NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 22 September 2017 10:00 a.m.
Hendon Town Hall, The Burroughs,
London NW4 4AX

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Alison Kelly (Chair) and Richard Olszewski (L.B.Camden), Abdul Abdullahi and Anne Marie Pearce (L.B.Enfield), Pippa Connor (Vice Chair) and Charles Wright (L.B.Haringey), Jean Kaseki and Martin Klute (Vice Chair) (L.B.Islington)

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack, Pete Moore and Vinothan Sangarapillai

AGENDA

1. NC LONDON JHOSC - AGENDA PACK (PAGES 1 - 138)

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 22 SEPTEMBER 2017 AT 10.00 AM
HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

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

Councillor Alison Kelly (London Borough of Camden) (Chair)
Councillor Pippa Connor, London Borough of Haringey (Vice-Chair)
Councillor Martin Klute, London Borough of Islington (Vice-Chair)
Councillor Danny Beales, London Borough of Camden
Councillor Alison Cornelius, London Borough of Barnet
Councillor Abdul Abdullahi, London Borough of Enfield
Councillor Jean Roger Kaseki, London Borough of Islington
Councillor Graham Old, London Borough of Barnet
Councillor Anne-Marie Pearce, London Borough of Enfield
Councillor Charles Wright, London Borough of Haringey

Issued on: Thursday, 14 September 2017

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 22 SEPTEMBER 2017

THERE ARE NO PRIVATE REPORTS

AGENDA

1. APOLOGIES

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Members will be asked to declare any pecuniary, non-pecuniary and any other interests in respect of items on this agenda.

3. ANNOUNCEMENTS

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

5. DEPUTATIONS (IF ANY)

6. MINUTES (Pages 7 - 16)

To approve and sign the minutes of the meeting held on 7th July 2017.

7. ROYAL FREE LONDON NHS FOUNDATION TRUST FINANCIAL UPDATE (Pages 17 - 32)

To note a presentation updating members on the financial situation at the Royal Free London NHS Foundation Trust.

8. NCL STP: STAFFING AND WORKFORCE (Pages 33 - 62)

To consider presentations on the staffing workstream in the STP.

9. NCL STP: ENGAGEMENT UPDATE (Pages 63 - 70)

To consider a communications and engagement update.

10. NORTH CENTRAL LONDON APPROACH TO COMMISSIONING PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (Pages 71 - 82)

To consider a report from the North London CCGs on the Procedures of Limited Clinical Effectiveness (PoLCE) Programme.

11. DEMENTIA PATHWAY

(Pages 83 - 134)

To consider reports from Barnet, Camden, Enfield, Haringey and Islington on dementia services.

12. WORK PROGRAMME

(Pages 135 - 140)

Members are asked to consider the work programme for the Committee.

13. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

14. DATES OF FUTURE MEETINGS

The dates of future NCL JHOSC meetings will be:

- Friday, 24th November 2017 (Enfield)
- Friday, 26th January 2018 (Camden)
- Friday, 23rd March 2018 (Islington)

AGENDA ENDS

The date of the next meeting will be Friday, 24 November 2017 at 10.00 am in Enfield Civic Centre, Silver Street, Enfield EN1 3XA.

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 7TH JULY, 2017** at 10.00 am in Committee Rooms 1 & 2, Haringey Civic Centre, High Road, Wood Green, London N22 8ZW

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Alison Cornelius, Abdul Abdullahi, Jean Kaseki, Graham Old, Anne Marie Pearce and Charles Wright

MEMBERS OF THE COMMITTEE ABSENT

Councillors Martin Klute and Danny Beales

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

MINUTES

1. ELECTION OF CHAIR

Councillor Alison Kelly was nominated as Chair of the Committee. There were no other nominations.

RESOLVED –

THAT Councillor Alison Kelly be elected Chair of the North Central London Joint Health Overview and Scrutiny Committee (NCL JHOSC) for the 2017-18 municipal year.

2. ELECTION OF VICE-CHAIR(S)

Councillors Martin Klute and Pippa Connor were nominated as Vice-Chairs of the Committee.

RESOLVED –

THAT Councillors Martin Klute and Pippa Connor be elected as Vice-Chairs of the North Central London Joint Health Overview and Scrutiny Committee (NCL JHOSC) for the 2017-18 municipal year.

3. APOLOGIES

Apologies for absence were received from Councillors Martin Klute and Danny Beales.

4. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

For reasons of transparency, Councillor Pippa Connor declared that her sister was a GP in Tottenham and Councillor Alison Cornelius declared that she was a trustee of a care home in Barnet.

5. ANNOUNCEMENTS

There were no announcements.

6. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of any items of urgent business.

7. TERMS OF REFERENCE

The Terms of Reference of the JHOSC were noted.

8. MINUTES

Consideration was given to the minutes of the meeting held on 21st April 2017.

RESOLVED –

THAT the minutes of the meeting held on 21st April 2017 be approved and signed as a correct record.

9. DEPUTATIONS

LUTS clinic deputation

Members heard a deputation led by Dr Kate Middleton, a former LUTS clinic patient. She highlighted that there was anxiety amongst patients about the future of the service and there had not been direct communication from the hospital to affected patients.

Dr Middleton said that she wanted to see a definite date for the reopening of the clinic to new patients. Various promises had been made about the timescale which had not materialised.

The rate at which the clinic would be treating patients would be 2 patients per week per doctor. This would mean that it would take a long time to go through the waiting list.

There was concern from the patients about referrals having to come from secondary care physicians rather than GPs. Patients had ended up at the LUTS clinic because of other secondary care services not being able to treat them.

Dr Middleton drew attention to what she felt was the perilous condition of paediatric patients. The long-term plan for the clinic needed to include a procedure for treating child patients.

Siobhan Harrington, Deputy Chief Executive of the Whittington, responded to the deputation. She said that a multi-disciplinary team needed to be put in place for patient safety. This was in accordance with the advice from NHS England and NHS Improvement. As such, she said she was not in a position to given a date for the re-opening of the service to new patients.

In terms of the appointment of a new consultant, Ms Harrington said that this would be a joint appointment with UCLH and would be likely to be made in mid-2018.

Members queried how long the multi-disciplinary team would take to assemble. They were informed that would take about three months. Members asked who would decide whether the team was fully functional, and were informed that it would be the Trust and commissioners.

A member asked who the lead commissioner was – and was informed that it was Islington, with Haringey involved as well.

Ms Harrington was asked why the referral route would be a secondary care one, and she said that this was the RCP (Royal College of Physicians) report's recommendation.

The Chair noted the concern about paediatric patients and said that, if the matter was not resolved, it would be helpful to have attendance from Great Ormond Street Hospital at a future meeting to discuss this issue.

Keep Our NHS Public (KONP) deputation

The meeting heard a deputation led by Rod Wells, from Keep Our NHS Public (KONP). Mr Wells outlined KONP's concerns about the STP being a cost-cutting exercise.

He said that concern had been voiced by chairs of Healthwatch and that there had not been meaningful consultation. He asked that the committee emphasise co-production and the empowerment of patients in their comments.

Helen Pettersen, the new STP convenor and Chief Executive of the 5 CCGs, responded to the deputation and said that each sub-region was required to have a STP. She said that documents available to the public were planned to be published earlier on, but that this had been delayed by the general election.

She said that media reports of a risk to the viability of the North Middlesex hospital were incorrect, and that there were no plans to end services there.

In terms of costs, she said that the North London health economy (CCGs and hospitals) had a deficit of about £200m for 2016-17. However, the STP area was only £61m short of its 2017-18 'control target'. It was aiming to close this £61m gap.

10. NCL STP: FINAL PLAN INCLUDING FINANCE

Helen Pettersen introduced the presentation to the Committee. She highlighted that the STP was not a statutory body with decision-making powers of its own, but a partnership of health organisations within the North-Central London area.

Tim Jagguard spoke on the financial situation. The five CCGs in the NCL area had approximately £2bn in budgets for commissioning, and there were additional sources of income for providers from NHS England for specialist services and for education, training and research.

Mr Jagguard said that the NCL CCGs had received a 2.2% funding increase for 2017-18. However, cost pressures would increase by 3% - as a result of an aging population and more people living with long-term health conditions. As such, the financial position of the CCGs was relatively poor.

They were aiming to save £61m to meet their 'control total' targets. A number of measures were being undertaken to reduce costs – such as trying to reduce the reliance on temporary and agency staff and controlling costs for medicines and pharmaceutical products. If control total targets were not met, this would put £28m of national sustainability funding from the Department of Health at risk.

Members asked about liaison with local authorities. Health officers said they had been working with local authorities at the office level on social care measures that could keep people out of hospital and help them to be discharged earlier. Directors of Social Services had been meeting with CCG leaders.

Councillor Connor agreed with the idea of keeping people out of hospital where possible and discharging them as early as was appropriate. However, she expressed concern that the local authority services health providers relied on to do this had been seriously affected by cuts.

Councillor Cornelius welcomed the co-operative working between health officers and Barnet officers. She voiced concern that there was not such good co-operative

working with Hertfordshire local authorities, and so there were delayed discharges of Hertfordshire patients from NCL hospitals.

Members noted mention of investment in the presentation and asked whether there could be continued investment in a time of real terms budget cuts. Ms Pettersen said the STP was aiming to protect investment as this could deliver savings in the long-run.

Councillor Pearce asked that more attention be paid to the importance of primary care. She had particular concerns about the insufficiency of primary care services in Enfield.

Health officers recognised the importance of primary care in preventing health problems worsening and people being admitted to hospital. Jo Sauvage noted that there were quality variations in the primary care system, and the STP was aiming to drive quality improvement in this sector.

Councillor Connor had concerns about sale of some of the St Ann's hospital estate. She wanted to ensure that there was still some mental health provision there, given the high demand for mental health services in the area.

The Chair echoed these concerns about the sale of land and suggested that a sub-group could be established to look into the sale of health land in Haringey and sales by the Camden & Islington NHS Mental Health Trust.

Dr Sauvage said there was an aim to incorporate mental health into primary care, as this was preferable for patients to having to present themselves at A & E when they were in a crisis situation.

Councillor Connor welcomed this, but was concerned about the length of time people were having to wait to receive mental health treatment. She said 50% of psychosis cases were not seen within two weeks.

Health officers said there was some 'parity of esteem' money which was being invested in mental health. Ms Pettersen said she would bring information to a future meeting of the committee on mental health in primary care.

Members queried the NHS 111 service and how it dealt with callers who had mental health issues. Dr Sauvage said there were protocols in place to identify people who could be directed down the mental health pathway.

Members expressed dismay that the NC London health economy could miss out on the £28m national sustainability funding if it did not keep to its control total. They wanted to put pressure on the Department of Health to ensure that this money which was earmarked for North Central London was not lost, even if the control total targets were not met.

There was a discussion about costs of delayed discharges. Members were informed that the costs were met by CCGs. Councillor Kelly asked that the paper from Camden on delayed discharges be circulated to interested members.

It was noted by members that a large proportion of the NCL deficit was from the Royal Free and North Middlesex hospitals. Members thought it would be informative to hear from them at a future meeting.

Comments were made by deputees and other members of the public present. The view was voiced that the processes followed for service changes were organisation-led not resident-led and that genuine co-production was not taking place. A speaker also said that local authorities should not take instruction from NHS England, and should use their own judgement as to what was best for residents of their borough.

There was a discussion on consultations. Health officers said that they aimed to use existing consultation structures to hear from the public about service changes flowing from the STP. Genevieve Ileris said there had been a well-attended meeting in Barnet with the CCG and Healthwatch on mental health care closer to home.

Councillor Abdullah mentioned that there were area and ward forums in Enfield, which CCG officers had attended in the past. He said it would be beneficial if health organisations could attend these and hear about public concerns there at first-hand.

The Chair said she wished to see co-operation between the NCL STP Board and officers, the JHOSC, and local residents to agree general principles. She agreed to liaise with NCL STP Watch and Keep Our NHS Public to draw up a set of principles they would like to see the STP work to in its consultation work. Ms Pettersen said she welcomed this.

The Chair made reference to the recommendation from the December 2016 meetings that there be a joint Health and Wellbeing Board covering the five NCL boroughs, and the subsequent request at the 3rd February 2017 JHOSC meeting to the Leader of Enfield Council and Committee Members to pursue this. The Vice-Chair suggested that local authority Chief Executives and Leaders be invited to a future meeting so the JHOSC could hear from the key decision-makers from local authorities in a wider forum than purely within their borough. It was also suggested that joint meetings between Leaders of the five Councils and the Health and Wellbeing Board Chairs from the five boroughs could be held instead of a large joint Health and Wellbeing Board.

The Chair undertook to write a letter to NHS England asking how secure the national sustainability funding was.

The Chair also asked that the paper on delayed discharges be circulated and that a sub-group meeting be established involving Camden, Haringey and Islington members regarding sales of health land.

RESOLVED –

(i) THAT the presentation and comments above be noted.

(ii) THAT local authority Leaders and Chief Executives be invited to speak to the JHOSC in January 2018.

(iii) THAT the Chair write to NHS England outlining the Committee's concerns about the loss of national revenue funding in the event control total targets were missed.

(iv) THAT a paper on delayed discharges be circulated

(v) THAT information come to a future meeting on mental health services in primary care

(vi) THAT a sub-group meet to consider the disposals of parts of the health estate in Camden, Haringey and Islington.

11. NCL STP: CCGS JOINT COMMITTEE - NORTH LONDON PARTNERS IN HEALTH & CARE

Helen Pettersen reported that the CCGs had established a joint commissioning committee to make joint decisions.

The committee would include: two representatives from each CCG, 3 clinical members, an Accountable Officer and a Finance Director. It would also have non-voting members, including an independent Chair, Council representatives, Healthwatch representatives and a Director of Public Health.

The remit of the committee was acute hospital services, integrated urgent care and learning disability services.

Members asked if the creation of this joint committee would mean the end of CCGs. They were informed that the abolition of CCGs would need separate primary legislation, which the government had not proposed.

Members were informed that there was information available to the public on CCG websites.

The Chair asked that more information be provided about how the committee was working in six months' time.

RESOLVED –

(i) THAT the report be noted.

(ii) THAT an update be submitted to the JHOSC in six months' time

12. WORK PROGRAMME

Consideration was given to the report on the JHOSC work programme.

Members agreed that the dementia pathway item be on the agenda for the September meeting.

They agreed that the social care item be delayed to November. Members said that they wanted to see more information on staffing and workforce planning. There was particular concern about staffing in care homes.

It was agreed that there be an item on private ambulances at the January 2018 meeting, and Councillor Abdullahi agreed to lead on it. The Chair said she would lead on the risk management item.

Members asked that there be more information and attention paid to the equalities strand in the STP. Officers said that an EIA should be incorporated into each workstream. Equalities was suggested as a potential item for the January meeting.

Members reiterated their view that it would be desirable to hear from the Leaders and Chief Executives of the five boroughs and that consideration be given as to the best way to obtaining their views if they were not able to attend JHOSC meetings.

Members, as discussed at Item 10 above, agreed that a sub-group meet to consider specific concerns about sales of parts of the NHS estate in Camden, Haringey and Islington.

RESOLVED –

THAT the work programme report with the amendments detailed above be agreed.

13. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no items of urgent business.

The meeting ended at 12.45pm

CHAIR

Contact Officer: Vinothan Sangarapillai

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MINUTES END

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North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Royal Free London NHS Foundation Trust Financial Update	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 22nd September 2017
SUMMARY OF REPORT To consider a presentation updating the Committee on the Royal Free London NHS Foundation Trust's finances. **Presenting Officers:** • David Sloman, Chief Executive, Royal Free London • Caroline Clarke, Chief Financial Officer and Deputy Chief Executive, Royal Free London	
RECOMMENDATIONS Members are asked to consider the presentation on the Royal Free London's financial situation.	

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Royal Free London financial position in the context of the NCL STP position

NCL Joint Health Overview & Scrutiny Committee

Caroline Clarke – Chief Financial Officer and Deputy Chief Executive, RFL

September 2017

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What will we cover?

Recap of STP financial position
The Royal Free London NHSFT within the STP
Diagnosis
Context for the financial strategy
Key elements of the strategy
Delivery

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NCL STP financial position – as presented to the July meeting

Financial position for 2017/18 - summary

	Total £m
2016/17 underlying position	-200
Allocation growth for CCGs	41
Growth in demand/cost pressures	- 175
Investments	-15
Planned savings	227
Non- recurrent items	89
2017/18 In year position	- 33
Control total target	28
Variance	-61

This is the position previously presented to the committee.

The plans include ambitious efficiency savings (4.6% for trusts and 4.7% for CCGs).

The plans leave us £61m short of our 17/18 control total target. Failure to hit our control total puts a further £28m of national sustainability funding at risk.

Given the scale of the ambition in savings plans we have assessed the risks of non-delivery of existing plans as c£100m.

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NCL STP financial position – as presented to the July meeting

The STP also takes a longer term financial perspective to 2020/21. The position presented to the July meeting as below

	£m
Do nothing	-811
Impact of service transformation	205
Investment in new services	-92
Provider efficiency savings	357
Additional funding (sustainability & transformation fund	105
Specialised commissioning savings	137
PFI savings	24
TOTAL	-75

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Royal Free London NHSFT position within this NCL aggregated position

Financial position for 2017/18 -summary	NCL £m	RFL £m	
2016/17 underlying position	-200	-123	
Allocation growth for CCGs	41	0	
Growth in demand/cost pressures	-175	-18	
Investments	-15	0	
Planned savings	227	45	
Non-recurrent items	89	69	
Lost STF funding	-28	0	*
Deficit	**-61**	**-28**	
Control total target	28	24	
Variance to control total	**-89**	**-51**	

** n.b. RFL did not receive it's STF funding in 16/17*

The NCL STP position previously presented was for an in-year deficit of £33m. Once the risk of loss of Sustainability and Transformation Funding of £28m is included this equates to a deficit of £61m (£89m worse than control total).

The RFL share of this £89m variance in £51m. The underlying deficit of £123m at the end of 16/17 will be reduced in 17/18 but it will take a number of years to reach break even. During this time we will continue to implement non-recurrent measures to minimise the loss.

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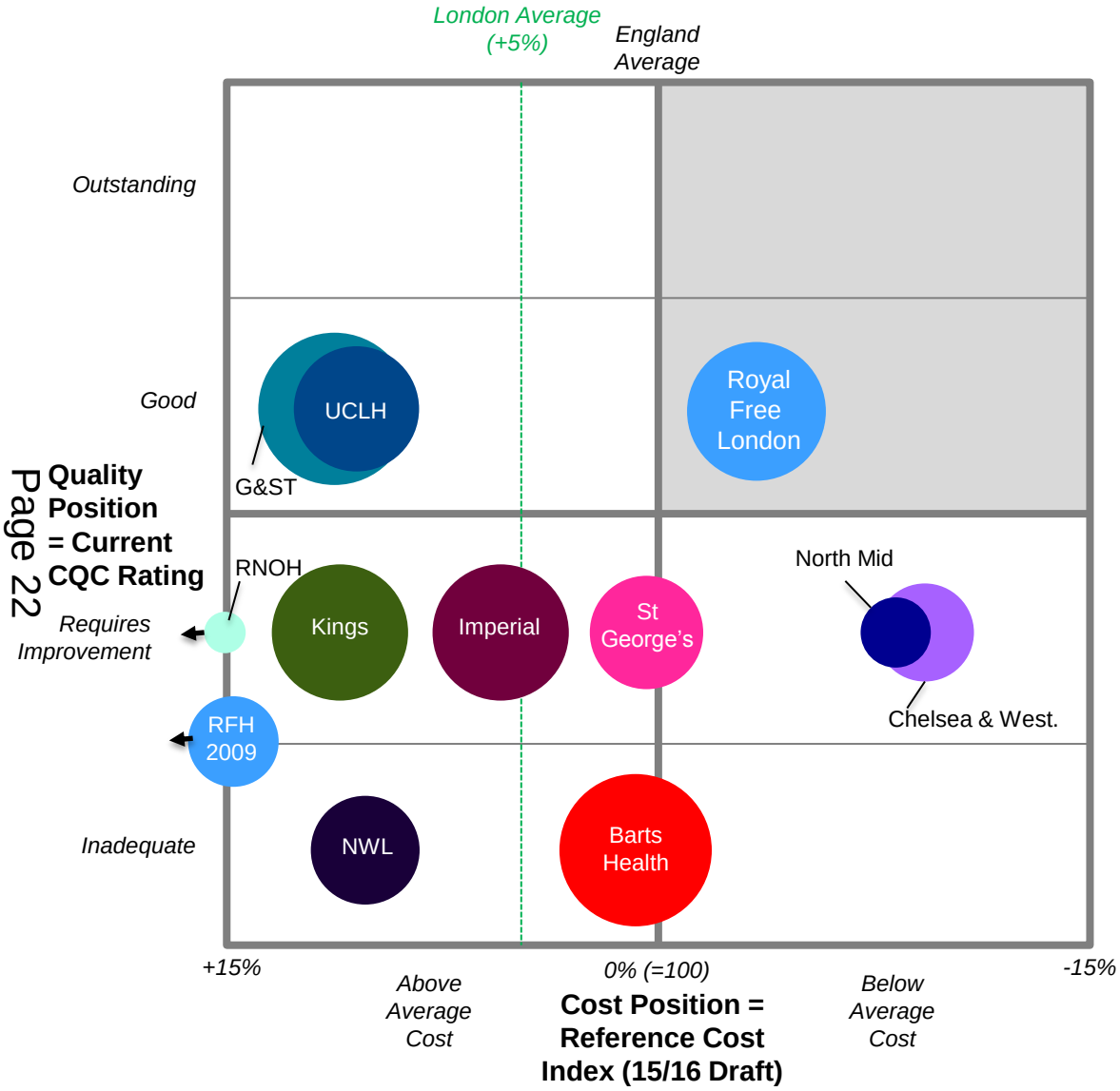
Our current position on quality and cost



- RFL 3% lower cost than national average and 8% lower than London acute trust average
- RFH was c20% higher cost than national average in 2009
- Simultaneous move from non-compliance with CQC to "good" rating
- Other dimensions of quality, such as mortality rate have remained better than average

Bubble size = 2015/16 Income

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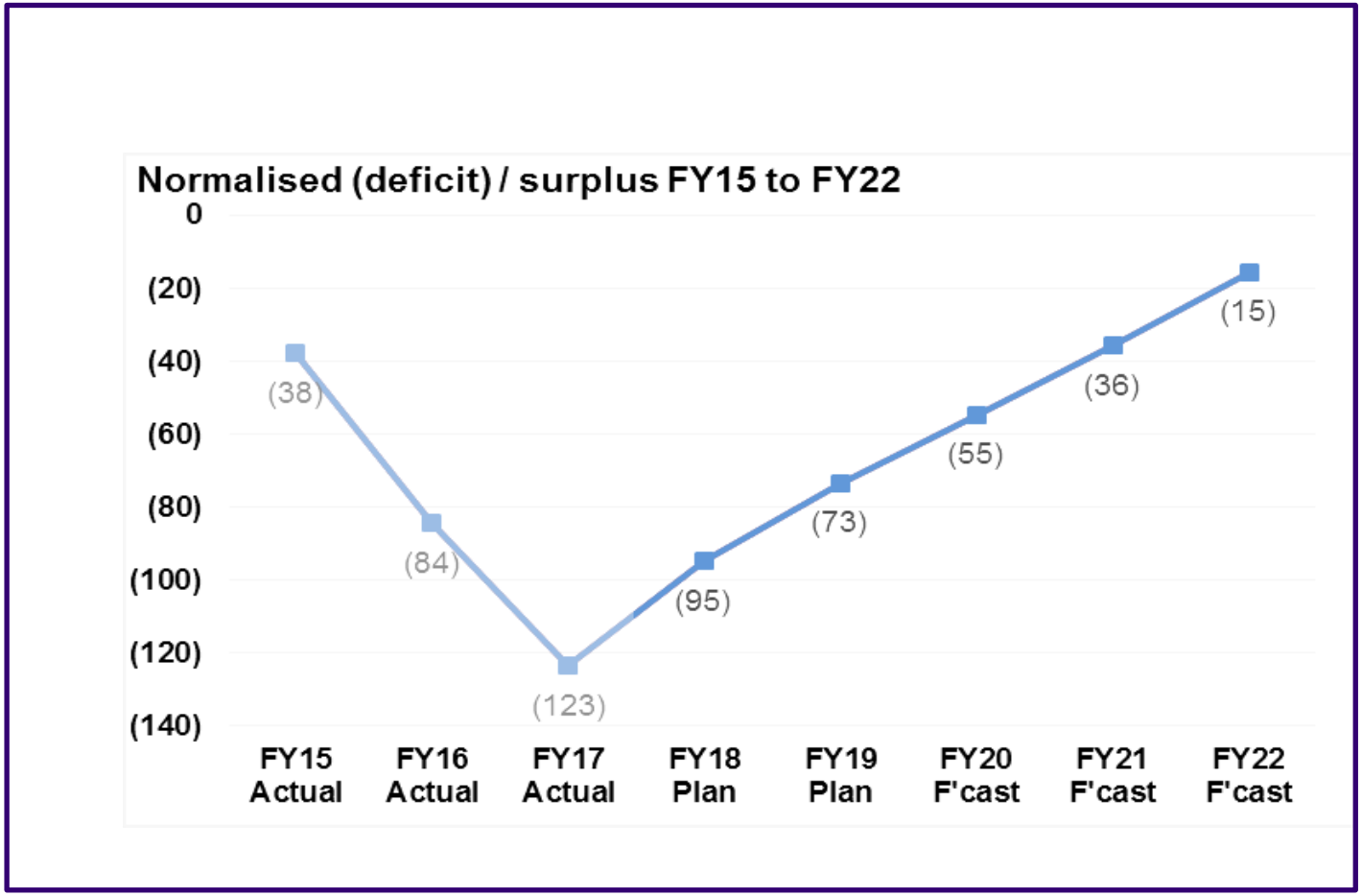
How has our financial position changed over time?



