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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 **18 January 2016 at 7.30 pm.**

John Lynch
Head of Democratic Services

Enquiries to : Peter Moore
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Despatched : 8 January 2016

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury (Vice-Chair)
Councillor Raphael Andrews
Councillor Gary Heather
Councillor Nurullah Turan
Councillor Rakhia Ismail
Councillor Tim Nicholls
Councillor Una O'Halloran

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Donovan
Councillor Alex Diner
Councillor Jean Roger Kaseki
Councillor Jenny Kay
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.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	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.

5.	Order of business	
6.	Chair's Report	

The Chair will update the Committee on recent events.

7.	Confirmation of Minutes	1 - 8

8.	Public Questions	
9.	Health and Wellbeing Board Update - Verbal	
B.	**Items for Decision/Discussion**	**Page**
10.	GP Appointments update -Verbal	
11.	Presentation UCLH Performance - to follow	
12.	Scrutiny Review - Health Implications of Damp Properties - witness evidence/Holly Park Estate evaluation	9 - 38
13.	Margaret Pyke Centre - Update - to follow	
14.	111/Out of Hours service - Update	39 - 54
15.	Work Programme 2015/16	55 - 58

The next meeting of the Health and Care Scrutiny Committee will be on 8 February 2016

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

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Monday, 23 November 2015

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Monday, 23 November 2015 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Chowdhury (Vice-Chair), Andrews, Heather, Turan, Kaseki and O'Halloran
Also Present:	**Councillors**	Janet Burgess
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

153 **INTRODUCTIONS (ITEM NO. 1)**
The Chair introduced Members and officers to the meeting

154 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**
Councillors Rakhia Ismail and Tim Nicholls

155 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**
Councillor Jean Roger-Kaseki stated that he was substituting for Councillor Nicholls

156 **DECLARATIONS OF INTEREST (ITEM NO. 4)**
None

157 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 5)**
RESOLVED:

That the minutes of the meeting of the Committee held on 19 October 2015 be confirmed as a correct record of the proceedings and that the Chair be authorised to sign them

158 **ORDER OF BUSINESS (ITEM NO. 6)**
The Chair stated that the order of business was as proposed in the agenda

159 **CHAIR'S REPORT (ITEM NO. 7)**
The Chair stated that the update on the Margaret Pyke centre would be discussed as requested at the last meeting.

The Chair also referred to a discussion that had taken place at the JOHSC on the intervention by the Whittington Hospital in relation to the lower urinary tract service and that following discussions it appeared that there appeared to be a possible resolution to the difficulties. There would be a deputation to the next meeting of the JOHSC on this issue however it is hoped that agreement would be reached.

160 **PUBLIC QUESTIONS (ITEM NO. 8)**
The Chair outlined the procedure for Public questions and the filming and recording of Public meetings

161 **UPDATE MARGARET PYKE CENTRE (ITEM NO. 9)**
The Chair stated that the Committee had requested an update on this matter at the last meeting and a report had been circulated.

Mark Maguire, Service Director, Sexual Health and HIV and Sarah Marriott, Divisional Medical Director of CNWL and Jonathan O'Sullivan Public Health were present for discussion of this item.

During discussion the following main points were made –

- Members were informed that no final decision had been made on the future of the buildings, however CNWL's sexual health services collectively have a significant funding gap this year and next. The trust's funding gap is expected to be about £5.8m in total over this period
- CNWL is looking at ways to maintain its services whilst addressing the current and expected funding pressure. Buildings are under review since re-provision of services onto fewer sites would significantly reduce the estate costs and be a good way of closing the funding gap
- The Trust has not reached a final recommendation but is looking at options to move from the current 3 major sexual health service sites across Camden and Islington. The Margaret Pyke Centre is the smallest and most expensive building per patient seen and the Trust's assessment is that the building would not be able be in a position to absorb either of the other sexual health services. Another option considered is to retain all three sites, but transfer some of the services to other locations
- Commissioners have been and will continue to work with the Trust to develop and understand options for savings and their impact
- In response to a statement that the Trust will consider an options appraisal on estates at its Board meeting in January 2016 and once a recommendation is made, it will need engagement with stakeholders, the Committee expressed the view that there should be expanded stakeholder engagement and this should be reported back to the Committee at its January meeting
- It was stated that the budget reductions could result in approximately 60 staff losing their posts out of 240/250 posts
- All the services operating from all 3 sites were rated outstanding and the CNWL priority is to retain services with fewer staff and patient satisfaction at all of the sites is high
- Options to reduce costs were being looked at including remote screening and the introduction of new technology and there is an extensive consultation process that will take place with GP's, Commissioners and Councils to buy into this process
- The integrated sexual health tariff had initially been developed, but not implemented, by the NHS in London, but progress had been halted at the point when sexual health services would be transferred to Councils.
- The London Association of Directors of Public Health re-activated the integrated tariff programme in 2014 and the analysis has indicated that overall there is potential for significant savings across London commissioners, assuming activity levels remained unchanged following introduction of a new tariff. This would result in SRH services generally seeing an increase in commissioner income and a reduction in commissioner income for GUM on existing levels of activity
- Together the integrated tariff and transformation programmes are intended to be important in achieving a clinically and financially sustainable model for open access sexual health services and it is expected a move to the integrated tariff could save Islington as a commissioner about £1.5m a year, across all sexual health services, and combined with the transformation programme could increase to a £2m saving. It is expected that a decision on whether to proceed with implementing the tariff will be made in the near future
- Reference was made to the fact that costly refurbishment had taken place at the Margaret Pyke Centre and there needed to be public scrutiny of any decision taken on relocation of services

- There is a need for services to be located near to transport routes
- It was stated that before the Board met to discuss options CNWL would meet with Executive Members for Health and Wellbeing at Camden and Islington and their communications team would be carrying out a pre-consultation exercise and the Board would consider the options
- It was stated that the economies of running the service needed to be considered in the context of losing 40/50 staff
- The view was expressed that there was a synergy between the staff working at Margaret Pyke and in terms of the buildings options there was underutilised space at Margaret Pyke and that this should be looked at
- A Member stated that 60% of the users of the service were not local residents and that the Archway premises lease was up for renewal in 2 years time and enquired whether this had been taken into consideration as to whether a service could be provided if the Archway lease was not renewed. It was stated that discussions had been held with the landlord as to renewal of the lease as 60% of service users were local residents and there needed to be a presence maintained in this area, There will also be local provision at Crowndale and Finsbury to serve the needs of the local population
- Members were informed that a small group had been established to look at options and a representative of Margaret Pyke is on the group. Staff were also invited to feed in their views and there would be close working with commissioners on how to engage the Public and CNWL were looking for support on this

RESOLVED:

That the report be noted and a further report on discussions around expanded stakeholder engagement be submitted to the January meeting of the Committee

The Chair thanked Mark Maguire, Sharion Marriott and Jonathan O'Sullivan for attending

162 **HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 10)**

Councillor Janet Burgess, Executive Member Health and Wellbeing Committee was present and verbally outlined the recent developments at the Health and Wellbeing Committee.

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

- Continued Better Care funding had been agreed although the actual level of funding is not yet known
- It was reported Dr.Gillian Greenhough was leaving the borough, as she was retiring and this would be a great loss to the borough
- The Whittington hospital were consulting patients on the estate strategy
- The Council would be able to increase the Council Tax by 2% in order to fund social care initiatives

The Chair thanked Councillor Burgess for her update

163 **VALUE BASED COMMISSIONING (ITEM NO. 11)**

Rebecca Kingsnorth, Islington CCG, and David Egerton GP and Clinical Lead for Value Based Commissioning were present for discussion of this item and presented the report.

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

- Value based commissioning means changing how healthcare is organised, measured and reimbursed in order to improve the value of services. In a value based commissioning service, services delivered by a number of providers are organised around patients with similar sets of needs, to ensure that these needs are met in the most cost effective manner
- Health and care organisations are being asked to work together, across boundaries, for patients with similar needs and as commissioners contracts will describe the outcomes that are expected to be achieved. A proportion of the payment will be linked to the outcomes that are achieved collectively by the range of providers involved in providing care for that group of patients
- In response to a question it was stated that a lot of work had been carried out to look at measurements of outcomes and these will be developed over time
- It was anticipated that this would be put in place for the next financial year and measurements would be developed and defined over the next 5 year period
- The Chair stated that the Friends and Families test is a good way in his view to encourage patients to respond and the Committee concurred with this view

RESOLVED:
That the report be noted together with the Committee's comments above

The Chair thanked Rebecca Kingsnorth for her presentation

164 **HEALTHWATCH WORK PROGRAMME (ITEM NO. 12)**

Emma Whitby, Islington Healthwatch, was present and outlined the report. Bob Dowd, co-opted Member of the Committee was also present, together with Phil Watson Islington Healthwatch.

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

- Healthwatch were developing a model for effective engagement of children and young people and also had done work on how to inform residents on how to make a complaint about services offered at local GP practices and had disseminated a leaflet on making complaints about health services to local libraries, community centres, voluntary organisations and health services
- There was however difficulties faced in ensuring that all the actions proposed were implemented by partners
- The Committee welcomed the work of Healthwatch and that there were a large number of initiatives for a small organisation. It was stated that there are a team of volunteers who assist in the work of Healthwatch
- Healthwatch had been commissioned by the CCG to carry out some work ín relation to ophthalmology provision

RESOLVED:

That the report be noted

The Chair thanked Emma Whitby, Phil Watson and Bob Dowd for their presentation

165 **EXECUTIVE MEMBER HEALTH AND WELLBEING PRESENTATION (ITEM NO. 13)**

Councillor Janet Burgess, Executive Member Health and Wellbeing was present for discussion of this item and made a presentation to the Committee, copy interleaved.

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

- Life expectancy has increased for both men and women, however life expectancy for men in Islington remains lower than England and is the 4th. lowest amongst all London Boroughs
- Infant mortality has fallen by 68% since 2003-2005 and has the 8th. lowest infant mortality of all local authorities in Islington
- Children's oral health has improved but there is still work to be done
- The Committee expressed concern that child obesity levels were still too high and there had been a significant increase in the number of children referred and assessed for autism
- There had been a 46% reduction in early deaths from heart disease over the past 10 years. This is a faster reduction rate than both London and England, however the rates remain higher than the national and London averages
- There are significantly worse admissions to hospital as a result of alcohol and the rates have increased in Islington over the last 5 years
- An estimated 15% of 5-16 year olds experience mental health conditions, which is higher than England, despite higher levels of investment than London or England. Addressing prevention and earlier intervention is key to improving mental health
- Historically under-represented groups, such as men, people living in deprived communities and people from Black Caribbean groups are now well represented, amongst service users of ICope (Camden and Islington psychological services)
- Challenges for the coming year include increasing the number of smokers who successfully quit, addressing the high levels of alcohol related admissions, improving the physical health of those with mental health problems, increasing the number of people with LTC's who are in employment, tackling social isolation in vulnerable groups, such as older people, those with mental health and learning difficulties, and parental mental health in the early years and building resilience is being addressed
- In 2014/15 Islington offered 3820 residents a social care service and the proportion of service users receiving a service to address a physical disability of frailty increases dramatically amongst the over 65's, however it is the largest primary category for all service users aged over 40
- Islington has the highest diagnosis rate for dementia in London and the 5th. highest in England
- The numbers of adults with learning disabilities who require services is expected to increase as people transition from Children's Services
- The Adult Social Care Plan 2015/19 outlines how the Council will support the Council to deliver the Corporate Plan towards a Fairer Islington
- During the period 2011-2015 the Council has had to close a net budget gap of £150m and adult social care has contributed £31m to the £150m during this period
- The department has made savings of £6.8m in 2014/15 and has plans in place to facilitate the delivery of £10.5m savings in 2015/16. The estimated savings target is £20m over the next 4 years
- There will be newly integrated adult social care teams and streamlined services to social care and community health services and there will be a new role leading on delayed transfers of care to support and monitor hospital discharges
- There will be further integration with health on ambulatory emergency care, integrated community ageing team and intermediate care
- There are proposals to improve mental health services in the borough
- The making it real programme has led on embedding co-production into the delivery of social care in Islington and developing more personalised services

- The challenges for 2015/16 include continuing to improve outcomes in Islington who use adult social care in the context of a very difficult financial position
- Reference was made to the fact that there needed to be discussions with schools about combating child obesity

The Chair thanked Councillor Burgess for attending

166 **SCRUTINY REVIEW - HEALTH IMPLICATIONS OF DAMP PROPERTIES (ITEM NO. 14)**

Sinead Burke, Housing and Adult Social Services was present for consideration of this item.

