windows for 15 minutes each morning. Human breathing puts considerable moisture into the indoor air.
- ✓ Move items of furniture away from the wall slightly so that air can pass behind them. Leave the doors of cupboards open from time to time to air them.
- ✓ Do not ventilate cold basements when the outside temperature exceeds the inside temperature because the humidity of the warm air will condensate on the cold surfaces. In summer, only ventilate basements at night when outdoor temperatures have dropped.

c. Insulate your building or heat your home a little more

- ✓ Thermal comfort ranges are very subjective. When at home, the ideal temperature usually ranges between 19-22 degrees Celsius in the living rooms, including the kitchen and bathroom, and 16-20 degrees Celsius in the bedrooms.
- ✓ When away from home, the temperature in the rooms should not drop under 15 degrees Celsius to avoid condensation and increased humidity levels.
- ✓ Do not heat up cold bedrooms in the evening by opening the door to heated rooms. The warm and humid air will condensate on the cold walls of the bedroom.
- ✓ Good insulation of the building helps preventing mould growth due to higher temperature of the walls. Again: note that tight windows and buildings require more active ventilation!

If problems persist

Some households will find that despite taking steps to reduce the condensation, humidity remains a problem. It may then be worth considering:

- Covering cold surfaces, such as cold water pipes, with insulation.
- Installing ventilation flaps or grilles in windows.
- Using electric fans or forced ventilation systems.
- Contracting a professional building inspector for a thermal insulation assessment.
- Insulating the loft or wall cavity, and draught-proofing windows and doors.

In summary: avoid damp and mould in your home by

- ✓ removing mould when it appears.
- ✓ opening windows for short periods at least 2-3 times per day.
- ✓ not stopping mechanical ventilation systems (if installed).
- ✓ using fans in bathrooms and kitchens.
- ✓ not letting rooms and walls become cold.
- ✓ always repairing leaks and other building faults.

Further information sources

WHO and the Health and Environment Alliance (HEAL) have developed this information brochure. Further information on health effects of damp and mould can be found at the WHO Indoor Air Quality Guidelines web site at http://www.euro.who.int/air/activities/20070510_2 and technical and policy recommendations on damp and mould can be found at the WHO housing and health web site at http://www.euro.who.int/Housing/support/20080403_1. Further references providing information on damp and mould to the public are listed in the references box below.

The Health and Environment Alliance (HEAL) has set up a one-stop-shop for sources of public information on damp and mould in Europe. Next to this brochure, this information service features a contact list of agencies in countries in the WHO European Region that provide information and support on damp and mould to members of the public (for the list, see http://www.env-health.org/r/157).
These agencies should be able to help you with technical or possibly legal questions. If a local certification scheme exists, they may also be able to provide you with a list of contractors recommended under this scheme.

In some cases, grants or other financial support may be available to help households resolve damp and mould problems within the home.

The contact list (contained in a database) has been compiled from two sources:

- responses to a questionnaire disseminated by HEAL to WHO and HEAL's own international networks of organizations, governments and experts; and
- a series of comprehensive internet searches of where consumers can seek advice at the national and local level.

Organizations, institutions and individuals that wish to be added to the contact list of agencies should complete and submit a short questionnaire (available at http://www.env-health.org/a/3226) on the offered services on damp and mould.

Further reading

WHO expert meeting on policy recommendations on damp and mould interventions, Bonn, Germany, 9-10 February 2009. Copenhagen, WHO Regional Office for Europe, 2009. (http://www.euro.who.int/Housing/support/20090107_1 , accessed 12 June 2009).

WHO working group meeting on interventions and actions against damp and mould. Bonn, Germany, 28-29 February 2008. Copenhagen, WHO Regional Office for Europe, 2008. (http://www.euro.who.int/Document/E91664.pdf , accessed 12 June 2009).

WHO working group meeting on development of WHO guidelines for indoor air quality: dampness and mould. Bonn, Germany, 17-18 October 2007. Copenhagen, WHO Regional Office for Europe, 2008. (http://www.euro.who.int/Document/E91146.pdf , accessed 12 June 2009).

