THE ROYAL BOROUGH OF KINGSTON UPON THAMES

KINGSTON HEALTH OVERVIEW PANEL

ANNUAL REPORT 2016-17

Foreword by Councillor Andrew Day, Chair of the Health Overview Panel

I am pleased to introduce my third annual report as Chair of the Panel. We have continued to look at topics in depth and this year these have considered the Care Quality Commission (CQC) inspection reports of Kingston Hospital NHS Foundation Trust, South West London and St George's Mental Health Trust, and Camden and Islington Mental Health Foundation Trust (which provides some community mental health services in Kingston). Members put forward a number of topics for scrutiny and so we invited officers to present on Accessibility at Train Stations in Kingston, Air Quality in Kingston, Reablement Services and volunteer schemes at Kingston Hospital. The Kingston Clinical Commissioning Group requested that we consider the engagement plan for their Choosing Wisely Programme. There were no other requests to the Panel to consider formal consultations.

As part of identifying items for consideration during 2017/18 we have approached a number of partner organisations, both voluntary and statutory, for suggestions.

We have continued to respond to questions from members of the public and a summary of questions raised are included in this report.

Members from the Panel have participated in the SWL Joint Health Overview and Scrutiny Committee which is now considering the South West London Sustainability and Transformation Plan and how this will re-shape health services in South West London.

I would once again like to take this opportunity to thank all of our partners from South West London & St George's Mental Health Trust, Kingston Hospital NHS Foundation Trust the Clinical Commissioning Group, and officers from the Royal Borough of Kingston for their co-operation and contributions to the work of the Panel. I also wish to thank all members who served on the Panel during 2015/16 and for the contributions made by our advisory members: Patricia Turner, Kingston Voluntary Action, Grahame Snelling, Chair of the Kingston Healthwatch, and Dr Jane D'Souza, GP Advisory Member.

I would like to draw attention to the sad loss of Dr Jonathan Hildebrand, the Council's Director of Public Health who passed away on 30 November 2016. His considerable contribution to the Panel and the work of the Council as a whole and beyond is missed greatly. We hope that the Public Health Team will be able to take forward and build on the strong foundation he leaves behind. Stephen Taylor, Director of Adult Social Care has provided professional support to the Panel since January 2017.

Finally, the report covers a selection of the major items and fuller details can be found by exploring our minutes and agendas on Kingston's website via this link HOP.

Councillor Andrew Day, Chair of Health Overview Panel

What we did in 2016/17 at a glance:

MAY MEETING

SEPTEMBER MEETING

NOVEMBER MEETING

JANUARY MEETING

MARCH MEETING

1. HEALTH SCRUTINY – what it is

Councils with social care functions can hold all providers and commissioners of publicly funded health and social care to account for the quality of their services through powers to obtain information, request attendance at committee, ask questions in public and make recommendations for improvements which then need to be considered by the relevant health body. Health and Social Care policies arising from the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are also included within the remit. Where proposals for major changes to health services are not considered to be in the interests of local health service provision, as a last resort these can be referred to the Secretary of State for determination. Health scrutiny also has a valuable pro-active role in helping to understand communities and tackle health inequalities.

2. MAY MEETING

2.1 Update on the deficit at Kingston Hospital

The Panel previously looked at the deficit at Kingston Hospital in November 2015. The Panel considered latest information from the Trust's board reports about the financial situation, the deteriorating financial situation for hospital trusts in England and the reported drop in performance on some key performance areas nationally.

The Hospital's Deputy Director of Finance attended the Panel and stated that the final audited deficit for 2015/16 was £6.9m which was in line with the revised forecast and the position agreed with the Financial Regulators. The Plan for 2016/17 had been for an underlying deficit budget of £4.2M, which is a reduction of £2.7M on the previous year. However following the receipt (with conditions) of Sustainability and Transformation funding of £8.1M the deficit would translate into a £3.9M surplus. The Deputy Director noted that whist funding is available this year the position for 2017/18 is uncertain.

The Deputy Director explained where changes had occurred in comparison with last year. There were some non-recurrent items in 2015/16 e.g. costs associated with the improvements to A&E, cost inflation of £6M, increase in capital spend for essential building maintenance, IT infrastructure, additional medical staffing, medical equipment additional medical insurance costs, IT and investments in quality which are primarily additional staffing.

In response to a question about whether the Trust was receiving budget reductions year on year, it was confirmed that the Trust will benefit from a 1.1% increase in this year's tariff and there is further opportunity to increase income by increasing activity. Furthermore, the DH previously has required efficiency savings of 4% but this year the DH has reduced this level to 2% as there is now recognition that it is difficult to achieve year on year.

The total agency spend for 2015/16 was £18M and included nursing, clinical and corporate staff. Agency costs are 9% of the total pay budget and are comparable with other Trusts. Whilst agency caps introduced by DH are reducing this spend, there is still a national shortage of nurses. Recruitment is continuing in the Philippines and the Trust is increasing the number of student nurse placements from September for students from Kingston University. Fewer nurses are now being recruited from Europe due to a Nursing and

Midwifery Council requirement that European applicants to undertake the same international English language tests as those from outside Europe.

In relation to risks in delivering this year's financial plan, the Panel heard that there is a small contingency fund of £1M. However, events such as junior doctors' strikes could jeopardise the budget as elective work would be cancelled and income reduced. Other risks are around recruitment difficulties particularly as a consequence of the capped agency rates for medical staff. Winter pressures particularly from viruses could lead to the need to open additional beds but the hospital is not funded for these.