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What drove the deficit – diagnosis

Independent analysis on how the deficit arose (based on NHSI methodology)

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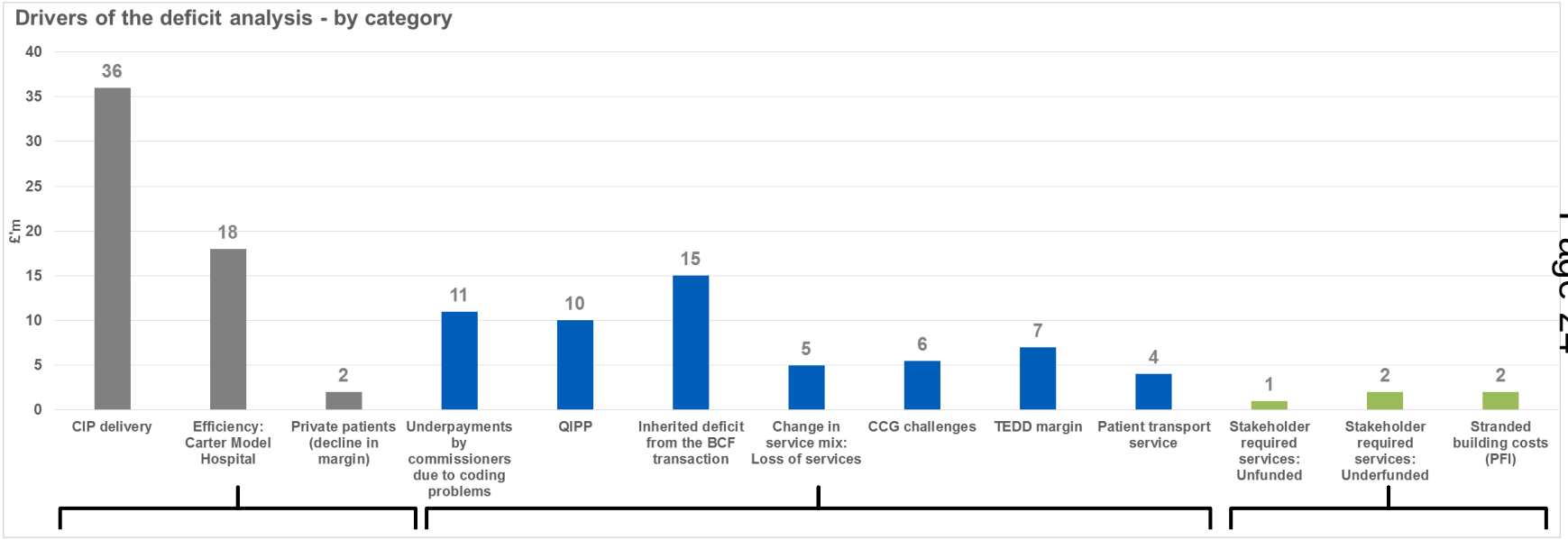
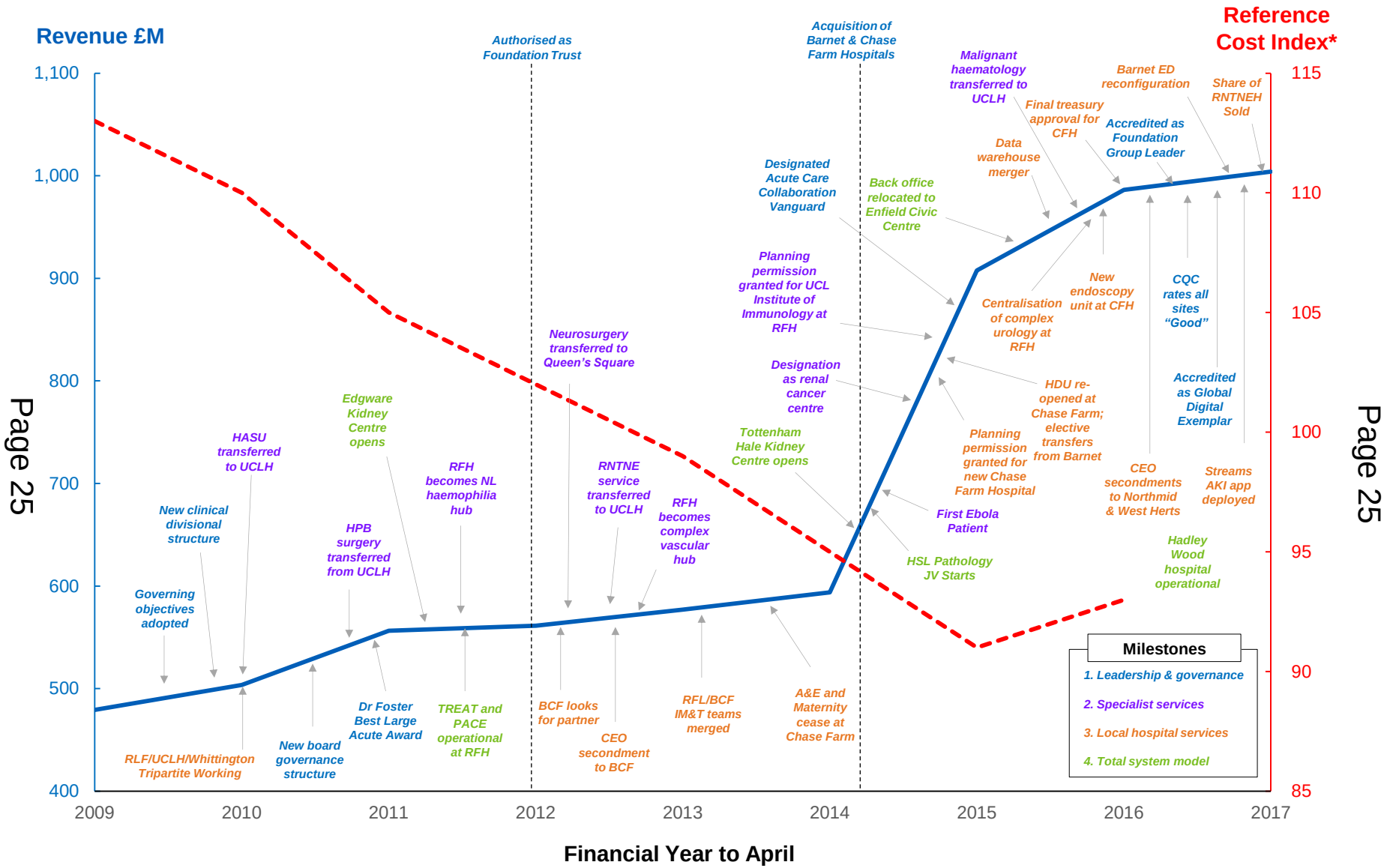


The high level drivers of the deficit total c.£120m. The drivers of the deficit have been categorised by the degree of control that the Trust has over them as follows:

- **Operational drivers**, considered broadly within the control of the Trust, total £56m (47%)
- **Strategic drivers**, issues that the Trust may be able to influence but not control, total £58m (49%), and
- **Structural drivers**, issues not considered within the control of the Trust, total £5m (4%).

We have already done a lot: revenue and relative costs



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* Smoothed using 24-month moving averages except starting year

Building blocks of our financial strategy

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Internal Efficiency

CIP programme
£41.6m delivered 16/17
£44.7m plan for 17/18

New Chase Farm Hospital
Quality services and eliminate £20m deficit

One off transactions
Asset sales from unused property

RFL Group

Benefits of group
see next slide

Clinical Practice Groups
Reduce unwarranted variation at scale - outcomes and cost

Support Services Scale
Consolidate to improve quality at lower cost

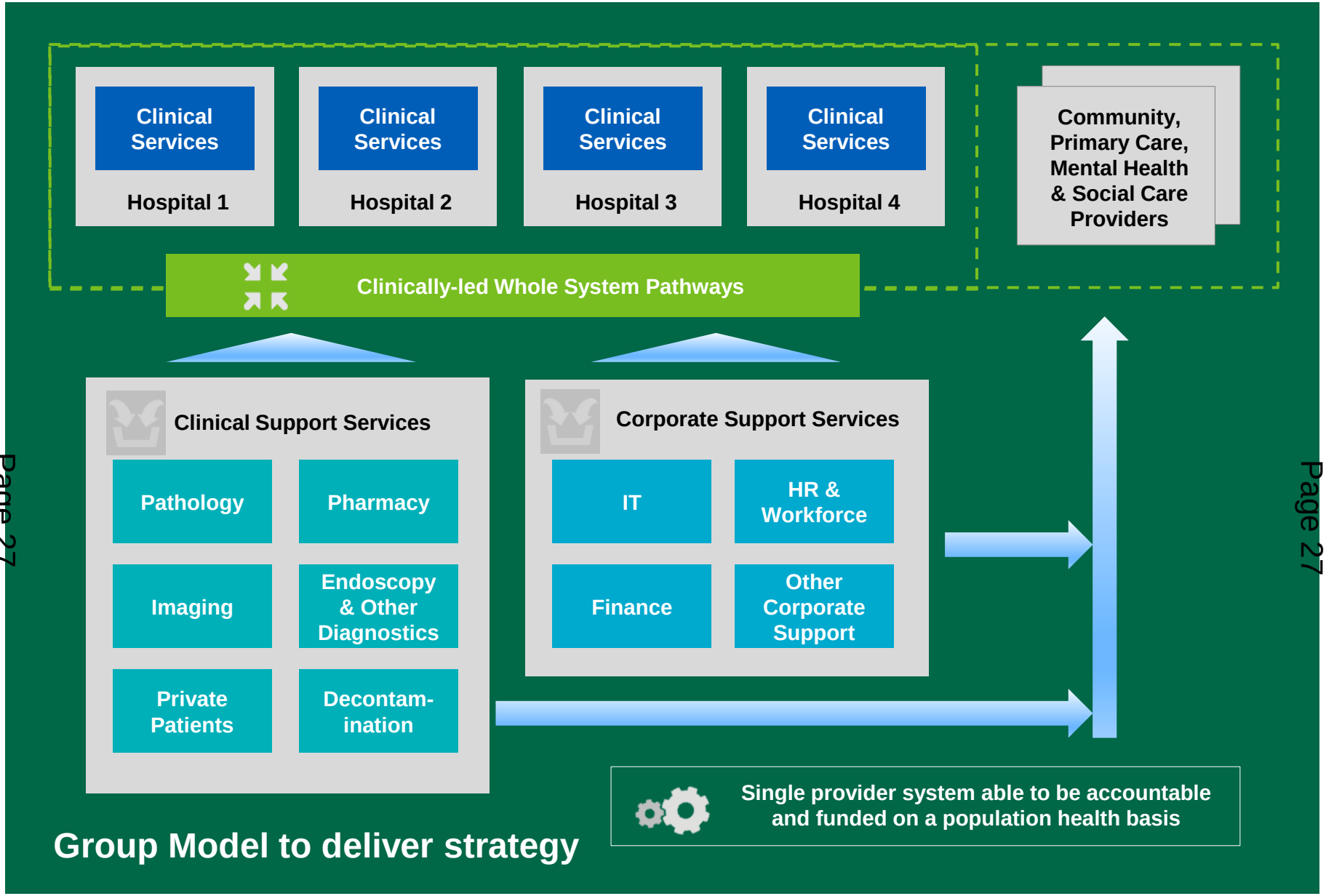
STP

STP Interventions
Planning & delivery of STP interventions

Cross provider productivity
e.g. decontamination

Long term transformation
e.g. Digital

The above are all linked and mutually supportive – to deliver both RFL and system sustainability



Group Model to deliver strategy

Benefits of Group

Recruiting, developing and retaining talent	Reducing unwarranted variation in clinical practices	Achieving excellent operational and financial performance	Delivering clinical and support services at lower cost and higher quality	Implementing total system patient pathways
Quality improvement and leadership committee	Clinical Standards and Innovation Committee	Group Board (+ Hospital unit executives)	Group Services Committee	Population Health and Pathways Committee
Leadership and expertise to drive improvement	***Reduce variation***	***Achieving excellent financial and operational performance***	***Consolidate clinical and non-clinical activity***	***Delivering system wide benefits through whole pathway re-design***
Effective leadership and workforce development	Reduce variation in clinical processes	Cost improvement through scale	Consolidate clinical services to drive quality and value	Collaborative partnership working
Continuous improvement supporting better outcomes	Standardise approach to non-clinical processes	Consistent good performance across sites	Consolidate clinical support services across the group	Demonstrable system leadership
	Research and innovation supports world class ambition		Centralise non-clinical activity	

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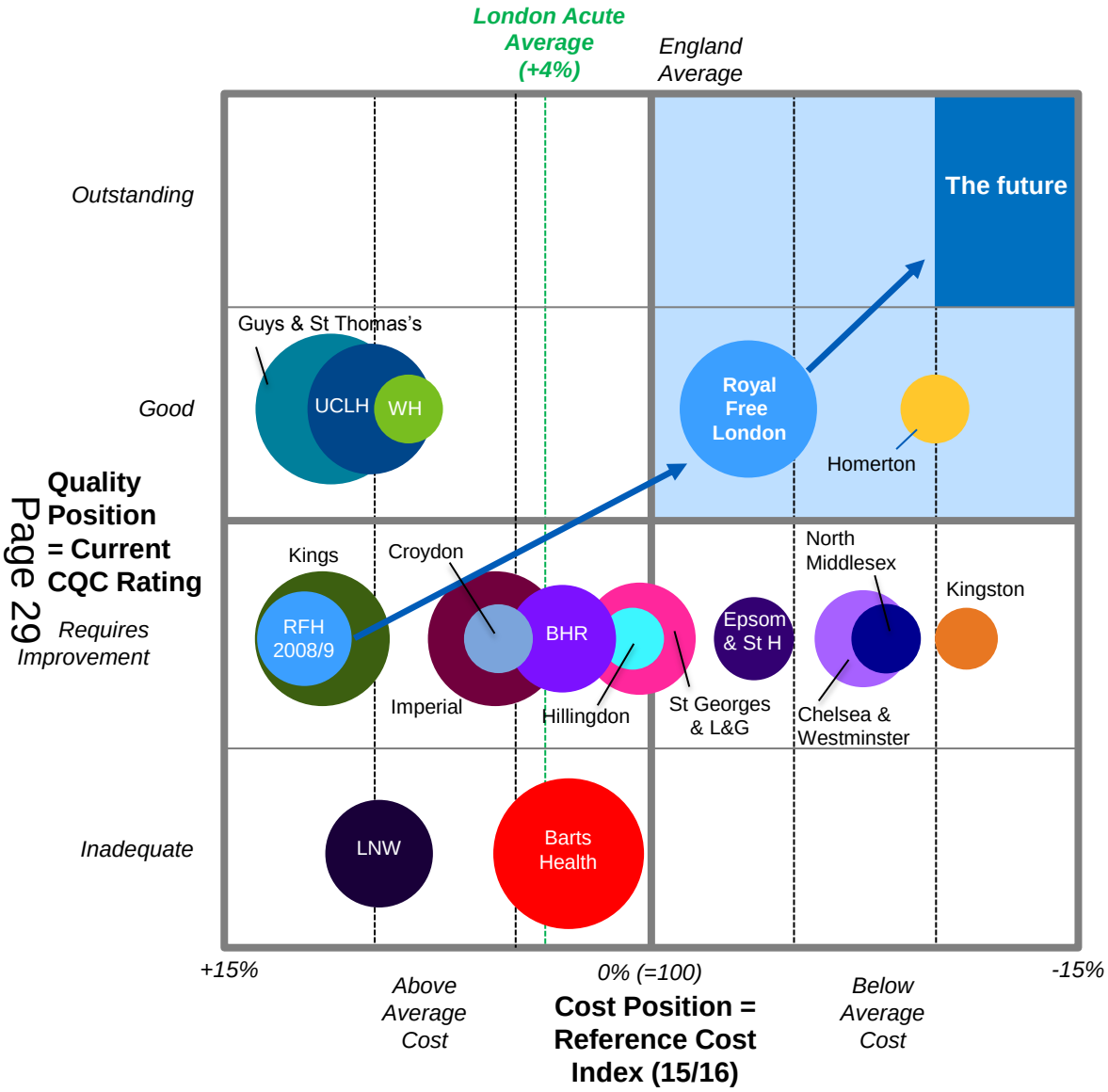
Patient Benefits
Improved Safety, Efficacy and Experience of Care

Staff Benefits
Better Career Progression, Professionalism, L&D

System Benefits
Lower Unit and System costs

Our ambition for our hospitals



- RFH has progressed from 13% higher cost than national average in 2008/9 to 3% lower cost - and is 7% lower costs than the London acute (non specialist) average
- Simultaneous move from non-compliance with CQC to "good" rating; other dimensions of quality, such as mortality rate have remained better than average
- Whilst the progress has been good, we have some way still to go on both quality and cost dimensions

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*Covers £9.93BN of costs in 2015/16
Bubble size = 2015/16 Income; L&G and St George's are represented by the same 'bubble' as both have almost identical profiles

RFL – how far will this get us to and by when?

Our next steps

- Updated Financial Strategy to key stakeholders
- Agree investment profile

What will the Royal Free group deliver?

- We want to deliver outstanding services with a 10% cost advantage over other providers, and sustainable financial position
- We believe that this will be a model others will want to join
- This will take at least four years

What we need from others

- All continue to work together and deliver the objectives of the STP
- May need to make some difficult decisions together (e.g. service locations)
- Reduce transaction costs and distractions in the system

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North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE NCL Sustainability and Transformation Plan (STP): Staffing and Workforce	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 22nd September 2017
SUMMARY OF REPORT To consider presentations on the workforce workstream. **Presenting Officers:** • Dr Sanjiv Ahluwalia – Co-Chair, LWAB and Postgraduate Dean at HENCEL • Julia Tybura – Interim Programme Director (Workforce) • Claire Johnston - NCL Capital Nurse Project Director	
RECOMMENDATIONS Members are asked to consider and comment on the presentations.	

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NORTH LONDON PARTNERS in health and care

Joint Health Overview and Scrutiny Committee

Update - Workforce Workstream, North Central London Sustainability and Transformation Programme

22nd September 2017

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Introduction

- Dr Sanjiv Ahluwalia – Co-Chair, LWAB and Postgraduate Dean at HENCEL
- Julia Tybura – Interim Programme Director (Workforce)
- Claire Johnston - NCL Capital Nurse Project Director

Workforce Workstream

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Our Vision and Long Term Objectives

Our vision is to ensure we have a workforce that can deliver the care models and strategic priorities described in our STP and help us to meet our financial obligations we need to address two key issues:

1. We need to secure the right number of staff to work in the NCL health and care systems to meet the growing needs of our population in an affordable way; and
2. We need to develop our existing staff so they have the right skills to deliver the transformed models of care described in the STP.

To deliver our vision we are seeking to ensure:

- support and development of the NCL health and social care workforce in all care settings, promoting integrated care working across professional and organisational boundaries
- workforce activity is aligned to, and supports all clinical redesign themes set out in the STP, based on clear, agreed clinical models
- that we have an understanding of the skills and competencies the workforce of the future need to possess across health and social care
- Developing HR services to help make organisations 'Model Employers' and a place where people want to work.
- that robust place-based and nationally led workforce planning processes drive local investment in workforce transformation
- we have the right leadership skills and organisational development programmes to take forward the ambitions of the STP

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Key Issues and Difficulties

Workforce underpins all clinical redesign and therefore needs connectivity across the STP. Specifically the issues are in the following areas:

1. Attracting healthcare and social care professionals to work in North Central London
2. Retaining existing Workforce
3. General Practice Workforce
4. Social Care Workforce – directly employed e.g. social workers, commissioned workforce e.g. care workers, carers
5. Medical Workforce Composition

We have distilled our programme of activity into the following overarching themes:

1) Recruitment and Retention
2) Primary Care Transformation
3) New Care Models
4) Learning, development, and transforming our workforce

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Capital Nurse Programme - London Nursing Retention

%	2011	2012	2013	2014	2015	2016
after 1 year	88	87	86	85	84	84
after 2 year	78	77	75	74	74	
after 3 year	71	68	66	66		
after 4 year	63	61	60			
after 5 year	57	56				
after 6 year	52					

- From the 2011 snapshot, 1% of the staff in post equates to 492 nurses.
- From the 2016 snapshot, 1% of the staff in post equates to 557 nurses.
- The difference in one year snapshot retention is 4% between 2011 and 2016.
- If the retention rate in 2016 was the same as 2011 then London would have retained a further 2,000 nurses.
- In 2016 London commissioned around 2,000 adult nurses to start training.

