Open Agenda

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Thursday 21 March 2019
7.00 pm
Bromley Civic Centre, Stockwell Close, Bromley, BR1 3UH

Membership

Councillor Judith Ellis (Chairman)
Councillor Philip Normal (Vice-Chair)
Councillor Daniel Adilypour
Councillor Juliet Campbell
Councillor Richard Diment
Councillor Barrie Hargrove
Councillor Mark James
Councillor Chris Lloyd
Councillor Robert Mcilveen
Councillor John Muldoon
Councillor Caroline Newton
Councillor David Noakes

Reserves

INFORMATION FOR MEMBERS OF THE PUBLIC

Location: The meeting will be held in the Council Chamber. Please follow the signs at the Civic Centre directing members of the public to the Council Chamber.

Contact Graham Walton on 0208 461 7743 or graham.walton@bromley.gov.uk

---

MARK BOWEN
Director of Corporate Services
London Borough of Bromley

Date: 13 March 2019

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

Item No.	Title	Page No.

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Thursday 21 March 2019
7.00 pm
Bromley Civic Centre, Stockwell Close, Bromley, BR1 3UH

Order of Business

Item No.	Title	Page No.

1. APOLOGIES

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

In special circumstances, an item of business may be added to an agenda within five working days of the meeting.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

Members to declare any interests and dispensations in respect of any item of business to be considered at the meeting.

4. DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING

5. MINUTES OF THE MEETING HELD ON 26TH SEPTEMBER 2018 1 - 5

To approve as a correct record the Minutes of the meeting held on 26th September 2018.

6. CONSULTATION ON CONGENITAL HEART DISEASE (CHD) SERVICES IN LONDON (NHS ENGLAND) (TO FOLLOW)

7. POPULATION HEALTH AND LIFE EXPECTANCY 6 - 11

8. ROLL-OUT OF HUBS/UCC/UTC 12 - 18

9. KENT AND MEDWAY HYPER ACUTE STROKE UNITS 19 - 20

Item No.	Title	Page No.
10.	**CONSULTATION ON PROPOSAL TO MOVE MOORFIELDS EYE HOSPITAL (VERBAL UPDATE)**	21

11. NEXT MEETING/WORK PROGRAMME

12. PART B - CLOSED BUSINESS

13. EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to information Procedure rules of the Constitution."

14. DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 13 March 2019

EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the sub-committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to Information Procedure rules of the Constitution."

Agenda Item 5

OUR HEALTHIER SOUTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held on 26 September 2018 at 7.00 pm at Lambeth Town Hall, Brixton Hill, London SW2 1RW

PRESENT:

Councillor Judi Ellis (Chairman)
Councillor Philip Normal (Vice-Chairman)
Councillor Richard Diment
Councillor Barrie Hargrove
Councillor Mark James
Councillor Robert McIlveen
Councillor David Noakes

OFFICER & PARTNERS SUPPORT

Mark Edginton, Programme Director, Community Based Care – OHSEL STP
Andrew Eyres, Accountable Officer, NHS Lambeth CCG & NHS Croydon
Julie Lowe, Programme Director – OHSEL STP
Tom Wake, Head of Programme Management Office (PMO) – OHSEL

12 ELECTION OF CHAIR AND VICE-CHAIR

It was proposed and **AGREED** that Cllr Judith Ellis be appointed Chair of Our Healthier South East London Joint Health Overview and Scrutiny Committee (OHSEL JOSC) and that Cllr Philip Normal be appointed vice chair of OHSEL JOSC.

13 DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were apologies from Cllr Juliet Campbell, Cllr Chris Lloyd, Cllr John Muldoon, Cllr Caroline Newton. The following declarations of interest were made:

- Cllr Judith Ellis declared that her daughter is an employee of Oxleas NHS Foundation Trust;
- Cllr Richard Diment declared that he is a Governor of Oxleas NHS Foundation Trust; and,
- Cllr Barrie Hargrove declared that he is a member of Guys and St Thomas' NHS Foundation Trust.

14 MINUTES OF THE MEETING HELD ON 12TH MARCH 2018

The minutes of the meeting held on 12 March 2018 were agreed as a correct record of the proceedings.