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

- The Andover Estate pilot works concentrated on some of the ground floor units to Todds Walk, which are considered to be the worst affected flat units, being those with condensation and dampness within the ground floor units to the four storey blocks which have individual garages. The pilot works were completed in December 2014
- The pilot phase is now complete and following on from the initial works it is recognised that the pilot did not go far enough and there has been a re-assessment and re-evaluation of the areas of risk and processes, design and products, with a view to achieving the best solutions for the benefit of any future works. There have also been issues identified in relation to existing heating and cold water supply systems, which are now proposed to be renewed
- The Council has a delivery plan to address the issues starting with the External and communal cyclical repair works, which will pick up on the considerable areas of external repairs, defects and improvements necessary to the fabric of the building
- In addition, the proposed decent home bathrooms, and kitchens that were missed last time will be incorporated with the proposed dampness and condensation remedy works and these are proposed to be completed together within each flat at the same time
- Further to this there is co-operative work with the new build team and the various initial feasibility options are being considered and the impact and consequences of how this team will fit in with the above proposed measures
- External and internal surveys have now been undertaken to the whole building envelope to address various defects/weaknesses/faults and the design of the proposed condensation/dampness works to take into account all possible potential areas of cold bridging for the various types of properties, together with LBI Building Control and the leading trade suppliers/manufacturers
- Whilst there is now a noticeable change to the insulation levels within all properties, where works were carried out on the pilot, there are still various measures required that are necessary to be undertaken to improve building performance and living conditions. Internally to improve the thermal performance of the flat units changes have been made to the insulation materials and the insulation material will be fixed direct to backing surfaces without the use of batons, which will save time and cost
- The insulation will now be fitted for the garage side to the rear wall of the bathroom, bedroom and the kitchen. Some enforcement may be required where access to the garages is not forthcoming. All the exposed external living room, bedroom and hallway wall surfaces will now be insulated, as opposed to

the partial wall works carried out in the pilot and will also include insulation to windows and front entrance/garden door reveals

- Externally insulation will now be fitted to the sloping living room roof void from the outside, in lieu of internally to the living room ceiling, thus reducing resident disruption and disturbance to the Artex finishes to ceilings, which contain an element of asbestos. This will reduce overall cost
- Ventilation will be improved by the supply of a mechanical fan that runs for 24 hours a day but is quiet and economical to run. Permanent ventilation is also to be provided to ventilate the garden doors, which are not currently ventilated. Externally air vents are to be provided to the lower level sloping roof voids
- The heating system dates back to 1978 and is overdue for replacement with old pipework and some radiators showing signs of leaks. The proposed works to affected properties will require the removal of radiators/pipes to allow the installation of thermal insulation to the walls to reduce heat loss, condensation etc. and the heating system will be replaced in its entirety and the new radiators are positioned on internal un-insulated walls where possible and with new surface run pipework
- The majority of boilers in the ground floor properties were replaced around 2004-6, however these are now having performance problems. Advice is to replace them at this stage as they are reaching the end of their economical service life
- The water storage tanks are over 30 years old and have inadequate insulation, many with open tops causing condensation problems. The pipework within the cupboards containing the tanks is also un-insulated and there are signs of heavy condensation, due to lack of insulation and defective ball valves. The tanks are recommended for replacement
- The works to the most affected blocks will be done first and endeavours will be made to reduce to a minimum the timescale of works taken to each flat. High levels of labour will be working in their flats and there will be considerable disruption to residents. The contractor will need to ensure highly skilled labour is employed and willing to be flexible and responsive to resident's requirements. The resident liaison team, which worked well on the pilot will be required
- It is important that early resident profiling and pre-surveys of residents needs in advance will speed up works, particularly if residents have any OT or environmental requirements. The Occupational Therapy process for the estate has already taken place. The use of alternative temporary respit**e** facilities for some residents during the daytime is considered desirable for the success of the scheme and whilst this is currently unresolved although options are being considered
- Residents and interested parties will be regularly updated throughout the scheme
- Education is also important to provide residents on how to avoid condensation
- It was noted that the whole package of measures proposed is a massive opportunity to improve the current living conditions of the residents and make a difference to welfare and reliable contractor to deliver the scheme
- Reference was made to the leaflet to be circulated to residents regarding the proposals and Members stated that they would wish to see this before it is circulated

RESOLVED:

That the report be noted and the leaflet referred to above be circulated to Members prior to circulation to residents

The Chair thanked Councillor Burgess for her presentation

167 **WORK PROGRAMME HEALTH AND CARE SCRUTNY COMMITTEE (ITEM NO. 15)**

RESOLVED:

That, subject to the amendment of the 111/Out of Hours specification/consultation report being moved from the November meeting to the January meeting, and a further update on the Margaret Pyke Centre, the work programme be noted

MEETING CLOSED AT 10.05P.M.

Chair

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Holly Park: External Wall Insulation Evaluation

December 2015

Researched and written by:

Esther Dickie, Assistant Qualitative Information Officer

Mubasshir Ajaz, Qualitative Information Officer

Minkyoung Choi, Assistant Public Health Information Officer

Reviewed by:

Baljinder Heer-Matiana, Senior Public Health Strategist

Introduction

- This report presents the findings of an evaluation of External Wall Insulation (EWI) across the Holly Park estate in Islington.
- Before the EWI was installed, the 1950s solid-brick built properties were prone to damp and loss of heat.
- Camden and Islington Public Health Knowledge and Intelligence Team collected data before and after the installation of the EWI to evaluate the impact on residents' wellbeing.
- This includes the impact on thermal comfort; energy use and bills; condensation, damp and mould, as well as residents' health and wellbeing.

Housing and Health

- There are long established links between housing and health inequalities.
- Evidence suggests that cold and damp homes are linked to increased respiratory and heart disease as well as stress and depression[1].
- In Islington, evidence indicates that residents living in areas with a high level of social housing are more likely to have a long-term condition than areas with no social housing (22% prevalence in areas with more than 80% social housing compared to 9% prevalence in areas with no social housing)[2].
- Once age has been taken into account, in areas with the highest density of social housing (81% and above), prevalence of long-term conditions is still higher than expected[2]:
  - **24%** higher prevalence of **Chronic Obstructive Pulmonary Disease**
  - **15%** higher prevalence of **Asthma**
  - **42%** higher prevalence of **Depression**

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About Holly Park

- Holly Park is situated in the Tollington ward in the north of the borough.
- The estate comprises of 269 properties across 10 blocks.
- 84% of the properties are occupied by council tenants (2013 data).
- The estate was built in 1952 using brick solid-wall construction. It is estimated that solid walls let through twice as much heat as cavity walls[3].

About External Wall Insulation (EWI)

- Solid-walled properties have historically been seen as difficult to insulate, as insulation has to be fitted to the interior or exterior of the walls.

External Wall Insulation (EWI) is where insulating material (such as expandable polystyrene or mineral wool) is applied to the outside of a building and encased in render in order to reduce the amount of heat loss.

- EWI is generally considered less disruptive when compared to internal wall insulation, as it does not impact on internal decoration and fixings, or the internal size of rooms[4].
- EWI also has the advantage over internal wall insulation of reduced risk of moisture build up in external walls and condensation on internal walls[5].
- Limited evidence on the impact of EWI indicates fuel cost savings in the region of £145 per year for a gas-heated flat[4].

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External Wall Insulation at Holly Park

- Funding was secured to install External Wall Insulation (EWI) across the estate to alleviate fuel poverty and reduce instances of damp and mould.
- The total cost of the EWI at Holly Park was £2.1m. This was part funded through the Energy Company Obligation and Green Deal Cashback payments with the remainder funded by London Borough of Islington.
- Work began in September 2013 and was completed in May 2014.

Holly Park before the installation of EWI

Holly Park after the installation of EWI

Evaluation: Aims

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- EWI is a relatively new approach to insulating solid-walled properties, and while there is limited evidence on potential energy bill reductions, very little is known on the potential wider impact on wellbeing.
- This evaluation aims to improve our understanding of the impact of the EWI on residents' wellbeing by measuring a range of indicators before, during and after installation (table 1).

Table 1: Self-reported indicators measured during evaluation

Area	Self-reported indicators
Thermal comfort	• Perceived warmth of home during winter • Effectiveness of heating (speed at which property heats up after heating is switched on; length of time property stays warm after heating is switched on or off)
Energy use and bills	• Heating usage (average number of hours per day that heating is used) • Cost of bills (self-reported amount) • Ability to pay bills (extent to which heating is not switched on due to concern over cost; level of worry about paying heating bills).
Damp, mould and condensation	• Number of rooms in which residents report that they have problems with condensation damp or mould. • Knowledge of prevention (ability to pick out actions which can help reduce condensation, damp and mould from those which may exacerbate condensation, damp and mould).
Health and wellbeing	• Health and Wellbeing (perceived overall wellbeing) • Symptom severity (self-reported severity of health conditions associated with damp and cold homes) • Use of planned and emergency health services

Evaluation: Methods

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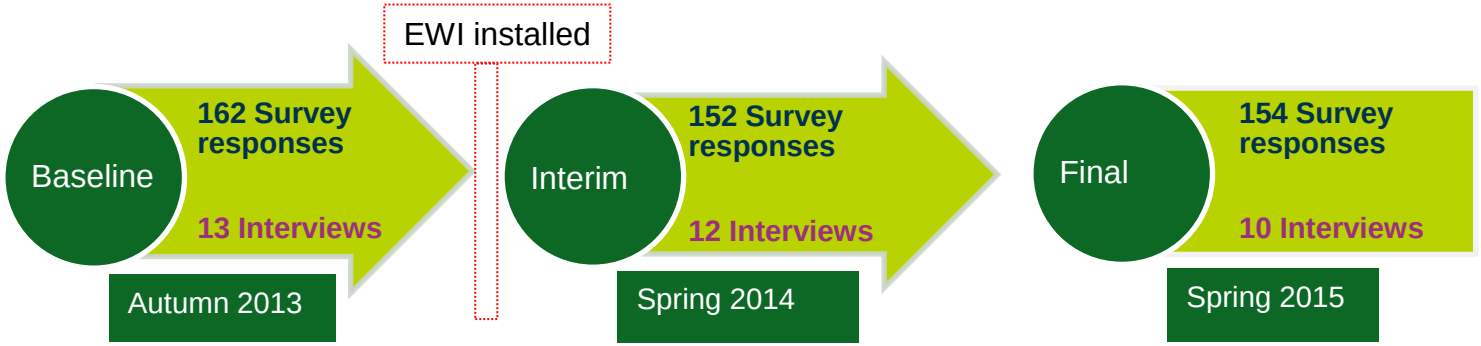
- The evaluation was conducted by the Camden and Islington Public Health Knowledge and Intelligence Team.
- Surveys and qualitative interviews have been completed at three separate time points. **Baseline data** was collected before the EWI was installed**. Interim data** was collected after the work to install EWI had been completed (May-June 2014) and a **final stage of data** was collected in (May 2015) after the EWI had been in place for one full winter.



- Surveys were sent to each household (269 in total) with stamped return envelopes. Follow–up door-to-door surveys were also conducted in each stage to increase the response rate, which was between **57 – 60%** in each of the three stages. Surveys were not just sent to the cohort of individuals who completed the baseline survey, in order to increase the sample size.
- Approximately one-third of the final survey sample were the same individuals who had completed a baseline survey (57 responses out of a total of 154).
- Interview participants were recruited through notices in a resident newsletter and through information included in the initial postal survey in Autumn 2013.
- The same group of residents took part in the interviews over the three stages (10-13 residents).
- Full details of the methods (including copies of the survey and interview guide used) are included in the interim report, available at: http://evidencehub.islington.gov.uk/housing/Councilsocialhousing/Pages/default.aspx

Findings: Survey respondents' representativeness (1)

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Survey respondents were broadly representative of the Holly Park population in terms of gender, age ethnicity and tenancy type (figures 1-4).

Figure 1: Gender of survey respondents, by research stage, compared with Holly Park population

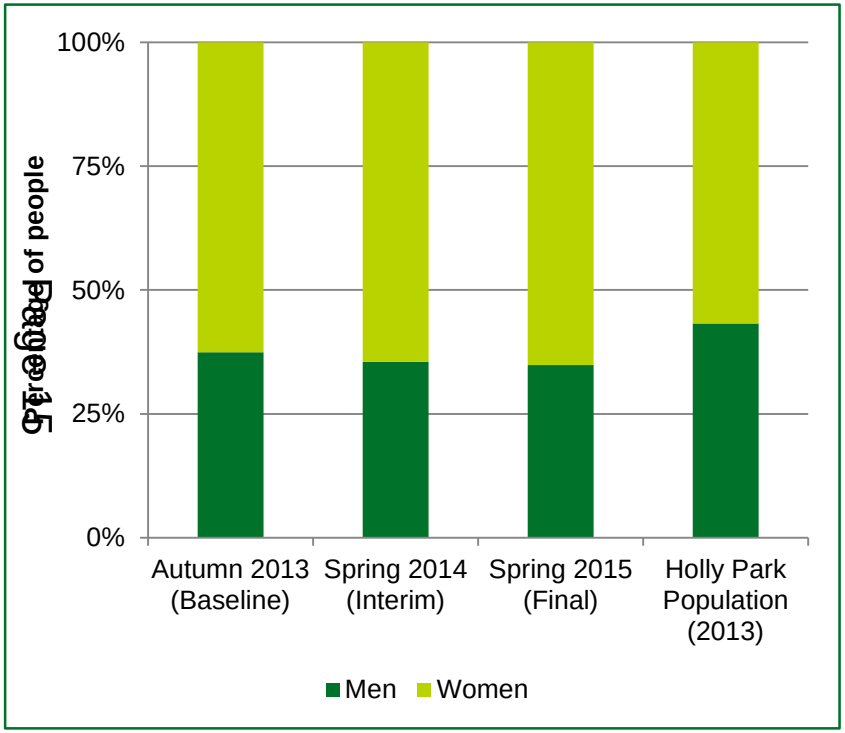
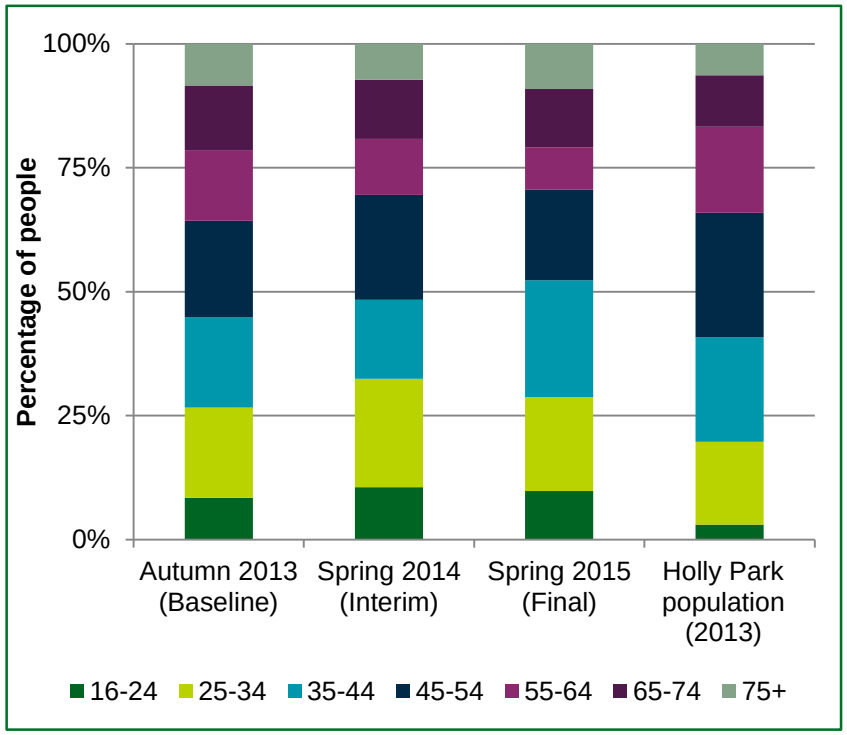