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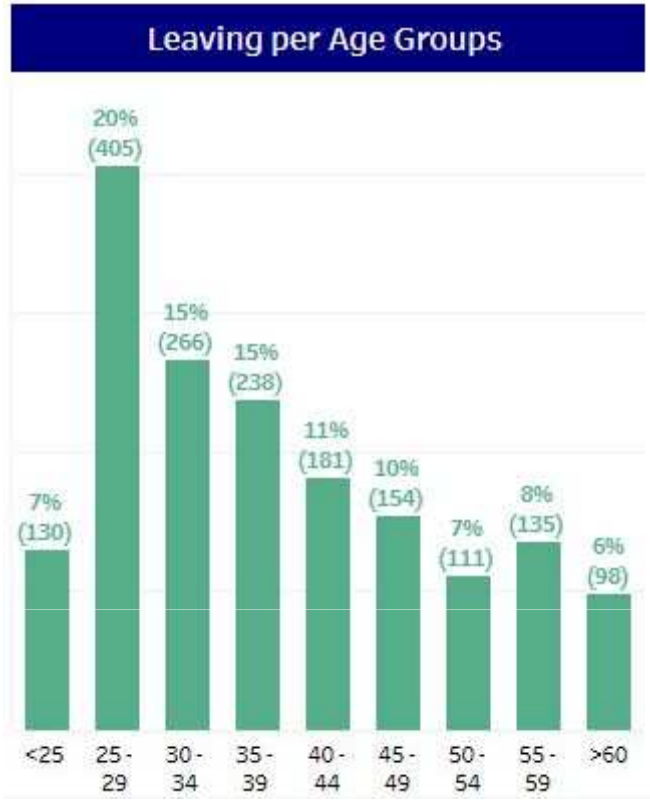
London Nursing Turnover



	2016/17	2015/16	2014/15	2013/14	2012/13
BARNET ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	14%	18%	15%	13%	10%
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	18%	19%	21%	13%	22%
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	16%	18%	17%	16%	17%
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	17%	17%	16%	11%	12%
ROYAL FREE LONDON NHS FOUNDATION TRUST	19%	18%	19%	18%	16%
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	16%	16%	13%	14%	14%
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	33%	27%	25%	24%	20%
THE WHITTINGTON HOSPITAL NHS TRUST	14%	19%	18%	18%	17%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	15%	21%	15%	13%	13%

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Programmes to Tackle the Issues

- Network of transfer clinics, transfer schemes and career clinics
- Early career progressions programmes
- Preceptorship – first year
- Rotation programmes across care pathways
- Retaining older nurses – extending working life
  - health
  - social care
- Chemotherapy passport
- Digital career framework

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Key Blocks to and Drivers for Change

- Increased staff turnover (transient workforce)
- Silo working across health and social care
- Accommodation – supply, cost and quality
- Staff shifting from one area to another e.g. Care workers becoming HCAs
- National pay challenges

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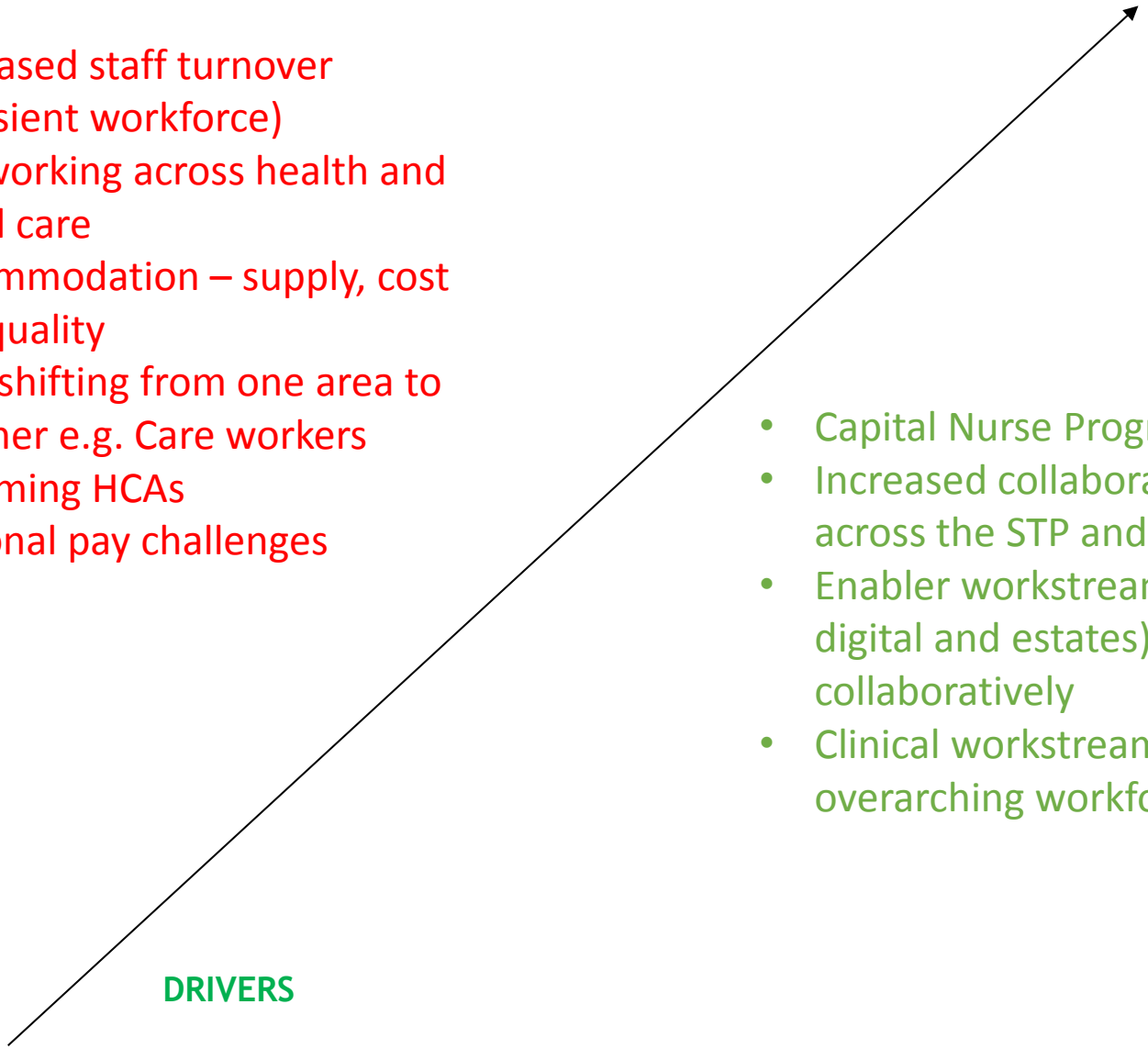

- Capital Nurse Programme
- Increased collaborative working across the STP and 5 Boroughs
- Enabler workstreams (workforce, digital and estates) working collaboratively
- Clinical workstreams and overarching workforce workstream

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Next Steps and Questions

- System Leadership
- Initiating strategic workforce activity - LWAB
- Connectivity within the programme to the next level
  - Enablers
  - Clinical workstreams
- Further develop partnership working – STP and 5 Boroughs
- 5 boroughs collaborating on social care workforce

- **Questions and Recommendations**

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NORTH LONDON PARTNERS in health and care

WORKFORCE WORKSTREAM

MONTHLY WORKSTREAM-TO-PMO REPORT

REPORTING PERIOD: 01/08/2017 – 01/09/2018

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- Programme Delivery Board: Key Discussion Points -

Status summary:	Last report RAG	This report RAG	*[How is the workstream progressing overall (complete adjacent RAG ratings)? More specifically, is it on track against the planned schedule, projected savings, and projected benefits? (complete the below as applicable)]* • Delivery against planning schedule is mostly on track • Realisation of anticipated savings (if applicable) is at risk • Realisation of anticipated benefits is at risk
Significant achievements:	*[Summary of the 3 most notable workstream achievements over the reporting period]* • Further significant progress has been made in creating links with key stakeholders across the STP including other enabling workstreams e.g. Digital, Finance and Estates. Local Authority HR Reps and Social Care reps are now more closely linked to the Workforce workstream. Trade Union officials are also more closely linked. All of this will continue and is aimed to increase collaboration and ensure support for the delivery of the STP work programme. • Stakeholder event for L&D workstream on 28 September 2017 with HR Directors, Directors of Nursing and Regional Trade Union officials invited • The Mandatory and Statutory training survey has been compiled finalised and sent out to stakeholders across health and social care. The survey will run from 8 August – 7 September 2017. • Engaged a number of clinical workstreams to discussed workforce implications. Some key dependencies identified – other implications/requirements will be identified as clinical workstreams' work plans develop further. The dependencies will be fed into the STP wide interdependencies workshop on 18th September.	
Significant risks / issues:	*[What are your three most significant delivery risks/issues?]* • The roles of the LWAB and the STP are being considered; how they link and where the connectivity needs to be. Discussions are also taking place on the development of the Workforce 'Observatory' and how this might link to the development of the LWAB. The risk is that the LWAB does not meet the strategic workforce needs as appears to be the case in other areas of the country.		
Critical capacity gaps:	*[Are there any <u>critical</u> gaps in capacity. If so, please state these here along with details of the impact of not having the resource in place and what steps have/should be taken to fill the gap] N/A* Within the Resourcing workstream insufficient resources to deliver the Workforce Programme 2017/18. Funding		

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- Programme Delivery Board: Progress Dashboard -

Progress made during current reporting period	Progress planned for the coming month
RESOURCING : • Procurement exercise arranged on 14 September to review three competitive proposals received for survey and focus group works ahead of procurement exercise (project 1) • Draft framework for a common recruitment policy has been drafted further to consultation with DDG and benchmark review (project 3). Further clarifications from finance and quality are being requested for the bidders for the purpose of clarifying engagement terms and costs (project 5)	**RESOURCING :** • **Project 1: Retention** Undertake procurement exercise on 14 September and finalise re-plan of retention assessment in conjunction with agreed specialist qualitative and quantitative research and analysis service provider. **Project 2: Reward** A report on the current NCL financial rewards and non-pay benefits offered to be submitted to HRD network, which will outline business cases for the benefits to each organisation of adopting a common framework for financial rewards and menu for non-pay benefits, and high level implementation plans and timeframe. **Project 3**: **Recruitment** A report detailing the outcome of a review of relevant policies of the organisations in NCL to be submitted to the HRD network for review, including a high level implementation plan and timeframe. In addition to planned output, inclusion of proposals of recruitment initiatives for consideration of NCL implementation , in conjunction with Capital Nurse. **Project 4**: **Temporary staffing pay strategy:** Plan for alignment of medical locum rates (in conjunction with pan-London wok in this area) and AfC bank rates to be established **Project 5: Bank Tender:** Colleagues from the original STP representatives to reconvene once quality and finance clarification achieved to finalise procurement process.

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- Programme Delivery Board: Progress Dashboard -

Progress made during current reporting period	Progress planned for the coming month
L&D • The MAST survey has been compiled finalised and sent out to stakeholders across health and social care. The survey runs from 8 August - 7 September 2017 with reminders to all the stakeholders including the HRD's on 22nd August and 5 September 2017 • The stakeholder engagement event has been set up for 28 September 2017. The invitations to the event went out via Eventbrite on 14 August 2017. There will be a maximum of 60 places available. • Attended UCLP Event on 8 August 2017 - Rapid Savings Programme Training workshop, Whittington Hospital. This was run by Ayming who has been commissioned to lead some work on making savings across the North London procurement hub. 4 Trusts were in attendance. • Apprenticeship policy and common pay framework. Feedback sought from HRDs, final design and delivery meeting taking place on 23rd August 2017 to make final changes to policy and pay structure	**L&D** • Send reminders to those that have not responded and alert the relevant senior leads. • Collate the survey results and discuss with a small stakeholder group. • Arrange a date for a mixed stakeholder group to review the findings. • Finalise the programme for 28 September 2017. • Finalise the research and evidence that will be included and discuss with the relevant HR Directors. • Share the presentation with the speakers and get final agreement on the content.. Apprenticeship policy and common pay framework: • Final draft of apprenticeship policy and pay framework sent to HRDs for comments and agreement. • Meeting held with STP trade union lead • HRDs to present apprenticeship policy at respective staff side committees

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- Programme Delivery Board: Progress Dashboard -

Progress made during current reporting period	Progress planned for the coming month
Clinical Workstreams • Revised primary care workforce action plan in place. • CEPN Engagement Survey analysed and shared with key stakeholders. • Clinical work streams engaged and discussions on key expectations/workforce requirements commenced. • Engaged CEPNs for the next round of GP International Recruitment proposals • Royal Free leading on a new Physician Associate Programme, coordinated with CEPNs, including placement opportunities within General Practice	**Clinical Workstreams** • Define existing expectations/requirements of other work streams from primary care and new models of care work streams, and maintain engagement to capture new expectations as their work plans develop further • Develop a communications plan in response to the CEPN engagement survey • Encourage and support NCL CEPNs to develop a proposal for GP International Recruitment • Determine appetite for Physician Associate student placements and finalise plans for a January 2018 intake

Major milestones to 31 March 2018		Importance	Deadline	Status
M1	**Resourcing - recruitment and retention:** Select partner, design survey and set up focus groups - Options appraisal LWAB decisions	An enabler for the resourcing workstream.	Original: 30/04/2017 Current: 31/10/2017	
M2	**Resourcing - recruitment and retention:** Common recruitment policy and process designed	An enabler for the resourcing workstream.	Original: 30/04/2017 Current: 31/10/2017	
M3	**Resourcing – temporary staffing:** Data analysis complete	An enabler for the resourcing workstream.	Original: 30/04/2017 Current: 31/10/2017	
M4	**Resourcing – temporary staffing:** Pay Data Report LWAB decision	An enabler for the resourcing workstream.	Original: 30/04/2017 Current: 31/10/2017	
M5	**Resourcing – bank staffing:** Preferred bidder identified	An enabler for the resourcing workstream	Original: 30/04/2017 Current: 31/10/2017	Complete
M6	**Resourcing - Shared approach to procurement:** Mapping of existing information across all organisations	Linked to savings	Original: 31/07/2017 Current: 31/11/2017	
M7	**Resourcing - Capital Nurse Programme:** Implementation of cross organisation Transfer Window scheme	Linked to savings	Original: 31/12/2017 Current: 31/12/2017	

RAG KEY:	On track	At risk - improving	At risk - worsening	Not on track / blocked

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- Programme Delivery Board: Progress Dashboard -

Major milestones to 31 March 2018		Importance	Deadline	Status
M8	**Resourcing - Capital Nurse Programme:** Establish 3 rotation schemes for post preceptorship nurses	Linked to savings and benefits	Original: 31/10/2017 Current: 31/10/2017	
M9	**Learning and Development - Statutory & mandatory, shared provision:** Resources obtained	Linked to benefits	Original: 30/04/2017 Current: 31/05/2017	Complete
M10	**Learning and Development - Statutory & mandatory, shared provision:** Options appraisal / LWAB decisions	Linked to benefits	Original: 31/08/2018 Current: 30/11/2017	
M11	**Learning and Development – Apprenticeships:** Options appraisal / LWAB decisions	Linked to Savings;	Original: 31/08/2018 Current: 31/10/2017	
M12	**Primary Care – Recruitment:** GP Trainee redistribution programme agreed	Linked to savings and benefits	Original: 31/05/2017	Complete
M13	**Primary Care – Recruitment:** Recruitment to new GPs 2017/18	Linked to savings and benefits	Original: 30/09/2017	
M14	**Primary Care – Recruitment:** GP International recruitment -submit proposals	Linked to savings and benefits	Original: 30/11/2017	
M15	**Primary Care – Recruitment:** Recruitment to Medical Assistants cohort 1 commence	Linked to savings and benefits	Original: 30/04/2017	
M16	**Primary Care – Recruitment:** Medical Assistants cohort 1 completion	Linked to savings and benefits	Original: 31/03/2018	
M17	**Primary Care – Recruitment:** Physicians Associates - Identify requirements and funding model	Linked to savings and benefits	Original: 30/09/2017	
M18	**Primary Care – Retention:** Develop a retention strategy	Linked to savings and benefits	Original: 31/08/2017	
M19	**Primary Care – Retention:** Form stakeholder group to review PC employment terms and CHIN OD model	Linked to savings and benefits	Original: 31/07/2017	

RAG KEY:	On track	At risk - improving	At risk - worsening	Not on track / blocked (see exception report)

Workforce Workstream

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- Programme Delivery Board: Progress Dashboard -

Major milestones to 31 March 2018		Importance	Deadline	Status
M20	**Primary Care – Retention:** Implement CEPN retention programmes	Linked to savings and benefits	Original: 31/12/2017	
M21	**Primary Care – Training:** Pilot 5 x new schemes	Linked to savings and benefits	Original: 30/09/2017	
M22	**Primary Care – CHIN design:** Development of joint strategic planning	Linked to savings and benefits	Original: 30/06/2017	
M23	**Primary Care – CHIN design:** Scope of NCL education network confirmed	Linked to savings and benefits	Original: 30/06/2017	
M24	Learning and Development – Apprenticeships: Finalise apprenticeship policy and pay framework at NCL design and delivery groups	Linked to benefits	Original: 30/06/2017 Current: 31/08/2017	
M25	Learning and Development – Apprenticeships: Final policy shared at HRDs and with STP trade union lead	Linked to benefits	Original: 31/07/2017 Current: 30/09/2017	
M26	Learning and Development – Apprenticeships: HRDs to take policy through staff side committees	Linked to benefits	Original: 31/07/2017 Current: 30/09/2017	

RAG KEY:	On track	At risk - improving	At risk - worsening	Not on track / blocked (see exception report)

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- Programme Management Office: Comms and Engagement Report -

Recent stakeholder communications / engagement

Date	Type of Initiative	Stakeholder Group	Feedback / Issues	Recommendations	Key Contact
02.08.17	Engagement	HRDs in STP area	Redeployment approach discussed	Revised version to be developed	Julia Tybura and Tom Nettel
09.08.17	Engagement	Workforce Workstream and HEE	Development if workforce planning and modelling capacity/capability	Further discussion taking m place over the development of the 'Observatory' by HEE	Nigel Burgess, Julia Tybura
10.08.17	Engagement and Introductory meeting	Social Care and Workforce Workstreams	Identifying areas of collaboration and mutual support	To continue to meet to ensure workstreams are aligned	Julia Tybura and Anne-Marie Gray
15.08.17	Programme Meeting	STP Workforce Steering Group	Progress on L&D workstream. CEPN concerned over lack of engagement with LWAB	Continue establishing contact	Julia Tybura Cheryl Samuels (L&D)
25.08.17	Engagement	HRDs in NCL	Invited by HEE to submit views on the development of the Workforce Observatory	Detailed responses submitted on behalf of HRDs. Positively received by Moorhouse on behalf of HEE.	Jon Head, Tom Nettel
29.08.17	Programme Meeting	STP Workforce Steering Group	Development of the LWAB to ensure it is delivering its remit	Paper on the development of the LWAB to be produced and submitted to LWAB on 20.9.17	Sanjiv Ahluwalia, James Cain, Jon Head

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Programme Management Office: Comms and Engagement Report

Recent stakeholder communications / engagement

Date	Type of Initiative	Stakeholder Group	Feedback / Issues	Recommendations	Key Contact
Various dates	Engagement	HEE/NHSI colleagues re : learnings from other STP's/workforce modelling and planning	Engagement and connectivity with other workstreams was welcomed as essential	Continue engagement and understand how that works in detail through Interdependencies	Julia Tybura
03.08.2017	Programme Management	Mapping of 'wiring diagram' for STP. Will Huxter, Sanjiv Ahluwalia, Simon Goodwin, Julia Tybura and Jo Sauvage	Valuable meeting that identified key issues to be addressed to ensure connectivity between workstreams to deliver the benefits	Work to be further developed through Interdependencies workshop and possible further changes to the programme management system	Will, Huxter, Julia Tybura
16.08.2017	Engagement	Preparation for JHOSC and deepening engagement with Social Care	Useful information to be part of presentation to JHOSC	Include issues in presentation and continue to develop connectivity with Local Authority HR	Julia Tybura and Chris Atherton
22.08.2017	Engagement	Preparation for JHOSC with Alison Kelly	Outline of requirements of presentation established	Use as basis for preparation for the presentation	Julia Tybura
11.08.2017	Engagement	Connectivity with estates and workforce	Exploring the links and dependencies with Workforce and Estates	Take forward in Enablers meeting (6/9/17) and Interdependencies workshop (18/9/17)	Julia Tybura, Neil Webster
17-18.08.2017	Trade Union Engagement	Meeting with lead health union rep	Meeting with Sue Lister (RCN) and Phil Thompson (UNISON)	Seek to engage unions in a number of issues	Julia Tybura

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Programme Management Office: Comms and Engagement Report

Recent stakeholder communications / engagement

Date	Type of Initiative	Stakeholder Group	Feedback / Issues	Recommendations	Key Contact
09/08/2017	Alignment / review of current requirements	NCL Work Experience Working Group	NCL wide policy drafted	Policy to be used once finalised for all activities utilising work experience, including apprenticeships	Sule Kangulec / Jane Connor
11/08/2017	Mapping / Review of current requirements	Health and Care Closer to Home Board	Areas for collaboration	CCGs to revise road map and timetable, and CHIN specs	Sule Kangulec
15/08/2016	Improved and streamlined reporting processes	Workforce Metrics Working Group	London W'Force Dashboard finalised	Pilot iteration of the dashboard to be completed to provide a proof of concept	Sule Kangulec / Mandi Madavo
16/08/2017	Mapping / Review of current requirements	Mental Health WS	Workforce plan for mental health discussed	Continue to raise profile of LWAB	Sule Kangulec
17/08/2017	Mapping / Review of current requirements	Maternity Workstream	Roles to support shift services from secondary care to community are not there	Work with HEIs and CEPNs to increase placements in community. Link up with the pilot	Sule Kangulec / Julie Juliff / Charlotte McClymont

Upcoming stakeholder communications / engagement

Date(s)	Type of Initiative	Aim / Rationale	Priority	Support Needed	Key Contact
TBC	Mapping / Review of current requirements	Workforce and CC2H & Prevention WS	TBC	TBC	Mubassir Ajaz, Daniel Morgan
15/08/2016	GPFV Workforce Metrics Working Session	Metrics working session	Finalise London W'force Dashboard	TBC	HLP
06/09/2017	Enablers Workshop	Workforce and Estates & Digital WS	TBC	TBC	Neil Webster

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Programme Management Office: Comms and Engagement Report

Upcoming stakeholder communications / engagement

Date(s)	Type of Initiative	Aim / Rationale	Priority	Support Needed	Key Contact
15.9.17 and fortnightly	HRD engagement and progress checking	Ensure all HRDs feedback and are sighted on all HR projects in workstream. Fortnightly pre and post calls between Chair and Prog Director to sense check.	High	n/a	Tom Nettel Julia Tybura
11.9.17	Engagement	Update on Workforce Workstream to C&I NHS Trust	High	n/a	Jon Head
20.9.17	Quarterly meeting	LWAB – oversee and collaborate across sectors on STP	High	n/a	Sanjiv Ahluwalia
6.9.17	Design and delivery	HR system and process leads/Capital Nurse consultation	Key to engagement	n/a	Peter Cocco
End 9.17	HRD network/trade unions	Engagement of Trade Union colleagues on Resourcing	Key to engagement	n/a	Ben Morrin
07.09.17	Statutory and mandatory training survey	Mapping across health and social care	Key to engagement and getting a steer.	n/a	Cheryl Samuels
22.09.17	Engagement and accountability	Presentation to Joint Health Overview and Scrutiny Committee	High	n/a	Julia Tybura
28.09.17	L&D Stakeholder Engagement event	Raise awareness &Enhance understanding across the system.	High	n/a	Cheryl Samuels
TBC	Mapping / Review of current requirements	Workforce and CC2H & Prevention WS	TBC	TBC	Mubassir Ajaz, Daniel Morgan
08/09/2017	Independent Prescribers (IPs) Task & Finish group	To initiate planning to better utilise IPs within NCL.	TBC	TBC	Sule Kangulec

Workforce Workstream

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- Programme Management Office: Governance Report -

Upcoming Workstream Meetings

Date of meeting	Meeting Name	Name of Chair	Key Contact (e.g. Meeting Organiser)
13/09/2017	NCL STP Workforce Steering Group	Sanjiv Ahluwalia	Barry Letham
20/09/2017	NCL Local Workforce Action Board	Sanjiv Ahluwalia/Simon Pleydell	Barry Letham
6.9.17 11.10.17 8.11.17 5.12.17	Design and Delivery Group meetings - Resourcing	Peter Cocco	Aysen Fevzi, Project Administrator, UCLH
7.9 and weekly	SRO update with Programme Director	Julia Tybura/Simon Pleydell	Julia Tybura
6.9.17	Enablers Workshop	Neil Webster	Neil Webster
18.9.2017	Interdependencies Workshop	Will Huxter	STP PMO

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Our vision is to **get nursing right** for London**:** Ensuring that London has the **right number of nurses**, with the **right skills** in the **right place**, working to deliver **excellent nursing** wherever it is needed.