Cllr Diment advised that re the Kent and Medway Stroke Service Consultation (Minutes: item 7), the assessment process has now been worked through and the preferred option is for three hyper acute stroke units including one at Darent Valley Hospital in Dartford, along with units at Maidstone and Ashford.

15 OUR HEALTHIER SOUTH EAST LONDON PROGRAMME

The chair asked NHS colleagues to introduce themselves:

- Julie Lowe, Programme Director – OHSEL STP;
- Mark Edginton, Programme Director, Community Based Care – OHSEL STP;
- Tom Wake, Head of Programme Management Office (PMO) – OHSEL STP; and,
- Andrew Eyres, Accountable Officer, NHS Lambeth CCG & NHS Croydon CCG.

The chair invited NHS colleagues to run through the presentation circulated with the agenda papers. In her introduction, Julie Lowe Programme Director noted that a number of members are new appointees to the JOSC. The presentation was designed to provide an overview of the OHSEL programme, which represents the region's Sustainability and Transformation Plan (STP) and the JOSC covers the same boundaries as the STP. The Plan is designed to ensure a sustainable future for the NHS in South East London delivering high quality patient care with the best possible outcomes in ways that are affordable. In 2018 the focus is on three key things: (1) Integrated Care Systems; (2) End to End Pathway Work; (3) Provider Collaboration. The Programmed Director set out the headline issues and an update on the programme groups (as set out in the report). The committee was then invited to ask questions. The following issues were raised and responses given:

- A member questioned on the extent to which NHS England had devolved responsibilities for primary care to CCGs in SEL and therefore if there was a greater opportunity through the STP to look at primary care and reducing pressures on A&Es and admissions. It was confirmed that there is primary care delegation across the whole of SEL. The primary care executive meets together regularly to share best practice and opportunities to do things at scale. Officers advised that a core concept of the Community Care Based Strategy is that primary care comes together in Local Care Networks and look at alternative ways to provide care closer to home, as well as addressing issues around SEL population health more generally.

- A member sought clarification on the Urgent and Emergency Care Programme and proposals to enhance care in other settings and changing urgent care centres (UCC) into urgent treatment centres (UTC). Officers explained that there is national criteria for UTC, in SEL the NHS is looking at where it can meet that national criteria. It is also important for members of the public to be able to understand what service they can expect in going to a UCC or to a UTC and this accordingly will also help people determine where they should go when seeking

treatment. For the public the definitions can be confusing and there is a need for greater clarity and a level of standardisation across SEL. It was acknowledged that some people will automatically go to A&E/UCC without checking on the availability of a GP appointment: pilots are being undertaken at A&E triage which signposts an individual to where they might be more appropriately treated and offered an alternative arrangement/appointment. There was also a need to open up access to GPs more generally and promote wider understanding about GP Hubs and that people can generally get a next day appointment to be seen by a GP, though that may not be their GP.

- With regard to the status of Orthopaedics and arrangements going forward, officers advised that over a period of 18 months CCGs and providers are looking at whether consistent outcomes can be demonstrated across all current providers, and if that is the case that will be the commissioned arrangement going forward. The focus thus far has been on hip and knee replacements which is high volume work and is looking consistent; there is a however a need to look at lower volume work and whether that is better centralised.

- A member questioned on Pathology Services and the future of Lewisham & Greenwich services specifically. Officers advised that NHS Improvement has sought the formation of 29 Pathology networks nationally and the recommendation is that SEL forms a network. There is flexibility to join a different geographic network, however arising from specialist advice there is not flexibility for standalone services. A review process has been undertaken across SEL provision and a tender invitation issued to see whether partners are interested in providing the service. It was noted that Kings and Guys & St Thomas' have been in a joint venture partnership which has a commercial element for approximately ten years. Notwithstanding the status of that contract which is up for renewal, Lewisham & Greenwich are considering the position and interested in exploring the options for being engaged in a purely NHS provision, rather than the potential for being in provision which has a commercial element. It was expected that more would be known in January. However it was not considered that this is an issue around the patient or clinical experience of care.