Figure 2: Age group of survey respondents, by research stage, compared with Holly Park population



Findings: Survey respondents' representativeness (2)

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Figure 3: Ethnicity of survey respondents, by research stage, compared with Holly Park population

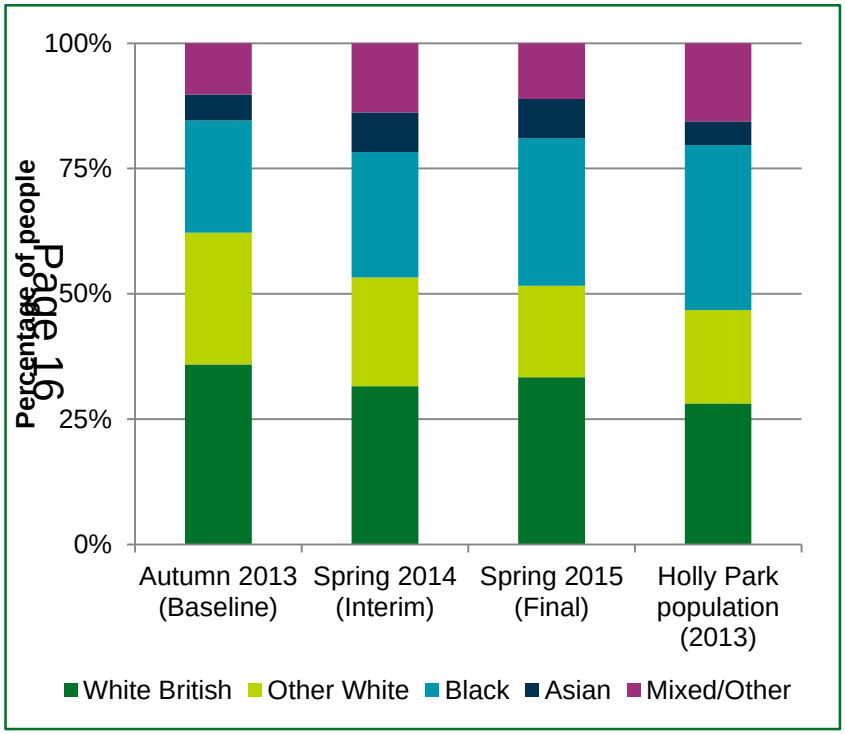
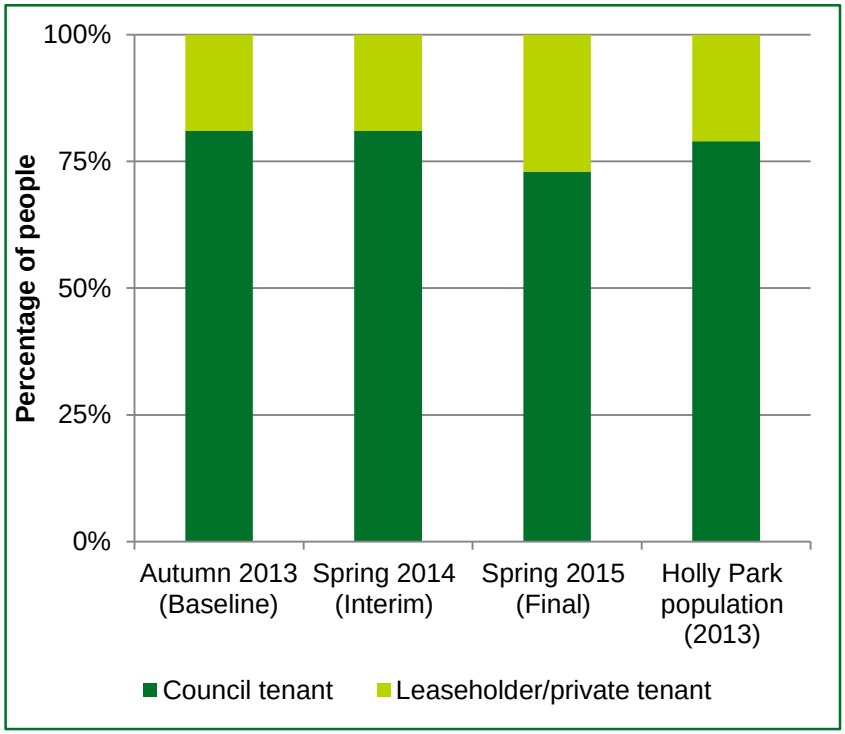


Figure 4: Tenancy type of survey respondents, by research stage, compared with Holly Park population



Interview participants' representativeness

- Eight women and five men took part in the first stage of interviews
- They included a range of ages, extending from participants in their 30s to their 80s
- Three participants were living with children and young people.

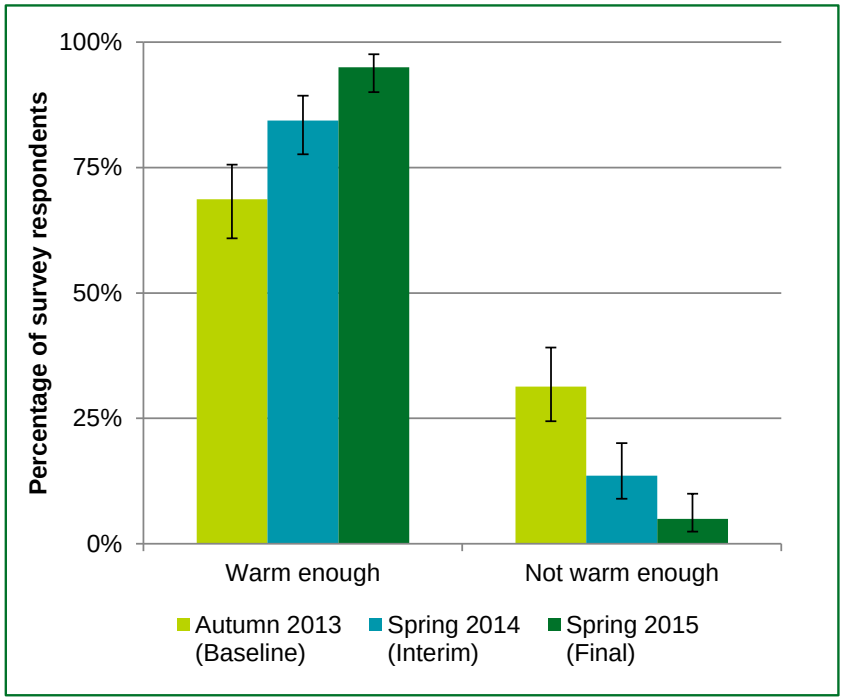
Findings: Thermal comfort (1)

- Following the installation of the EWI – 95% of respondents (133 out of 140 people) said their property was warm enough with the heating on compared with 69% (103 out of 150 people) before the insulation was fitted (figure 5).

- When asked to rate the overall temperature of their homes, 51% of respondents (or 76 out of 150 people) said their property was a bit or a lot colder than they would like before the insulation was fitted. After the EWI had been fitted, this fell to 5% (7 out of 140 people).

- It should be noted that thermal comfort is a subjective measure. Measurement of internal temperatures (using thermometers) was outside the scope of the evaluation.

Figure 5: Perceived warmth with the heating on before and after EWI fitted



See appendix 1 for guidance on interpreting the graphs in this report.

Unless otherwise stated, findings are statistically significant (95% confidence intervals).

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Findings: Thermal comfort (2)

Of the 56 people who completed both the baseline survey (Autumn 2013) **and** the final survey (Spring 2015):

- **Just over one-quarter (16 out of 54)** said their property was too cold with the heating on in 2013 but warm enough with the heating on in 2015*****.
- **Just over two-thirds of people (38 out of 54)** said their property was warm enough with the heating on before the insulation in 2013, and warm enough after.
- **Less than 5 people** said in 2013 their property was too cold with the heating on before the insulation was fitted in and is still not warm enough following the installation of the EWI.

*****The average temperatures in winter for 2013 and 2015 were comparable (3.3 and 3.9 degrees Celsius respectively), according to the Met Office Climate Summaries for these years.

Understanding differences in thermal comfort experience

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- The survey results recorded a dramatic drop in the number of people reporting that their property was too cold (from 51% or 76 out of 150 people in Autumn 2013, down to 5% or 7 out of 140 people in Spring 2015). The qualitative interviews provide helpful insight in understanding the survey findings.
- It was clear from interviews that the position of properties within the block and the extent to which respondents "feel the cold" created very different starting points in relation to thermal comfort; emphasising the subjective nature of this measure.

> *"It was warm [my property this most recent winter], but it was warm before. It's a third floor in the middle, so it' was never cold".*

> *"I have got no complaints, the house was fine, it was warm but then again all my family are the same, we don't really feel the cold so I've got nothing to complain about".*

- Over the course of the research, it also became apparent that four residents interviewed felt that the full impact of the EWI in improving thermal comfort had not been fully realised. Two participants felt that the gains in improved heat efficiency from the EWI were being lost through draughty windows. A further two felt that they were not feeling the full benefits of the EWI because of (perceived) inefficiencies in their heating system:

> *"[I've had] new central heating, that [radiator] is thermostatically controlled. Where the heater I had before would keep at the maximum temperature the whole time unless I turned it off, this one now regulates itself, for whatever reason, so probably again I'm using the [electric fan] heater more often".*

> *"It's only [in] his room, that if you go close to the window you can feel it's cool. There's no wind, but you can feel it's cooler, and if you've got insulation it should work properly".*

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Case study: Thermal comfort

Judith* has lived in her three bedroomed property in Holly Park as a Council tenant since the early 1980s. Now in her 60s and retired, she lives with her grown up daughter.

Before the insulation was fitted, Judith described the overall temperature of her property with the heating on as comfortable, but she reported this as inconsistent across the property, with some cold spots:

"This room is quite cold [the living room]. I think it's because it's [an external] wall that it seems the coldest".

At the outset, Judith described the impact that she hoped the External Wall Insulation would have:

"I'm hoping it's going to make the house warmer and we might not have to have the heating on as much".

Eighteen months on Judith reported a considerable improvement in the temperature of the property:

"It makes a hell of a difference this [the External Wall Insulation], my gosh it does. It's definitely warmer".

"I didn't have to put the heating on in the morning I found [last winter]. No, I felt warm enough, and I thought 'well I'm not going to put it on, I don't feel cold".

*** Names have been changed to preserve anonymity.**

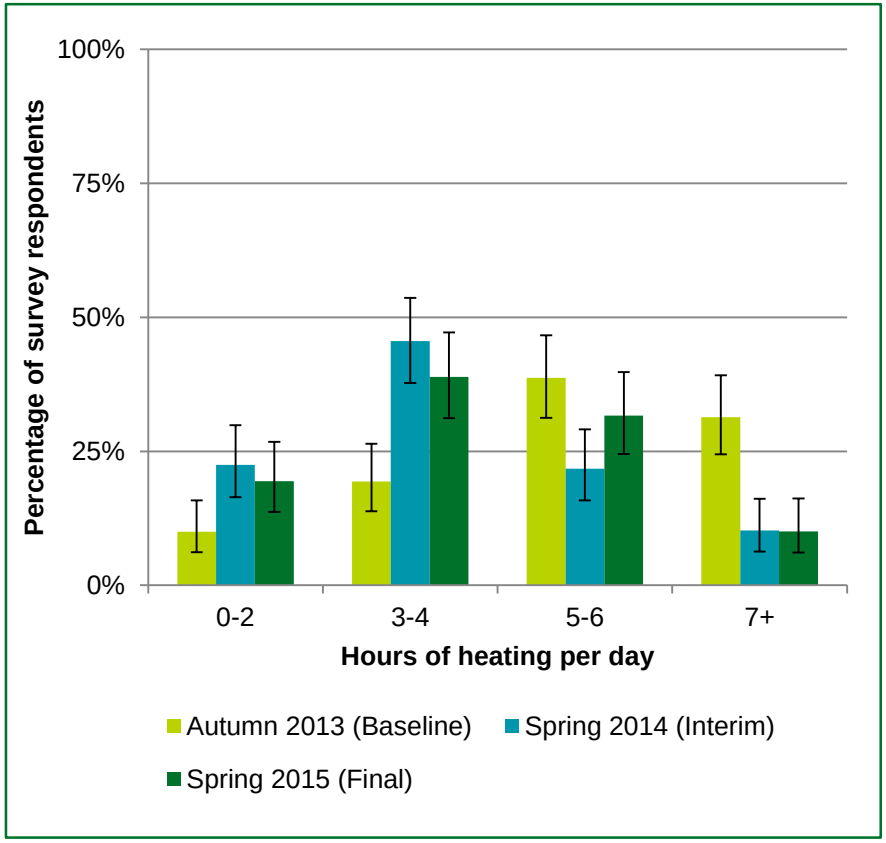
Findings: Energy use and bills (1)

- The average number of hours that people used their heating decreased after the insulation was installed: 31% of respondents (47 out of 150 people) in Autumn 2013 said they used their heating for more than 6 hours a day which dropped to 10% (14 out of 139 people) in Spring 2015 (figure 6).