The Panel heard that delayed transfers of care are generally caused for reasons which are external to the hospital such as availability of community beds and social care reasons. The hospital ensures assessments for on-going care are undertaken as quickly as possible to ensure delays are minimised. The Director of Nursing confirmed that there are a number of work streams with the CCG and social care to improve community arrangements to support discharges.

2.2 Accessibility at Train Stations in Kingston

This item was requested by a member of the Panel because a local resident who was visually impaired had experienced difficulties at New Malden station and had been unable to access train information. The Panel heard that the Community Rail Liaison Manager had personally been involved with this matter. There had been an intermittent problem with the PA system and that this has now been solved.

The report to the Panel outlined accessibility at the Borough's ten train stations and the access policies which Network Rail and South West Trains (SWT) have in place. Three stations in the Kingston area (Kingston, Surbiton and Worcester Park) are fully accessible with ramps or accessible lifts. Other stations have some accessibility but there is some difficulty with transfer to platforms. The Office of Rail and Road monitors compliance against access policies and current policies are being refreshed. Any comments about accessibility issues in SWT are considered across the network and used to improve services both locally and more widely. All staff are trained for accessibility and staff are regularly re-briefed on issues.

Network Rail and the Department for Transport (DfT) allocate budgets every 5 years to enable accessibility works to be carried out at a small number of stations. However, proximity to fully accessible stations is one of the criteria for nominating additional stations for improvement and no further Kingston stations have been put forward for further improvement in the near future.

35% of the 180 stations in the SWT area are accessible; however, by footfall accessibility covers 75% of passenger journeys. Members felt that 35% was relatively poor and there should be wider publicity about transfers to accessible stations. The Panel asked a range of questions e.g. about how people could be taken to other stations when the stations are unstaffed, disabled parking at stations and ensuring spaces are only used by disabled people plus the problems encountered by people with young children and buggies with the long flight of steps to reach the Chessington platforms. The question of the reduced Chessington service in the evenings plus the later start in the morning was also raised.

The Manager explained the accessibility booking system for people who do not use trains regularly. Leaflets about arrangements are available and detailed information can be found on the internet or by contacting National Rail Enquiries. If booked in advance people will be met and helped on and off the train either by station staff or the guard. SWT will provide transfers by taxi for people with mobility problems from an inaccessible station to an accessible train station. Passengers with specific accessibility requirements are encouraged to make their needs known to staff so that they can be assisted appropriately. They can, for example, be advised on the best position on the platform from which to board the train to minimise the gap.

The Manager agreed that SWT were aware of the problems with accessibility on the Chessington line and stated that Worcester Park was made accessible in the last round of works.

Attention was drawn to the plans to radically change the Tolworth roundabout to deal with traffic issues and for significant development close to this area to provide hotel, residential and business/office development. There would be a significant increase in journeys. The Manager advised that the Council would have provided input into the associated DfT consultation along with other boroughs in the SWT area.

A request was made for signage saying “alight here for Kingston Hospital” below the station sign at Norbiton Station and to provide an announcement on the train and the Manager agreed to take forward these suggestions. However the platform step height at Norbiton Station could not be changed as it is required to accommodate a range of rolling stock which runs through this station. He confirmed that Norbiton Station complies with the requirements for the gap between the platform and the train but saw the difficulty this presents for elderly people. Every SW train had a guard who could assist people to the train. Work has been undertaken to ensure ramps are in a visible place but he agreed to take away the point about where people should stand so the guard knows that they need assistance.

3. SEPTEMBER MEETING

3.1 Care Quality Commission inspection of Kingston Hospital NHS Trust

The Care Quality Commission (CQC) published its inspection report in July 2016, following the visit to the Trust in January 2016. The registration and inspection process ensures that providers reach specified standards concerning the care facilities, policy systems and procedures and how they are run.

During the course of inspections five key questions are pursued: Are Services Safe, Effective, Caring, Responsive and Well-led? Eight core services are examined and each is rated:

Urgent and emergency services	Requires improvement
Medical care (including older people’s care)	Requires improvement
Outpatients and diagnostic imaging	Requires improvement
Surgery	Good
Critical Care	Good
Maternity and gynaecology	Good
Services for children and young people	Good

End of life care	Good

The overall rating for the hospital was “requires improvement”. Whilst there were some shortfalls in the Emergency Department, medical care, outpatients and diagnostics, the CQC inspection identified a lot of good practice. It highlighted the strengths of the Surgery Department, the success of the Dementia Strategy, the professionalism and care provided by the Specialist Palliative Care Team and the Sexual Health Services at the Wolverton Clinic particularly those for young and vulnerable people with a learning disability. The Panel considered information about the Trust’s detailed action plan to address shortcomings.

The Panel also looked at the service ratings of other nearby hospitals and Kingston Hospital compared favourably with these. Kingston was rated “good” for Surgery and Critical care whereas those areas at Croydon, Epsom and St Helier all required improvement. For maternity & gynaecology and children and young people only Kingston and Croydon were rated as “good”.

The Director of Nursing and Patient Experience gave a detailed presentation to the Panel and outlined the actions taken and planned on the seven “must do” areas identified by the Inspection which were:

- Ensure the management, governance and culture in A&E supports the delivery of high quality care
- Improve the quality of performance data in A&E and use it effectively to improve performance
- Record all identified risks in A&E on the department’s risk register and take action to manage the risks
- All patients without mental capacity area are assessed and if restraint is required this is recorded in the patient’s record (Note - restrain primarily referred to the use of mittens to prevent removal of IV lines etc.).
- Ensure medicines are secured and stored safely and not accessible to unauthorised persons
- Improve the system for monitoring equipment maintenance and safety checks
- Ensure Duty of Candour is followed and include a formal apology within correspondence and keep a record

The Panel was assured that the seven “must do” actions will be completed by December 2016 and the majority of the 47 “should do” items will be completed by March 2017. Actions included:

- Appointment in January of a new A&E clinical director
- Additional funding to provide 7 day a week palliative care service on site (previously 6 days)
- Remodelling/rebuilding - a new 6 bed clinical decisions unit in A&E, outpatients, transport lounge and radiology waiting areas, a new dementia friendly unit (to be completed in November) and approval for changes to the MRI/ICT waiting areas in 2017

In relation to A&E performance Kingston Hospital is achieving 91-92% of patients being seen and treated within 4 hours but this is short of the national standard of 95%. There has been a 4.8% increase in A&E attendances and the hospital is seeing increasing numbers of patients

who are older and sicker. The Trust is exploring new approaches to extend roles within the A&E as there is now a national shortage of middle grade A&E doctors.