- A member questioned the status of Local Care Networks (LCN), their governance and how they are monitored. Officers advised that LCNs are defined in part by historic working arrangements so LCNs across the region are at different stages of development with some at a more mature status than others. Work is ongoing through the STP to share good practice including how to develop the clinical voice, understanding the benefits of being in a LCN, and exploring opportunities for greater partnership working – examples include Federation working or an Alliance model with community and mental health providers. There are 8 LCN across SEL (from 15 previously) and the move is towards larger scale collaborations. Arising from external issues such as financial challenges, patient pressures and NHS reporting requirements General Practices generally are starting to understand the benefits of being in a LCN and managing matters at scale, there is also increasing confidence from the clinical voice of the benefits to patients. Whilst some arrangements only commenced within the last two years, in Lambeth and Southwark there has been GP collaborative working for a much longer period and the learning from those areas have been key to informing the areas which are less

developed. GPs value the opportunities to work across different professional groups and interact in multi-disciplinary teams (e.g. involving social workers, pharmacy etc), to support patients who have multiple issues and needs which are difficult to address in isolation. LCNs are about professional networks and delivering better outcomes for patients; they also provide an opportunity to be outward looking and think about populations and health, rather than addressing solely the needs of an individual who attends a surgery.

- In response to questions on winter pressures and planning, the committee was advised that winter plans are expected to be signed off in the next week arising from work which started in the spring with a debriefing on the previous winter. A lot has been done to educate people about when to attend A&E and alternative options, and this work is ongoing. UTCs can take the pressure off hospital services and are available to patients at weekends. As well as looking at the front end of services, work and testing is also taking place around patient discharge and whether discharge happens in a timely manner. In particular, and reflecting the nature of the regions hospitals and patient flow, there is a focus on whether the offer is working well across the whole of the SEL population and whether management systems and mechanisms for working with social care departments are effective. In response to a suggestion that there needs to be a team for discharging patients, rather than this being managed through each individual borough, officers advised that this is something which is being explored.

- Further information was sought on the Digital Enabler programme and whether there is an associated policy, where it would impact and timelines. Officers advised that there are a number of work streams underway such as Virtual Care Records where a person's record can be seen in real time and the One London Programme whereby every record is always available. For health professionals having access to the most current up to date information will mean that patients get the best care and accurate decision making immediately and it will also improve the patient pathways as there will be better join up across services and support systems.

- In relation to the differential costs and payments associated with a patient going to a GP, to a UCC or to A&E, a member questioned on referral mechanisms from A&E for patients seeming non-urgent treatment. Officers advised that patients attending A&E will be triaged and if the patient does not need to be there the hospital can re-direct and refer to local practice or book into a Hub. However if a patient is not local this is more difficult. There is a balance of risk for clinicians in turning somebody away and a more likely scenario is a short consultation. It was also noted that there are some issues around borough boundaries and using a Hub where a patient is not registered in that borough. Members questioned whether there might not be benefits of cross boundaries in SEL and officers agreed to take back this issue and consider what reciprocal arrangements might work and look like.

In concluding the discussion it was noted that there were no major consultations pending. The following issues were raised by members and officers as potential matters for future scrutiny by the JOSC:

- Hubs – roll out; public/patient awareness; geographical arrangements and cross

boundary;
- UCC & UTC – people understanding where they should go;
- Population health, life expectancy and long term planning in SEL (e.g. age pressures in different boroughs);
- Children and Young People mental health;
- Residential care beds and access to beds close to home/where families are; and,
- Integrated care.

16 WORKPLAN AND FUTURE BUSINESS

It was proposed and **Agreed** that the committee next meet in February 2019, with a subsequent meeting to be held in June 2019. The indicative issues would be:

- February 2019 (i) population health and life expectancy - long term planning reflecting age and pressures in different boroughs; and (ii) roll out of hubs/UCC/UTC and people/patients understanding where to go; and,
- June 2019 - Integrated Care.

CLOSE OF MEETING

The meeting ended at 8.30pm

CHAIR

Date of Despatch: Thursday 22 November 2018
Contact for Enquiries: Elaine Carter
Tel: 020 7926 0027
E-mail: ecarter@lambeth.gov.uk
Web: www.lambeth.gov.uk

Agenda Item 7

Our Healthier South East London
Improving health and care together

NHS

Meeting: **SE London Joint Health Overview and Scrutiny Committee**

Location: **Bromley Council, Civic Centre**

Date: **Thursday 21st March 2019**

Title: **Population health & life expectancy**
Long term planning reflecting age and pressure in different boroughs

Presenter: **Julie Lowe, Programme Director, Our Healthier South East London**

---

1. Summary

In south east London, we have some very good health services. People are living longer, and many people are healthier. But we also have some services that could be better. We have services that people find hard to access and some people do not get the help they need to keep themselves and their families well. We also have wide variation in life expectancy and too many people die early from preventable diseases.

Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs, with NHS England as co-commissioner, are working in partnership with local authorities, local providers, patient and public voices (PPVs) and other key stakeholders to define a strategy for health and integrated care services across south east London.

This paper provides borough level information as background information as requested by the committee, together with some context. Further work on the reasons for the differences between boroughs and the action being taken is in progress as we develop our response to the Long Term Plan.

2. Background

The health of our population has improved significantly over the last five years, but there is more to be done. A detailed case for change has been previously developed to understand the health and wellbeing needs of our population.

In summary:

- We have a vibrant, diverse and mobile population with extremes of deprivation and wealth. 26% of children are classified as living in poverty, concentrated in certain parts of SEL. Premature death and differences in life expectancy are significant issues
- 75% of over 55s have at least one Long Term Condition, while 32% of children are overweight or obese
- We need to improve the health of the population overall. Keeping well, at all ages, is critically important.

3. The Office - National Statistics

The national office for statistics report (2015 to 2017) include life expectancy (LE), healthy life expectancy (HLE) and disability-free life expectancy (DFLE) at birth and age 65 by sex, UK, 2015 to 2017, which is available by local authority areas.

- Life expectancy at birth in the UK did not improve between 2015 and 2017 and remained at 79.2 years for males and 82.9 years for females. Within the UK, life expectancy at birth declined by 0.1 years from 2015 to 2017 for males and females in Scotland and Wales, and for males in Northern Ireland; life expectancy at birth remained unchanged from 2014 to 2016 for females in Northern Ireland and males and females in England.

- The slowdown in life expectancy improvements in the UK has continued, as 2015 to 2017 saw the lowest improvements in life expectancy since the start of the series in 1980 to 1982. Some decreases in life expectancy at birth have been seen in Scotland, Wales and Northern Ireland whilst in England life expectancy has remained unchanged from 2014 to 2016. This slowing in improvements is reflected in the chances of surviving to age 90 years from birth, which has also seen virtually no improvement between 2012 to 2014.

- Life expectancy in the UK remained lower than in many other comparable countries internationally.

4. Developing plans to take forward and actions to address

1) New evidence-based NHS prevention programmes, including to cut smoking and to reduce obesity (partly by doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme); to limit alcohol-related A&E admissions; and to lower air pollution.
2) Responding to the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multimorbidity and healthy ageing including dementia, children's health, cardiovascular and respiratory conditions, and learning disability and autism as well as the priorities outlined in the Long Term Plan.
3) System wide working and leadership on our response to the LTP is important.
4) Development of an Integrated Care System (ICS). NHS services have an important role to play in improving population health, however wider socio-economic and environmental factors often play a greater role. At its best an ICS will allow health, local government and other partners to work together at a range of levels in a coordinated way to tackle the wider determinants of health.

REFERENCES

The Office – National Statistics; National Life Tables: 2015 to 2017

The Guardian Office for National Statistics says growth in life expectancy is lowest since records began (25/09/18)

APPENDIX

The Office – National Statistics; National Life Tables: 2015 to 2017

Notes

- Health state life expectancy figures are not calculated for City of London or Isles of Scilly due to small numbers of deaths and populations.
- The symbol '..' is used to show that data are not available.

- Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years
- Figures are based on geographical boundaries as of May 2018
- Figures for England, Wales, regions, counties and local authorities exclude deaths of non-residents
- Scotland includes non-usual residents who die in Scotland and do not have an area of residence within Scotland and imputation is used to assign to geography of 'residence'
- (see section 1.3.1 in the following: http://www.scotpho.org.uk/downloads/hle/HLE-technical-paper-2015-v9.pdf)
- Northern Ireland also includes non-usual residents whom are allocated to place of death (see http://www.nisra.gov.uk/archive/demography/vital/deaths/life_tables/LE%20Information%20Paper.pdf for more details)
- Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.