- The median monthly bill amount **over winter** decreased by £10 from before the insulation was installed to the final survey: from £70 per month to £60 per month.

- This is likely to be a conservative estimate, as those paying by Direct Debit will accrue these savings throughout the year and not just during the winter months.

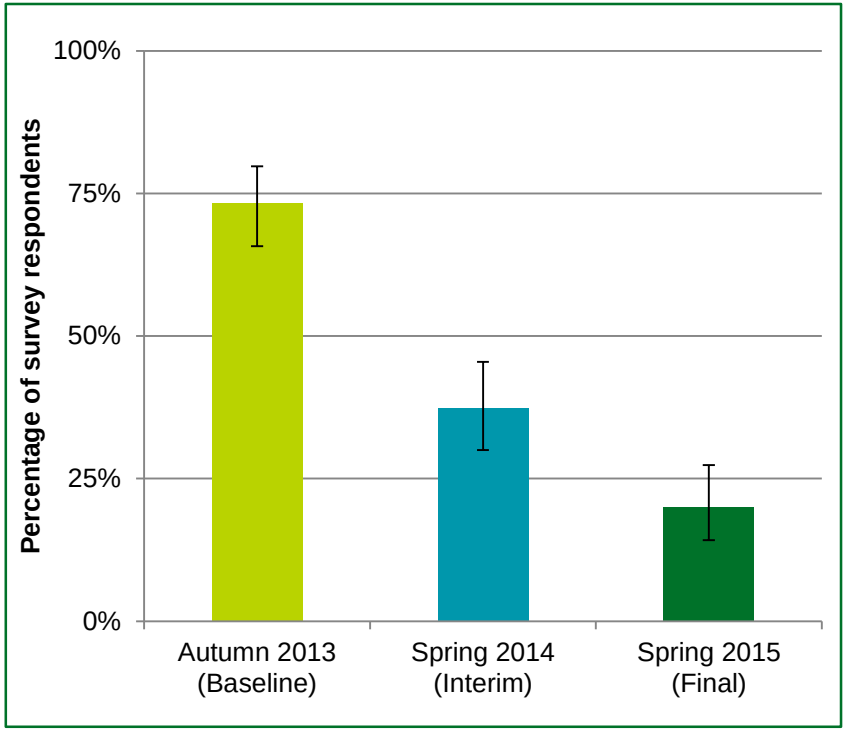
Figure 6: Number of hours per day heating is on, before and after EWI fitted



Findings: Energy use and bills (2)

- The proportion of people who restricted their heating due to concern over the bills decreased from 73% (110 out of 150 people) before the insulation was installed to 20% (28 out of 140 people) in the final survey (figure 7).
- This drop in the proportion of people who restricted their heating due to concerns over the bills was present among all age groups (16-34 year olds; 35-54 year olds and 55 and above).

Figure 7: Proportion of people who restrict the hours they have their heating on due to concern about cost, before and after EWI fitted



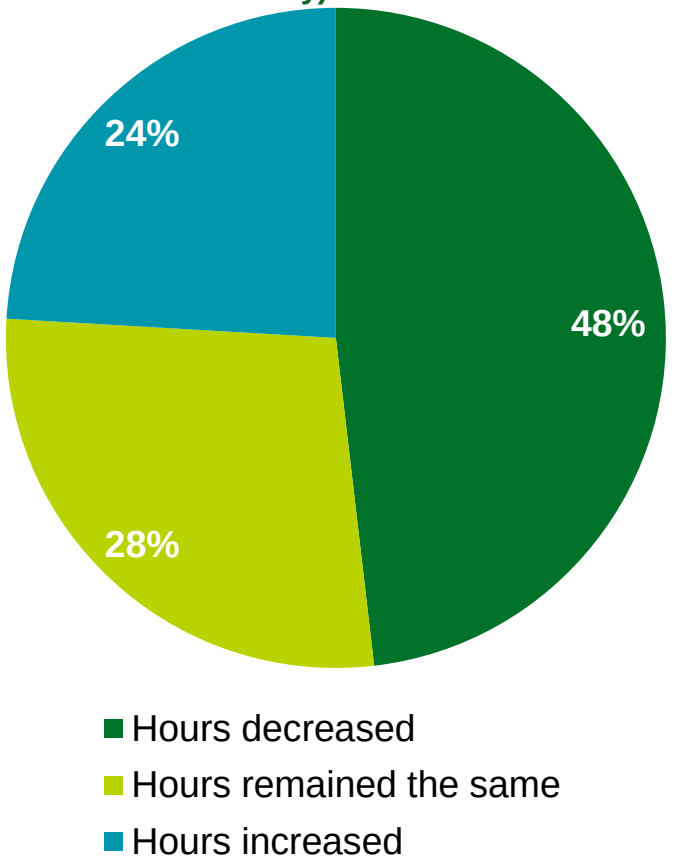
Findings: Energy use and bills (3)

Working in partnership

Of the 54 people who completed both the baseline (Autumn 2013) and the final survey (Spring 2015):

- **48%** (or 26 out of 54 people) had reduced the average number of hours per day that they used their heating after the insulation was fitted.
- **28%** (15 out of 54 people) showed no change in the number of hours that they used their heating when comparing before and after insulation heating use.
- **24%** (or 13 out of 54 people) showed an increase in the number of hours that they were using their heating after the insulation was fitted.

Figure 8: Reported Energy use before and after EWI fitted (among respondents to both the baseline and final survey)



Understanding differences in reductions in energy use and bills

- The survey findings showed a £10 decrease in the monthly median bill over winter. However, it was apparent from the interviews that it was difficult for residents to recall the amount they paid for the energy bills. This was particularly the case where bills were paid by Direct Debit.
- With the insulation work not fully completed until May 2014, not all residents have had two full winters with the insulation in place. It is possible that Direct Debits over winter 2014/15 were forecast from pre-insulation energy consumption over winter 2013/14. Further reductions in residents' energy bills may therefore be seen next winter (2015/16).
- Two interview participants also reported inefficiencies in their current heating system which they felt limited the energy cost savings arising from the EWI:

> *"I had a boiler done before all this started [the installation of the EWI], because it had a fault. The only thing I haven't had changed is my radiators... If I had the new heating in I don't think I'd be using as much [energy] as I'm using now. I know I'm using less than what I was using two years ago, but I believe I would be using much less [with new radiators]".*

> *"The boiler is lovely and new and works, but as far as energy use goes, for me personally and for the climate, it is not a good system. As a single person, I don't know where I'm going and what jobs I will be doing. So I don't use [the timer] part of it I just flick it on. But if I then get myself side-tracked it can be an afternoon, quarter of a day, possibly a couple of days if I forget [that the immersion heater has been on constant]".*

- It is possible that similar experiences to those highlighted in these quotes may help to understand the increased heating use reported by a quarter of respondents who completed both baseline and final survey (slide 15).

Case study: energy use and bills

Working in partnership

Julie* lives in a two bedroom property in Holly Park with her son. She is a council tenant and has lived in the property for over 25 years. She is in full time employment.

Before the EWI was fitted, Julie used her central heating for long periods of the day:

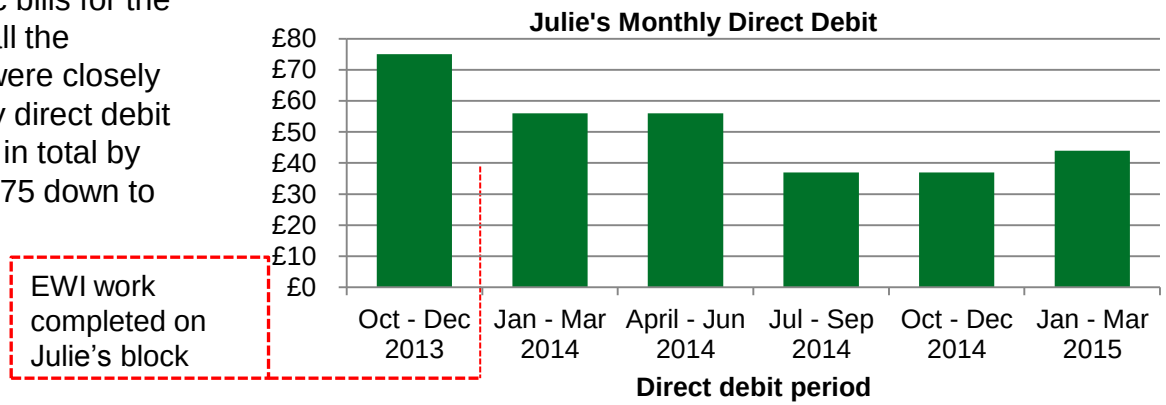
"I usually have it on the timer in the morning for about two hours then it comes on the timer again about 4 o'clock, it goes off about 10. So probably about 6-8 hours a day but if my son's in, he'll probably put it on intermittently throughout the day".

"I think I'm paying about £75 a month which I think is quite expensive and that's throughout the whole year. I wouldn't say I am worried but if I can keep it off, thinking that I'm saving some gas, I will".

On completion of the EWI, Julie reported a considerable reduction in heating use:

"I've found this flat to be warmer once the insulation was installed, so yes I felt the immediate benefits of it. I used to have it [the heating] on a timer so it was coming on just before I go to work about 6 o'clock and it would be on for two hours but there was no need for that all through the winter, I just put it on when I needed it and more often than not, I didn't need it".

Julie was able to provide gas and electric bills for the 18 month period from when work to install the insulation began. It was not until these were closely examined, that Julie realised her monthly direct debit had gradually reduced over this period – in total by 40% from Oct 2013 to Mar 2015 (from £75 down to £44 per month by March 2015).



*** Names have been changed to preserve anonymity.**

Findings: Condensation, Damp and Mould (1)

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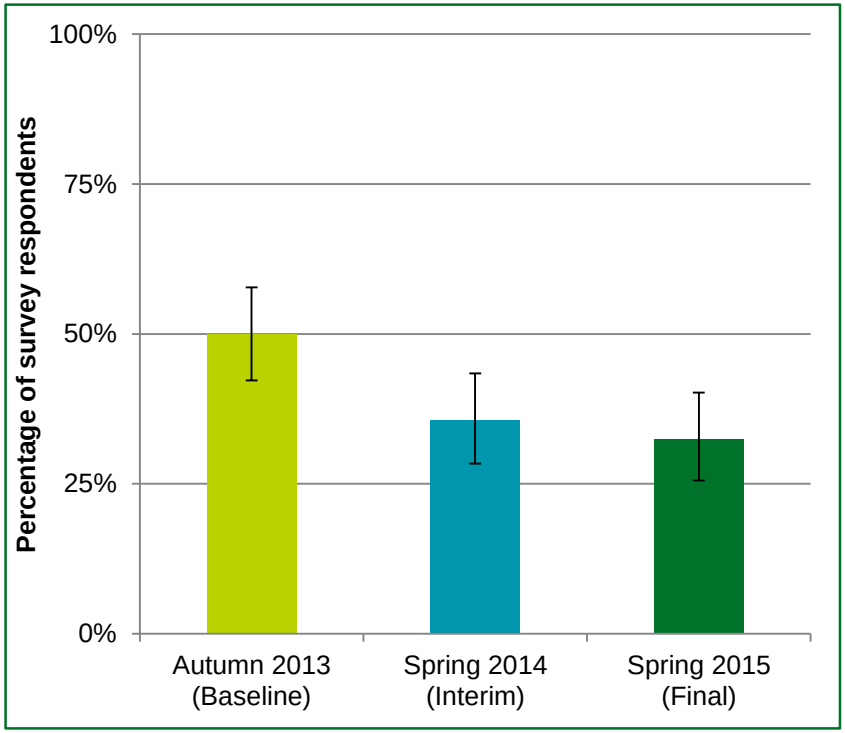
- There was a reduction in the number of people self-reporting problems with damp and mould from 50% (78 out of 156 people) before the insulation was fitted to 32% (50 out of 154 people) after (figure 9).
- Among those reporting problems with condensation, damp and mould in the final stage of research, half (25 out of 50 people) felt that the extent of the problem was the same as before the insulation was fitted; less than five people felt the problem had increased and about one-third (17 out of 50 people) reported an improvement since the insulation has been fitted.
- In all three stages of the evaluation, over half of those who said they had problems with condensation, damp and mould listed bathrooms/toilet among the problem rooms

Figure 9: Proportion of people self-reporting damp present in at least one room, before and after EWI fitted



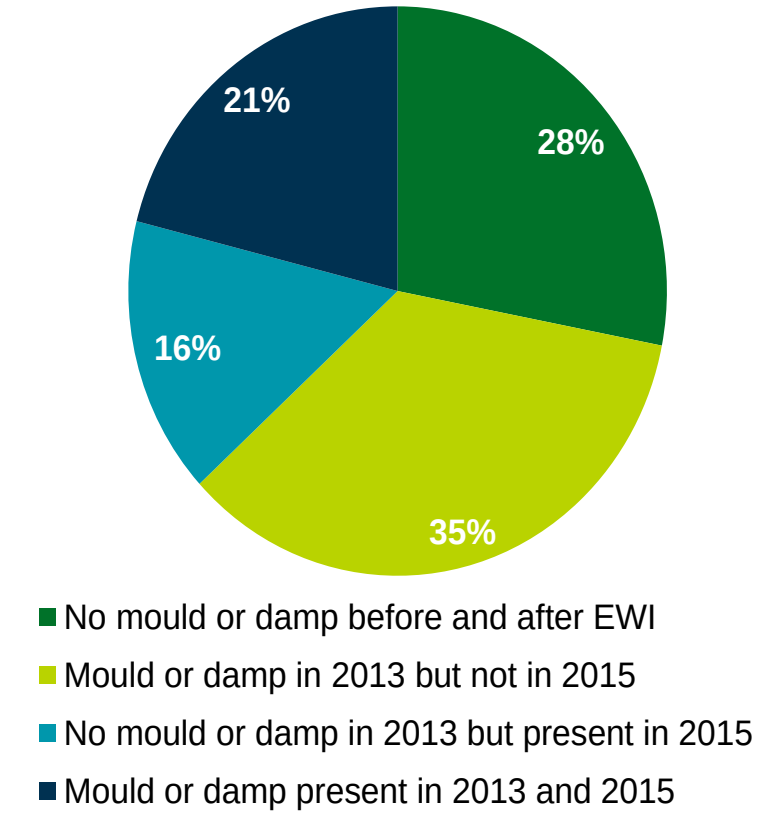
Findings: Condensation, damp and mould (2)

Working in partnership

Of the 57 people who completed both the baseline (Autumn 2013) and final survey (Spring 2015):

- **35%** (20 out of 57 people) said they had a problem with condensation, damp or mould before the insulation was fitted, but reported no problems with condensation, damp and mould after the insulation was fitted.
- **28%** (16 out of 57 people) reported no problems with condensation, damp and mould before the insulation and no problems after.
- **16%** (9 out of 57 people) reported no problems with condensation, damp and mould before the insulation was fitted in 2013, but would appear to have since developed a problem.