4. NOVEMBER MEETING

4.1 Care Quality Commission Inspection of South West London and St George's Mental Health Trust

The CQC inspection report was published in June 2016 following the CQC's visit in March. The registration and inspection process ensures that providers reach specified standards concerning the care facilities, policy systems and procedures and how they are run. Whilst the overall rating of the services was requires improvement seven of the ten service areas were rated as good. The three rated as requiring improvement were:

- Long stay/rehabilitation mental health wards for working age adults
- Community based mental health services for adults of working age
- Community based mental health services for older people

However, the CQC highlighted that there is much for the Trust to be proud of including the commitment of the senior executive team to improving services and provide a high standard of services. There has also been significant improvement in the care pathway. Comment was made about the improvements in the management of access to acute beds across the Trust and facilitation of practical arrangements associated with discharge. Most community teams were meeting their targets for assessing and treating people in a timely manner. The Trust board provides effective challenge to ensure the Trust meets its objectives and there is a largely healthy culture and good relationships with patients.

The main areas for improvement were around:

- Support on rehabilitation wards to enable patients to achieve independence
- Need for better identification on forensic and CAMHS wards where patients are being secluded and ensuring observations and medical review take place appropriately
- One to one professional individual supervision of staff was patchy in the community
- Recent changes around centralisation of administrative support (now at Kingston) had resulted in poor standards for communications with patients and GPs about appointments etc. but the report noted that this situation was improving
- Risk assessment needs to improve across a number of team

A number of Requirement Notices were issued and these related to aspects of supervision, seclusion, risk assessment, medicines management, skill mix and support to implement the recovery model in rehabilitation services and safeguarding. However the CQC have confirmed that the Trust was on the borderline of a "good" rating. Following actions by the Trust and a further visit by the CQC in September 2016, the CQC have confirmed that the Trust had made very positive progress and all regulatory requirements had been met.

The Medical Director gave further information about actions related to Community Services for Older Adults (waiting time for the memory clinic), Staff supervision, Restrictive practices and seclusion, Safety of Medicines and Administrative support. Problems had developed following the recent restructuring of the administrative function involving new IT systems. This had led to delays in issuing letters to service users and GPs.

The Panel heard that there were some staffing challenges in the Community Mental Health Teams but recruitment to substantive posts is increasing and there is less reliance on temporary staff. The Trust has made much progress to address the identified shortcomings particularly in the community services.

The CCG commented that very few mental health trusts have been awarded a good or outstanding rating and that it is unusual for the CQC to indicate that there is an opportunity for regrading and whilst this is awaited to be formally announced by the CQC, a positive outcome was expected.

The Medical Director confirmed that the Trust did not provide primary mental services in Kingston and it was agreed to invite Camden and Islington Mental Health Foundation Trust as concern was expressed about that Trust's CQC rating.

4.2 Kingston Clinical Assessment Service and access to GP appointments

A member of the Panel asked that we look at this topic. The Kingston Clinical Assessment Service (KCAS) was introduced in 2006 to support GP practices making routine (non-emergency) outpatient referrals through the Choose and Book system and to ensure that referrals were appropriate for the patient's condition. At that time the Panel had been requested to review KCAS as there were suggestions that the service was leading to delays in appointments. The Panel found that many of the initial teething problems which prompted the review had been resolved and it was noted that the KCAS approach had helped raise GPs' awareness of alternative clinical approaches to patients' conditions. The Panel also learned of a significant cost saving which was being made at the time.

In 2015 a new electronic method of making referrals "e-referral" was introduced by the NHS which addressed many of the functional weaknesses of the previous Choose and Book system. Two GP practices in Kingston piloted e-referral to test how much of the referrals process could be undertaken by practices. The Panel was informed that the CCG is reviewing referral processes, including the role of KCAS, and consultation on proposals would happen shortly. It is expected that the current administrative team arrangements will change and freed-up skills and resources will be used to support practices differently.

The Director confirmed that that practices had received incentives to use choose and book and similar incentives would be provide for e-referrals. The e-referral tools would include forms, triage processes and a suite of referral protocols for specified conditions/intervention and the CCG would update the panel on the proposals going forward

Information was also given about the new arrangements for GPs appointments on Saturdays at limited surgeries and by April 2017 all patients in Kingston will be able to book Saturday morning appointments with a GP or nurse. Practices will also be providing dedicated appointments for children to ensure sick children can be seen by a GP quickly.

Surbiton Health Centre began providing a primary care extended service in the autumn on Saturdays and Sundays from 8am to 8pm which is available to all. The CCG plans to open two more such services by April 2017 which will include offering appointments from 8am to 8pm seven days a week. The CCG will also be piloting a single point of access via phone to book appointments across a number of practices so that if an appointment is not available at a patient's usual practice they can be offered an earlier appointment at a surgery nearby.