Health state life expectancies at birth for males, United Kingdom, 2015-2017

Life Expectancy (LE), Healthy life expectancy (HLE) and Disability-free life expectancy (DfLE) with lower confidence limits (LCL) and upper confidence limits (UCL)

Area Codes	Area Names	LE	LCL	UCL	HLE	LCL	UCL	%	DfLE	LCL	UCL	%
K02000001	**UNITED KINGDOM**	79.2	79.2	79.3	63.1	63.0	63.3	79.7	62.7	62.6	62.9	79.2
E92000001	**ENGLAND**	79.6	79.5	79.6	63.4	63.2	63.5	79.7	63.1	62.9	63.2	79.3
E12000007	**LONDON**	80.5	80.4	80.5	63.9	63.4	64.4	79.4	64.8	64.3	65.3	80.6
E09000004	Bexley	80.0	79.6	80.4	65.0	62.7	67.3	81.2	67.0	64.4	69.6	83.7
E09000006	Bromley	81.4	81.0	81.7	65.7	63.2	68.2	80.8	64.8	62.1	67.5	79.7
E09000011	Greenwich	79.2	78.7	79.6	63.2	60.4	66.0	79.9	61.3	58.4	64.3	77.5
E09000022	Lambeth	78.7	78.2	79.2	59.4	56.2	62.6	75.5	61.5	58.1	64.8	78.1
E09000023	Lewisham	79.0	78.6	79.5	61.9	59.2	64.6	78.4	62.7	60.0	65.4	79.3
E09000028	Southwark	78.9	78.4	79.4	62.4	59.5	65.3	79.1	66.4	63.6	69.2	84.2

Footnotes

Figures exclude deaths of non-residents

Figures are not available for City of London and Isles of Scilly due to small numbers of deaths and populations. This is denoted by the symbol '..'

Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.

Life Expectancy estimates for England are based on lower tier local authorities, Healthy and Disability-free life expectancy estimates are based on Upper Tier Local Authorities.

Local areas are Local Authorities in Wales, Council Areas in Scotland and Local Government District in Northern Ireland.

Figures are not available for City of London and Isles of Scilly due to small numbers of deaths and populations. This is denoted by the symbol '..'
Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.
Life Expectancy estimates for England are based on lower tier local authorities, Healthy and Disability-free life expectancy estimates are based on Upper Tier Local Authorities.
Local areas are Local Authorities in Wales, Council Areas in Scotland and Local Government District in Northern Ireland.

Health state life expectancies at age 65 for males, United Kingdom, 2015-2017

Life Expectancy (LE), Healthy life expectancy (HLE) and Disability-free life expectancy (DfLE) with lower confidence limits (LCL) and upper confidence limits (UCL)

Area Codes	Area Names	LE	LCL	UCL	HLE	LCL	UCL	%	DfLE	LCL	UCL	%
K02000001	**UNITED KINGDOM**	18.6	18.6	18.6	10.3	10.2	10.5	55.6	9.8	9.7	9.9	52.5
E92000001	**ENGLAND**	18.8	18.7	18.8	10.4	10.3	10.6	55.6	9.9	9.8	10.0	52.7
E12000001	**NORTH EAST**	17.9	17.8	18.0	8.8	8.4	9.2	49.2	8.4	8.0	8.9	47.2
E12000007	**LONDON**	19.3	19.3	19.4	10.1	9.7	10.6	52.4	10.3	9.8	10.7	53.0
E09000004	Bexley	18.5	18.2	18.8	9.3	7.4	11.3	50.4	11.3	9.0	13.7	61.3
E09000006	Bromley	19.6	19.3	19.9	11.0	8.9	13.0	55.9	11.4	9.4	13.4	58.2
E09000011	Greenwich	18.5	18.1	18.9	10.1	7.7	12.4	54.5	10.0	7.6	12.4	54.2
E09000022	Lambeth	18.2	17.8	18.7	7.0	4.3	9.7	38.3	7.7	4.9	10.5	42.3
E09000023	Lewisham	18.4	18.0	18.8	7.7	5.5	10.0	42.0	8.3	6.1	10.5	45.1
E09000028	Southwark	18.3	17.8	18.7	8.6	5.8	11.3	46.9	11.6	8.8	14.3	63.1

Footnotes

Figures exclude deaths of non-residents

Figures are not available for City of London and Isles of Scilly due to small numbers of deaths and populations. This is denoted by the symbol '..'

Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.

Life Expectancy estimates for England are based on lower tier local authorities, Healthy and Disability-free life expectancy estimates are based on Upper Tier Local Authorities.

Local areas are Local Authorities in Wales, Council Areas in Scotland and Local Government District in Northern Ireland.

Health state life expectancies at age 65 for females, United Kingdom, 2015-2017

Life Expectancy (LE), Healthy life expectancy (HLE) and Disability-free life expectancy (DfLE) with lower confidence limits (LCL) and upper confidence limits (UCL)

Area Codes	Area Names	LE	LCL	UCL	HLE	LCL	UCL	%	DfLE	LCL	UCL	%
K02000001	**UNITED KINGDOM**	20.9	20.9	20.9	10.9	10.7	11.0	51.9	9.7	9.6	9.9	46.5
E92000001	**ENGLAND**	21.1	21.1	21.1	10.9	10.8	11.0	51.7	9.8	9.7	10.0	46.6
E12000007	**LONDON**	21.9	21.9	22.0	10.8	10.4	11.3	49.3	10.3	9.9	10.8	47.0
E09000004	Bexley	21.7	21.4	22.0	8.7	6.6	10.7	39.9	9.4	7.5	11.4	43.5
E09000006	Bromley	22.4	22.1	22.7	13.7	11.8	15.6	61.2	12.1	10.2	13.9	53.8
E09000011	Greenwich	20.7	20.4	21.1	9.3	7.4	11.2	44.7	9.6	7.9	11.3	46.3
E09000022	Lambeth	21.4	20.9	21.8	13.9	9.5	18.3	65.1	13.1	9.3	16.8	61.1
E09000023	Lewisham	21.4	21.0	21.8	10.1	7.5	12.7	47.2	10.9	8.3	13.4	50.8
E09000028	Southwark	22.1	21.6	22.6	17.8	14.8	20.9	80.8	14.5	10.6	18.3	65.5

Footnotes

Figures exclude deaths of non-residents

Figures are not available for City of London and Isles of Scilly due to small numbers of deaths and populations. This is denoted by the symbol '..'

Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.

Life Expectancy estimates for England are based on lower tier local authorities, Healthy and Disability-free life expectancy estimates are based on Upper Tier Local Authorities.

Local areas are Local Authorities in Wales, Council Areas in Scotland and Local Government District in Northern Ireland.

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Agenda Item 8

Urgent and Emergency Care Services in SE London

South East London Joint Health Overview and Scrutiny Committee meeting

21st March 2019

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Examples of services available

- Emergency departments
- Urgent care centres / urgent treatment centres
- GP hubs
- GP out of hours
- GP at hand
- 999
- NHS 111

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Emergency departments

- There are five emergency departments (also called A&E departments) in south east London, based at the following hospitals:
  - St. Thomas' Hospital
  - King's College Hospital (Denmark Hill)
  - Princess Royal University Hospital (Bromley)
  - University Hospital Lewisham
  - Queen Elizabeth Hospital (Greenwich)
- Patients can access any emergency department they choose through walking in to the department. Patients may also access an emergency department through being brought in by an ambulance.

Urgent care centres / urgent treatment centres

- There are nine urgent care centres in south east London. Some of these are based next to an emergency department, whereas others are 'standalone' units:

Urgent care centre	Next to an emergency department or standalone?
St. Thomas' Hospital	Next to an emergency department
Guy's Hospital	Standalone
King's College Hospital	Next to an emergency department
Princess Royal University Hospital	Next to an emergency department
University Hospital Lewisham	Next to an emergency department
Queen Elizabeth Hospital	Next to an emergency department
Beckenham Beacon	Standalone
Erith	Standalone
Queen Mary's Hospital (Sidcup)	Standalone

- Patients can walk into any urgent care centre or may be referred there, by their GP for example. If a patient goes to a site where there is both an emergency department and an urgent care centre, information about the patient will be taken and they will be directed according to clinical need (this is often called 'streaming').
- By the end of 2019, all urgent care centres will be called urgent treatment centres. Urgent treatment centres are GP-led and open for at least 12 hours a day every day of the week (including bank holidays).