Programme update 25th July 2017

Background

Capital Nurse is a programme of collective action by the nursing community in London focused on securing a sustainable nursing workforce for the capital. The programme is jointly sponsored by HEE, NHSE & NHSI and reports to the London Workforce Board. The programme is aligned with each STP via the LWABs. Joint SROs are Oliver Shanley, Chief Nursing Officer for London, NHSE/NHS and Therese Davies, Acting Regional Director, HEE, London and South East.

Programme activity is aligned around three **workstreams**:

1. **Training** - Attracting students to choose nursing degree programmes in London
2. **Recruitment** – Guaranteeing employment and streamlining employment processes
3. **Retention** – Preceptorship, career progression & 'nurse friendly' employment processes.

The programme supports the development and testing of 'once for London' solutions as well as promoting STP-wide acceleration of activities and seeding, evaluating and spreading local innovations.

This newsletter provides an overview of recent developments for the London-wide programme since our previous newsletter May in 2017.

Programme Management and Delivery – The Programme Board met at the beginning of July. A full set of papers for this meeting can be provided if required. In July Christine Taylor was appointed to lead the programme management and Jacqueline Katz was appointed to lead the communications, stakeholder engagement and marketing of the programme. Over the next couple of months our communication and engagement process will be reviewed and further strengthened.

Highlights

Since the last newsletter the CapitalNurse programme has made significant progress against the targets and these are set out briefly below:

Training: Results from a pan-London survey indicate **strong HEI/placement partnerships in place between HEIs and employers**. The workstream is currently under review whilst we await the outcomes of the recruitment processfor students entering in September 2017.

Employment: All HEIs are now engaged with implementing a standardized measure of clinical numeracy and work continues to develop a similar approach for clinical literacy. To support employers in strengthening the recruitment process for first destination jobs, a survey is underway to understand students' behaviour in selecting their first job with results due in the Autumn.

Retention:

Streamlining & strengthening Career Pathways:

CapitalNurse Skills Framework: 15 Trusts and over 500 nurses have **completed piloting** the tool with very positive feedback. **The digital tool is now being developed** for launch in November 2017.

Preceptorship - The aim of this project is to share and build upon existing best practice regarding preceptorship and the HEE preceptorship standards, to **develop a CapitalNurse Preceptorship programme framework**, providing a **standardised approach across London**. Through pan-London engagement we have developed a CapitalNurse Framework for preceptorship which includes the length, and constituents of a preceptorship programme, provision for preceptees, and support for preceptors. We have also Identified the **fundamental clinical competences for the preceptorship period**, as outlined in the HEE preceptorship standards and developed a **role descriptor for preceptors** and a **recommended preparation programme for preceptors**. All this will enable the establishment of a **dashboard to measure quality metrics for preceptorship**. Workshops are being held in July to finalise the framework to enable employers to begin implementation over the next year from September 2017.

Training in specialism/generalism:

CAMHS - **second meeting of CAMHS London Nursing Network was held** 12th July 2017

Beverley Stephenson from Oxleas NHS Trust has been appointed into the CapitalNurse CAMHS Specialism post to support network and **'Grow Your Own' Model**

Cancer - Ruth Hammond from the Royal Marsden NHS FT has been appointed into the CapitalNurse Cancer Specialism post to support the development and launch of the London **'Chemo Passport' jointly developed by London Lead Cancer Nurse Group and UKONS**, supported by CapitalNurse. This document will **extend nationally** after the London launch

Care of Older People - Systems Leadership for Older Peoples Nurses to be delivered between Nov 2017-Mar 2018. A Steering group is being set-up to support a London network of older peoples' nurses

Urgent & Emergency Care - Inaugural U&EC Nurse Educator Network meeting held in June - great collaboration and support from across London. Sue Whaley from Guy's & St. Thomas' NHS FT has been appointed into the CapitalNurse U&EC Specialism post to support the network in the development of the U&EC Qualification in Specialism framework.

NHSI Improvement Retention Support Programme – The CN programme was showcased as one of the case studies for good practice at the recent launch masterclasses for this NHSI initiative. For those organisations in London who are taking part in the programme we are keen to align the support offered with engagement in CapitalNurse work. We will be writing to Trusts individually to discuss how best this might be achieved.

Communications and Stakeholder Engagement

CapitalNurse Charter and Brand Licensing
The current version of the Charter is attached to this newsletter. Please circulate this widely. Several organisations have approached us requesting to use the programme branding in a range of different nursing workforce initiatives aligned to the CapitalNurse vision and charter. As we develop our stakeholder engagement plan for 17/18, we will be offering to organisations to 'sign up' to the Charter and in return, we will grant use the programme branding under 'licence'. Trusts will be able to use CapitalNurse branding in electronic media and for recruitment, for example to enable them to use the Capital Nurse logo in advertisements. This month we began working with the London Diabetes Clinical Network with a view to using the branding to support the development of a pan-London approach to training and development of Diabetes Inpatient Nurse Specialists. We are delighted that the London Region's Director of Nursing Talent Management Programme will be a CapitalNurse programme.

Engagement & attendance at events – over the past two months we have continued to promote the programme across London and beyond. Key events have included the HEE London & South East Executive and the L&SE LETB Board, HEE North West London and North Central & East London Directors of Nursing Groups, and the London Mental Health Programme Board.

We are keen to get involved with your events, large or small, to spread the word and will either send someone along or will provide you with some slides and briefing materials – just get in touch.

CapitalNurse and the STPs – Proposal are progressing at various stages in each STP area to enable the CN programme objectives to be embedded locally tailored to local needs. The programme's work has been discussed at NEL, SEL and NCL STP Local Workforce Action Boards. NEL STP held its inaugural meeting of the sector nursing leadership to consider the key nursing workforce action areas for the geography and proposals for how NEL STP nurse leaders would use the resource offered by CapitalNurse to increase the pace and scale of

developments locally activity. The **NCL STP CN project** is most progressed to date: Highlights include, in NCL, the **career clinic/transfer window model is now established in all acute provider organisations**; **five different rotation programmes** have been launched, maximising the potential for intra- and inter-organisation rotation programmes including into community and primary care; the **system leadership programme bringing together 28 mid-level nurse** leaders from Trusts, CCGs, HEIs, primary care, local authority care and the voluntary/independent sector to learn together and work on projects aligned to the STP priorities has held its first module. Workshops are also being held this month focusing on **placement capacity for pre-registration nursing**, nursing in social care and **nurse friendly employment practices aimed at of older nurses**. In addition, across NCEL, a proposal is currently being considered to test a **streamlined recruitment process for all newly registered nurses** graduating from the Universities in summer 2018. In NW London, the **sector-wide Foundation Rotation Programme** initiative is aiming to have over 300 nurses signed up from across all NHS acute mental health and some primary and voluntary care settings by the autumn. A **pan-London joint engagement event for HRDs and Nurse leaders** explored progress with join areas of work in relation to the nursing workforce and agreed several actions for improving engagement and spreading good practice, including a recommendation to establish a **Strategic Nursing and Midwifery Workforce Board for London**.

Advanced notice - CapitalNurse Expo Conference 29th November – Building on from the success of our previous events we are starting to plan an interactive 'expo' style event using a range of structured networking activities including workshops and 'show and tell' to enable us to get input into the many different projects underway, to bring together and spread the wide range of innovative nurse friendly employment initiatives we have discovered over the past two years.

CapitalNurse **behaviour-change drama film project –** We are looking for people to **join the steering group** for this project. The purpose of the film is to improve the appeal of nursing in London as a potential career choice. It could also be used to promote positive culture change behaviours within the profession to reinforce a nurse friendly and patient centred culture in the work place. It aims to challenge the negative attitudes which prospective students, their parents/career choice influencers and even those working in nursing might have about the profession and is aligned to the national professional image work.

Making Contact and getting involved - please share this briefing with your colleagues, join the debate on Twitter (@capital_nurse #CapitalNurse) or email us on capitalnurse@hee.nhs.uk).

Chris Caldwell
Programme Director
Email: chris.caldwell@hee,nhs,uk

Our Charter

This charter sets out the scope and objectives of CapitalNurse. It identifies the participants and key stakeholders and outlines roles, responsibilities and the project's authority.

Objective

CapitalNurse is a programme of collective action amongst the nurse leaders of the capital[i] who have agreed to collaborate rather than compete with each other to deliver the programmes mission on behalf of the people of London.

Vision & Mission

Our vision and mission is to **get nursing right** for London**:** Ensuring that London has the **right number of nurses**, with the **right skills** in the **right place**, working to deliver **excellent person-centred nursing** wherever it is needed.

Purpose

1. To ensure on-going supply of an appropriately skilled nursing workforce to meet the changing requirements of health care within London.
2. To ensure that efficient and effective recruitment, retention and career development structures are in place for nursing to deliver high quality person-centred care across the capital.

Activities

To deliver activities which:

1. Attract enough students to choose nursing degree programmes in London & supporting them to graduation and registration.
2. Ensure the employment of newly registered nurses
3. Streamline the recruitment & transfer process for all nurses.
4. Encourage the adoption of 'nurse friendly' employment practices to aid recruitment and retention
5. Enable a streamlined approach to career progression to retain nurses in London.
6. Make best use of our resources and reduce unnecessary variation.

Duties

- To engage, connect and inspire widely making effective use of technology.

- To work in partnership, collaborating sharing & disseminating demonstrating openness transparency & accountability.
- To harmonise and align approaches to remove unnecessary variation.
- To act in the public's interest and demonstrate good stewardship of public money.
- To celebrating the diversity of nursing in London and our work together through CapitalNurse.
- To create a 'social movement' to energise nurses and those working in nursing workforce activities.
- To use data and research to effectively demonstrate a measurable impact.

Stakeholders, Responsibilities and Ownership

Nurse Directors and Human Resources Directors in NHS Trusts, senior nurse leaders in service commissioning, higher education, have formally 'signed up' to CapitalNurse. The RCN and Unison and a range of other organisations in London have also committed to be partners or participate.

In opting in, all these collaborators have committed that they and their teams will to work together within the principles set programme's charter.

Collaborators will work through the joint stewardship of Health Education England, NHS England and NHS Improvement. As a programme of collective action, however, CapitalNurse belongs to all nurses in the Capital and we can all take some level of responsibility for, and a role in, the success of its mission.

Brand and Licence

Those engaged in activities within the scope of the programme will be granted a 'licence' to use the programme 'brand'. The specific terms of these licences will be agreed and monitored based on the nature of the activity[ii]. Collaborators will be expected to ensure that they remain within the terms of their licence.

Join in …

Twitter: @capital_nurse #CapitalNurse

E-mail: capitalnurse@hee.nhs.uk

Website: https://www.healthylondon.org/workforce/capital-nurse

[i] Nurse Directors and Human Resources Directors in NHS Trusts, senior nurse leaders in service commissioning, higher education, and a range of other organisations in London, including the RCN and Unison have agreed that they and their teams will to work together across London under the joint leadership of Health Education England, NHS England and NHS Improvement.

[ii] E.g. an organisation engaged in recruiting nurses to a CapitalNurse programme activity will be licenced to use the programme logo and dissemination routes for recruitment purposes for that programme only

Agenda Item 9

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE NCL Sustainability and Transformation Plan (STP): Engagement Update	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 22nd September 2017
SUMMARY OF REPORT To consider a presentation updating members on communications and engagement. **Contact Officer:** Gen Ileris NCL STP Communications and Engagement Lead 5 Pancras Square London N1C 4AG Genevieve.Ileris@camden.gov.uk	
RECOMMENDATIONS Members are asked to note and comment on the engagement update.	

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NORTH LONDON PARTNERS in health and care

Communications and engagement update

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North Central London JHOSC

22 September 2017

Engagement funding and resources

Proposal to NHSE for £75 k for public engagement

(suggestion only, activity to be co-designed with local people and groups)

- 5 x Forums/roadshows
- 20 x Resident focus groups
- E-newsletter platform with e-survey capability
- 1 x STP ‘conference style’ event
- 1 x youth event (to be co hosted with East London health and care partnership)

- 1 x full time band 7 comms/engagement manager for 12 months
- 1 x day per week digital support
- Access to NHSE London regional engagement team and resources

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NHSE Offer

- £80,000 for public engagement activity
- 1 x full time band 7 engagement manager for 18 months
- 1 x day per week digital support NHSE digital team
- Access to NHSE London regional engagement team and resources

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Next steps – October/November/December

- Recruit a '*coalition of the local willing'* to create a public engagement strategy
- To develop a communications plan to ensure residents know where, when and how to participate
- To procure a e-newsletter platform
- Recruit an engagement manager

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Implementation

- Funded engagement programme to run January to July 2018
- Continue to engage with event participants via the e-newsletter and e-survey platform at both ‘STP and workstream’ level.
- Share news, updates and more workstream specific engagement opportunities with residents via online and newsletter formats

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NORTH LONDON PARTNERS in health and care

Any questions?

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE REPORT TEMPLATE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Enfield**

REPORT TITLE
Update on North Central London PoLCE Programme

REPORT OF
The North Central London CCGs

FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE:** September 2017

SUMMARY OF REPORT

This is a report from the North Central London CCGs to the Joint Health Overview and Scrutiny Committee (JHOSC) providing an update on:

The North Central London (NCL) Procedures of Limited Clinical Effectiveness (PoLCE) Programme.

The following document(s) has been used in the preparation of this report:

No documents that require listing were used in the preparation of this report.

Contact Officer:

Mark Eaton
Director of Recovery
Enfield CCG
mark.eaton1@nhs.net
07841-464916

RECOMMENDATIONS

The JHOSC is asked to:

1. Advise on any engagement or communication required for Workstream 2 of the NCL PoLCE Programme, this being the adoption of previously agreed clinical changes and clarifications to the NCL PoLCE Programme.

2. Advise on the proposed consultation for adopting the Enfield CCG changes across the wider NCL footprint including providing advice on duration, pre-engagement and any specific local actions that the JHOSC deems that the four NCL CCGs (Camden, Barnet, Haringey & Islington) to support the joint consultation across the four CCG areas.

3. Comment on any other aspect of the NCL PoLCE Programme as the JHOSC deems appropriate.

North Central London

Procedures of Limited Clinical Effectiveness (PoLCE) Programme

September 2017

1. Executive Summary

Background

Modern medicine has led us to expect that there is an immediate cure for every ailment. Many treatments and operations have been undertaken in the past with little regard to their benefit or outcome. It is frequently true that many conditions get better on their own without the need for surgery, which may not be helpful for some patients or too risky for others; for example, the added risk of complications arising if a person is overweight or a smoker.

There is considerable national and international evidence that some procedures offered routinely by the NHS have limited or no benefits for patients in some (or all) circumstances and therefore draws funding away from services that do provide benefit to patients whilst also exposing patients to risks (such as those associated with surgery) for little or no gain. These procedures are termed 'Procedures of Limited Clinical Effectiveness' (PoLCE) in North Central London although there are differing names used elsewhere within the NHS across England.

The North Central London PoLCE (Procedures of Limited Clinical Effectiveness) policy is a list of treatments that are only offered on the NHS when a patient meets certain clinical criteria. This helps ensure that patients are only put forward for procedures that have a high chance of being successful and of making a measurable improvement to their health and quality of life.

We want to ensure we do our best to spend our allocated resources with care. This includes taking sensible steps to make sure treatments are undertaken when there is evidence of making things better and people are encouraged and helped to personally take part in their programme of care.

Collectively the North Central London (NCL) Clinical Commissioning Groups (CCGs) along with our provider partners are seeking to undertake a wide-ranging review to ensure that there is both consistency of approach in how we deal with existing PoLCE referrals and also a review of the evidence supporting changing access and referral criteria for other procedures and treatments where the clinical effectiveness does not warrant the risk to patients nor the investment of limited resources.

About the North Central London PoLCE Programme

The NCL PoLCE Programme is a clinically led and evidence based programme focused on the following areas:

1. Ensuring that the current NCL PoLCE Policy is consistently applied across the region to avoid any postcode related bias.

2. Updating the current NCL PoLCE Policy to incorporate revised evidence that has been published since the document was first produced and also to clarify some of the language that has been shown to introduce ambiguity for triaging clinicians.

3. Seeking to adopt additional procedures as PoLCE that have been agreed by Enfield CCG following clinical review and public consultation across the whole of North Central London to ensure a consistent approach is used and to decommission Homeopathic Treatments.

It should be noted by JHOSC that there is also a London Wide PoLCE Programme looking at a wide range of procedures and treatments and that the process currently underway within NCL is unlikely to be the final stage in the process of review and amendment to PoLCE.

The three elements described above are outlined in more detail in the following three sections.

2. Consistent Application of the NCL PoLCE Policy

The first element of the NCL PoLCE Programme is concerned with consistently applying the current NCL PoLCE Policy and involves the following steps:

1. Understanding current referral/triage arrangements across NCL for both GP Referrals and Consultant to Consultant (C2C) Referrals and where necessary agreeing changes that are required.

2. Agreeing with providers how they will manage the C2C referrals going forward as part of the NCL Claims and Challenges Process.

3. Establishing a joint group involving CCGs and Providers to monitor and track activity and undertake targeted audits as required.

The timescales for completing this piece of work is by the End of October 2017.

3. Updating of the existing NCL PoLCE Policy

In 2016 an extensive piece of work was undertaken to review the evidence concerning a number of existing PoLCE procedures and also clarifying some of the terms used in the existing policy to make it easier for triaging clinicians to make decisions about eligibility for treatment. However, despite this work being supported by a wide range of clinicians from both primary and secondary care the changes were not incorporated into the NCL PoLCE Policy.

The second element of the NCL PoLCE Programme is therefore focused on adopting these clinically agreed changes and this will involve the following steps:

1. Agreeing with the Health & Care Cabinet and Joint Commissioning Committee as well as the Joint Health Overview & Scrutiny Committee (JHOSC) about the level of engagement necessary to update the policy.

2. Forming a small Clinical Working Group to revisit the previously agreed changes and determine whether these are still clinically valid. This is being led by Barnet CCG with input from both providers and other CCGs.

The timescales for completing this piece of work is by the End of November 2017 depending on the feedback with regards to engagement.

4. Adopting the Enfield CCG additional PoLCE Procedures

Enfield CCG completed a consultation at the end of June 2017 and are now proceeding with changes in the policy for 11 procedures (subject to final Governing Body approval on the 20th September 2017). The consultation undertaken by Enfield CCG had included 13 procedures and the following two tables detail the procedures that will and the two that won't be taken forward:

Changes That Will Be Adopted
The changes that were proposed in the Enfield CCG Consultation Document will be put in place for the following procedures/treatments:
• Bunions (hallux valgus) • Hernia • Vasectomy • Uterovaginal Prolapse • Revision Mammoplasty • Revision of Hypertrophic scars • Penile Procedures (Penile Implants) • Cholecystectomy for Gallstones • Chalzions • Correction of Ptosis • Decommissioning of Homeopathy

Changes That Will Not Be Adopted
The changes that were proposed in the Consultation Document will not be adopted for the following procedures/treatments:
Hearing Aids The proposed changes will not be adopted. The CCG will instead seek to put in place outcome based measures for all audiology contracts to ensure that patients obtain the maximum benefit from the provision of NHS Hearing Aids and are supported both in the use of equipment and to maximise the gains from the use of the equipment.
Knee Replacement Whilst no new evidence of substance was provided to change the CCG's view that there was a clinical need to change access criteria for Knee Replacements in some circumstances it was recognised that the supporting services needed by patients to help them lose weight along with access to other treatments such as community physiotherapy required further work on before the changes could be adopted. In addition, the referral pathway for primary care clinicians needed to be both reviewed and clarified. The CCG will therefore not proceed with the proposed changes at this time but will seek to introduce the changes when there is sufficient assurance that patients will be able to access the support they need to make the lifestyle changes necessary and to access appropriate alternative services. This will be subject to a further public paper (but no further consultation) at the appropriate time in the future and the Equality Impact Assessment (EIA) will be updated at that time.

Enfield CCG will be adopting these changes as soon as possible after the approval by their Governing Body. The third element of the NCL PoLCE Programme is the adoption of the proposed changes by Enfield CCG across NCL. To facilitate the debate the full list of changes that Enfield are adopting are given in the tables below.

Bunions (hallux valgus)

http://www.nhs.uk/Conditions/Bunion/Pages/Introduction.aspx

Revised Criteria
Bunion surgery is justified and appropriate when:

• the patient experiences persistent pain and functional impairment that is interfering with the activities of daily living.

AND

• all appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: up to 12 weeks of evidence based non-surgical treatments, i.e. analgesics/painkillers, bunion pads, footwear modifications

AND

• the patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car)

OR

• there is a higher risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment. A patient should not be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Hernia

http://www.nhs.uk/conditions/Hernia/Pages/Introduction.aspx

Femoral Hernia
Surgery will be funded.

Inguinal Hernia
Patients with asymptomatic or mildly symptomatic inguinal hernias should not be referred. Surgery will not be funded unless there is:

• difficulty in reducing the hernia

OR

• an inguino-scrotal hernia

OR

• pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living.

Abdominal (including incisional and umbilical) hernia

Surgery will not be funded unless:

• there is pain/discomfort significantly interfering with activities of daily living.

AND

• for patients with BMI≥45kg/m2, there have been attempts at weight reduction and these have not resolved the pain/discomfort.

Divarication of Recti
Surgery will not be funded.

Groin pain with clinical suspicion of hernia (obscure pain or swelling)
These patients should not have diagnostic testing in primary care, but be referred for specialist assessment. Funding criteria for surgery are then applied as laid out in this policy.

Recurrent and bilateral hernia
These are considered in the same way as primary hernias and funding criteria for surgery will be applied as described in this policy. Referral should be made to appropriate specialists with expertise in open and laparoscopic surgery.

Vasectomy

http://www.nhs.uk/Conditions/contraception-guide/Pages/vasectomy-male-sterilisation.aspx

Revised Criteria
Vasectomies will only be routinely commissioned under local anaesthetic.

Uterovaginal Prolapse

http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx

Revised Criteria
Enfield CCG will only fund surgical interventions for Uterovaginal Prolapse when conservative management has failed and when one of the following criteria has been met:

1) In cases of mild to moderate symptomatic prolapse where a comprehensive, documented course of pelvic muscle exercises has been unsuccessful and a trial of pessary has either failed or is inappropriate for long term management.

2) Moderate or severe symptomatic prolapse (including those combined with urethral sphincter incompetence or urinary/faecal incontinence).

Note: Patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

Revision Mammoplasty

http://www.nhs.uk/Livewell/Breastcancer/Pages/Reconstruction.aspx

Revised Criteria
This procedure will not be available on cosmetic grounds unless the original procedure was performed locally on the NHS because of health reasons and the patient now has a gross deformity.