4.3 Stay Well this winter

The CCG's Director of Quality and Engagement gave a detailed presentation on "Stay well this winter". This was the second year of the national campaign led by the Department of Health, Public Health England and NHS England and built on the achievements of last year's. The CCG would be including some local key messages especially about how to access health care and advice.

The main national campaign brief is "to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take actions what may avoid admission this winter". It would focus on C to DE Adults age 65+, people with long term conditions (LTCs) and their carers, encouraging up take of flu vaccine especially for pregnant women, parents with children age 2 – 7 and people with LTCs. LTCs include asthma, chronic obstructive pulmonary disease, and diabetes; these can be exacerbated if people fall unwell with flu.

The Director emphasised that the campaign was not about preventing admissions among target groups, but to help them stay well to avoid the need for a visit to hospital. Key messages included seeking advice from pharmacists at the first sign of feeling unwell, stocking up with medicines, prescriptions and food ahead of the holiday period, keeping warm, having a flu vaccination and keeping an eye on elderly or frail friends, neighbours and relatives.

The local plan included arrangements for primary care access – which for this winter included:

- **Weekend services** at Surbiton Health Centre offering booked in advance appointments and appointments available on the day for registered and non-registered patients. (Two more weekend walk in services would be operational by 1 April 2017 in North Kingston and Chessington/Hook).
- **Saturday morning GP clinics** (walk-in and booked) at Berrylands Surgery, Canbury Medical Health Centre, Chessington Park (alternate weeks), Orchard Practice, Claremont Medical Centre, Fairhill Practice, Groves Medical Central Holmwood Corner. Kingston Health Centre, Manor Drive Medical Centre, West Barnes Surgery for patients registered at those practices.
- **Same Day consultation for** children **under 10 years old (inclusive)** at Berrylands Surgery, Brunswick, Canbury Medical Health Centre, Groves Medical Centre, Kingston Health Centre, Orchard Practice
- **Mental Health** Street **Triage**
- **GP in A&E** available 18 hours per day and currently seeing 50-60 patients per day

A detailed communication plan had been developed using a range of actions including free NHS materials, information on the CCG's website and twitter, help from local partner organisations and neighbourhood notice boards, media engagement and a number of engagement activities including stalls at Christmas light switch on events. Local key messages were about locations of weekend walk-in access, Saturday morning appointments and same day consultations for children under 5, plus self-care and keeping warm, and avoiding slips and trips.

Questions were asked about the locations of the primary care extended services and a request was made that one be sited in New Malden. It was also suggested that public transport routes are taken into account when considering locations. The Director responded that the CCG was intending to continue to expand weekend surgery opening but that there were budget and workforce constraints to provide 7 day a week service. The Director of Primary Care Development explained that a piece of work was being progressed to look at where services could be best located and this would include looking at patient flows and transport links. She also explained that neighbouring CCGs were also undertaking similar approaches and it could make sense for patients to be seen just across the border in some locations.

In relation to questions concerning the mental health street triage, the Director explained that this builds on past work and involved trained professionals (nurses and psychologists) supporting the police and working closely with the ambulance service.

The important role of pharmacists and the new Health Living Pharmacies initiative were highlighted. This has involved mapping of locally available voluntary services and pharmacists are able to signpost people to these.

5. JANUARY 2016 MEETING

5.1 Air Quality in Kingston

One of our Panel members requested that we look at this topic. The Panel received a detailed position statement on the Council's approach to air quality and was asked to recommend that a Joint Strategic Needs Assessment of air quality in Kingston is developed.

We heard that air quality is an important Public Health Issue in Kingston contributing to shortening life expectancy and disproportionately impacting on the most vulnerable. Tackling air quality contributes to increasing healthy life expectancy and reducing early death from cardio-respiratory disease and cancer. Public Health worked with Environmental Health in the compilation of the Air Quality Action Plan which was adopted in July 2016. The Council designated the borough as an Air Quality Management Area for NO2 and PM10 in 2003. An Air Quality Action Plan was introduced and revised in 2016 and can be viewed on the Council's website. A fuller Strategy for Air Quality will be finalised later this year.

Air Quality standards regulations enshrined in UK legislation set standards for: Particulate matter (PM10 AND PM2.5), Nitrogen dioxide (NO2), Ozone, Sulphur Dioxide, Carbon monoxide, Lead, Benzene and Denso(a)pyrene. Whilst the majority of air pollutants have declined in the UK due to the reduction in burning coal and wood, some - particulates, Nitrogen Dioxide (NO2) and ozone - are found at levels which continue to pose a risk of harm

to health. The main focus for Kingston is on Particulate Matter (PMs) and NO2 and an Air Quality Management Area has been established.

Particulate matter aggravates respiratory and cardiovascular conditions and PM2.5 are very significant, because being smaller, they can deposit deeper within the respiratory tract and affect children, older people and those with existing heart and lung conditions.

The Council has monitored PM10 at two kerbside sites in the borough. The objectives are to achieve:

- an annual average of less than 40 μg/m^3 and
- the 24 hour mean should not exceed 50 μg/m^3 on more than 35 days per year.

The annual averages for the two stations located at Sopwith Way and Tolworth Broadway were well within the target (21.3 μg/m^3 and 20.0 μg/m^3 respectively). The 24 hour objective was exceeded three times at Sopwith Way and once at Tolworth, both therefore met the objectives in 2015.

RBK also monitored NO2 at the same two kerb sites within the borough in 2015. The national objectives are:

- an annual average less than 40 μg/m^3 and
- no more than 18 hours per year where the hourly mean exceeds 200 μg/m^3.