Figure 10: Self-reported damp, mould and condensation before and after EWI fitted (among respondents to both the baseline and final survey)



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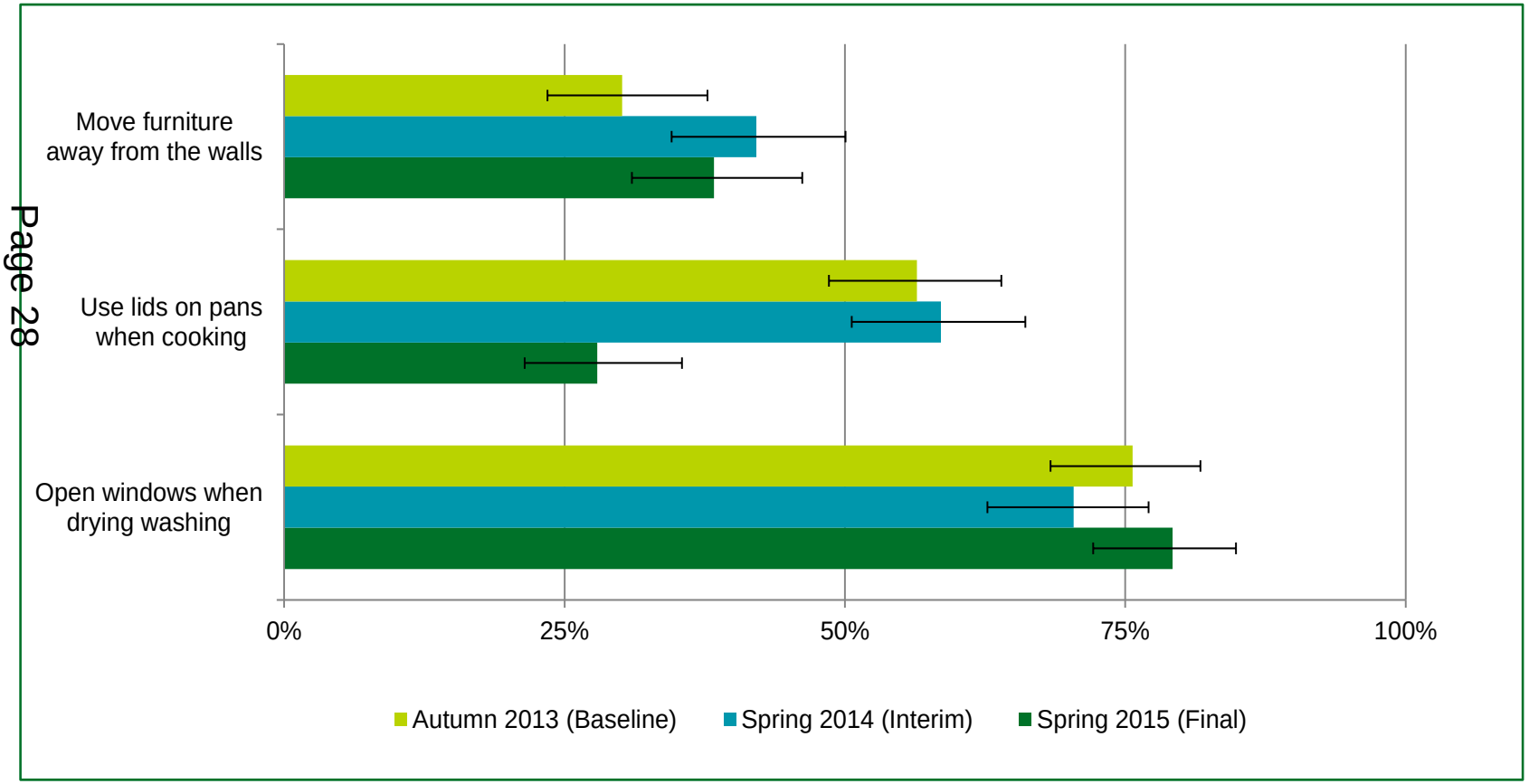
Findings: Condensation, damp and mould (3)

Figure 11: Knowledge of condensation, damp and mould prevention measures before and after EWI fitted



Understanding differences in experiences of condensation, damp and mould

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- While the survey findings showed a reduction in the number of people reporting problems with condensation, damp and mould, one-third (50 out of 154 people) said they were still experiencing problems after the EWI had been fitted. The qualitative interviews highlighted some possible explanations.
- Interview participants who were still experiencing problems with condensation, damp and mould a year after the insulation was fitted described difficulties in ventilating the bathroom to keep this at bay.

  "There's still damp in the toilet,…there's no extractor, so we have to have the window open, but there's still water dripping and it makes the whole pipe damp and black".

- Over the three phases of research, interview participants were on the whole unable to recall receiving any information from the EWI contractor on preventing condensation, damp and mould. Where interview participants had picked up information, it had come from a variety of sources (including Islington Council; on-line materials from other Councils; and a information session held in the community centre next to Holly Park).
- There was no increase in knowledge of damp prevention measures before and after the insulation was fitted (figure 11).
- Even where residents were aware of damp prevention mentions, the interviews highlighted difficulties in implementing these. These included reluctance to open widows during winter when they were struggling to keep their properties warm as well as difficulties moving furniture away from walls when properties were reported as already being cramped.

Case study: Condensation, Damp and mould

Working in partnership

Stephanie* lives in a two bedroom property in Holly Park with her partner and two young children, aged 5 and 7. They have lived in the property as council tenants since 2011.

They have experienced problems with damp and mould since moving in to the property, affecting both bedrooms; the kitchen and the bathroom.

"We noticed very soon after we moved that it was damp and there was mould. It's worst in the children's bedroom, they have a cupboard in the corner against an outside wall. It's completely black, it's completely mouldy".

Stephanie worried about the how the damp might impact on the health of the family:

"I don't believe damp is good for you, it must affect us even if we can carry on functioning. [My partner] didn't have asthma as a child, he developed it as an adult quite late, where we lived before. We don't know what triggered it, we're not sure why he started to have asthma, whether the conditions of the home contributed".

In research completed shortly after the completion of the EWI (interim stage) Stephanie expressed concerns that the EWI was not impacting on the presence of damp and mould, with an exposed glass panel believed to be cause of the problem. However, twelve months on from the completion of the EWI, Stephanie reported a considerable improvement in the presence of damp and mould in her property.

"*After the [insulation] work, someone came and treated the mould and it hasn't returned. Because you can treat it but then after a while it returns so the fact that it's not, well, it hasn't returned, I'm hoping that the insulation has got something to do with it".*

"We repainted our bedroom so it looks really nice now. The toilet had mould as well but that's been repainted recently and at the moment there isn't any sign of mould. In the children's room, you can still see, more hasn't grown again, but you can see where there's been mould at some point".

*** Names have been changed to preserve anonymity.**

Findings: Health and Wellbeing (1)

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- About one quarter of survey respondents (in both the baseline and final survey, 36 out of 156 and 37 out of 154 people respectively) reported having a limiting long-term illness, higher than the borough average of 16%.
- In the final evaluation survey, 82% of respondents (127 out of 154 people) rated their health as good or better than good. There was no statistically significant improvement in overall perceptions of health among survey respondents.
- The vast majority of respondents (86% or 120 out of 140 people) in the final evaluation survey rated their overall health the same as it was two years ago. Nine percent felt that their health had deteriorated; while 5% felt it had improved from two years ago.
- There was a decline in the frequency of coughs and colds reported among survey respondents; 16% of respondents (24 out of 154 people) having experienced these within the three months before the final survey (March, April and May 2015) compared with 37% (or 57 out of 156 people) in the three months before the baseline survey (September, October and November 2013). Some of this reduction may also be seasonal as the time periods considered were not directly comparable. There was no difference in before and after insulation levels of Asthma; Eczema; allergies or Depression/Anxiety (figure 12).
- It has not been possible to analyse change in severity of these conditions due to the relatively small number of people reporting these conditions in the survey.
- With the exception of fixed GP appointments, there was no statistically significant difference in self-reported health service use before and after the insulation was fitted (figure 13). It is not possible to determine the cause of the fall in GP fixed appointments which could be related to other external factors.

Findings: Health and wellbeing (2)

Working in partnership

Figure 12: Prevalence of health conditions before and after EWI fitted

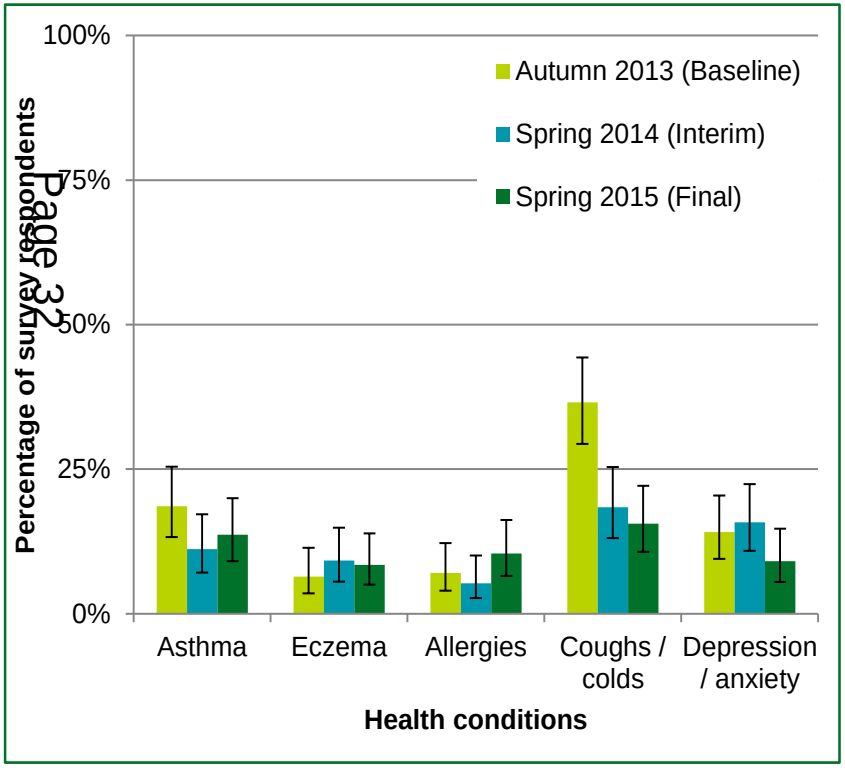
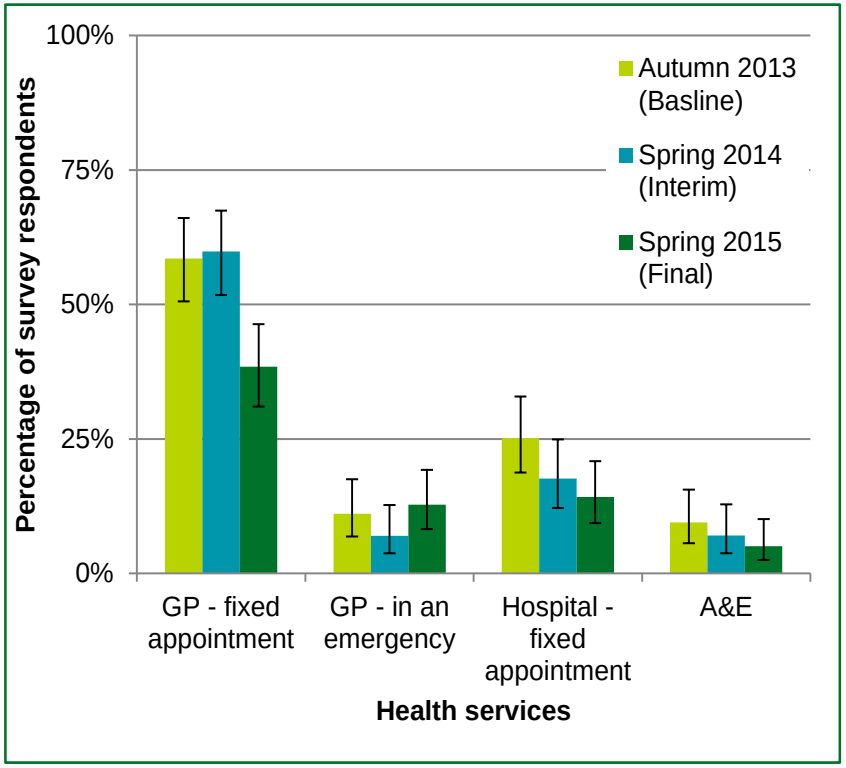


Figure 13: Self-reported health service use before and after EWI is fitted



Summary (1)

Working in partnership

The findings show that the installation of EWI across the Holly Park estate has had a positive impact on improving residents' thermal comfort and reducing their energy usage and bills. They also show some respite in problems with condensation, damp and mould.