WHO Indoor Air Quality Guidelines on Dampness and Mould. Geneva, WHO, 2009. (http://www.euro.who.int/air/activities/20070510_2, accessed 12 June 2009).

Keep your home free from damp and mould. Leaflet to help householders deal with damp, particularly condensation. The Scottish Government, 2005. (http://www.scotland.gov.uk/Resource/Doc/1125/0011805.pdf , accessed 12 June 2009).

Je peux résoudre les problèmes d'humidité dans ma maison! Série "La Sante et l'Habitat", Fiche d'information no 1. Region Wallonie, Belgique, 2006. (http://www.espace-environnement.be/pdf/sante_fichehumidite.pdf , accessed 12 June 2009).

A brief guide to Mold, moisture and your home. Washington, US Environmental Protection Agency. (http://www.epa.gov/mold/pdfs/moldguide.pdf , accessed 12 June 2009).

Una breva guía para el moho, la humedad y su hogar. Washington, US Environmental Protection Agency. (http://www.epa.gov/mold/pdfs/moldguide_sp.pdf , accessed 12 June 2009).

Mold. Tips of Prevention and Remediation. International Code Council. (http://www.iccsafe.org/safety/pdf/mold2.pdf , accessed 12 June 2009).

Leitfaden zur Vorbeugung, Untersuchung, Bewertung und Sanierung von Schimmelpilzwachstum in Innenräumen („Schimmelpilz-Leitfaden“). Berlin, Umweltbundesamt, 2002. (http://www.umweltdaten.de/publikationen/fpdf-l/2199.pdf , accessed 12 June 2009).

Directory of Agencies Providing Information on Damp and Mould to the Public. Brussels, Health and Environment Alliance, 2009. (http://www.env-health.org/r/157 , accessed 12 June 2009).

HEALTH SCRUTINY COMMITTEE
WORK PROGRAMME 2015/16

19 MAY 2015

1. Membership, Terms of Reference and Dates of Meetings
2. Work Programme 2015/16 and prioritisation of scrutiny topics
3. 11/Out of Hours service specification
4. Islington CCG Annual report
5. Scrutiny Review – Patient Feedback – Draft recommendations
6. Health and Wellbeing Board - update

02 JULY 2015

1. Drug and alcohol misuse – Annual Update
2. Camden and Islington Mental Health Trust Quality Account
3. Whittington Hospital defecit
4. Islington Healthwatch Annual Report
5. Scrutiny Review – Health Implications of Damp Properties – Approval of SID
6. Work Programme 2015/16
7. Health and Wellbeing Board – update

14 SEPTEMBER 2015

1. NHS Trust – Whittington Hospital – Performance update
2. Scrutiny Review – Health Implications of Damp Properties - Presentation
3. 111/Out of Hours service
4. Work Programme 2015/16
5. Hospital Discharges
6. Health and Wellbeing Board – update

19 OCTOBER 2015

1. London Ambulance Service – Performance update
2. Scrutiny Review – witness evidence
3. Annual Adults Safeguarding report
4. Work Programme 2015/16
5. Procurement of GP premises
6. Health and Wellbeing Board - update

23 NOVEMBER 2015

1. Scrutiny Review – witness evidence
2. Work Programme 2015/16
3. Presentation Executive Member Health and Wellbeing
4. Health and Wellbeing update
5. Value Based Commissioning

07 JANUARY 2016

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – witness evidence
3. Work Programme 2015/16
4. Health and Wellbeing Board - update

08 FEBRUARY 2016

1. Child Protection in Islington – Annual Update
2. Scrutiny Review – Draft recommendations
3. NHS Trust – Moorfields – Performance update
4. Work Programme 2015/16
5. Health and Wellbeing Board - update

11 APRIL 2016

1. Scrutiny Review – Final report
2. Scrutiny Review – Final report
3. Scrutiny Review – GP Appointments – 12 month report back
4. Work Programme 2015/16
5. Health and Wellbeing Board – update

16 MAY 2016

To be determined

This page is intentionally left blank