Whilst neither site exceeded the hourly mean, both failed to meet the annual average objective with Sopwith Way averaging 53.5 μg/m^3 and Tolworth Broadway 48.5 μg/m^3. The Sopwith Monitor has been decommissioned but a further two monitors are being procured with an intention to locate these near to the Robin Hood junction and in Kingston Town Centre (subject to site assessment).

Other Monitoring devices at a further 40 locations in the borough collect data to assess against the annual mean objective. Concentrations of NO are highest on roads with high traffic flows and/or congestion.

The following areas in Kingston are the worst in a list of the 10 most disadvantaged areas:

- Birkenhead Avenue to Hawks Road area
- Kingston Town Centre
- Canbury Park Road/Willoughby Road area
- Richmond Road/East Road area

Four other areas in the top 10 most deprived for air quality are located along the A3 corridor. The best air quality in Kingston is in South of the Borough.

There has been a lot of health research on air pollution. The Royal College of Physicians report “Every Breath We Take”, 2016, concluded that people who are most vulnerable to poor air quality are those who live in deprived areas, who live, learn or work near busy roads and the young and the old. Similar risks apply to people who spend longer in traffic. Car occupants are typically exposed to higher levels of air pollution than cyclists or pedestrians as the latter can use quieter streets with lower traffic volumes which are less polluted. People with respiratory problems such as asthma, chronic bronchitis and emphysema are particularly vulnerable.

The Committee on the Medical Effects of Air Pollutants identified that there is evidence to support a causal relationship between exposure to traffic-related air pollution and exacerbation of asthma. There is also suggestive evidence of a causal relationship with onset of childhood asthma, other respiratory symptoms, impaired lung function and cardiovascular morbidity and mortality. The International Agency for Research on Cancer listed diesel exhaust as a Class 1 carcinogen and extended this to all ambient air pollution in 2013. Recently studies are looking at possible links to cognitive decline in older age. The National Institute of Clinical Excellence is consulting until 25 January 2017 on guidelines for Councils "Air Pollution – outdoor air quality and health" which are expected to be published in July 2017. This includes a range of measures to reduce for traffic related air pollution and whilst the individual benefits are small, the cumulative effect is significant. Proposals include recommendations to reduce speed humps and introduce 20mph areas, changes to driving style, selection of vehicles by the public sector, introduction of cycle lanes, clean air zones, and congestion charging. TfL contracts are now introducing cleaner buses.

The range of questions and discussion was wide ranging and included the following:

- the impact of HGVs observing of warning notices to leave the A3 at certain junctions to avoid the low emission zone.
- concerns about locations of schools near to roads with high traffic volumes - the Panel; was assured that air pollution drops off quite quickly at a relatively short distance from a road.
- whilst aircraft pass across Kingston this is at a high level and the majority of air pollution is dispersed and it is not possible to distinguish between air pollution arising from traffic and that from aircraft.
- There has been more research on the effects of PM10 as this was the most harmful
- leaving the European Union will not affect UK actions around Air Pollution as the EU regulations are enshrined in UK legislation.

The Panel recommended that the Council considers undertaking a Joint Strategic Needs Assessment of Air Quality in Kingston.

5.2 Mental Health services provided by Camden and Islington NHS Foundation Trust (CQC Inspection report)

Camden and Islington NHS Foundation Trust were responsible for primary care mental health services in Kingston. As the recent CQC inspection rating for community services was "requires improvement", Members requested that the Trust be invited to discuss how this related to primary care mental health services in Kingston. The Trust's Chief Operating officer explained that the CQC inspection was focussed on the St Pancras site and the health based places of safety at the Royal Free, Whittington and University College London Hospitals and that actions were being progressed. No visit had been made to services provided in Kingston and the Chief Operating Officer explained that IAPTS services generally do not get inspected but these are covered by self-assessment processes. The Trust had put a huge amount of effort into the development of the new service in Kingston including good levels of quality improvement and supervision audits. In his opinion the issues for secondary care services do not apply to primary care mental health services.

He explained that the Trust was providing services in Kingston as the service had been put out to tender and it had been successful. The primary mental health service is designed to replace the traditional referral process to secondary care mental health services and 95% of patients are seen and treated in primary care settings. The support to primary care meant that patients' needs could be managed more quickly and earlier interventions accessed and the aim is to ensure mental health capability in every GP surgery. Generally only 5% of people with mental health needs require secondary services. An outcome of better provision in primary care is that community mental health teams are freed up to provide more intensive help for patients. This new approach also improves contact with the patient's GP.

The Trust is particularly proud of the development of services for the Korean Community in Kingston. Further developments are underway with Kingston College and Kingston University for young people age 18-21 and IAPTS are also beginning to work alongside employment services. With regard to waiting time targets, initial referrals and for first line treatment are very quick but there can be waits for the more stepped up therapies and this is an area that the Trust is focussing on. Support for primary mental health services is very good and advice is given on the same day to GPs.

The Panel heard details about the services that the Trust provides in Kingston:

Kingston iCope (Improving Access to Psychological Therapies services (IAPTS) – this is psychological therapy is provided on a on a stepped-care approach with a range of group interventions. The service performs very well on targets for 16 week wait and 18 week wait. iCope is also on track to meet the recovery target. However there can be a wait if clients need a step-up intervention i.e. more than group or on-line approaches. In these circumstances they receive supportive "holding" interventions.
A Korean version of the on-line iCope has been developed and the service is actively recruiting Korean speaking therapists.

Primary Care Mental Health Team (PCMHT) – this service was introduced in late 2015 as a pilot multi-disciplinary team led by a psychiatrist and aims to support Kingston GPs to manage a greater proportion of mental health needs within primary care. Patients are offered treatment at a GP practice close to home wherever possible or at the team base at Hollyfield House. The service received 484 referrals between April and November 2016 with two-thirds of referrals coming from GPs. Less than 10% of patients go on to be referred to secondary mental health services. GPs receive a same day response to requests for advice by phone or email. Service user feedback is very positive.