Revision of hypertrophic scars, skin graft for scars

http://www.nhs.uk/Conditions/Scars/Pages/Introduction.aspx

Revised Criteria
Surgical revision of scarring will only be commissioned where the scar is causing a demonstrable functional problem that is likely to be resolved with surgery e.g. difficulty closing their eyes or inability to close the mouth properly when eating, and has been present for a minimum of 18 months post injury/surgery.

Conservative methods e.g. silicon sheets, steroid creams and injections should also have been tried where appropriate

Scars caused by severe burns are not affected by this policy.

Penile Procedures (Penile Implants)

http://www.nhs.uk/Conditions/Erectile-dysfunction/Pages/Treatment.aspx

Revised Criteria
Enfield CCG will not fund penile implants as first or second-line treatment for erectile dysfunction (Grade C recommendation).

Exceptions to this policy are patients with severe structural disease, where first and second line treatments may not be effective, are conditions such as:

- Peyronie's disease
- post-priapism
- complex penile malformations

Cholecystectomy for Gallstones

http://www.nhs.uk/conditions/Laparoscopiccholecystectomy/Pages/Introduction.aspx

Revised Criteria
Enfield CCG will not fund cholecystectomy for asymptomatic gallstones.

Funding will be available if one of the following criteria is met:

- Confirmed episode of gall stone induced pancreatitis.
- Confirmed recurrent episodes of abdominal pain typical of biliary colic.
- Confirmed episode of obstructive jaundice in the presence of gallstones where the gallstones are thought to be the cause.
- Confirmed acute Cholecystoitis.
- Where there is clear evidence from an ultrasound scan that the patient is at risk of Gallbladder Carcinoma.
- Patient has Diabetes Mellitus, is a transplant recipient or has Cirrhosis, and has been managed conservatively within Primary Care but subsequently develops symptoms which cause significant functional impairment.

The preferred procedure is laparoscopically unless clinical indications suggest otherwise.

Chalazions (Internal Stye or Meibonian Cyst)

http://www.nhs.uk/Conditions/stye/Pages/introduction.aspx

Revised Criteria
Enfield CCG will fund excision of chalazia when the patient presents with two or more of the following:

- Present for more than six months
- Recurrent infection
- Interferes with vision
- Conservative management has been tried & failed and there is no appropriate alternative to surgical intervention.
- The site of the lesion or lashes renders the condition as requiring specialist intervention.

Correction of Ptosis

http://www.nhs.uk/Conditions/stye/Pages/introduction.aspx

Revised Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

- Symptoms/signs of ocular surface disease should be treated conservatively before consideration of surgery.
- Skin only, or skin – muscle blepharoplasty may be performed in the presence of a symptomatic visual field defect, if other causes of field defect have been excluded. In some instances, there may be a clear history of reduction of vision in specific circumstances (e.g. when driving, reading or when tired), even in the absence of a formally demonstrated visual field defect.
- When symptoms of ocular surface disease or other symptoms persist despite conservative measures, a skin (+/- muscle) blepharoplasty may be undertaken, if it is likely that they are attributable to the presence of dermatochalasis.
- Pre- and post-operative clinical photos should be taken.
- There is no indication for lower lid or fat blepharoplasty within this policy.
- Formal visual fields tests should be performed even if there are special circumstances which need to be considered.

Homeopathy

Revised Criteria

The CCG will no longer fund Homeopathic Treatments and services will be decommissioned.

Proposed Consultation Process

Enfield undertook an extensive pre-consultation programme as well as a series of public engagement events during the consultation. The proposed approach to consultation across the four remaining NCL CCGs is as follows and JHOSC is invited to comment on this proposed approach:

1. The consultation will be for a full 90 days with the aim to start in early/mid-November.

2. The initial conversation and further updates will be provided to the JHOSC rather than to the four individual HOSCs.

3. The consultation document will be tested with a variety of partners to ensure it is as accessible as possible without compromising the need to use exact medical terminology to avoid future confusion. JHOSC is invited to provide guidance on how this could be most effectively undertaken.

4. There will be at least one public event in each CCG area and ideally two or more.

5. Key stakeholders will be contacted before and during the consultation including Medical Leads, Key Providers, MPs, Council Leaders and others by the programme team whilst individual CCGs will be required to contact local stakeholders such as Healthwatch, Patient Participation Groups, Voluntary and Third Sector bodies, member practices etc. In addition, local CCGs will be required to engage with their local Health & Wellbeing Boards.

6. The consultation document will be available for completion online or returned via a Freepost Envelope.

7. A budget will be made available to advertise the programme and again local CCGs will be required to make the best use of their networks to promote the consultation.

8. The consultation responses will be written up by an independent organisation.

Actions Arising

The actions arising from the third element of the NCL PoLCE Programme is focused on adopting the Enfield CCG proposed changes and this will involve the following steps:

1. Agreeing with the Health & Care Cabinet and with individual CCGs if need be that the policy changes being adopted by Enfield CCG are appropriate for all NCL CCGs.

2. Agreeing a joint consultation programme (as outlined above) with the support of Islington CCG's Communications & Engagement Team and with early engagement with Healthwatch organisations locally and with a steer from the JHOSC.

3. Agreeing the timelines with the Joint Commissioning Committee in October 2017.

4. Undertaking the consultation, producing a report and approving the changes and finally updating the existing NCL PoLCE Policy.

Currently it is expected that the timeline will be as follows:

- September 2017 – Agreed by Health & Care Cabinet and JHOSC.
- October 2017 – Agreed at Joint Commissioning Committee and Consultation Document created.
- November 2017 – Pre-Engagement Work and/or Commencement of Consultation
- February 2018 – Consultation Ends
- March 2018 – Report Produced
- April 2018 – Report Approved and Policy Updated/Communicated

The above is clearly subject to change depending on feedback and is presented for discussion only.

5. London Wide PoLCE Programme

A London Wide PoLCE Programme is being sponsored by NHS England to look at the existing and possible expansion of procedures and treatments classed as PoLCE. At this time it is unclear what impact there will be on North Central London and further analysis as to potential benefits to patients and the health and care system are being analysed. Any work on expanding the programme is unlikely to commence until 18/19 and any future plans will be brought back to JHOSC at a later date when it is clearer what the plan will be.

Document Produced By:
Mark Eaton, Director of Recovery, Enfield CCG (mark.eaton1@nhs.net).

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Dementia Pathway	
FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 22nd September 2017
SUMMARY OF REPORT To consider reports from Barnet, Camden, Enfield, Haringey and Islington on dementia services.	
RECOMMENDATIONS Members are asked to note and comment on the reports.	

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Dementia Support in Barnet-

Report for the North Central London (NCL) Joint Health Overview and Scrutiny meeting

1. Context

It is estimated that there are over 4,300 people with dementia living in Barnet and by 2021 this figure is expected to increase by 24%[1]. Dementia presents a significant health and social care challenge to the borough.

Barnet Council (the council) and Barnet Clinical Commissioning Group (BCCG) are committed to supporting people with dementia to live a full and active life, enabling them to live at home for longer and ensuring that carers are empowered and supported in their daily lives. The council and BCCG commission dementia support services focusing on early and timely diagnosis, improving information and supporting people with dementia and their carers in the early stages.

The services provided through the dementia pathway are a key component of the council's prevention and early intervention initiatives, forming important components of Tier 2 of the integrated health and social care model being implemented through the Barnet Better Care Fund Plan. The services also play a key role in implementing the Dementia Manifesto for Barnet.

2. Key facts about Barnet and Dementia

The Barnet over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030, and the rate increases more in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%[2].

In 2017 about 14.02% of Barnet's population was over 65, which represents over 55,000 people[3].

It is currently estimated there are over 4100 people with dementia aged 65 and over in Barnet, and by 2025 an estimated increase of 27%. [4]

Barnet has one of the largest numbers of care homes in Greater London, with the highest number of care homes registered for dementia[5].

The **Dementia Diagnosis rate is 73.5% for Barnet as of 30 June 2017[6].** The estimated **national rate is 68%[7].**

[1] Barnet's Joint Strategic Needs Assessment 2015 - 2020
[2] Barnet's Joint Strategic Needs Assessment 2015 - 2020

[3] POPPI (Projecting Older People Population Information
[4] POPPI (Projecting Older People Population Information
[5] Barnet's Joint Strategic Needs Assessment 2015 - 2020
[6] NHS Digital, Recorded Dementia Diagnosis June 2017

3. Barnet's Integrated Dementia Pathway

Working with partners in the public and voluntary sector, Barnet has developed local dementia services with a focus on improving information and advice and supporting people mainly in the early stages of the condition, as research suggests that people have a better quality of life if they receive an early diagnosis followed by support.

Over the past 3 years a number of changes have been made at different stages of the pathway in order to ensure a more joined up approach between health and social care and also to prepare for the challenges ahead. This has been achieved through:

- improved access to memory assessment and building capacity and support in the community.
- working with primary care to improve the Dementia Diagnosis rate
- utilising the Better Care Fund - Dementia is included in Barnet's Integrated Care Model tier 2 Health and Well Being and tier 3 Access services, and is also a theme across all tiers
- an existing network of services, now joined by newly commissioned services

4. Components of the Barnet Services

A remodelled Memory Assessment Service (MAS) is commissioned by Barnet Clinical Commissioning Group (BCCG) and provided by Barnet Enfield and Haringey Mental Health Trust (BEHMHT). Early diagnosis of dementia is a government priority and the National Dementia Strategy 2009 describes the value of early diagnosis and intervention. The then Prime Minister was committed to ensuring the Memory Services were established in all parts of the country. Prior to 2013 Barnet had no specific memory service and there were long waits for patients to be seen by the nurse led memory treatment clinics. The establishment of a memory service also followed NICE/SCIE guidance, and NHS Mandate 2012.

The service was fully operational by summer 2014.This provides:

- early holistic assessment for people with memory problems
- a multi-disciplinary service, follows NICE guidelines and has now achieved Memory Service National Accreditation programme (MSNAP) standards (Oct 16)
- integrated community support for people with dementia (PWD) and their carers, at the point of diagnosis, working closely with the Alzheimer's society
- increased capacity, the waiting list has reduced and people receive a diagnosis within 12 weeks of referral to the MAS by their GP, meeting one of the Barnet Health and Well Being Board (HWBB) targets.

Investment in wellbeing, prevention, and support to carers**;** a Dementia Day Opportunities service and carer support, has been established for a number of years. A dementia advisor service, with one advisor, was established in April 2014. An additional 2 advisors were added in May 2015. The Dementia café service commenced in summer 2013. All these services were provided by the Alzheimer's Society.

[7] NHS England, Dementia Diagnosis Rate June 2017

LBB commissioned a new contract commencing April 2016 with Alzheimer's Society for dementia support services in the community. The National Dementia Strategy 2009 recommended the provision of better and local information for people with dementia and their carers, that allows them to manage the condition more effectively and remain at home for longer. The new service is similar and comprises:

- Dementia Advisors - work with people at an early stage, helping them at the point at which they are diagnosed to make the choices which will let them live as independently as they possibly can. Dementia cafes - an informal social point at which PWD and their carers can come together, sharing views, obtaining mutual support and gathering information and participating in arts and crafts activities.
- A dementia Day Opportunities service and carer support, the day experience will now also offer half day slots at different venues across the borough.
- In addition to the above the Alzheimer's Society has opened a Dementia Hub in Hendon, providing a visible presence for the integrated dementia support services and a central focus for the further development of the Barnet Dementia Network.

A Dementia Action Alliance Co-ordinator (DACC),is provided by the Alzheimers Society. The DACC is initiating a Dementia Action Alliance, recruiting stakeholder members and working towards Barnet becoming a dementia friendly community.

5. The Barnet Dementia Manifesto

Below is a brief summary of progress against commitments in the Manifesto, which was approved by the Barnet Health and Well Being Board in November 2016.

Barnet continues to improve its diagnosis rate which is 73.5% at 30 June 2017

The MAS continues to meet the target for people to receive a diagnosis within 12 weeks of referral.

Barnet supported Dementia Awareness week in 2015, 2016, and 2017. Various events took place across Barnet and a number of staff from LBB and BCCG have become Dementia Friends. Awareness events have been held in Brent Cross Shopping Centre– led by a Barnet elected Member.

A number of organisations have signed up to join the Barnet Dementia Action Alliance; this will enable Barnet to progress towards becoming a 'Dementia Friendly Community'. Many of these organisations are already undertaking dementia friendly work – e.g. Dementia friendly screening of films at Phoenix Cinema, dementia friendly swimming at Barnet Copthall.

Barnet libraries partnership with BEHMHT for 'Books on Prescription' is progressing well, a large number of dementia support materials having been successfully delivered to Barnet's care homes, Carer's Centre and GP surgeries. A health information sharing event at Chipping Barnet Library proved very successful and a follow up event took place in Spring 2017. Earlier this year BEH held a series of promotional events for mental health professionals and community groups. . A variety of titles from the 'Pictures to Share' collection are available in Barnet libraries.

The Mayor's charity for 2016/17 was Dementia Club UK, which provides Dementia Club sessions at a range of venues in Barnet. The Saracens support a Dementia Club held at Finchley Memorial Hospital four times each month. In addition to this there are 10 café's/clubs run across the borough for dementia, 4 are commissioned by the council, and there are additional groups such as Singing for the Brain.

The council have also commenced a support service which utilises innovative support for carers and their clients. This service offers psychological support sessions, activities such as art therapy and ongoing care throughout the pathway linking with the services from both the Alzheimer's Society and the MAS. Since the Council Specialist Dementia Carers Service was established in June 2016 the service has supported 52 adults. 77% of the carers attending the training/peer support of the programme strongly agree and 23% agreed that 'the support/information and guidance they had received through the programme would support them to be sustained in their caring role'. Since the service's establishment no adults with dementia who have been supported via the service have entered into residential care.

The Dementia Advisor Service is also running regular advice and support sessions in a GP surgery, Barnet Carers Centre, and the Phoenix Cinema in addition to having a presence at the MAS. One off events and/or talks information stalls include: Spurs Foundation, Almshouses Trust, Practice Nurse Event, altogether Better Barnet, Age UK and Jewish Care.

The Royal Free London has a Dementia Implementation Group, an action plan and a number of work-streams. Recent work includes:

- 18 in-patient wards have signed up to John's Campaign – this is about the rights of people with dementia to be supported by family carers in hospital and care settings
- Various carer events including the establishment of the Lindsey Café
- Dementia questions are asked by recruitment panels across the organisation
- Each ward receives a CAPER folder containing dementia tips and advice
- The Delirium Pathway is being embedded and this includes a step by step guide for clinical staff.

Central London Community Healthcare (CLCH) is Barnet's community health provider and services include rehabilitation wards, District Nurses, intermediate care etc. CLCH has a Dementia Care Strategy and action plan. Work includes:

- A programme of dementia training has been developed which includes Dementia Care Champion training tier 3 (developed with Bucks University); in Barnet 5 people have completed the training include a member of staff from the Barnet Integrated Locality team (BILT)
- A new post of Dementia Engagement Lead has been established, they have been gaining feedback on what is important to PWD, and the aim is to develop a training programme co-produced with patients.
- In August 2016 a Barnet resident's patient story was gathered. This detailed involvement with seven local services. This had positive elements and areas

to improve. All the actions plans were followed up and included sharing the positive comments with the 4 CLCH services involved and ensuring that other services were given the compliments as well as information to check, and if validated, to follow up internally.

Care homes, both residential and nursing, are an essential part of care provision for people with dementia. A number of services and training modules have been developed by BCCG and LBB to support the care sector in Barnet. Two dementia training modules, linked to QCF, are being offered to all care staff in Barnet, along with End of Life training.

6. Performance Summary

The London Borough of Barnet and Barnet CCG together have made a pledge to ensure dementia remains a key focus for future activities, as set out in our Dementia Manifesto. Barnet has a dementia diagnosis rate of 73.5% as at 30 June 2017, which is in excess of the national rate of 68%.

The Barnet Memory Assessment Clinic has a referral to assessment time of six weeks with a low non-attendance rate of 2-5%. This has been achieved through alterations to the procedure within the unit. Patients and carers are called prior to the appointment to ensure attendance. The MAS have also recently gained MSNAP accreditation October 2016.

During 2016/2017 664 patients were seen in the Memory service with 448 new cases of dementia diagnosed. At the end of the year out of 179 patients surveyed, 97% were happy with the service.

2016/2017 Performance Data for Dementia Support Service:

	Total number of Activities	Total number of service users
Dementia advisor	1248	340
Information provision	N/A	452
Marillac (dementia) Day services	2160	45
Four dementia café's	878	178

The Dementia Fingertips tool from the Department of Health and the Dementia Atlas provided by Shapeatlas.net utilising data from a range of services including DH fingertips, Alzheimer's Society and dementia friends, gives key performance information. Both Fingertips and the atlas are very similar and publicly accessible. Key figures from a brief analysis of this data are shown here:

Headline	**Barnet figure**	**National and London comparison where available**	**Source/dates**
Diagnosis	73.5%	National 68%	NHSE June 2017
Emergency	3,856 per 100,000	National 3306	Fingertips tool

admissions for people with dementia	on Fingertips tool	London 3721	
Rates for Dying in normal place of residence	56.6%	67.5% nationally 56.1% London	Fingertips tool

7. Plans for 2017 and Beyond

The Barnet Dementia Action Alliance will be developing its Action Plan with the aim to be a Dementia Friendly borough in 2019/20.

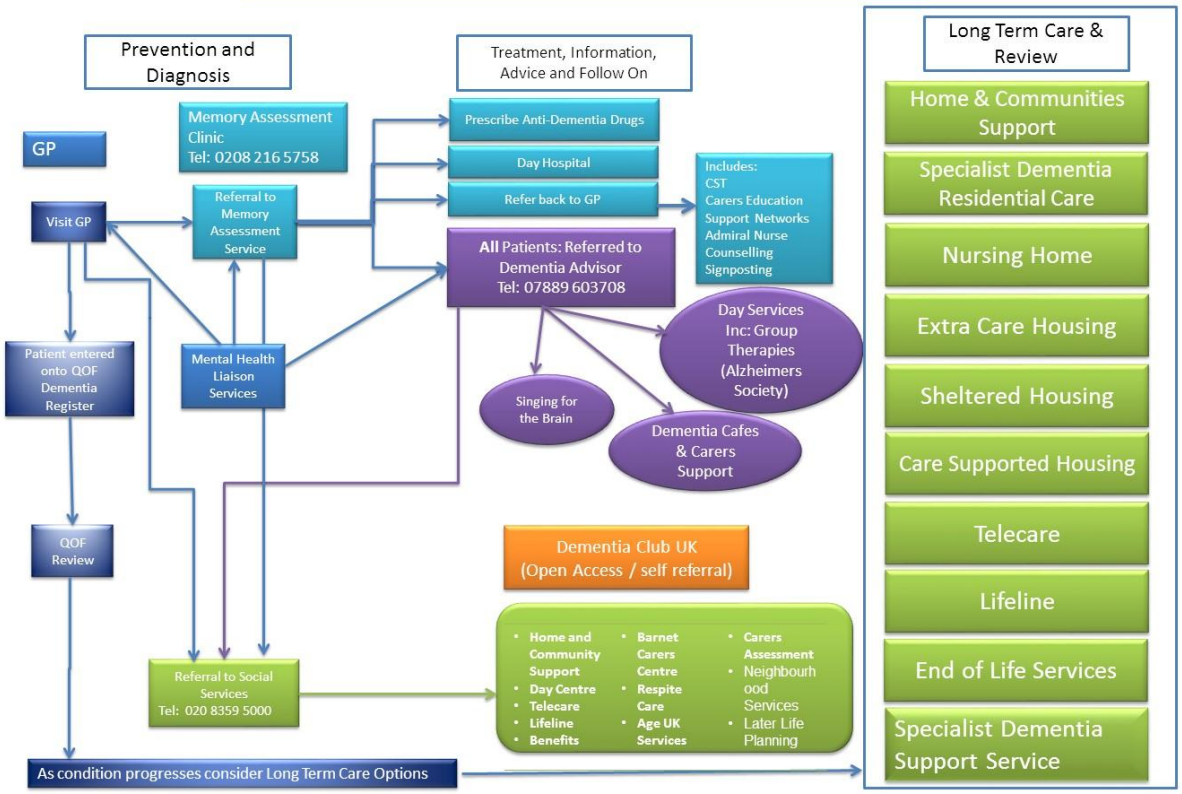
The council is commissioning an innovative dementia focused extra care housing (ECH) scheme at Moreton Close comprising 51 flats opening in spring 2018. ECH is a popular and cost effective alternative to residential care, located within local communities so that residents can continue to participate in local activities. ECH has been shown to reduce unplanned hospital and/or care home admissions, and enable people with dementia to remain living for longer in the community. The scheme will reflect best practice in terms of design and the delivery of flexible person centred care. The council has plans to build a further 150 extra care units in the next 5 years.

The Barnet Dementia Hub in Hendon was launched on 11th May 2017. This is providing 'Day Experience' - a range of activities; cognitive, physical and social for people with dementia in a safe and welcoming environment with trained staff and volunteers. Individuals will be encouraged and supported to maintain their skills and remain a part of their communities. The Day Experience offer is also being run in half day slots at different venues across the borough. The Hub includes a resource element and individuals can access support and the resource either by telephone or visiting the Hub where there will be a Dementia Advisor present during opening hours.

A 'Dementia Information in Barnet Working Group' has been meeting; the focus has been to look at the sort of information people would like to receive and what formats are best placed to achieve this. Membership had been drawn from Barnet's People Bank, Barnet Healthwatch, part of this work will include engaging with local community groups to ensure the needs of BME members is addressed. A report from the work was presented at the Barnet Engagement Board on 22 March 2017. Additionally a detailed action plan has been developed which focuses on key priorities for the council to raise awareness of dementia amongst the public, included targeted communications for minority communities.

There is also a focus to raise awareness of dementia amongst staff and a 'Dementia Friendly Training Workshop' has been arranged for September 2017. This further supports the council's commitment to being a Dementia Friendly borough.

Dementia – Pathway Overview



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Camden Dementia provision

Background

The population of Camden is living longer, growing and constantly changing and marked by significant differences in health experience and outcomes between its richest and poorest communities. According to the latest estimates from the Greater London Authority, there are 241,100 people living in the borough, a figure predicted to rise to around 261,500 in the next 10 years.

Life expectancy at birth (2012-14) for men is now 81.8 years, an increase of approximately seven years from 10 years ago and is significantly better than that of the London average (80.3 years) and England (79.5 years). For women, life expectancy is 86.7 years and significantly higher than London (84.2 years) and England (83.2 years).

The local older people population in Camden has seen sustained growth over the past five years. The GLA forecasts that this trend is likely to continue and it estimates the following trends between 2016 and 2031 as shown in the table below:

Ages	Numbers	% change
45 to 64	+12,800	+27%
65 to 74	+4,400	+28%
75+	+7,300	+59%

Source: GLA

This will have a significant impact on our expected dementia prevalence.