Thermal comfort:

- Living in a cold home (under 16 degrees centigrade) impacts detrimentally on physical and mental wellbeing[7]. It is estimated that at least 1 in 10 excess winter deaths are caused by fuel poverty[8].
- EWI at Holly Park had a positive impact improving thermal comfort. The number of people who said their property was warm enough with the heating on rose considerably after the EWI was fitted: from 69% (103 out of 150 people) before the insulation was fitted to 95% after (133 out of 140 people).
- The evaluation compares thermal comfort over three winters. The external air temperature is a key influencing factor on thermal comfort. The 2013/14 (interim) winter was relatively warmer than both the 2012/13 (baseline) and 2014/15 (final) winters. However, the average temperature of the baseline and final winters were similar, suggesting this is a valid comparison.

Energy use and bills:

- Between 2004 and 2013 national average domestic energy bills doubled [9].
- It is estimated that around 20% of the population in Islington spend more than 10% of their income after housing costs on energy bills and reducing energy bills is a priority in Islington's current corporate plan.
- In line with the findings on improved thermal comfort, survey respondents reported a considerable reduction in the amount of time they used their heating.
- The proportion of people who used their heating for more than six hours per day decreased from 31% (47 out of 150 people) before the EWI was fitted to 10% after (14 out of 139).
- Survey findings record a £10 monthly saving in the median bill amount over winter, from Autumn 2013 to Spring 2015. This is likely to be an underestimate as those paying by Direct Debit would accrue these savings through every month of the year and not just during winter months.

Summary (2)

Working in partnership

Condensation, Damp and Mould

- Survey findings recorded a reduction in the number of people reporting problems with condensation, damp and mould from 50% (or 78 out of 156 people) in the baseline survey, to 32% (50 out of 154 people) in the final survey. One-third of respondents in the final survey (17 out of 50) experiencing issues with condensation, damp and mould felt that that this was not as severe as it had been before the insulation was fitted.
- There was no evidence of an increase in knowledge of damp prevention measures among residents, with the vast majority of those interviewed unable to recall receiving any information on this from the EWI contractor.
- The findings indicate that bathrooms and bedrooms are the rooms most commonly affected rooms. Interview participants with persistent mould problems described difficulties ventilating bathrooms.

Health and Wellbeing

- The survey and interviews indicated that the EWI had an impact on wellbeing; for example, there was a dramatic fall in the number of people who said they restricted their heating due to concern over heating bills; 73% of respondents (110 out of 120 people) said this was sometimes or always a concern before the insulation was fitted which fell to 20% after (28 out of 140 people).
- The survey findings revealed a marked improvement in the frequency of coughs and colds among respondents – with 37% (57 out of 156 people) reporting to have had a cough or cold within the three months before completing the pre-insulation survey, compared with 16% (24 out of 154 people) in the final post-insulation survey.
- Prevalence levels of asthma; allergies; eczema and anxiety or depression remained unchanged over the research stages. This is to be expected given the chronic and long-term nature of these conditions. Unfortunately, due to relatively small numbers of survey respondents reporting these conditions it was not possible to conduct analysis to understand whether there was any difference in the self-reported severity of these conditions.

Conclusion and recommendations

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- This evaluation found that the EWI has positively impacted on residents in Holly Park – significantly improving the warmth and comfort of their homes and reducing the amount of money they spend on their bills. Interview participants also highlighted the improved appearance of the estate following the installations of the external cladding.
- For some, there was also an improvement in problems with condensation, damp and mould but this was not reported across the board.
- Understanding the full impact of the EWI on health and wellbeing has proved more difficult. While the research indicates there may have been some improvements in wider wellbeing, such as a reduction in the level of concern over heating bills from the baseline to final surveys, the impact on physical health conditions has been harder to track. The number of people self-reporting conditions which can be associated with living in cold and damp homes was too small to identify whether or not there had been any changes in the severity of these long term conditions.
- The findings of this evaluation should be viewed in the context of wider evidence considering the efficiency of external wall insulation. It has not been possible within this evaluation to undertake a cost-benefit analysis and wider evidence in this area is limited. The relatively expensive installation costs of external wall insulation when compared with other energy efficacy interventions means that it can be a long period of time before cost savings offset installation costs.

Further information

For further information please contact Esther Dickie, Assistant Qualitative Information Officer on esther.dickie@islington.gov.uk or 0207 527 8766.

References

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Appendix 1: understanding the graphs in this report

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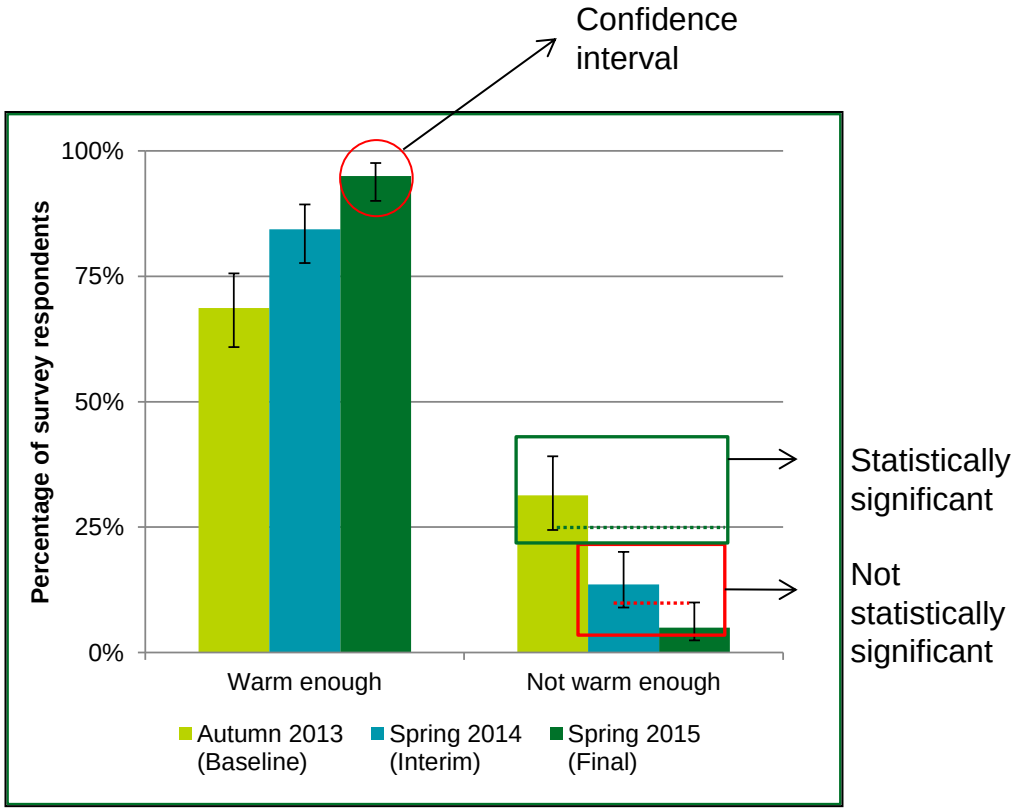
- The black bars on the graphs are confidence intervals.
- Confidence intervals are used to quantify the imprecision in the calculation of a particular value – if we repeated the survey 100 times the results would fall in this range 95% of the time.
- This reflects the uncertainty in survey responses – for example we know that not all Holly Park residents completed the survey.
- The wider the confidence interval, the greater the uncertainty in the estimate.
- By comparing confidence intervals around estimates we can talk more definitely about differences:
  - Where confidence intervals do not overlap we can be sure that differences are real, whereas with confidence intervals that do overlap it may be that the difference would disappear if more, or different, people completed the questionnaire.



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Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Commissioning of an integrated NHS 111 and GP out-of-hours service across north central London: Update

November 2015

1. Purpose

This report provides an update to the north central London Joint Health Overview and Scrutiny Committee on the commissioning of the integrated NHS 111 and GP out-of-hours (NHS 111/OOH) service across Barnet, Camden, Enfield, Haringey and Islington (the five NCL CCGs).

GPs representing the NCL CCGs attended the JHOSC on 25 September 2015, and discussed extensively the core principles behind this service model, the engagement that had been carried out, and the timeline for the procurement. The NCL CCGs were asked to return with detail on some of the areas covered verbally in discussions on that occasion, specifically:-

- How commissioners will undertake monitoring of the contract and, in particular, obtain relevant performance information
- Detail on the key performance indicators; and
- Procurement and KPI differences between individual boroughs.

2. Background

NCL CCGs have presented this matter to the JHOSC on four prior occasions. This paper will not cover everything that has been discussed before, but below is a summary of the programme.

2.1. NHS 111

NHS 111 is a free telephone number to help people who have urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways[1] to assess patients and direct them to the most appropriate service.

The NHS 111 service in NCL is currently provided by a single provider – London Central & West Unscheduled Care Collaborative.

2.2. GP out-of-hours services

Out-of-hours services are available so that people can access primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians offer advice and face-to-face appointments if needed. Patients get access to the out-of-hours service by first calling NHS 111.

The out-of-hours services in NCL are currently provided by two different organisations – Barndoc Healthcare Ltd for Barnet, Enfield and Haringey, and Care UK for Camden and Islington.

2.3. Proposed integrated NHS 111 and GP out-of-hours service

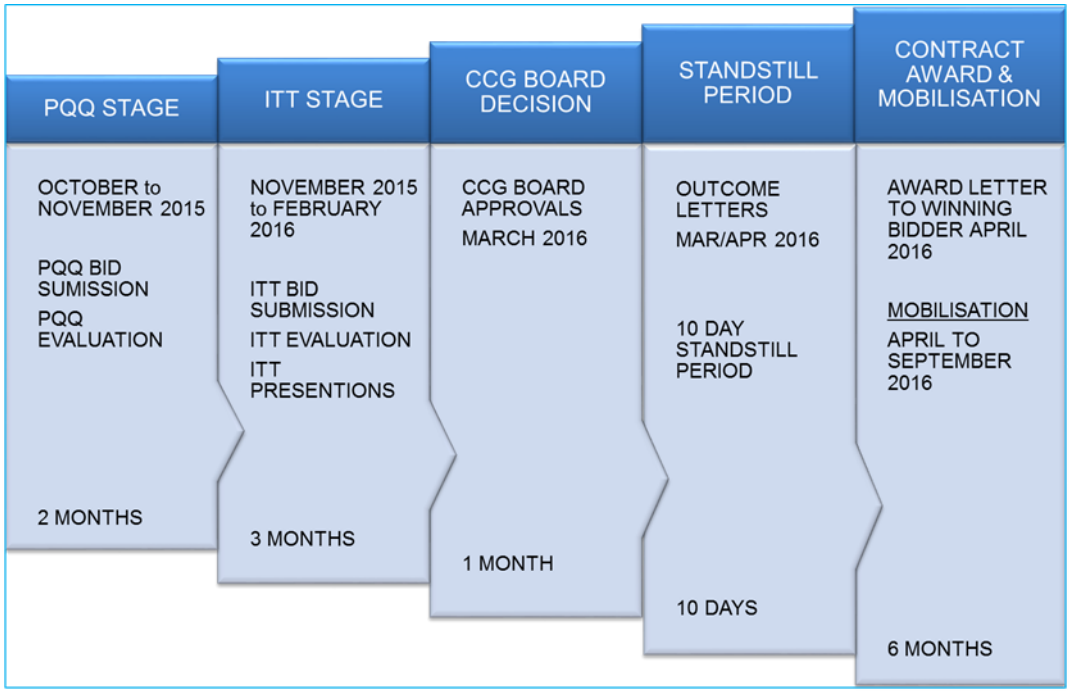
The NCL CCGs are commissioning NHS 111 and OOH as an integrated service across north central London, and this integrated service is expected to begin in October 2016.

[1] NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required.

3 Update on the procurement

3.1 Timeline

The procurement for the integrated NHS 111 and GP out-of-hours service remains in line with the timeline below:-



The Pre-Qualification Questionnaire (PQQ) stage, inviting expressions of interest, was opened on 1 October and closed on 2 November. We are currently in the process of evaluating the responses to the PQQ to determine which participants can be carried forward to the Invitation to Tender (ITT) stage. For reasons of commercial confidentiality, we are unable to give information about the identity of the potential bidders.

As has been discussed at previous meetings and consistent with standard procurement methods the evaluation of bids at the ITT stage will require a balanced scrutiny of quality and cost. The NCL CCGs have opted to weight the evaluation to favour quality in a ratio of 80:20. This means that 80% of the marking used to differentiate bidders will be assigned to quality questions and measures.