Substance Misuse Services – this covers drug and alcohol issues and all clients are seen within the three weeks target time. Effective links have been built with local police and magistrates courts. Stronger links are being developed with Kingston University and Job Centre Plus. A very high proportion of clients referred by the criminal justice system complete court ordered treatment. The service performs well compared to others on the number of clients who leave the service who are no longer using substances.

The Panel noted that there would be a re-inspection of the Trust later in the year and requested that the Trust is invited to provide an update on the re-inspection.

5.3 Kingston Safeguarding Adults Board Annual Report

The annual report for 2015/16 was presented by Julie Phillips, Head of the Safeguarding Service. It listed eleven objectives which were fully achieved. These included some governance matters and some key objectives were:

- Signing up to and implementing the new Pan London Safeguarding Adults at Risk policy in March 2016
- Reviewing the Deprivation of Liberty Safeguarding (DoLS) process and work is in progress with internal audit to identify and improve process
- Embedding "making safeguarding personal" across all partners including the development of new safeguarding forms in line with the new Pan London Safeguarding Adults at Risk policy

Statistics covering a three year period from 2013/14 to 2015/16 were presented. There has been a 6% increase in the number of reported cases of adult abuse during 2015/16 which totalled 690. 124 cases went onto investigation and 60 were substantiated. Most of the safeguarding cases occur at the person's own home possibly suggestive of carer stress. The report also included details from local partner agencies on their involvement and work on adult safeguarding: Kingston Clinical Commissioning Group, Metropolitan Police, Kingston Hospital, Your Health Care, South West London & St George's Mental Health Trust and the London Ambulance Service.

The following priorities are being progress in 2016/17:

- Developing greater community awareness about safeguarding and protecting vulnerable people
- Working with care providers to improve the way they can support and protect vulnerable people
- Ensuring that performance information from all organisations continues to be a focus to inform future target improvements and provide challenge
- Continuing to ensure practice is embedded – "making safeguarding personal" so citizens who are safeguarded/protected can determine for themselves the outcomes they want to achieve.
- Progress with compatible electronic data management in Kingston Adult Social Care and the mental health trust
- Development of more robust processes and understanding around safeguarding adults at risk and children at risk of harm by close working and training with Adult Social Care and Achieving for Children

The CCG's Director of Quality and Engagement drew attention to the considerable progress that had been made in Kingston by partner organisations including the CCG and Kingston Hospital as a result of the direction and professionalism of the Safeguarding Service with the outcome of making people in Kingston much safer.

5.4 Update on the South West London Sustainability and Transformation Plan

The KCCG's Director of Quality and Engagement spoke about the steps taken to date. He explained that the SWL STP is closely linked with the NHS's Five Year Forward View. It is a collaborative approach of all provider trusts and CCGs in SWL and is not commissioning led.

All regions were asked to submit STPs and South West London is one of 44 footprints. The SWL draft plan was submitted to the NHS in October 2016 and was published by both the CCG and the Council for public discussion. Public engagement events took place in early spring, including in Kingston. Earlier local engagement was captured on the issues paper published the last year.

The objective of the STP is to provide high quality and effective care and to ensure services are the best possible. This will include investment in estates and bringing services closer to people. The plan includes wide ranging initiatives, one being the development of locality teams across SW London, working in a similar way to Kingston Co-ordinated Care. Each locality team would provide services for 50K people. New technologies will be introduced including virtual clinics and the use of apps. Workforce redesign will improve capacity and there will also be greater clinical networking to share skills and improve outcomes.

The plan does not specify whether there will be 3, 4 or 5 hospital sites in SWL but the optimum is considered to be 4 or 5 hospital sites. Not every hospital will provide all of the same services. There is a financial challenge of £900m across the SWL health and social care sector up to 2020 and hospital buildings are in need of considerable maintenance and modernisation.

Reorganisation of CCGs will provide a single management team for Kingston and Richmond CCGs from 1 April 2017. Work has also commenced on joining back office functions of hospitals.

Questions and comments made by Councillors included the lack of coordination and release of information to all members in the early dialogue with the JHOSC. Concern was also expressed about opportunities to consider firmer proposals on potential hospital reductions.

6. MARCH MEETING

6.1 Update from Ann Radmore, Chief Executive at Kingston Hospital NHS Foundation Trust

Ann Radmore, Chief Executive spoke about progress made by the Hospital. It provides services for 380K people i.e. the whole of Kingston, half of Richmond, one third of Merton and significant numbers from East Elmbridge and Wandsworth.

Kingston Hospital performs as a good average on the A&E target when compared to hospitals in London and London hospitals perform better than the rest of the country. The Trust is working with the CCG to make changes both in hospital and out of hospital to help lift performance further.

Performance and financial position:

- A&E performance for February 2017 against the 95% target was 87.1% and for March to the 9th 92.8%.
- Delayed transfers of care as at 10 March are 28 across the 6 boroughs. The largest single factor is access to neuro rehabilitation.
- 18 week performance for January was 94.8% above the 92% target and the number of cancelled operations was small during this winter
- Cancer performance exceeded all targets in January and Kingston was the best performer in London for the 62 day target.
- The forecast end of year deficit is £7.1M compared to the 2016/17 deficit of £4.2M. Reasons for the deteriorating position are:
    - Changes to non-elective (non-planned cases) income/case mix
    - Financial effect of the tariff change
    - Unfunded costs of opening additional beds and delayed discharges
    - Cost improvement plans have not delivered as much as expected

CQC Inspection and progress with the "must do" actions: Ann Radmore referred to the Director of Nursing's report on the Hospital's response to the CQC inspection in January 2016. The inspection identified seven "must do" items which related to systems and processes. Audits and walkabouts have been undertaken to test progress on the 7 "must do" and 42 "should do" areas. She confirmed that good progress had been made on the 7must do items and the CQC is happy with this. 33 of the "should do" items have either been completed or are due to be completed in 2016/17 but the remainder will take longer or require funding to complete. The most significant actions which require funding are reviewing maternity capacity, A&E capacity and improving the ICU environment.