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

GP hubs / GP out of hours / GP at hand

- GP hubs
  - GP hubs offer additional appointments to patients registered with GP practices who are working together as a partnership. For example, the Bromley GP Alliance Access hubs support Bromley GP practices and their patients by offering additional appointments across Bromley. The hubs offer evening and weekend appointments for patients registered with Bromley practices, and staff have access to patients' GP records. The Bromley hubs are Cator Medical Centre, Crown Medical Centre, and Poverest Medical Centre.
- GP out of hours
  - GP out of hours services can also be used for evening and weekend GP help. Arrangements will differ depending on what has been commissioned in a particular area. An example of a GP out of hours service in SE London is SELDOC – patients in Lambeth, Southwark and Lewisham can access SELDOC through calling 111, where appointments / home visits can be arranged. SELDOC does not have access to GP medical records.
- GP at hand
  - GP at hand can be accessed via mobile 24/7, and has face to face appointments at certain locations.
  - To access this service patients must register with the service, which means no longer being registered with their current GP. To register, an application must be made.

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

NHS 111

- NHS 111 is available 24 hours a day, 7 days a week and can be called or accessed online if a patient has an urgent medical problem and is unsure what to do.
- NHS 111 will ask questions about the patient and their condition and suggest what the patient should do – this may be to see their GP, go to A&E, or manage their condition through self-care.
- In south east London NHS 111 now includes an Integrated Urgent Care Service – this means that there is a Clinical Assessment Service comprised of different health and care professionals, to help call handlers decide the most appropriate course of action for a patient's condition.
- The Clinical Assessment Service can also perform other functions:
  - Refer patients to 999 and provide advice to 999 call handlers.
  - Provide advice and guidance to health and care staff working in the community.
  - Directly book appointments for patients where appropriate. By the end of 2019 appointments will be bookable in all SE London urgent treatment centres; the next steps are to then introduce direct booking into GP hubs.

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

999

- 999 should be dialled in a medical emergency. This is when someone is seriously ill or injured and their life is at risk.
- Medical emergencies can include:
  - loss of consciousness
  - an acute confused state
  - fits that aren't stopping
  - chest pain
  - breathing difficulties
  - severe bleeding that cannot be stopped
  - severe allergic reactions
  - severe burns or scalds
  - heart attack, where a patient may be taken to heart attack centre rather than the nearest A&E
  - stroke, where a patient may be taken to a hyperacute stroke unit
- Calling 999 does not mean that an ambulance crew will be sent to the caller – sometimes other London Ambulance Service staff may be able to care for the patient. If an ambulance crew does come, you might not be taken (conveyed) to hospital.

Our Healthier South East London
Improving health and care together

Agenda Item 9

Meeting: **SE London Joint Health Overview and Scrutiny Committee**

Location: **Bromley Council, Civic Centre**

Date: **Thursday 21st March 2019**

Title: **Decision on Hyper Acute Stroke Units in Kent**

Presenter: **Julie Lowe, Programme Director, Our Healthier South East London**

---

1. Summary

The purpose of this paper is to update the committee on decisions made to change the configuration of stroke services in Kent. The impact on SE London residents is minimal with the exception of Bexley (see below).

2. Background

Stroke services in London were reconfigured nearly a decade ago to enable patients experiencing a stroke to benefit from modern treatment options which significantly improve the chances of survival and then recovery. Simply patients with a suspected are taken to a Hyper Acute Stroke Unit (HASU) where expert staff and equipment are available 24 hours a day, 7 days a week. After initial treatment and stabilisation they are transferred to an Acute Stroke Unit (ASU) which may be at the same hospital or closer to home for further treatment and early rehabilitation before being discharged home or to a community-based unit. This model has worked well and evaluation has shown significantly improved survival and recovery rates.

In Kent the HASU and ASU model does not yet exist and patients suspected of having a stroke are taken to their local A&E department. The recent decision taken by Kent CCGs will lead to the creation of a HASU and ASU model in Kent. A letter describing the decision is attached. In Kent HASUs and ASUs will all be co-located (this has the advantage that patients will not move hospital part way through their treatment and more experts in stroke are based together, but the disadvantage that they may spend a longer period in a hospital at some distance from home). There will be a HASU and ASU at Darent Valley Hospital.