There are patient/public representatives - selected from members of the Patient and Public Reference Group (PPRG) which has been involved with the procurement process since April 2015 – on the Evaluation Panel, and we are planning to have additional representatives supporting the OSCE (Objective Structured Clinical Examination) stage, wherein bidders will be tested on their response to a range of specific, locally-devised scenarios.

3.2 Service specification

We engaged on the draft service specification for this service in July and August, and received hundreds of comments from our Patient and Public Reference Group, GPs and other clinical experts, specific interest groups, service users and members of the public in the five boroughs.

In light of these comments the specification was revised extensively. We are unable to include the final version in this paper as it remains a confidential document because of its commercial

sensitivity, until the Invitation to Tender (ITT) has been published. However, we have included a summary of the main changes as a result of our engagement, at Appendix A.

The service can be summarised as follows:

This service is designed for patients, carers and their families when:

- They need medical help fast, but it is not a 999 emergency.
- They do not know whom to contact for medical help.
- They think they need to go to A&E or another NHS urgent care service.
- They need to make an appointment with an urgent care service.
- They require health information or reassurance about what how to care for themselves or what to do next.

The integrated urgent care services which encompasses NHS 111 and the out-of-hours service must:

1. Be available 24 hours a day, 365 days a year (366 days in a leap year) for telephone advice;
2. Receive referrals through telephony and online channels;
3. Provide consultations with GPs and other clinicians during the out-of-hours period;
4. Connect service users to clinicians where indicated;
5. Provide access to health records and patient notes
6. Request an ambulance without delay where indicated; and
7. Provide a consistently high quality service irrespective of the geographic area served.

3.3 Commissioning Standards

NHS England published new Commissioning Standards for Integrated Urgent Care on 30 September 2015. These have been circulated to JHOSC already, and are available at https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf. As anticipated, and in part because NCL leads have taken a key role in steering their development, these standards are very much in line with the service model that NCL CCGs have been developing. E.g.

> (p10) The offer for the public will be a single entry point – NHS 111 – to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.
>
> Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists (GPs, dentists, pharmacists) and specialists.
>
> *(Note: It is important to note that the term 'Clinical Hub' (as used in the Commissioning Standards for Integrated Urgent Care) is a functional description, it being a joined up network of clinical support to be drawn upon depending on the person's need. It is not about a new building or a specific service.)*

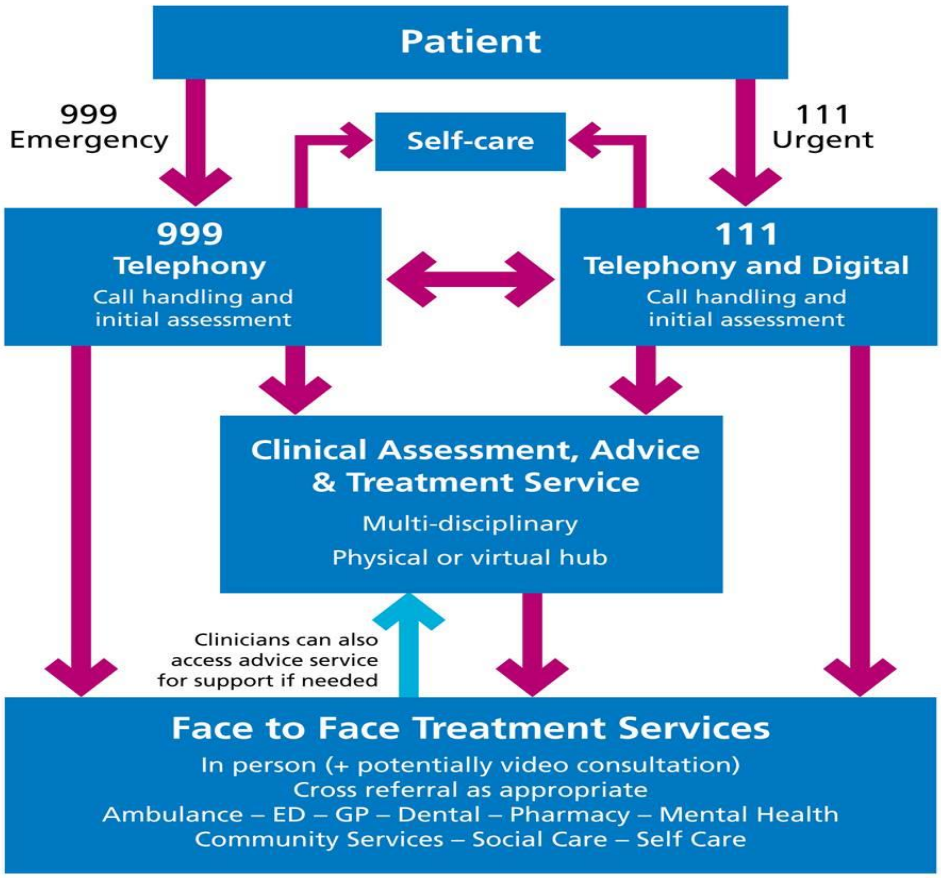
(p17) The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service.

(p17) It is envisaged that both large and small providers will have an important part to play in delivering a successful and Integrated Urgent Care service. 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 current NHS 111 and Out-of-hours organisations to collaborate or work within a lead provider arrangement, to deliver the standards for an Integrated Urgent Care service.

(p20) Integrated Urgent Care will have the capability to make an electronic referral to the service that can best deal with a patient's needs as close to the patient's location as possible.
 Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service whenever this is supported by local agreement.

(p31) The clinical workforce will be comprised of generalist clinicians (paramedics, nurses and GPs) who have specialised skills and competences in remote and telephone assessment and management, supported by specialised clinicians from a range of professions cover specific clinical areas, including mental health, dental health and paediatrics.

The model for Integrated Urgent Care services as described by NHS England is illustrated below:



3.4 Contract management

We will establish a governance structure within which a lead CCG will be responsible for the overall contract management. The contract will however be overseen by representatives of all five CCGs, who will hold the future provider/s to account, through regular quality review meetings and ongoing monitoring to ensure all aspects of the service adhere to the highest of standards and meet the needs of service users in each of the five boroughs.

As at present, there would be monthly meetings involving representatives of both providers and commissioners. These involve a Contract Technical Group looking at financial and similar aspects of the provider's performance, and a Contract Quality Review Group (CQRG) looking at performance data, serious incidents, complaints and service user feedback.

The Patient and Public Reference Group, with input from local Healthwatch, is currently considering how best to involve service users in the contract review process – one suggestion is that there will be one or more public or Healthwatch representatives on the CQRG, who will in turn feed back to a broader patient/public group who may have a role in oversight of the whole NCL Urgent and Emergency Care Network.

Outside of these monthly meetings, commissioners and relevant bodies (i.e. Healthwatch) will have the right to make unannounced inspections of NHS 111 and GP out-of-hours sites, as part of best practice, information sharing and a collaborative approach to joint working. During the mobilisation period the CCGs will continue to work with public and patient representatives to develop the quality and activity reports that can be shared more widely.

Taken together, these approaches will give us early insight into any issues which may arise, and enable us to work with the providers to ensure these are addressed and do not have a significant impact on patients.

If commissioners continue to have concerns about a provider's performance, they will be subject to the terms for financial penalty and ultimately suspension or contract termination, as set out in the NHS standard contract[2]. Relevant excerpts from this are included at Appendix B.

3.5 Quality requirements and key performance indicators

Monthly reporting on a detailed set of performance measures will provide the CCGs with early notice should the provider struggle to meet the expected standards. As at present, there will be a published set of National Quality Requirements (NQRs) allowing for comparability between the local service and those elsewhere, as well as some measures reflecting local priorities. The contract will be flexible, allowing measures to change over time, so we can be sure we are checking the right things.

The current NQRs for NHS 111, published on the NHS England website[3], collect performance data in areas such as:-

- Percentage of calls answered within 60 seconds
- Percentage of calls transferred to a clinical advisor

[2] https://www.england.nhs.uk/nhs-standard-contract/15-16/

[3] https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2015-16/

- Percentage of call-backs with 10 minutes
- Percentage of calls resulting in ambulance dispatch
- Percentage of callers recommended to attend primary or community care.

These measures are intended to assess whether the NHS 111 service is fulfilling its role within the broader urgent and emergency care system, and operating in a sufficiently robust way so that service users can have confidence in it.

The out-of-hours service is subject to the same reporting mechanism, so that we will have comparable service-appropriate data, locally derived and compared month by month, but also benchmarked to regional and national metrics. An important measure in this section, in terms of demonstrating the benefits of service integration will be the number of callers whose issue is dealt with wholly within the integrated urgent care service, without onward referral.

There is also a set of patient experience indicators, based on regular surveys sent out to callers. This data records patients' satisfaction with the service, their outcomes (i.e. whether they complied with the advice from the integrated urgent care service, and whether their problem was resolved) and what service they would have used had 111 not been available – again, this is a way of checking that service users have confidence in the service, and that it is diverting patients from A&E and other parts of the system that are under pressure.

The provider/s will also be required to have processes in place that allow patients and carers to share experiences and provide feedback about the service on an ongoing basis. This patient feedback will form part of the monthly reporting to CCGs.

There is also a mechanism for doctors and other clinicians to submit feedback forms on an ongoing basis as part of Clinician Feedback. There will be regular commissioner-provider meetings to review clinical interactions from initial call to ultimate disposition. This will enable qualitative assessment of contacts on a case-by-case basis, and provide a much richer sense of how the service is performing. All calls in the integrated urgent care service are also recorded – commissioners will listen to a selection of recordings to ensure the quality of this part of the service, and this is also a useful tool for assessing any complaints that are received.

Clinical audit of all cases is a requirement of the continuous quality improvement element of this service. Commissioners will require the provider to undertake clinical audit at a local level. Commissioners will review data on all referrals that are made within the integrated urgent care system –this means we can ensure that providers are making appropriate referrals for all callers, and that different providers within the system are working together in an integrated fashion, in the best interests of patients and the health system as a whole.

The provider/s will also be required to meet any changing quality requirements established by NHS England for NHS 111 and OOH services.

3.6 Local service developments and indicators

Representatives of all five NCL CCGs have been involved in developing the service specification and procurement model for this service. To a large extent, therefore, the new service model is intended to meet all the service needs of all the population – where one CCG has proposed improvements to the model based on local experience, these have been applied across all five CCGs, so that all our service users will benefit.. An example of this is the requirement to adopt

end of life care plans within the service for Haringey patients; this has been adopted for all boroughs involved in this service.

As has been discussed previously, the local approach to integrating NHS 111 and the out-of-hours service came out of local work in Camden and Islington with The Primary Care Foundation (PCF). The PCF observed in detail the exact ways in which the disconnect between the services impacted on patients, and made recommendations about the importance for patient safety of having an integrated service and removing unnecessary delays in call transfer between services.

It is this work, and the model that has evolved out of it, that has gone on to inform NHS England's approach to commissioning integrated urgent care. Since then, we have conducted a huge amount of local engagement, and local residents and commissioners have been involved at every stage to inform the development of the specification.

There are many service requirements included in the specification to reflect input from local patients, public and clinicians. These broadly fall into the following areas (see Appendix A):-

1. Clinical quality and safety
2. Clinical Governance and Integrated Governance
3. Operational
4. Technical
5. Patient and Public Involvement
6. Social Marketing and Communication
7. Performance and Contract Management
8. Workforce
9. Access and Availability

The performance indicators described above will be reported on a borough-by-borough basis (based on the location of the caller so that individual CCGs can continuously monitor whether the provider is meeting local variations in need and providing a consistently good service.

Local needs vary between (and within) the NCL boroughs. There are variations in the types of people who use our services, in terms of age, ethnicity, levels of deprivation and prevalent conditions. The future providers will be expected to flex their service delivery to ensure they meet all these needs – for example to adjust the numbers, skill mix and shift hours of staff at the out-of-hours bases to fit with local demand – exactly as already happens. The key principle is that there should be equity of access and service delivery for patients across the whole of NCL. Equity of access is not the same as services being identical.

There is also local variation in the other services commissioned by the NHS or local authorities. For example, a mental health crisis hotline is currently commissioned for patients in Camden and Islington and will be a referral point used by the integrated urgent care service in those boroughs – elsewhere the equivalent patients will be supported in a different way.

Similarly, while all NCL CCGs are developing extended GP services, these projects are at different stages, will offer different services in different areas, and will continue to develop over the five-year lifetime of the urgent care contract and beyond. These developments will clearly have a big impact on 111/OOH referrals during the 8am-8pm period and at weekends, and the volume of calls received from different areas at different times – the new providers will need to be sensitive to this variation, and adapt their service accordingly. The specification makes this requirement clear.

North central London CCGs have commissioned a comprehensive Directory of Services to ensure that, outside the scope of NHS 111/OOH itself, there is comprehensive understanding of what local services are available when. This will greatly enhance the quality of advice and referral provided by NHS 111. One of the significant benefits of the new model, as we track patient pathways through and out of the urgent care service, is that we will be equipped to assess where needs are or are not being met across the whole health system. For example if referrals in a particular area or for a particular service type are not working smoothly or proving satisfactory for patients, this is where it will show up, and how CCGs will be alerted that there are changes that need to be made.

4 Recommendations

- JHOSC members are asked to consider and comment on the information provided.
- The JHOSC is asked to consider at what stage they would like a further update on this programme, bearing in mind the projected milestones which should see the contract awarded in April 2016, and the new service beginning in October 2016.