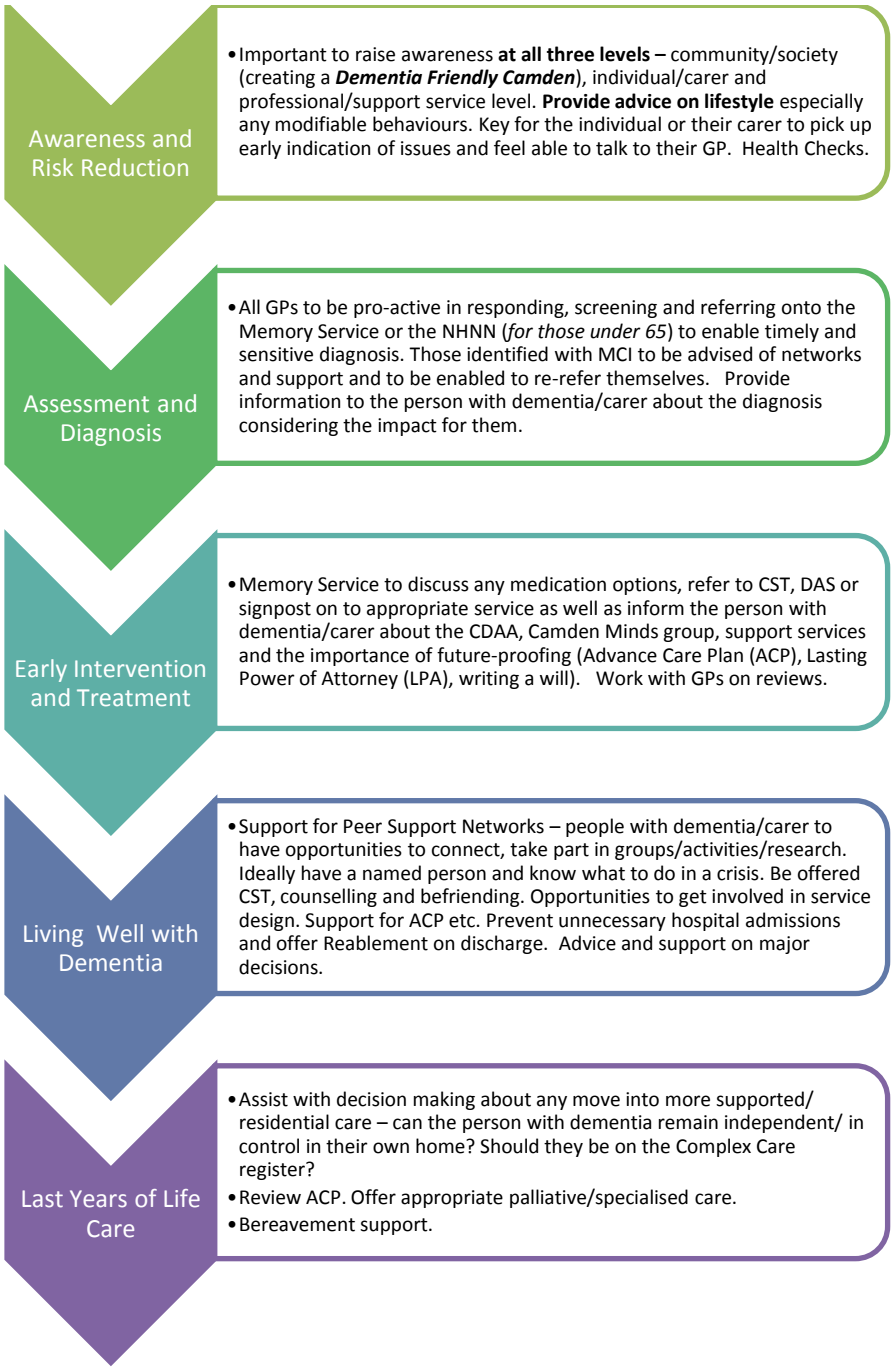
Currently the expected dementia prevalence in Camden is 1723 people. With the age of our older population increasing dramatic we expect to see a 25% increase in dementia prevalence by 2021. Currently 2/3 of people living with dementia in Camden are female, 1/3 are male. 10% of people living with dementia in Camden are from BME communities. Approximately 3% of people living with dementia in Camden are under the age of 65 – this equates to about 50 people.

In Camden we have developed our dementia plan, which lasts from 2012-2017. The aims of the plan are that by 2017 people living with dementia and their carers will be able to say:

- I was diagnosed early.
- I understand, so I make good decisions and provide for future decision making.
- I get the treatment and support which are best for my dementia, and my life.
- I am treated with dignity and respect.
- I know what I can do to help myself and who else can help me.
- Those around me and looking after me are well supported.
- I can enjoy life.
- I feel part of a community and I'm inspired to give something back.
- I am confident my end of life wishes will be respected. I can expect a good death

Camden Dementia Pathway

See below for the Camden Dementia Pathway:



We currently provide the following services:

- Memory service – assessment, diagnosis and ongoing support with medication
- Dementia advisers – provide ongoing advice and support
- Dementia befrienders – provide support for socially isolated people living with dementia

- Two day centres for advanced dementia and three day centres for people with early-moderate dementia
- Dementia counselling
- A dementia engagement group called Great Camden Minds
- Support for carers through respite activities
- A fortnightly dementia café

Performance – summary

In the Improvement and Assessment Framework 2016/17 for key clinical areas, Camden was rated as “performing well” for dementia, with a diagnosis rate of 68.7% and 79.4% of Patients diagnosed with dementia whose care plan had been received with a face to face review in the preceding 12 months. While this is a positive result, there is still further room for improvement.

As of January 2017 our dementia diagnosis rate is 73.6%. We have seen significant improvements in our diagnosis rate. We are working to further increase our diagnosis rate to make sure people have access to the right level of support.

Innovative work of note

People living with early onset dementia face a number of different challenges to people who develop dementia later in life. Services may not be configured to effectively support people living with early onset dementia. To ensure we are meeting the needs of this patient group we have commissioned our local Carer’s centre to work with people living with early onset dementia and their families to help identify what improvements we can make to current service provision. This will help to inform our commissioning intentions moving forwards and improve the quality of services we provide for people living with early onset dementia.

Through the Better Care Fund we have invested additional funds into the Camden memory service to develop a new service model. The service will provide post diagnostic support for every person diagnosed with dementia, helping people to navigate the dementia pathway by providing information, advice and support throughout a person’s journey with dementia. This new service will help people to access services in a timely manner, provides additional support for carers and will help people to live well with dementia.

Future plans for services

We are working in partnership with the Alzheimer’s society to create a dementia friendly Camden through our Dementia Action Alliance (DAA). We will accomplish this by helping organisations to become dementia friendly through developing action plans and bringing together organisations across the borough to share their learning. The alliance began with four members and has since grown to fifteen members. We will ensure that people living with dementia and their carers are at the heart of our decision making processes.

We are developing a joint exercise class for people with dementia and their carers to promote healthy living and help minimise the risk of people falling.

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Dementia Report

Background

Dementia refers to a range of diseases affecting the brain leading to memory loss, mood changes, a decline in reasoning and communication and loss of the ability to carry out basic daily living tasks. The most common conditions are Alzheimer's disease and vascular dementia, with the risk of these conditions increases with age.

Over the last 2 years we have seen a growth in our Dementia diagnostic rates. In 2015 there were 2600 older people diagnosed with dementia in Enfield and this has grown rapidly to 2900 in 2016. Over the next 30 years the number of people with dementia is set to double

Older people are more worried about developing dementia than any other condition, and 70% of those with dementia think society isn't geared up to help them, but one in 3 of us will develop dementia beyond the age of 65, which means most families will be touched by it. Most people will live for 7-12 years with the condition. Sadly, not everyone is diagnosed early enough to get the advice, help and treatment to lead as fulfilling a life as possible.

Pathway

Types of Service

The vast majority of people living with memory loss and their families will turn to their GP to help with a diagnosis and treatment. Whilst receiving a diagnosis of dementia can be devastating, the majority of older people tell us they want to know what's wrong with them, and will often want to know what advice, help and treatment is available to them to have as full a life as possible. It is therefore important for people to go to their GPs – perhaps as part of a health check – as early as possible if they are worried.

There are many different forms of dementia and their treatments do vary. Many GPs will therefore refer those patients with memory loss to Enfield's Memory Treatment Service, a specialist diagnostic, assessment and treatment unit to be sure of their precise diagnosis and to get the specialist help they need. The help they might get doesn't just include drugs to slow the condition's progress or alleviate its symptoms, but also cognitive therapy, e.g. reminiscing about the past, to keep people as mentally alert as possible, as short-term memory is often initially affected by the condition. Physical activity, such as walking, is also known to help manage the condition's symptoms.

A range of specialist voluntary sector support is available to help people with dementia and their families. This ranges from specialist day care and social opportunities, including Age UK's Parker's Centre and Alzheimer's Society Singing for the Brain to help memory and their Dementia Café, specialist dementia workers, including those funded by the Alzheimer's Society and Enfield Asian Welfare Association, and help and befriending and peer support for families via Enfield Carers' Centre.

The Council funds care and support tailored to older people's needs and preferences to live at home for as long as possible. Many individuals, particularly those aged 85+, will also have other conditions or be frail, which will mean they will face problems in daily living, such as getting out and about or

washing and bathing. One way the Council works with individuals with dementia and their families is to help maintain or improve their ability to do such tasks, including through long-term support within mutually agreed care plans tailored to needs and preferences. Each plan is allocated a sum of money, a Personal Budget, which an individual or carer can choose to take (a Direct Payment) to select and manage their own care (which the Council can help them arrange) or allow the Council to manage their care on their behalf. These Personal Budgets are used to pay for services such as home care, day care or companionship services, short-breaks or Personal Assistants, amongst many other choices.

The Council also funds other support, including small items of equipment such as grab rails and their fitting and personal and household alarms and sensors, which if triggered can lead to a mobile response within 30 minutes 24/7; minor repairs to people's properties; and some major adaptations to help alter their home to make it more suitable for their needs.

The overwhelming majority of older people want to live at home for as long as possible. This is especially important for those with dementia for whom their home represents an often long-standing and familiar part of their lives, including living with their loved ones. Sadly, some people in the most advanced stages of dementia aren't able to stay at home because of their condition(s) or circumstances. Some of these individuals may be better suited to living in Council-funded specialist housing for people with dementia, in which they have their own "front door", but in which care and support is available to meet their needs 24/7. In some cases, however, the needs and circumstances of individuals and families may be such they feel there's no alternative but to live in one of Enfield's 41 older people's residential or nursing care homes: 60% of older people admitted to homes have dementia.

Joint working

The Enfield Joint Dementia Strategy 2011 – 2016 set out the local direction for dementia services and was developed in partnership with the Council, NHS and voluntary sector. Its goals built on national policy to make sure people concerned about memory loss or dementia – and family and friends - feel well-supported to get a diagnosis as early as possible and are helped to live as full a life as possible right up to the end of their life. The Strategy set out how we would do this in Enfield by working together:

- ***Improve professional & public awareness of dementia*** **– Helping reduce the risk of preventing or minimising vascular dementia through promoting healthier lifestyles of older people; and raising awareness and understanding will encourage people to come forward for diagnosis and help;** Training programmes, including dementia-awareness, are in place in NHS and open to all professionals. A catalogue of services was produced, including across the voluntary sector. The Council, NHS and Voluntary Sector partners launched an awareness campaign about the importance of early diagnosis and help to those affected by memory loss/dementia and the public in 2013 based on the national Dementia Friends campaign. Partners launched an Enfield Dementia Action Alliance – the first in London - to work with organisations – both care and other organisations (e.g. schools or retailers) – to promote dementia-friendly communities.

The Council is promoting initiatives to improve physical activity which can reduce the risk of developing vascular dementia amongst those 50+, e.g. older people worked with leisure centres across Enfield to develop a Healthy Lifestyle Programme, which includes ballroom dancing and tai-chi.

- ***Improve early diagnosis and treatment;*** GP-based health checks for those aged 65+ will include test for memory loss, with the aim of identifying individuals with the condition earlier. The NHS provides specialist Memory Treatment Service to make sure people get the right diagnosis and advice, treatment and help as early as possible. Due to awareness-raising, the number of referrals to the Service increased significantly.

  Increase access to a flexible day, home based and residential respite options **– making sure people are able to benefit from solutions tailored to them which they can choose and control for themselves to live as fulfilling a life as possible;** ***Develop services that support people and families to maximise their independence*****: making sure training, support and therapeutic services and specialist housing are of high-quality;** The Council continues to provide financial support for a number of specialist voluntary sector schemes for those with dementia and their families. With the sector, the Council is supporting a greater number of older people through *personalisation*, i.e. the support chosen is tailored to individuals' needs over which they and their families have control over a financed support plan. People can choose let the Council arrange and manage this care or take a financial allocation (a Direct Many people with dementia and their families have chosen to use their financial support plans to access day care (often provided through the voluntary sector), home care and short-break or respite care to help them live as independently as possible in their own home, which is what the overwhelming majority of people want. Payment to choose and manage their solutions directly, with help from a broker if needed.

- ***Improve workforce skills and competencies*** **– making sure health and social care staff are well-trained and have a good awareness of how to work with people with dementia and their families in line with local expectations and national regulation;** A wide range of training programmes for health & social care staff are well-established. Both acute hospitals, North Middlesex University Hospital and Royal Free London Hospitals have introduced a Butterfly Scheme for ward and other staff and provide training to staff to become Dementia Champions, i.e. experts in helping people with dementia, who provide training and support to other staff. Training in dementia is also part of GP practise learning and Council workforce training plans, with a GP lead for dementia appointed in the NHS Enfield Clinical Commissioning Group.

- ***Improve access to support and advice following diagnosis for people with dementia and families*****;** ***Reduce avoidable hospital and care home admissions and decrease length of stay*** **– nationally, people with dementia are at greater risk of being admitted to, and dying in, hospital or to care homes, so it is important to provide training and support to hospital and care home staff and to develop as joined-up a hospital discharge as possible;** *Enfield CCG commissioned Age UK Enfield to provide a post-diagnostic support service.*

- ***Improve the quality of dementia care in care homes and hospitals*** **– making sure people in hospital and care homes access the right treatment to help them; Reduce care home & hospital admissions;** Development of Council re-provision & commissioning of supported accommodation, including residential/nursing care and specialist housing continues. Mental Health Liaison Service in place at both hospitals and Dementia champions in place for each appropriate ward in North Middlesex & Chase Farm. Both Trusts identified senior clinical leads to aid development of services for those with dementia. A multi-disciplinary team is working with care homes to improve the support offered to staff to manage challenging behaviour and medication, including anti-psychotic drugs.

- ***Improve End of Life Care for People with Dementia*** **– making sure people have the plans that suit them in place for end of life, and get the support they need as they approach the end of their life;** North London Hospice delivers regular training to care homes & domiciliary care providers in implementing the Gold Standard Framework, including for those with dementia.

- ***Ensure services meet the needs of people from black and minority ethnic groups*** **– making sure information, advice and help is accessible and available to all so that that all of Enfield's diverse population with dementia benefit;** Enfield is working with the national Alzheimer's Society's Connecting Communities to improve awareness about dementia across Enfield's diverse community. Current services have been assessed and community-based services are equitable in terms of take-up amongst black and ethnic minority groups.

Performance

Dementia prevalence amongst ECCG's 65+ population is estimated to be 2783 in May 2017, according to the second cohort Cognitive Function and Ageing Study (CFAS II), as applied to the GP-registered population. The CGG is maintaining a reported diagnosis rate above the national standard of 66.7%. Performance in May was at 71.9%. Waiting times and performance are reviewed at the Memory Service Action Planning Group.

Innovative work

Post Diagnostic Support

Enfield CCG commissioned Age UK Enfield to provide a post-diagnostic support service. Service functions include:

Early Support: When GPs refer clients for diagnosis, simultaneous sign-posting/referrals to the Post-Diagnostic Service will also be facilitated. The GP is also expected to work closely with BEH-MHT's Memory Service during and after the formal diagnosis of dementia.

Community Navigation: A navigator acts as a point of contact to help people with dementia and carers to access relevant information, advice & signposting to initial & ongoing solutions they need, act as an advocate and help them come to terms with the diagnosis.

Promoting Dementia-Friendly Communities: The provider will work in partnership with Enfield Dementia Action Alliance in cascading training among volunteers as part of its role in promoting dementia-awareness amongst organizations.

Care Homes Assessment Team

The vast majority of older residents in care homes fall under the cohort of people who are “frail” or “high-risk” pre-frail. Two-thirds of people with advanced dementia live in care homes or in supported accommodation, particularly as they develop significant problems in daily living.

Enfield CCG commissioned a Care Home Assessment team to work in care homes to identify and manage physical and mental health problems in residents at an early stage to help prevent the need for acute care and reducing call outs to GPs.

The team includes a band 7 prescribing mental health nurse who provides specialist mental health review which involves the reduction of unnecessary low dose Antipsychotic use in Dementia patients and optimise treatment of behavioural disturbances and also provides training to care home staff on Medication (side effects, how or when to take, risks & benefits), challenging behaviour, dementia awareness, depression and anxiety.

CHAT can now provide same day nurse led mental health interventions for the most complex patients in care homes, as well as non-urgent advice and reviews, informal training and education and monitoring and reviews of changes to medication or environmental recommendations. All of this has supported care home staff, reduced placement breakdowns, prevented escalation to hospital, improved residents quality of life and educated care home staff.

Future Plans

Not all mental health conditions of older people can be nurse led and so far 13 patients have required escalation to psychiatry for their input; of these 6 have benefited from joint visits between CHAT mental health and psychiatry. Therefore, the CCG has commissioned 2 sessions of a consultant psychiatrist to support the team further. In addition, the team will be joined by an OT with mental health/dementia experience to support the nursing role with environmental management of distress reactions associated with dementia, dementia care mapping as well as education and development of care home staff. The role will also provide support to the care homes with purchasing appropriate equipment for moving and handling and risk assessments for patients with complex moving and handling needs.

The additional capacity in the CHAT team will improve the level of support given to care home residents most especially patients with co-morbid mental health problems such as dementia, end stage Parkinson, neurological conditions, depression, delirium etc.

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Dementia services in Haringey – Report to North Central London (NCL) Joint Health and Overview Scrutiny Committee

1. Introduction

1.1 Haringey CCG (the CCG) and Haringey Council (the council) are working together closely to promote health and well being, provide safe and effective services and deliver care at the right time and in the right place. There are a number of strategies in place to deliver this, including the Health and Well Being Strategy, the NCL Sustainability and Transformation Plan and the council's Transformation Plan. These strategies also align with the Council Medium Term Financial Strategy and the CCG's QUIPP programme. This paper gives an overview of the services that are being delivered and developed for people with dementia in Haringey. It should be noted that these support the delivery of wider priorities in these existing plans.

1.2 These services form part of a pathway for people living with dementia and their carers. Stakeholders at our Dementia Steering Group (see **section 11.3)** have agreed a number objectives for this pathway and these are as follows:

Objective 1: Improve the identification and diagnosis of dementia
Objective 2: Good quality post diagnostic support for people with dementia and their carers.
Objective 3: Support for people with dementia when symptoms become severe and/or complex.
Objective 4: To improve end of life care for people with dementia**.**
Objective 5: To ensure that people who provide health and care services for people with dementia receive good quality training and education specific to dementia care.
Objective 6: To make Haringey a dementia friendly community.
Objective 7: This is a supporting objective about ensuring that we have the data we need to commission effectively and that we are monitoring outcomes for people with dementia and their carers.

1.3 It is important to note that these objectives were selected by the Dementia Steering Group on the basis of national guidance and to reflect the challenges that stakeholders, including service users and their carers, have identified as part of their experience of using or working in services that support people with dementia.

1.4 The paper begins by setting out some information about demography and prevalence and then spend. We then describe the pathway using the objectives set out above. Where the CCG and Council are facing significant challenges in meeting those objectives, these are identified in the paper. We then give an overview of how the council and CCG work together to deliver these objectives, a summary of the performance issues previously outlined, and conclude by looking at areas of innovation and future plans.

1.5 Wherever possible we have reflected service user and carer views and that of other stakeholders. However, it is to be noted that this paper has been written by Council and CCG officers and other stakeholders may have different views.

2. Demography /prevalence

2.1 It is estimated that there 1485 people over the age of 65 with dementia in Haringey, of these 1168 had a recorded diagnosis with their GP in January 2017, and there were estimated to be 317 people over 65 with undiagnosed or unrecorded dementia (see table below). The proportion of the estimated total of people with dementia over the age of 65 who are diagnosed on GP registers is known as the dementia diagnosis rate. The dementia diagnosis rate in Haringey is 78.6%, which is higher than both the London and England average.

2.2 A high diagnosis rate indicates that Haringey is doing relatively well in identifying people with dementia. This is important as it allows people with dementia and their carers to plan their care and access local support services. The high dementia diagnosis rate in Haringey also reflects focused work with local GP practices to highlight the importance of early diagnosis and recording of dementia. We recognise that we still need to focus in this area to ensure people with dementia have access to early diagnosis.

2.3 In addition to the 1,168 people over 65 diagnosed with dementia in Haringey, there are also 56 people under the age of 65 diagnosed with dementia in Haringey. This is sometimes known as early onset or working age dementia. Although the numbers of people with early onset dementia are relatively small, this is an important group of people because of the particular impact dementia can have on younger people, who may for example still be providing care for children under the age of 18 or still be in employment.

2.3 The number of people with late onset dementia (over the age of 65) is projected to rise over the next 20 years, this is because dementia becomes more common with increasing age, and we are projected to have significant increases in people reaching very old age (>90 years of age) over the coming decades.

Table: Dementia diagnosis rates and estimated and diagnosed numbers of people with dementia in Haringey: Source Quality Outcomes Framework (NHS England dementia diagnosis monthly workbook)

CCG Name	CCG registered population aged 65 and over (2016)	Estimated number of people with dementia (over 65)	Dementia Diagnoses (aged 65+) Jan-2017	Diagnosis Rate (aged 65+) Jan-2017	Dementia diagnoses (<65 years of age) Jan-2017
Haringey	29213	1485	1168	78.6%	56
England average				67.4%	

London average				72.2%	

3. Spend on dementia

3.1 Estimating spend on dementia services is challenging because most expenditure sits within services which are generally for older people and is not specifically badged as spend on dementia. Expenditure on older people generally is of course considerable for the council and the CCG and includes a significant proportion of spend on acute hospitals, community services, day opportunities and on packages of care at home and in residential settings.

3.2 At period 5 in 2017/18, the planned council spend for people recorded as receiving dementia specific types of care was £6.5m for the year. This is predominantly made up of temporary and permanent residential and nursing care.

3.3 The CCG spends £33.2m on the Barnet Enfield and Haringey Mental Health Trust (BEH MHT) block contract. This funding is for spend on all types of mental health and is therefore inclusive of spend on services provided by the Trust which support people with dementia. These services will in the main be for inpatient and community services for older people with mental health needs. The CCG is working with the Trust to disaggregate costs for specific service lines.

3.4 Within the BEH MHT services for older people with mental health needs, the only Haringey service specifically for patients with dementia is the memory clinic (see **section 4.2**). As at month 4, it was forecast that the Trust would offer 16,365 contacts to older people within the community in 2017/18. 1,992 of these are at the memory clinic. The Trust was also forecast to provide 4,710 bed days to inpatients but, as noted, only a proportion of these will have dementia.

3.5 In addition to the above, the CCG is forecast to spend £1.6m on packages of care for older people with mental health needs who require care at home or in a residential setting. A significant proportion of these will have dementia.

3.6 As noted in paragraph 3.1, wider spend for the council and CCG is not included in this analysis.

4. The pathway as it stands - Haringey's offer

4.1 Objective 1: Improve the identification and diagnosis of dementia

4.2 Primary care and the Haringey Memory Service

4.2.1 The CCG has a GP lead for dementia who supports GPs to follow best practice in dementia care and ensures that appropriate referral pathways and shared care arrangements are in place between practices and the memory clinic.

4.2.2 Haringey CCG commissions its memory clinic from BEH MHT (Haringey Memory Service or HMS). This clinic is where people with memory problems should be referred by their GP for a possible diagnosis of dementia once other potential causes of memory loss have been ruled out by the doctor. As well as offering a diagnosis, the service also offers a number of post diagnostic support interventions including Cognitive Stimulation Therapy, one to one and group support for carers and an Admiral Nurse. HMS has been inspected by the CQC and in March 2016 was given a rating of 'good' with very positive feedback including from users and carers. The service has also achieved accreditation with the Memory Services National Accreditation Programme.