Staff survey: There has been a significant improvement about how staff feel about working at the hospital and the Trust scored in the top 20% of all acute hospital on 13 of the indicators and it also has the best overall outcome in south west London.

Estates Strategy: The Trust is commissioning a new estates strategy and this will reflect the South West London 5 year forward view. It will consider the age and performance of the current buildings and what changes should be consider over the next 10-15 years

Members asked about the following areas:

Bed blocking and the number of beds: The Trust has good processes in place to ensure that social workers are in the hospital on a regular basis. However, there are a number of local pressures - a shortage of residential and nursing home placements, delivery of home care the supply of neuro rehabilitation. At any one time the hospital has 20-30 patients who are ready to go elsewhere but the appropriate placements are not available immediately.

Identification of capital funding: the Trust was developing a business case to bid for Treasury capital in response to the recent announcement of additional funding for A&E departments. It was also exploring sources of private capital although this requires approval by NHS Improvement.

Approach to the deficit: the Trust Board made a decision to invest in patient care and safety, the physical environment and a number of senior nursing and clinical posts. Changes

are being made to back office and process functions and the hospital is considering every possible avenue including non-pay elements to move to balancing the books. Very good progress had been made in reducing agency staff spending and there had been an increase of 800 permanent staff comparing December 2016 with December 2015.

Overseas visitors: Charges for treatment are the standard NHS charge plus 50%. Two members of staff recover costs and the recovery rate is 75%. The Government is looking to identify people at the point of entry to the system.

Sustainability and Transformation Plan: the approach is to do more for less and this is difficult to with increasing demands for health care and the increasing age of the population. But much can be achieved by changing people's behaviour and this is led by Public Health within the Council. New Locality Teams are being introduced covering 50,000 people which will integrate primary care GP services and community hospital services. One of the aims is to ensure that there is earlier intervention and deterioration is reduced or prevented. This should lead to reduction in demand on inpatient services. Bed reductions will only take place once the earlier intervention and support from community services are fully in place.

A&E performance: the Trust did achieve 95% seen or treated within 4 hours for the first half of 2016 but there was difficulty admitting patients quickly due to the shortage of beds and all nearby hospitals experienced bed shortages this winter. The Trust has completed a review of A&E. There are a number of patients attending who do not need to be there and the Trust has a service where people with minor conditions can be seen by a GP in a part of the A&E department. The hours for this service have been increased and the GP can redirect patients to the Surbiton Health Centre Walk in Clinic or other services. But there are various reasons why patients prefer to attend A&E. The best approach is to provide an appropriate range of services in the department i.e. nurse practitioners and GPs in the department. Kingston A&E sees fewer inappropriate attendances than many other A&E departments and this reflects improved hours of access to GPs, Surbiton Health Centre, other facilities and pharmacies.

6.2 Reablement Services in Kingston

The Council's Home Care Transformation Lead spoke about the Reablement Service. Reablement is: "Providing personal care, help with daily living activities and other practical tasks, to encourage people to develop the confidence and skills to carry out these activities themselves and continue to live at home. It tends to be provided to people who have just been discharged from hospital or are otherwise entering the care system following a crisis and will be in the person's home".

Under the Care Act 2014 it is provided free of charge and can last up to six weeks. During this time discussions may take place about arrangements beyond this period as clients would then need to fund additional this support.

The NHS provides similar support known as Intermediate Care which is a short-term intervention for people who might otherwise have a prolonged stay in hospital or inappropriate admission to hospital or residential care. This support can either be provided in the person's own home or in a bed-based setting.

Although Reablement is a Council responsibility service delivery was transferred to Your Healthcare in 2013. A review is underway as it is part of the Kingston Co-ordinated Care programme. It is expected to combine Reablement with the long term care model and make further improvements including greater engagement with the voluntary sector in the Active Supportive Community approach.

The current budget is £1.239M and approximately 500 people (approx. 50 per month) are referred to Your Healthcare by Adult Social Care every year. The criteria for access to the service are tight so a person has to have quite developed needs to access the service.

The key performance measure for Reablement is the number of people who leave the service fully independent. Performance in Kingston has varied between 20-30% over recent years, which is low compared with other councils. The national benchmark is 60%. Your Healthcare has developed an integrated approach to Reablement and Intermediate Care and reporting on independence has improved and has increased to 46%. Outcomes are influenced by the high number of older people aged 85+ who are referred for support. However, since January 2017 conversations about support are now taking place much earlier in the process.

Members asked about the following areas:

Respite care: can be provided and the offer depends on carers' needs. It can vary from occasional respite provision to a sitting service to give carers a few hours' break. Sometimes supporting carers is more effective than direct support to the cared for.

Support for carers' needs: the Care Act 2014 gives carers equal rights and there is a statutory duty to assess their needs separately from those of the person being cared for. Most carers' assessments are undertaken by Kingston Carers Network.

Service procurement: the current contract runs to September 2018 and procurement for the future model will need to commence by October 2017. The service model combined reablement and long term care.

Staffing: it was noted that Kingston is an expensive area to live and service models need to be innovative and providers need to be able to work well with diversity.