5 Appendices

Appendix A: Principal changes to 111/OOH service specification following public engagement

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

Appendix A: Changes to the Service Specification

Structure

As a result of the feedback from patients and the public we have edited the structure of the service specification and reorganised the presentation style. A summary has also been included to assist audiences that may not be familiar with the technical detail. The terminology has been modified to add clarity where providers are required to deliver functions, for example changes from 'should' to 'must'. A diagrammatic summary has been added to assist readers with the type of service to be delivered and to help reflect where the service fits into the rest of the system.

1. Clinical quality and safety

The commissioners and members of the governance committees will be able to enter the provider's premises for governance purposes and to check on service delivery. This group will also include patient representatives.

The clinical quality of the service will be monitored using regular clinical audit; this will operate at a borough level and also based on the professional group for clinicians in the service. The audit standards will include the professional standards that have been set by the relevant Royal College or Professional Body, for example the Royal College of GPs audit standard will be a requirement within this service.

2. Clinical Governance and Integrated Governance

The information security requirements have been refined so that it is clear that data cannot be shared outside of the permitted use for this service and certainly cannot be used for any commercial purposes.

3. Operational

The role of the clinical hub within the service has been clarified so that providers are aware of the precise scope of the service within north central London, to reflect the integration with local services in each of the boroughs. For example, with care homes in Barnet and mental health services in Camden and Islington.

The location of call centres is also specified with the added desire to make this close to the boroughs of north central London. The location of bases for out-of-hours GP appointments must be within the boroughs of north central London.

The minimum data requirements for service users have been changed to remove ethnicity, based on the public feedback.

Callers will have more direct access to clinicians and this will be based on any care plans that have been agreed with a patient's GP. This function has been introduced following feedback from NCL residents.

Callers falling into a number of categories will now have more direct access to a clinician including the following, these have been added following feedback from patients and the public in NCL

- Patients that are not happy with the initial advice given
- Patients who may want an ambulance but are unsure
- Those patients that want support with self-care or home care but do not want to visit an Emergency Department
- Patients with multiple symptoms and those patients who also have complex medical

histories
- Patients with clinical care plans including those who have an end of life care plan

The public wanted a more responsive service when seeing a GP in the out-of-hours period, therefore the time periods for responses have been shortened to improve the patient experience.

4. Technical

The online access to this service has been expanded for north central London.

The clinical decision support system will be more flexible so that it can be changed in the future to meet the needs of users in north central London.

Patients will be able to consent to record sharing when they call and will be able to make individual decisions on access to their patient record.

Telephone call routing has been improved so that calls for certain patients in north central London such as under 5s and over 85s will be routed to a clinical advisor more rapidly rather than being first managed by a health advisor.

5. Patient and Public Involvement

The provider will be required to involve the public and patients on an ongoing basis with service development.

The provider will need to develop their patient feedback techniques to reflect the local needs of each borough in north central London.

6. Social Marketing and Communication

As a result of very specific feedback from NCL residents the commissioners will require the provider to work with local organisations and groups within each borough to promote the service and help promote access.

7. Performance and Contract Management

The specification sets out that payment model and the performance indicators will be refined during the course of this contract and that the provider will be required to move to the new payment system.

The contract model will use the NHS standard contract but will include an annual review process that will enable the opportunity to agree any contract variations and changes that need to be made in response to developments in primary care and other parts of emergency care.

Public representatives will be part of the group that oversees the contract and will have an opportunity to provide ongoing recommendations for service development.

Contract monitoring data will be presented at an individual borough level which is a requirement that has resulted from public feedback.

Outcomes: The service will have a balanced set of key performance indicators which will include clinical outcomes and operational outcomes (e.g. where a patient was referred to)

The KPIs will be monitored monthly to start with, however north central London will be moving towards real time reporting so that outcomes can be more closely monitored. North central London is now a pilot site for real time reporting.

8. Workforce

The workforce component has been modified to ensure that the service includes clinicians that are familiar with local pathways, services and protocols such as local borough level formularies and services that exist in each borough. The clinicians will be supported with a local directory of services but will need to be familiar with the local services that they may be referring to and will need to demonstrate how they will integrate with local services in each borough, including local GP services.

The training requirement has also been expanded to ensure that the service is connected to local practices through the training of GP registrars in order to help improve the number of local GPs working in the service that are familiar with the needs of patients in each borough in NCL.

9. Access and Availability

The population that the service is being delivered for and the specific needs of each of the local boroughs is cited in the specification to reflect the local authority health profiles for each borough. This includes the need for specific accessible service locations within each of the boroughs of north central London. The times of operation of the service are clearly set out in the service specification. The performance indicators for north central London will include access and availability of the service to ensure that residents for each borough receive an equitable service.

Access to the service will be expanded to ensure that all people in north central London irrespective of where their GP is will be able to access this service.

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

GC9 Contract Management

9.4 If the Co-ordinating Commissioner believes that the Provider has failed or is failing to comply with any obligation on its part under this Contract it may issue a Contract Performance Notice to the Provider.

9.6 Unless the Contract Performance Notice has been withdrawn, the Co-ordinating Commissioner and the Provider must meet to discuss the Contract Performance Notice and any related issues within 10 Operational Days following the date of the Contract Performance Notice.

9.11 If a Remedial Action Plan is to be implemented, the Co-ordinating Commissioner and the Provider must agree the contents of the Remedial Action Plan within:

9.11.1 5 Operational Days following the Contract Management Meeting;

9.12 The Remedial Action Plan must set out:

9.12.1 actions required and which Party is responsible for completion of each action to remedy the failure in question and the date by which each action must be completed;

9.12.2 the improvements in outcomes and/or other key indicators required, the date by which each improvement must be achieved and for how long it must be maintained;

9.12.3 any agreed reasonable and proportionate financial sanctions or other consequences for any Party for failing to complete any agreed action and/or to achieve and maintain any agreed improvement (any financial sanctions applying to the Provider not to exceed in aggregate 10% of the Actual Monthly Value in any month in respect of any Remedial Action Plan).

9.16 If, 10 Operational Days after notifying the Governing Bodies, the Co-ordinating Commissioner and the Provider still cannot agree a Remedial Action Plan due to any unreasonableness or failure to engage on the part of the Provider, the Co-ordinating Commissioner may recommend the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), up to 2% of the Actual Monthly Value for each further month a Remedial Action Plan is not agreed.

9.19 If either the Provider or any Commissioner fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan, then the Co-ordinating Commissioner or the Provider (as appropriate) may, at its discretion apply any financial or other sanction agreed in relation to that failure.

9.20 If a Party fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan and does not remedy that failure within 5 Operational Days following its occurrence, the Provider or the Co-ordinating Commissioner (as the case may be) may issue an Exception Report:

9.20.1 to the relevant Party's chief executive and/or Governing Body; and/or

9.20.2 (if it reasonably believes it is appropriate to do so) to any appropriate Regulatory or Supervisory Body,

in order that each of them may take whatever steps they think appropriate.

9.21 If the Provider fails to complete an action required of it, or to deliver the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan:

9.21.1 (if the Remedial Action Plan does not itself provide for a withholding or other financial sanction in relation to that failure) the Co-ordinating Commissioner may, when issuing an Exception Report, instruct the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), in respect of each action not completed or improvement not met, a reasonable and proportionate sum of up to 2% of the Actual Monthly Value, from the date of issuing the Exception Report and for each month the Provider's breach continues and/or the required improvement has not been achieved and maintained, subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value;

9.22 If, 20 Operational Days after an Exception Report has been issued under GC9.20, the Provider remains in breach of a Remedial Action Plan, the Co-ordinating Commissioner may notify the Provider that any sums withheld under GC9.19 or GC9.21.1 are to be retained permanently. If it does so having withheld those sums itself on behalf of all Commissioners, the Co-ordinating Commissioner must distribute the sums withheld between the Commissioners in proportion to their respective shares of the Actual Monthly Value for each month in respect of which those sums were withheld.

GC16 Suspension

16.1 If a Suspension Event occurs the Co-ordinating Commissioner:

16.1.1 may by written notice to the Provider require the Provider with immediate effect to suspend the provision of any affected Service, or the provision of any affected Service from any part of the Services Environment, until the Provider demonstrates to the reasonable satisfaction of the Co-ordinating Commissioner that it is able to and will provide the suspended Service to the required standard;

16.8 Following and during the suspension of a Service the Provider must:

16.8.1 not accept any further Referrals of Service Users who require the suspended Service;

16.8.2 at its own cost co-operate fully with the Co-ordinating Commissioners and any interim or successor provider of the suspended Service in order to ensure continuity and smooth transfer of the suspended Service and to avoid any inconvenience to or risk to the health and safety of Service Users, employees of the Commissioners or members of the public including:

16.8.2.1 promptly providing all reasonable assistance and all information necessary to effect an orderly assumption of the suspended Service by any interim or successor provider; and

16.8.3 ensure there is no interruption in the availability of CRS or Essential Services including, where appropriate, implementing any Essential Services Continuity Plan.

Termination: Provider Default

17.10 The Co-ordinating Commissioner may terminate this Contract or any affected Service, with immediate effect, by written notice to the Provider if:

17.10.1 any Condition Precedent is not met by the relevant Longstop Date; or

17.10.2 the Provider ceases to carry on its business or substantially all of its business; or

17.10.3 a Provider Insolvency Event occurs; or

17.10.4 the Provider is in persistent or repetitive breach of the Quality Requirements; or

17.10.5 the Provider is in breach of any regulatory compliance standards issued by any Regulatory or Supervisory Body or has been issued any warning notice under section 29 or 29A of the 2008 Act, or termination is otherwise required by any Regulatory or Supervisory Body; or

17.10.6 two or more Exception Reports are issued to the Provider under GC9.19 (*Contract Management*) within any rolling 6 month period which are not disputed by the Provider, or if disputed, are upheld under Dispute Resolution; or

17.10.8 there is:

17.10.8.1 a Provider Change in Control and, within 30 Operational Days after having received the Change in Control Notification, the Co-ordinating Commissioner reasonably determines that, as a result of that Provider Change in Control, there is (or is likely to be) an adverse effect on the ability of the Provider to provide the Services in accordance with this Contract; or

17.10.8.3 a breach of GC24.9.2 (*Change in Control*) and the Provider has not replaced the Material Sub-Contractor within the relevant period specified in the notice served upon the Provider under GC24.10 (*Change in Control*);

GC18 Consequence of Expiry or Termination

18.2 If, as a result of termination of this Contract or of any Service following service of notice by the Co-ordinating Commissioner under GC17.4 or 17.10 (*Termination*), any Commissioner procures any terminated Service from an alternative provider, and the cost of doing so (to the extent reasonable) exceeds the amount that would have been payable to the Provider for providing the same Service, then that Commissioner, acting reasonably, will be entitled to recover from the Provider (in addition to any other sums payable by the Provider to the Co-ordinating Commissioner in respect of that termination) the excess cost and all reasonable related administration costs it incurs (in each case) in respect of the period of 6 months following termination.

18.3 On or pending expiry or termination of this Contract or termination of any Service the Co-ordinating Commissioner, the Provider, and if appropriate any successor provider, will agree a Succession Plan.

18.4 For a reasonable period before and after termination of this Contract or of any Service, and where reasonable and appropriate before and after the expiry of this Contract, the Provider must:

18.4.1 co-operate fully with the Co-ordinating Commissioner and any successor provider of the terminated Services in order to ensure continuity and a smooth transfer of the expired or terminated Services, and to avoid any inconvenience or any risk to the health and safety of Service Users or employees of any Commissioner or members of the public; and

18.4.2 at the reasonable cost and reasonable request of the Co-ordinating Commissioner:

18.4.2.1 promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the terminated Services by a successor provider;

18.5 On and pending expiry or termination of this Contract, or termination of any Service, the Parties must:

18.5.1 implement and comply with their respective obligations under the Succession Plan; and;

18.5.2 use all reasonable endeavours to minimise any inconvenience caused or likely to be caused to Service Users or prospective service users as a result of the expiry or termination of this Contract or any Service.

18.7 On expiry or termination of this Contract or termination of any Service:

18.7.3 subject to any appropriate arrangements made under GC18.4 and 18.5, the Provider must immediately cease its treatment of Service Users requiring the expired or terminated Service, and/or arrange for their transfer or discharge as soon as is practicable in accordance with Good Practice and the Succession Plan.

18.8 If termination of this Contract or of any Service takes place with immediate effect in accordance with GC17 (*Termination*), and the Provider is unable or not permitted to continue to provide any affected Service under any Succession Plan, or implement arrangements for the transition to a successor provider, the Provider must co-operate fully with the Co-ordinating Commissioner and any relevant Commissioners to ensure that:

18.8.1 any affected Service is commissioned without delay from an alternative provider; and

18.8.2 there is no interruption in the availability to the relevant Commissioners of any CRS or Essential Services.

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 – Health Implications of Damp Properties - witness evidence
2. Work Programme 2015/16
3. Presentation Executive Member Health and Wellbeing
4. Healthwatch Work Programme
5. Health and Wellbeing update
6. Update Margaret Pyke centre
7. Value Based Commissioning

18 JANUARY 2016

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – Health implications of Damp Properties
3. Margaret Pyke Centre – Update
4. 111/Out of Hours service
5. Work Programme 2015/16
6. Health and Wellbeing Board – update
7. GP Appointment update

08 FEBRUARY 2016

1. Scrutiny Review – Health Implications of Damp Properties – witness evidence
2. NHS Trust – Moorfields – Performance update

3. Work Programme 2015/16
4. Health and Wellbeing Board - update

11 APRIL 2016

1. Scrutiny Review – Health Implications of Damp Properties – Draft recommendations
2. Scrutiny Review – GP Appointments – 12 month report back
3. Work Programme 2015/16
4. Health and Wellbeing Board – update

16 MAY 2016

1. **Scrutiny Review – Health Implications of Damp Properties – Final Report**

Other items to be determined

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