4.2.3 The only area for improvement identified by the CQC was in the waiting time from assessment to diagnosis, identified as around 21 weeks at the time of the report. There is no national standard for this at this time and guidance is awaited. However, the CCG and the memory clinic have agreed an action plan to reduce waits. Over the first 4 months of the year, 20-47% of patients were diagnosed within six weeks. The CCG and HMS are continuing to work together to agree local targets pending national guidance, including determining the level of resource needed in the service.

4.3 The Locality Teams

4.3.1 Additionally, there are teams in primary care whom offer support to people with dementia. Haringey Locality Teams are multidisciplinary teams and work closely with GPs to support patients who are at high risk of hospital admissions. The Locality Teams consist of a team manager, physiotherapist, community matron, social worker, mental health practitioner and a pharmacist. From January 2017 there are two dementia navigators in the service (see **section 5.3** below) who work across the Locality Teams and the Memory Service to provide practical support for patients living with dementia as well as signposting to local services.

4.3.2 The teams support complex patients by completing a holistic assessment and developing a care plan according to the patient's goals. They listen to patients and talk to other professionals about their health or care requirements to ensure that their patient's care is co-ordinated and joined up. Each patient under the Locality Team has a named care co-ordinator who is their single point of contact for health or social care needs. The team has built good relations with the memory clinic so that patients with mental health as well as physical health or social care concerns are well supported in the community.

4.3.3 A full evaluation of the service is underway. Patient experience interviews have been very positive. Patients report that having a single point of contact and a named care co-ordinator is very helpful.

5.1 Objective 2: Good quality post diagnostic support for people with dementia and their carers

5.2 Good quality information

5.2.1 This has been an area of challenge. However, dedicated work has taken place on Haricare - Haringey Council's online directory providing information to those eligible for support under the Care Act - throughout 2016/17. There has been particular focus on reviewing and adding to the organisations listed/registered, as well as improving the type and consistency of information presented. A 'dementia' category has been created allowing relevant services and organisations to be found more easily. User-testing has been undertaken and has informed improvements to navigation to improve the user-experience. A working group is looking at the promotion of Haricare and ensuring that it is sign-posted on relevant webpages.

5.2.2 The Bridge Renewal Trust (BRT) has mapped over 700 community organisations, including details of the primary service offered and the primary beneficiary group(s). A searchable directory, Haringey VCS Directory, is now available on the BRT's website. The council has also worked with BRT to incorporate this work into Haricare.

5.3 Dementia navigators

5.3.1 In January 2017, 1.5 FTE Dementia Navigators (DNs) were recruited for the first time in Haringey. These posts have been developed and funded in response to the gap identified by the DSG in post diagnostic support services for people with dementia. The DNs will be responsible for providing further information about Dementia, signposting to appropriate services and organisations and providing support to those with Dementia and their carers.

5.3.2 The DNs work closely with the Memory Service Admiral Nurse, Haringey Integrated Locality Team, Haringey Dementia Action Alliance (DAA), and the Haynes Dementia Hub (see **section 5.4).** Day to day operational management is provided by the Locality Team Managers at Whittington Health. Clinical Supervision is provided by the Admiral Nurse at Barnet, Enfield and Haringey Mental Health Trust. The effectiveness and impact of the DNs will be monitored and evaluated as part of the Locality Team within existing governance.

5.4 Dementia Day Opportunities

5.4.1 The Council is in the process of a large transformation of adult social care, including day opportunities.

5.4.2 The council is moving away fro5.4m a traditional building based model which only meets the needs of 3% of people with dementia to a model which works for a larger dementia population through the creation of a dementia hub at The Haynes Day Centre.

5.4.3 The transformation of day opportunities has been developed through a co-production process, overseen by a steering group which is chaired by the Local Healthwatch provider Public Voice.

5.4.4 The Dementia Day Opportunities Co-Design Sub-Group has been set up to ensure that carers and service users are meaningfully engaged in the development and implementation of the new model. The Group has been involved in the development of the service specification for the Haynes Dementia Hub and service statement which details how the service will meet the requirements of the service specification.

5.5 Care Act compliance - carers and social work practice

5.5.1 The council is in the process of reviewing and developing a clear pathway for carers' assessments to make it more responsive to carers following extensive consultation.

5.5.2 A consultation with carers around carers' assessments was carried out in 2016. Following feedback, and further consultation with carers, it was decided that the assessment and support planning functions would continue to be delivered directly by the Council. Practitioner guidance has been developed in adult social care to ensure that carers' outcomes are identified and assessment take place in a timely manner.

5.5.3 The Council is also in the process of developing the local carers' offer including respite care and will be going out for consultation in late 2017 on a respite policy which will be a joint health and social care policy for all ages, including children and adults.

5.5.4 As part of the development of the council's social care workforce, it is commissioning a number of different dementia related workshops covering the varying levels and skills of practitioners dependent on their role within the organisation.

5.5.5 Dementia and dementia care are topics that are regularly discussed through monthly case discussion and social work forums. Case discussion allows practitioners to bring complex cases that they are working on but having difficulties in progressing. This is a supportive and reflective environment in which other practitioners will support each other in discussing the case and looking at ways in which outcomes can be met.

5.5.6 These sessions are beneficial in helping to share knowledge, experience and good practice in supporting those with dementia. The forums provide an opportunity for practitioners to raise issues relating to practice, systems, resources and quality

and looks at ways in which they might be able to deliver better services moving forward and help in shaping the processes and delivery of care including support for those who have been diagnosed with dementia.

6. *Objective 3: Support for people with dementia when symptoms become severe and/or complex*

6.1 Dementia care in acute settings

6.2 Dementia Care at Whittington Health

6.2.1 Leadership and Dementia Strategy:
Leadership for dementia care at Whittington Health (WH) is based in the Medicine, Frailty and Networked Service Integrated Care Service Unit (ICSU), one of seven ICSUs in the Trust. The current Trust Leads for dementia care have been tasked with leading and taking forward actions arising from the 'Burdett' dementia project that was set up and funded in the Trust 2013-15. During this time a number of projects were undertaken by the manager in post, which raised the profile of the dementia service, including, embedding the training strategy across the organisation and training local dementia champions. Some of the ongoing dementia initiatives aimed at improving the experience of patients with dementia and their families and carers are outlined below:

6.2.2 Screening and Identification of patients with Dementia**:**
The Frailty pathway includes geriatric assessment and screening for over 75s who are admitted via A&E for dementia. Dementia screening of inpatients was a CQUIN target in 2015/16 which the Trust achieved.

6.2.3 Dementia Training:
The Trust has a dementia training strategy in place which includes the requirement that all staff receive dementia awareness training on the 3-day corporate induction. The Trust has also invested in a specialist leadership programme for staff with an interest in dementia which has led to a network of dementia champions across wards in the Trust. Once trained, dementia champions are equipped with the key skills, knowledge and understanding to enhance current practice in dementia care.

6.2.4 Flexible visiting:
There are flexible visiting times for family and friends who care for people with dementia on WH Care of Older People wards. This enables family and friends to remain involved in the care of their relative, as they can visit to provide support at key points during the day such as mealtimes.

6.2.5 'This is me' booklet:
The 'this is me' booklet offers a practical way of informing staff about the needs, preferences, likes, dislikes and interests of a person experiencing dementia. This is particularly useful if the patient is not able to fully communicate their own needs, and

family and friends are not available to speak for them. The booklet can be filled in by the patient, with close family or friends, or completed with staff.

6.2.6 ‘Forget me not’ scheme:
The Trust are piloting the Forget me not scheme on the Care of Older People wards. This scheme improves patient safety and wellbeing by helping staff to recognise when someone is experiencing memory problems or confusion due to dementia or delirium.

6.2.6.1 Using the forget me not scheme helps staff to communicate more effectively with people experiencing dementia and to respond appropriately to their care needs. The scheme encourages staff to take more time when speaking with patients who have difficulty understanding information and offer additional help, or support with activities where needed such as eating, washing, dressing and being accompanied off the ward.

6.2.6.2 Whilst in hospital, patients are offered the opportunity to wear a blue wristband so that hospital staff can recognise they have specific needs due to cognitive impairment or acute confusion. The electronic patient records can be flagged to ensure staff are aware that the patient is experiencing cognitive impairment (this flag can be removed for those patients whose cognition or acute confusion improves following treatment). Forget me not is an opt-in scheme and patients and their families can choose whether or not to participate.

6.3 Dementia Care at North Middlesex University Hospital

6.3.1 The Trust has a dementia strategy, which has been in place since 2013. A Dementia Strategy Steering Group was set up in January 2016 and Healthwatch Enfield has been a member of that committee since June 2016; it has been chaired by the Director of Nursing since February 2017. The dementia action plan has been significantly reviewed and updated in 2017, and now forms a clear set of priorities being overseen by the Dementia Steering Group

6.3.2 The most recent North Middlesex University Hospital (NMUH) Care Quality Commission (CQC) report (December 2016) noted that although the trust had a dementia strategy in place, at the time of the inspection, only seven of the 23 action points had been completed - 16 remained outstanding. Following the refresh of the dementia action plan, there is now evidence of clear progress.

6.3.2 The Trust has previously advertised for a lead nurse for dementia care, which is a new post established in late 2016. The Director of Nursing confirmed at the February 2017 CQRG that unfortunately recruitment to the role was unsuccessful. An internal candidate was therefore identified, who has an interest in dementia and is being trained and supported to undertake this role. The Director of Nursing also confirmed that the Lead (medical) Consultant for dementia care left the Trust at the end of 2016; one of the Trust’s other consultant geriatricians was appointed into this role in July 2017.

6.3.3 The CQC report (December 2016) noted that on The Medical and Elderly wards “patients over the age of 75 years were screened for dementia within 72 hours of admission. Between April 2014 and March 2015, 90.4% of patients were being screened for dementia within 72 hours. However, the trust did not collect detailed up to date data to indicate all qualifying patients were screened”. The trust will address this as part of the Trust-wide improvement plan. It is understood this will also be in the role of the Lead dementia nurse (currently being recruited to).

There is also a QUIP programme to audit and improve. This will be repeated in an audit cycle.

6.3.4 Surgery was highlighted in the CQC report as an area where “The trust did not routinely collect data to indicate if all qualifying patients were screened for dementia” and a recommendation for Surgery was “The trust should review if all qualifying patients are screened for dementia”. The trust have confirmed that the Surgical matron is the dementia lead within the Surgery CBU and has been tasked with providing training and updates to staff.

Pre-assessment nurses have received training on identifying elective patients with dementia. The nurses use the Trust’s Dementia/Delirium pathway, which was developed by the lead consultant in old age psychiatry and one of the consultant geriatricians.

Cognitive assessments are done to identify patients who have dementia on admission as part of the medical clerking proforma. The consultant geriatrician has trained her team and the urology team in its use.

Approximately 75% of the nursing and healthcare support staff has received training on delirium and all have received level 1 training for dementia awareness. Training on improving communication and nutrition & hydration for patients with dementia is ongoing. The second phase of training will include staff in the Eye clinic, Fracture Clinic and Urology clinic.

6.3.5 In order to raise awareness to staff that a patient is living with dementia, the “Forget Me Not” scheme has been introduced into all inpatient wards. Similarly, food for patients who require additional assistance (including those with dementia or learning disabilities) is served on a red tray to indicate to ward staff that the patient may require longer to eat their food, or they may need extra assistance to help them eat.

6.3.6 In terms of dementia training, all new staff are required to attend the Trust induction programme, which includes dementia awareness training. The Trust dementia strategy includes the standard that all front line staff are required to have had basic dementia awareness training. Information provided by the trust to the CQC showed that only 62% of nursing staff within medicine and older people’s care specialities had undertaken the training. The CQC report (December 2016) included a ‘must do’ recommendation for Emergency and Urgent Care services that “The trust

must ensure medical and nursing staff are fully trained and able to identify and support the needs of patients living with dementia".

6.3.7 In the Critical Care unit, the CQC noted there was "limited evidence that the unit was equipped to provide consistent and reliable support to patients with dementia.

The Lead Consultant in Old Age Psychiatry and the Psychiatric Liaison Teams have provided dementia and delirium training for staff who work on the ICU. This included a 1 day conference.

The Critical Care Unit now has two Dementia Link Nurses and a Consultant lead for Dementia, they are already working closely with the Trust's lead nurse and lead consultant for dementia. The Critical Care Unit Link nurse and Consultant are near the completion of a Dementia resource folder for staff in the unit. The Critical Care Consultant is also working with the Trust's lead consultant for dementia to finalise a dementia checklist for patients in Critical Care Unit. This will complement the initial screening undertaken in A&E. Additional training in dementia training has now been added to the Critical Care Nurses training days.

Finally, the Critical Care Link Nurse and Consultant will be putting together a Dementia information board in the unit before the end of September 2017.

6.3.8 The Trust have responded to these concerns around lack of training in dementia care and confirmed that the corporate training needs analysis 2017/18 has been recently reviewed to include all the dementia training requirements. There is now a full day within the induction programme for new starters, full days planned as clinical updates for tier 2 training for identified staff.

6.3.9 CQC report noted that "Care of the elderly wards were seeking to improve the ward environment to make them more dementia friendly by becoming bright and airy, with each of the bays themed and colour coded. The trust completed the refurbishment of Pymmes Zero Ward in late 2016.

6.3.10 In August 2016, The Director of Nursing confirmed to Enfield Healthwatch (following a Healthwatch visit to Pymmes Zero in February 2016) that over the summer, the Trust Estates Team had undertaken some initial work on the dayrooms in all three care of the elderly wards, to make them better environments for patients, including those with dementia.

6.3.11 The CQC report recommended that "The trust should ensure that activities, such as cards, games or puzzles, are provided on the care of the elderly wards." The Trust reported to commissioners at the CQRG in February 2017 that it is working on a plan to improve the activities available for dementia patients across the Trust, including the use of reminiscence boxes and recruiting volunteers to help with co-ordinating activities for patients. In addition, Dementia Friendly signage has been introduced on the wards and further work has recently commenced with the Divisional Head of Nursing to secure funding for a range of activities.

6.3.12 The executive Management Board of the Trust has recently approved a business case for an increase in therapy staffing, including physiotherapist for frailty and admission avoidance, OT for Admission avoidance and a Speech and Language Therapist for Care of the Elderly and acute medicine. While there were no posts specifically identified for dementia, it is important to note that we already have dedicated teams in physiotherapy and OT for care of the elderly.

6.3.13 Following the CQC recommendation “The trust should ensure that staff are trained in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards and that staff seek patients’ consent before care or treatment is given”, the Medical and Elderly Care clinical business unit (CBU are identifying resource to commissioned external MCA training for all wards. Staff are able to access MCA e-learning modules, and City University have provided training for ward managers and deputies, with further dates planned for October. 30 staff have attended. The dementia lead and the education department are providing a one day session in induction for staff requiring Tier 2 training, with a one day update session for existing staff at tier 2. The Trust’s Safeguarding Adults Lead Nurse is also involved in supporting the MCA and DoLS training.

6.3.14 The Accessible Information Standard was introduced by NHS England and the Trust was required law to be compliant on 31st July 2016. The Trust has shared their Accessible Information Standard action plan with commissioners at recent CQRG meetings and has informed the CCG that some aspects of implementation have been delayed.

The Trust has published its Accessible Information Standard Policy internally and it is also available on the Trust’s website. AIS training is included in corporate induction programme and is also part of the trust’s mandatory training programme. This is available through e-learning and a face to face module will be introduced and made available shortly. The patient administration system was upgraded in August 2017 and now includes the AIS menu, so that patients’ needs can be clearly identified. Staff are currently being trained on the updated system. The Patient Experience Group receives regular progress updates, as does CQRG and the Risk and Quality Committee of the Board.

6.3.15 The CQC noted in their report that there was a leaflet called the Carers Passport Scheme. It described how the ward could issue a badge to the carer of a vulnerable patient to enable the relative to see the patient outside of visiting hours, assist the patient during mealtimes and help the patient with their personal care. Within the leaflet, it detailed a carers’ overnight rest room facility. The CQC noted however there were no relatives or carers rest rooms at the time of their inspection. Passes were issued at the ward staffs discretion. Within this leaflet, there were names, addresses and telephone numbers of other organisations that may be of assistance to the carer and the patient.

The Trust Carers Passport scheme has been re-launched and the Trust is updating and re-writing the carers passport scheme leaflet. Additionally, the Trust is also

writing a new Trust Dementia Information leaflet which will be included in the information that will be accessible via the Trust website.

6.4 Psychiatric liaison services

6.4.1 These are commissioned at both NMUH (provided by BEH) and the Whittington (provided by CIFT). Psychiatric liaison services are multi-disciplinary teams who operate in Accident and Emergency and on inpatient wards to offer interventions to patients with mental health needs. The teams also offer specialist mental health expertise to other staff in the hospital, including dementia awareness and training and can support the implementation of the recommendations outlined above in section 6.3. The teams play a key role in accurate identification of dementia, managing complex cases and liaising with community services to facilitate safe discharge.

6.4.2 Both teams are working towards an evidence based model which is required by NHSE as part of the national standards for mental health in the Five Year Forward View. The teams already operate close to this as they offer 24/7 care, a key feature of the model. The team at NMUH has also been accredited by the Royal College of Psychiatry's national framework for psychiatric liaison services.

6.4.3 The team at NMUH operates in an unusually busy Accident and Emergency department (A and E) which means that referral response times and the balance between interventions with patients in A and E and inpatients is not always in line with the desired model. The NCL CCGs have put in a bid to NHSE for non-recurrent monies to pilot interventions for addressing this. For NMUH, this includes a pilot of recruiting patients with lived experience of mental health to support and advise patients in A and E, freeing up clinical staff to offer treatment to other patients.

6.5 Discharge planning/intermediate care

6.5.1 Haringey has a number of initiatives in place for older people and people with long-term conditions to improve hospital discharge processes, improve support on discharge from hospital and to prevent admission to hospital. These initiatives include:

- An expanded nurse-led community rapid response team that will visit people in their own homes, in some care homes to provide short-term support to prevent hospital admission. The service also can take people home with support from A and E and medical assessment units.
- Intermediate care beds: Beds in nursing homes and extra-care housing that are supported by a team of health and care professionals to provide a short-term period of rehabilitation to people and allow early discharge from hospital, maximise independence and allow people to return to their own homes where possible

- Reablement services that support people for up to 6 weeks to regain confidence and independence in their own homes after a hospital admission or deterioration of independence at home

6.5.2 All these services have a focus on maintaining and maximising independence. While these services are not specialist services for people with dementia, people with dementia still benefit from these initiatives. We will continue to improve how "dementia friendly" these general services are to ensure that people with dementia can have maximal benefit.

6.6 Care home/nursing home provision and homecare

6.6.1 The London Borough of Haringey currently has 11 care homes for frail older people; 9 residential care homes and 2 nursing homes with a total of 431 beds. 7 care homes (2 nursing homes and 5 residential homes) are Care Quality Commission (CQC) registered to provide care for older people living with Dementia. The table below sets out the care homes by owner, type of bed offered and the latest CQC rating.

CARE HOME	**BED CAPACIT Y**	**OWNER**	**Latest CQC rating**
Priscilla Wakefield House Nursing & Residential	112	Magicare Ltd	17 May 2017 Requires Improvement
The Meadows Residential	40	Methodist Homes	30 December 2015 Good
Spring Lane Residential	62	GCH (North London) Ltd	8 June 2017 Good
Peregrine House	35	Goldcare Homes Ltd (New owner)	8 September 2016 Requires Improvement
Ernest Dene Residential	33	Brownlow Enterprises Limited	19 February 2016 Good
Osborne Grove Nursing Home Nursing	32	Haringey Council	26 May 2017 Inadequate
Morriss House Residential	25	Abbeyfield Society	25 May 2016 Good
Alexandra park Residential	15	D Weston	6 January 2016 - Good
Brownlow House Residential	24	Ventry Residential Care	9 May 2017 Good
Mary Fielding Guild Residential	47	Mary Fielding Guild	26 May 2016 Good
The Fer view Residential	6	Soonil Bodoo	22 July 2017 Good

6.6.2 Haringey CCG has a Quality Assurance Team for Care Homes comprising of a Quality Assurance Nurse Manager and a Quality Assurance Nurse. The team is responsible to enhance quality and standards within care homes by supporting staff and managers to achieve safe, effective evidence based practice care delivery. The Quality Assurance team work closely with the Local Authority Commissioning Team and the Adult Safeguarding teams, as well as the Care Quality Commission to provide quality assurance.

6.6.3 Examples of types of Dementia focus activities in care homes are as follows: The Quality Assurance Team in partnership with UCL Partners and 5 identified care homes A dementia mapping exercise and dementia awareness project was developed to support the workforce to deliver person centred dementia care. A total of 154 staff from a range of multidisciplinary roles within the targeted care homes took part in the dementia awareness sessions. An evaluation of these sessions show that staff who attended, reported that they felt more knowledge and confident in supporting the needs of residents with dementia.

6.6.4 In conjunction with the Haringey Community Mental Health team (HCMHT) a Behavioural & Psychological Symptoms of Dementia (BPSD) checklist for care homes has been develop and implemented across 11 care homes. The checklist is a guide for care homes to use promote proactive referrals to the HCMHT to support identification and diagnosis of dementia.

6.6.5 In addition to 11 care homes for frail older people, there are 16 home care agencies and 39 residential or learning disabilities care homes CQC registered to provide dementia care within the borough. An audit of the of this cohort of providers needs to be undertaken to review the quality of dementia care and support provided to residents living in these care homes or receiving home care.

6.6.6 The Local Authority has also been engaging with local providers to understand the current and future needs of people living with dementia in the borough, including the following steps:

- Worked with a range of organisations to encourage them to provide dementia-friendly day opportunities and advised on steps to take to develop their services accordingly.
- Introduced a core contract for day opportunities (including for people with dementia) to set consistent expectations around quality.
- Worked with the Dementia Action Alliance (see **section 9**) to encourage local organisations to sign up to the dementia action alliance and make 3 ‘pledges’ to becoming dementia friendly.
- The council has also set up Dynamic Purchasing Systems for home care and supported living, including for those with dementia. The system improves the ability of the council to identify appropriate providers of care.
- Two new Extra Care units have been opened in Tottenham in the East of the Borough; this has provide an extra 100 units to compliment those already provide in the west of the Borough. One of these (Lorenco House) has

specific provision for people with dementia. Ten units have been set aside for people with dementia requiring extra Care accommodation.

6.7 Mental health inpatient and community care

6.7.1 BEH Mental Health Trust provide inpatient care to older people with mental health needs on a number of sites, a proportion of whom will have a dementia. The Oaks and Silver Birches are in Enfield and Ken Porter is in Barnet. Haringey patients with dementia requiring assessment and treatment inpatient admission are seen on The Oaks, which is an acute ward. This is funded via the overall contract with BEH. The CCG also spot purchases beds for patients with dementia who require longer term care (continuing healthcare or section 117 patients) from the other units.

6.7.2 Cornwall Villas is in Enfield and the continuing healthcare services element of the provision is being re-provided at a new dual registered care home. The five patients in the service for whom the council and/or CCG have responsibility are being transferred to new care homes appropriate to their individual needs and we continue to work with patients, family, carers and advocates to transition patients from the ward back to the community.