Access to appropriate benefits: there are contractual arrangements on the provision of information about how to access benefits and the CAB are assisting with the provision of advice. Support can also be provided by the voluntary sector and Public Health is currently undertaking work about the role of community navigators. Needs can also be picked up during financial assessment discussions about people's ability to pay for services. It is in the Council's interests to ensure people are accessing benefits as this reduces the amount of funded support required.

Cost: people pay for an hour's care but the carer is only there for 30-40 minutes. It was explained that there is a 20% time gap difference between what has been commissioned and what is paid for. But there is a need now to focus on outcomes of support rather than time care workers are with people. Good quality care does not always relate to the length of the carer's visit. However, if agencies are charging people for care they have not received this

needs to be taken up with the agency. An “App” which is being developed to enable clients to report on the quality of care received on a daily basis.

Risk to service delivery: workforce capacity is the greatest risk - and not being able to cope with an increasing demand. Lack of capacity leads to poor quality and inconsistency in the delivery of care. However, the Council has a duty of care to vulnerable people who have no other options. The Council’s approach is to promote self-support and take up of community resources before looking at what direct care it should provide. It is important that the Council gets the message out to people in Kingston explaining what the role of the Council is and what role they have in supporting themselves.

The Panel agreed to look at other aspects of Kingston Coordinated Care at a future meeting.

6.3 Kingston CCG’s Choosing Wisely Programme and engagement plan

The Kingston Clinical Commissioning Group (KCCG) asked the Panel to consider its communications and engagement plan for the Choosing Wisely Programme. KCCG Chief Officer, and a Kingston GP, explained the Choosing Wisely Programme to the Panel and addressed a number of questions. They confirmed that the same approach is being progressed by all 6 CCGs in South West London but no decisions have yet been made.

KCCG has a gross savings plan target of £11.7M in 2017/18 i.e. approximately 5% of the CCG’s total budget. The programme if implemented fully could realise savings of £1.05M.

The Choosing Wisely programme proposes that the following items will no longer available on prescription unless they are needed for medical reasons i.e. where patients have potentially serious medical conditions:

- Self-care medications for acute illnesses (such as colds and flu) that will get better over time (could save £100K)
- Some baby milks where alternatives can be purchased over the counter (could save £150K)
- Gluten free products (could save £46K)
- Vitamin D supplements (could save £5K).

The CCG is also proposing changes to:

- IVF (in vitro fertilisation) treatment eligibility criteria (could save £250K)
- How patients are supported to be as ready as possible ahead of planned surgery by addressing smoking and excess weight to ensure best possible outcomes

The outcomes of the engagement programme will be considered by CCG Board (this has been delayed by the purdah period of the snap General Election).

The CCG explained that a range of engagement platforms were being used - Survey Monkey, paper surveys, direct approaches to relevant voluntary organisations such as the Coeliac Society - and the CCG would welcome any further suggestions and the Panel suggested:

- The importance of engaging with hard to reach groups e.g. Kingston Refugee Action, the MILLAP day centre and those that currently do not access the services under consideration e.g. younger people who may which to consider their need for IVF in the future.
- Using Facebook and putting information in the members' information pack
- Information is placed in GP surgeries and clinics
- Venues need to attract passers-by – some were better than others.
- Consideration needed to be given to material being produced in alternative languages

In response to questions it was explained that any one time there are about 100 couples in Kingston receiving IVF and members expressed concerns about the impact on low income couples. Formal consultation could take place on IVF and other elements of the Choosing Wisely programme at a later stage. (Richmond CCG had undertaken consultation on the future level of IVF service).

The Chief Officer also confirmed that if a patient had a medical condition which required one of the over the counter medications such as aspirin then the medication would still be prescribed and this would ensure patient compliance.

The Advisory member for Healthwatch expressed concern about small numbers of people who are in poverty who could be adversely affected by the cessation of prescriptions for routine medications for colds and flu.

The engagement outcomes would be considered by the Health Overview Panel at a future meeting.

7. Our Work Programme

The Health Overview Panel's work programme is flexible to accommodate requests from the NHS organisations about changes to service provisions and developments. An important feature for the coming year will be regular updates on the Sustainability and Transformation Plan for South West London to look at how this will impact locally on Kingston. We have written out to a number of NHS organisations and voluntary organisations to ask for their views on topics which it would be helpful for the Panel to consider. Whilst this is subject to change our current list of topics includes the following:

- Sustainability and Transformation Plan – impacts for Kingston e.g. intermediate care
- Aspects of the Kingston Co-ordinated Care e.g. Home Care and how this links to the STP
- KCCG's Choosing Wisely Programme engagement outcomes
- Update from Kingston Hospital following discussions with the Chief Executive at the March meeting.

8. Questions from Members of the Public

We received a wide range of questions including on the following areas: patients presenting with alcohol problems at A&E, government funding for CAMHS, appointment system at KHT,

GP winter hubs publicity, Eye Unit and off site clinics, Surrey Comet article on council and health merger, recovering moneys from “health tourists” at KHT, usage of the new out of hours service at Surbiton Health Centre.

9. SWL Joint Health Overview and Scrutiny Committee (JHOSC)

JHOSCs are appointed where a proposal affects more than one council. The South West London Joint Health Overview and Scrutiny Committee was formed early in 2014 to respond quickly to requests to consider health consultations. The Chair and Vice Chair of the HOP sat on this body and it is currently chaired by Councillor Carole Bonner from Croydon Council.

The JHOSC has begun considering the South West London Sustainability and Transformation Plan (see more detail on page 15). SWL JHOSC Agendas and Minutes can be accessed from the following link: SWLJHOSC

Marian Morrison
Democratic Services Officer
16 June 2017