3. Impact on S E London

Bexley CCG were consultors in the recent decision making process in Kent because for many Bexley residents a HASU in Darent Valley Hospital will be closer than one in London. (Bexley residents with a suspected stroke are currently taken to a London unit, usually the Princess Royal University Hospital). Bexley patients who responded to the consultation were generally supportive of a HASU at Darent Valley.

S E London STP was involved in the consultation more generally as some of the proposed changes for Kent would have resulted in significant increases in patients attending London units. Kent CCGs have now decided that there will be a stroke unit at Darent Valley and the impact of the changes is expected to have a minor impact only on the London units.

Our Healthier South East London
Improving health and care together

NHS

Sent: 15 February 2019 16:01
To: [redacted]
Subject: Kent and Medway Stroke Services

Dear Colleague

I am writing to let you know that yesterday the Stroke Joint Committee of Clinical Commissioning Groups reached unanimous agreement on the future of emergency stroke services in Kent and Medway and has made the decision to implement the preferred option to establish hyper acute stroke units at William Harvey Hospital, Darent Valley Hospital and Maidstone Hospital.

Yesterday's decision comes after a five-year review of urgent stroke services. The committee members considered a wealth of data and evidence which they believe shows that this is the right thing for patients.
At the moment despite the hard work of dedicated NHS staff, stroke services in Kent and Medway are some of the poorest in the country. This is not acceptable and that is why the Stroke Review Team has worked so hard over the last five years to bring about change to improve stroke care. I would like to thank everyone who has been involved in the review. This has been a detailed and robust process, led by stroke specialists dedicated to improving care for patients.

I realise this outcome may be disappointing for some areas and some organisations, however these new units will make it possible for the NHS in Kent and Medway to offer specialist stroke care round the clock, every day of the year. This will reduce disability and we believe will save an additional life every fortnight as a result.

As you know, there was an extensive public consultation on the proposed changes, involving thousands of people. Those who responded said they understand why stroke services need to change, but many had concerns about the impact of those changes.

The Stroke Review Team and the Joint Committee of CCGs listened carefully to those concerns and considered them in detail. While the proposals have not changed, we are working to address issues such as travel and transport and putting plans in place to make sure that rehabilitation and support services are closer to home and better planned.

We will now work in partnership with local hospital trusts, on the implementation phase of this programme, and we anticipate the new stroke service will begin in Maidstone and Darent Valley hospitals in about a year, and the service at William Harvey will begin in spring of 2021 due the larger scale building work required at this site. The two-phase approach to implementation has been recommended by local stroke clinicians. The clinicians feel very strongly that this is the best option to improve care for as many people as possible as quickly as possible. This approach will be confirmed in the coming weeks.

We will continue to keep you updated on the work of the Stroke Review, particularly around the timeline for implementation, the development of new rehabilitation services and travel mitigations for patients and carers.

Best wishes

Rachel Jones
Senior Responsible Officer for the Kent and Medway Stroke Review and Director of Acute Strategy and Partnerships, Kent and Medway STP

Our Healthier South East London
Improving health and care together

Meeting: **SE London Joint Health Overview and Scrutiny Committee**

Location: **Bromley Council, Civic Centre**

Date: **Thursday 21st March 2019**

Title: **Update on consultation and proposal to move Moorfields Eye Hospital (City Road, London)**

Presenter: **Julie Lowe, Programme Director, Our Healthier South East London**

NHS
South East London
Commissioning Alliance
Partnership of Clinical Commissioning Groups

[ADDRESS]

XX March 2019

Sent via email

RE: Proposed relocation for Moorfields Eye Hospital (City Road, London)

Dear Colleagues,

As you may be aware, Moorfields Eye Hospital NHS Foundation Trust is proposing to relocate all the services currently provided at its site on City Road (Islington) to a brand new, integrated, purpose-built facility on the St Pancras hospital site in Camden, subject to public consultation.

Only a small proportion (XX) of patients in XXX CCG use Moorfields Eye Hospital services. For those who do, we expect the proposed site near St Pancras is potentially easier to reach and therefore we do not anticipate that the relocation will cause a problem for the population of our boroughs.

We will provide further information when it becomes available and look forward to discussing on XXX. In the meantime please let me know if you have any urgent questions or concerns.

Yours sincerely

XXXXX

Managing Director
XXX CCG
NHS South East London Commissioning Alliance
(Bexley, Bromley, Greenwich, Lewisham, Southwark CCGs)