6.7.3 At the time of the CQC inspection in March 2016, all these services were rated as good. Ken Porter was identified as having insufficient occupational therapy input and this is being addressed by the Trust as part of its overall action plan. Community care is provided by the BEH Older People's CMHT (OPCMHT). Again, this service will see patients with dementia as well as other needs. The team provides support when needs are complex or there are particular risks for the patient. They are multi-disciplinary and will include social workers participating in the programme described in section 5. This service was again rated as good by the CQC in March 2016.

6.7.4 Commissioners meet with BEH every month to monitor performance of all their services, including those which provider support to people with dementia. This includes regular review of activity, wait times, responses to CQC and Mental Health Act Inspections, safeguarding and serious incidents and staffing levels. Where issues are identified these are addressed through these meetings.

7. Objective 4: To improve end of life care for people with dementia.

7.1 The Haringey Palliative Care Team is a multidisciplinary team that supports all people approaching the end of their life, including patients with dementia or frailty syndrome. They receive holistic care, treatment and support to meet their assessed needs, including patients with dementia. The service is provided seven days a week with 24 hour support available for patients known to the service.

7.2 Haringey CCG in partnership with Social Finance have developed a service to support Advance Care Planning (ACP) in Priscilla Wakefield and Osborne Grove nursing homes. The service started in April 2017. The aim of the service is to

improve the wellbeing and quality of life for residents approaching the end of their life.

7.3 The ACP facilitator supports care home staff to identify and have ACP discussions with residents approaching the end of their lives. The service works closely with the Haringey palliative care team. The facilitator will ensure that people who lack capacity to decide will not be excluded from the intervention.

8. Objective 5: To ensure that people who provide health and care services for people with dementia receive good quality training and education specific to dementia care.

8.1 Hospital trusts:
The Haringey dementia steering group receives regular updates from our local hospital trusts (North Middlesex and Whittington) on their programmes of dementia training for staff. Both hospitals have training programmes in place as described above.

8.2 Care homes:
A local example of good practice in this area was the provision of a programme of dementia training based on experiential learning to a number of Haringey care homes. This training was provided by UCL partners.

8.3 Domiciliary care agencies:
The dementia steering group carried out a survey of local domiciliary care managers about dementia training in these important providers of care for people with dementia in Haringey. The survey found considerable variability in the degree and coverage of training across providers. Dementia training in domiciliary care staff has been noted as an area we need to address locally, and we exploring how best to do this.

8.4 Homecare and care home/nursing home provision:
A rolling programme of dementia training for each care home, including more advanced training in the following areas: Advanced communication skills, Understanding behaviour, Activities. An audit and service peer reviews is to be undertaken to identify areas of best practice and improvements in dementia care across homecare and care home/nursing provision in the London Borough of Haringey.

9. Objective 6: To make Haringey a dementia friendly community

9.1 Haringey CCG and council are members of the Haringey Dementia Action Alliance (DAA) which is chaired by Hornsey Housing Trust. The DAA is a group of diverse organisations such as shops, banks, leisure centres, cinemas, health and care organisations and other public facing organisations who come together to help make their locale more dementia friendly. This can be done in many different ways including increasing their staff awareness of dementia through training or developing

dementia friendly activities. The Haringey DAA is facilitated by a Co-ordinator and this post is currently funded by Hornsey Housing Trust.

9.2 Thirty organisations are signed up so far (full list available on request) and a number of events have been held including dementia friendly cinema screenings, special 'relaxed' performances of plays and information sessions for people to become Dementia Friends. There was also a range of activities held across the borough during Dementia Awareness Week (15-19 May). The members of Haringey DAA have also begun to collaborate on different projects around greater dementia awareness and better access to a greater variety of services for people living with dementia.

10. **Objective 7:** ***This is a supporting objective about ensuring that we have the data we need to commission effectively and that we are monitoring outcomes for people with dementia and their carers.*** See **section 12** below.

11. How we work jointly with health and social care partners

11.1 Haringey CCG and Council have agreed to implement a model of commissioning and pooled budgets supported by a new partnership agreement under S.75 of the National Health Services Act 2006. This builds on previous S. 75 agreements for the Better Care Fund and Learning Disabilities. It is more over-arching than the previous agreements and enables integrated (lead or joint) commissioning for specified care groups and pooled budgets for these groups. It is governed by the Haringey Finance Performance and Partnership Board (member and Governing Body level) and the Joint Executive Team (Director level) between the council and CCG.

11.2 The agreement covers services that have been funded under the Better Care Fund and therefore patients and residents with dementia. The joint structures now in place will significantly facilitate decision making that enables the development of integrated approaches that have been described earlier in this paper, for example in relation to the localities teams and intermediate care.

11.3 The Joint Executive Team is supported by the Dementia Steering Group. This is a group of partners including providers, commissioners, service users and carers who have a strong interest in dementia care and take responsibility for developing and improving the overall pathway for patients with dementia. The group develops an annual work plan. The group does not duplicate the other working groups that exist to develop individual services or improvements for people with dementia but takes a whole system approach to ensure that these developments are co-ordinated and that gaps are identified and addressed.

12. Performance – summary

12.1 The dementia steering group regularly looks at summary data on dementia in Haringey including diagnosis rates, performance of hospitals in terms of identifying people with dementia as well as relevant carers' surveys. There has also been a basic needs assessment carried out looking at the demographics of Haringey's dementia population.

12.2 It is to be noted that benchmarking data in relation to outcomes for people with dementia is limited at present and is an area for development and improvement.

12.3 The key areas we do well and our challenges have been set out previously in this paper and can be summarised as follows:

12.4 Key areas we do well:

- Our diagnosis rate is above average.

- Services provided by BEH for older people on the whole do very well though we need to address the waiting times for diagnosis of dementia.

12.5 Key areas which require improvement:

- The challenges faced by the NMUH and the BEH psychiatric liaison service have been detailed above as well as the actions being taken to address these.

- There are a number of care homes that require improvement and the steps that the CCG and Council take to work with the CQC and providers to address these are set out above.

13. Innovative work of note

13.1 The programme of dementia training based on experiential learning that was delivered to a number of Haringey care homes, was an example of innovation. Previously, UCL partners who delivered this training had worked extensively on this type of programme with hospital trusts, but this was the first time they had worked with care homes. A number of case studies of excellent care for people with dementia in the care homes were noted in the evaluation of the training programme.

14. Future plans for services

14.1 As can be seen from the above narrative, significant work has taken place to work towards meeting the objectives agreed by the Dementia Steering Group. Very good progress has been made but challenges remain for services which have had CQC inspections that require improvement, in the post diagnostic support pathway, including good quality information and embedding new models of day opportunities

and carers' services. The Council and CCG remain strongly committed to ensuring that we continue to work with our partners towards these objectives.

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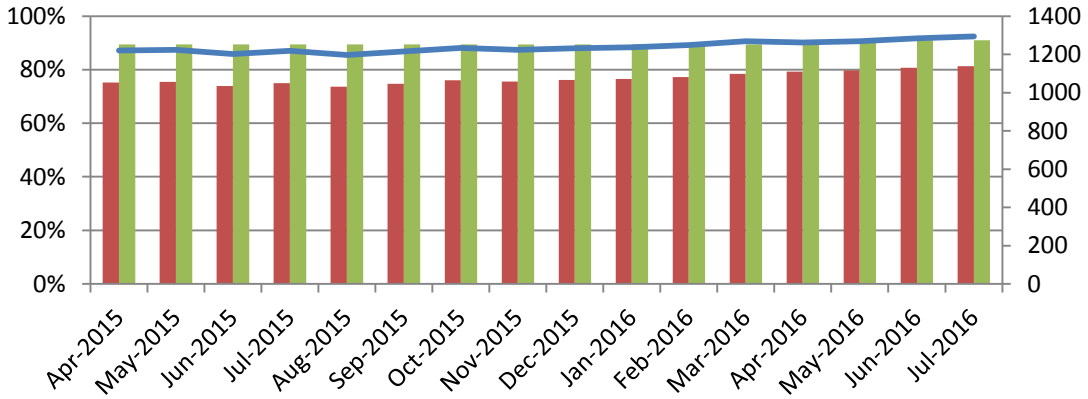
Dementia Support in Islington
Report for the North Central London (NCL) Joint Health and Well Being Board

Local Context

Locally, as of July 2016, Islington has a dementia diagnosis rate of 92% out of an estimated prevalence of 1273 could potentially have dementia but un-diagnosed. This is the 4th highest diagnosis rate in the country and the highest in London. Islington has the eighth highest prevalence (0.4%) of people recorded with a diagnosis of dementia in London (Islington Public Health, 2012). This is a substantial achievement due to mainly due to the relationship between our local memory service and Primary care.



	Apr-2015	May-2015	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	Mar-2016	Apr-2016	May-2016	Jun-2016	Jul-2016
Dementia_Diagnoses_All_Ages	1053	1056	1035	1049	1031	1046	1065	1058	1066	1071	1082	1098	1110	1116	1130	1138
Estimated_Prevalence_All_Ages	1252	1252	1252	1252	1252	1252	1252	1252	1252	1252	1252	1252	1273	1273	1273	1273
DDR%	87%	87%	86%	87%	86%	87%	88%	87%	88%	88%	89%	91%	90%	91%	92%	92%

Of the Islington population with dementia, the majority (95 %) are aged 65 years and over. This equates to about 4% of adults over the age of 65 having a dementia diagnosis in Islington, as nationally, there is a higher proportion of women than men, affected by dementia (4.4% vs. 2.7%).This could be due to women being affected less by other long term conditions at a younger age. Social housing seems to play a greater role, as areas with a high density of social housing have a significantly higher prevalence of dementia in those aged 65 and over (5.8%) than other areas (less than 4%). This highlights the issue that social housing environments needs to better equip to facilitate people living with dementia.

Long term conditions and co-morbidities

People with dementia aged 65 and over have a significantly higher prevalence of stroke / transient ischemic attack (TIA), psychotic disorders and chronic depression, when compared to Islington's general population aged 65 and

over. For stroke / TIA and psychotic disorders, the prevalence among people with dementia is over two and a half times that of older people (65 and over). For chronic depression, the prevalence is twice as high.

In Islington those 65 and over with dementia are most commonly diagnosed with hypertension (400 people). A further 159 adults have a stroke/TIA diagnosis, and 99 adults have been diagnosed with chronic depression and / or psychotic disorders.

In addition, people with dementia have a higher proportion of comorbidities compared to Islington's general population over the age of 65. Of those with dementia, 84% have more than one long term condition compared to 60% of the total population aged 65 and over, while 14% have five or more long term conditions compared to 4% in the older population.

Spend on dementia provision

In 2105/16 the CCG and LA spent £11.7m directly on services and provision for people with dementia in Islington. This does not take into account the undefined expenditure on dementia within the borough. For example, we do not have sufficient data for the number of people who receive domiciliary care due to dementia, and currently we do not have the direct costs associated with the acute sector for people with dementia.

Vision

Islington vision is to be the best borough in the UK for people living with dementia. The following principles underpin this vision:

- Raising public education and awareness of dementia in Islington
- Ensure that people living with dementia are not isolated
- Supporting people living with dementia to retain their independence but help and support is there if required
- People living with dementia comorbidities are effectively managed
- Carers of people living with dementia feel supported, retain a sense of freedom, and feel safe in the knowledge that if help is needed, it is there
- That end of life care be effectively managed without crisis and is personalised to the individual's needs and wants

Whole system overview

To enable a whole system review of the dementia pathway series of engagement events were organised to help us better understand the possible gaps and provision needed to help address those gaps. The engagement events were

designed to gather first-hand information from the people who live with dementia, care for people with dementia and the services who offer support for people with dementia.

Preventing and Diagnosing Well

This covers Prevention, Risk Reduction, Diagnosis, Memory Assessment, Concerns Discussed, investigation, Provide Information, and Care Plans.

Islington's main achievement is the high diagnosis rate which is the highest in London. This is mainly due to the quality of the memory service in the borough. The reasons behind this is because it is easy to access, has short waiting times and a quick response time from initial referral to assessing people. The assessment is comprehensive as it is completed by a specialist and therefore accurate, with the added benefit of people being able to be assessed at home. Dependent on the type of dementia, there are a range of interventions offered and the referrals lead onto a clear pathway.

All the above ensures that primary care have a system that supports a fast and accurate diagnosis.

Supporting Well

This covers Choice, Behavioural and Psychological symptoms of dementia, Liaison, Advocates, Housing, Hospital Treatments, technology, Health & Social Services

What is working well?

- Strong commitment from professionals in the dementia service area
- Integrated health and social care pathways for people with dementia
- Services for Ageing mental health and the community liaison team
- Forget me not scheme in hospital
- Commitment for professionals to improve services
- Whittington hospital has mandatory induction training on dementia
- Social prescribing and the impact on dementia
- Improved equality for dementia support
- Local hospitals are adapting as a dementia friendly environment
- All people within dementia seen by expert in the acute hospitals
- People with dementia are increasingly identified on emergency admission as per the national CQUIN being achieved

Living Well

This covers Integrated Services, Supporting Carers, Carers respite, Co-Ordinated Care, Promote Independence, Relationships, Leisure, and Safe Communities

Islington has a strong offer for carers compared to other boroughs. The START intervention is a national exemplar and potentially through further research the outcomes of this intervention will be further realised.

There is a good support network for people who care in Islington, facilitated through the Carer's Hub and this links into further carer support groups.

Anecdotally, there are a number of voluntary sector groups that are not dementia specific but enable people with dementia and their carers to get involved with activities in the local community as well as dementia specific groups such as Singing for the Brain and the Dementia Café.

The Dementia Navigators help to bridge the gap in terms of information, advice, and signposting to help people living with dementia and their carers further understand their condition and how to live well in the community. They also join up with other navigator services such as stroke and integrated care networks. Not all boroughs have this type of service although this is starting to become the norm.

Dying Well

This covers Palliative care and pain, end of life, preferred place of death

In Islington, there is a move towards increasing the awareness of the dementia cohort as increasingly people are being given advance care plans to facilitate their wishes as to how and where they want to die. GP's are beginning to fill out 'do not attempt to resuscitate' forms and AMBER care bundles are being to be implemented. Increasingly support is in place to allow people to die at home, but more support is needed.

Components of the Islington dementia pathway

Acute hospital care

Islington residents are mainly served by two local hospitals, The Whittington Hospital and University College London Hospital.

Both sites have specialist provision to help people living with dementia and have taken steps to ensure that their sites are dementia friendly and efficiently integrated with local services.

Nationally, it is understood that dementia is frequently not recognised within hospitals and this is compounded as it is generally not the primary reason for an admission. This can mean that the care that people living with dementia receive in hospitals could be sub-optimal when compared to other conditions such as cancer.

As a result, nationally, there has been a drive to improve dementia provision within hospitals and therefore both sites adhere to a dementia CQUIN. This promotes the effectiveness of the hospital to identify patients with dementia and delirium so that they receive appropriate treatment and follow up post discharge.

UCLH

The majority of older patients who enter UCLH through a non elective admission will go through to the acute medical unit. The unit has a geriatrician 7 days a week and a specialist palliative care nurse. This is generally where any cognitive issues are picked up when people with dementia enter as an emergency admission.

If the patient is attending elective treatment, they would be seen by a nurse that would assess for cognitive impairment at a pre-assessment stage, before admission.

If they believe someone has dementia that has not been diagnosed they will try and complete the assessment at UCLH. This would be completed by a consultant and would be facilitated through an MDT approach. If the diagnosis can wait they will be referred back to the community memory service.

UCLH are currently championing a drive to prevent delirium occurring by reviewing patients who are over the age of 74 regularly, for pain, infection, constipation, hydration, nutrition, medication, and also their environment. This is seen as being a major issue on the wards within the older person's cohort and can help to ensure people do not remain indefinitely in beds.

Whittington Hospital

Islington CCG is the lead commissioner for the Whittington hospital. Over the last few years, there has been a drive to try and improve the offer for people with dementia at the hospital, which has been facilitated through the Burdett project.

As part of the Burdett project there were several key components on how the Whittington hospital is developing its offer for people with dementia, as follows:

- Raising awareness of dementia
    - Dementia awareness training
    - Managing changing behaviour pilot training programme
    - Providing information about dementia
- Developing a clinical toolkit for dementia
- Developing a care pathway for dementia
- Creating a dementia friendly environment
- Establishing specialist dementia nurse roles
- Dissemination of good practice

The pathway for people with dementia at the Whittington is integrated between their community and hospital services. It is a person centred, individualised, integrated dementia pathway based on evidence and best practice.

The care pathway is designed to focus on where the person with dementia is likely to have contact rather than on the condition, and therefore covers home and hospital care. A systematic approach is then taken asking key

questions on what care should be delivered, with the patient and carers being at the heart of all the decisions that are made. It also acknowledges the palliative nature of dementia.

Whittington health concludes that staff are now more aware and have skills to deal with people with dementia, and that health professionals have more confidence in working with people with dementia. They now believe that care in the hospital has now become more person centred.

Following on from this, the Burdett report recommends that the Whittington hospital needs to continue with progressing the hospital into a dementia friendly environment through new funding opportunities and this could be further facilitated through the estates department.

Memory service – Camden and Islington NHS FT

Islington's memory service provides specialist assessment and treatment for people who have concerns about their memory. Referrals into the service are generally made through the GP although they can receive referrals from other sources such as hospitals or other C&I services. The service is for people 65 years or older, if the patient is younger they are referred to Queen Square for the early onset dementia service.

It is a consultant led service and the diagnosis can take place in the person home and referrals are seen with 2 weeks of a referral being made. This offers parity of esteem that is in contrast to other London boroughs and offers a bespoke dementia service and this coupled with our high diagnosis rate is evidence that it is an effective model.

The initial assessment is completed by a doctor and typically they are referred for a CT scan at the Whittington hospital to fully confirm the diagnosis.

After a diagnosis of dementia has been made, there are a number of referrals that could take place such as:

- Opt in / out of research
- Social care referral
- Health referral (Reach, Community Nursing)
- Telecare
- Psychological support (one to one)
- OT assessment / interventions
- Cognitive Stimulation therapy
- Advanced Care planning
- Maximise Physical health
- Medication Simplification and concordance
- Advise re driving DVLA
- Mental Capacity Act and Lasting power of attorney advice

At this point if a carer were involved in looking after the patient the memory service would refer the carer onto one or more of the following services:

- Carers Hub
- START (Evidenced base physiological intervention for carers)
- Systematic Family Therapy
- Carers Cognitive stimulation therapy
- Psychological Support (One to one)

If the patient were challenging or presented as high risk they could be referred to the community mental health team for review and care coordination. If prescribed anti-dementia medication, the patient would be retained by the Memory Service and reviewed every 6 months. If medication were not required, the patient would be discharged from the Memory Service and referred onto the Dementia Navigators service.

The service would also consider other high risk factors such as a stroke whereby the patient would be referred to cardiology for review.

Currently, the Memory Service working with approximately 670 patients annually.

The Memory Service conducts a daily multi-disciplinary team (**MDT**) meeting that brings together the team that comprises of doctors, Start Service, Navigators and the nurses. This is an opportunity to assess each case, decide on the collective approach and review them with the MDT. The MDT approach is considered to improve communication between professionals, improve the process of diagnosis and enable quick follow up through to other post diagnosis support such as the Dementia Navigators etc.

A secondary weekly meeting is held between the nurses and doctor to look at prescribed memory medication and any surrounding issues for patients.

Dementia Navigators

The Dementia Navigator service was commissioned in June 2014 to help bridge the gap for people who would have been discharged from the Memory Service if they could not be prescribed anti-dementia medication, as well as supporting people who could be prescribed medication. The primary aim of the service was to provide systematic and proactive support to people with dementia and their carers living in the community. It should be noted that the Dementia Navigators service is not clinical service but offers signposting and ongoing support in the form of scheduled, structured, holistic review of needs and a liaison / coordination to connect people with service they require to help them live well with dementia.

The frequency of the visits is based on a risk stratification tool as follows; this review takes place every time they make contact with the person.

Category	Contact	%
Green Lower	Telephonic- once every quarter, face to face once every six months	73.3%
Green Higher	Telephonic or face to face- once every quarter, face to face once every six months	
Amber Lower	Face to face once every 3rd month	22.7%
Amber Higher	Face to face once every 2 months	
Red Lower	Face to face fortnightly, telephonic weekly	0%
Red Higher	Face to face- weekly, telephonic -every other day	

Data taken from report June Q4 2015 – C&I

The post referral to first contact and assessment times are as follows:

- Referral to first contact 3 to 4 weeks
- Referral to assessment 2 to 3 months
- Review is usually within a week of due date

Patients can be referred from all different services but must have a diagnosis of dementia. If the service were unaware of a diagnosis they would either check with the GP or refer them to the Memory Service for a diagnosis. Dementia Navigators will visit their service users home to assess their coping skills and ascertain if they require additional support with housing, social care, or their finances. The Dementia Navigator would also assess how well the family were coping.

Dependent on the assessment and support required, service users would be referred to a wide range of services that are able to tailor support to the individuals needs. The graph below highlights the range of services that service users and or their carers might be referred to. The majority of onward referrals are to Reach service and Occupational Therapy.

The Dementia Navigators service are also invited to best Interest meetings to support with the assessments for mental capacity of the person living with dementia.

Unlike the Memory Service, the Dementia Navigators will support people with early on set dementia.

START

START is an evidence-based manual based course delivered by C&IFT for carers of people living with dementia. Primarily, the service supports carers to develop coping strategies, delivering delivered via 8 sessions over 8-14 weeks by a supervised graduate mental health worker.

At present, all carers are offered START when the cared for person receives their dementia diagnosis. In addition, a number of carers of people with dementia who seem either in need of or likely to benefit from START have been referred later in the care pathway at review. These are typically carers of people who were diagnosed prior to START being available and those who declined the intervention when it was first offered.

The 8 session programme covers:

Session 1: Introduction: Learning about dementia, carer stress and understanding behaviours of the person cared for

Sessions 2-5: Discussion of behaviours or situations that the carer finds difficult, incorporating behavioural management techniques; skills to take better care of themselves, including changing unhelpful thoughts, assertive communication, relaxation; increasing communication; promoting acceptance; where to get emotional support and positive reframing

Session 6: Future needs of the patient (with information about care and legal planning)

Session 7: Planning pleasant activities

Session 8: Maintaining the skills learned over time

Assessment is routinely conducted over the phone. The intervention has been offered face to face at the clinics and at home visits. Telephone START has also been trialled and found to be effective in supporting carers who live further away or have commitments that make it too difficult for them to attend appointments within service hours.

The intervention improves carers' quality of life and may prevent carer depression and anxiety. Initial evidence demonstrates it is highly cost effective in terms of quality-adjusted life years[1].

Dementia Café

This is a fortnightly service (Saturday) run by the Alzheimer's Society. Activities range from presenting local news to basic food and drink being provided. Guest speakers regularly attend and talk to the people living with dementia; they also participate in group singing and dancing activities. The whole session lasts for approximately 4 hours.

The Dementia Café is for people living with dementia in the borough. This service provides people living with dementia and their carers information and advice as well as increasing access to wider community support. In addition, the Dementia Cafe helps to reduce social isolation and promotes peer support.

Singing for the Brain

Singing for the Brain is a service provided and self funded through voluntary income by the Alzheimer's Society. It uses singing to bring people together. The two hour session is facilitated by a professional music therapist and is

[1] http://www.ncbi.nlm.nih.gov/pubmed/25300037

attended by both carers and people living with dementia. Those attending choose the songs that they remember well, often associated with emotive moments in their life.

Refreshments are served before and after the one hour singing session, encouraging people to sit down and get to know one another.

Peer support networks can start which support the person with dementia or carer in their journey, with emotive or practical needs. Information is provided at each session by local staff, both verbally and through leaflets.

Day centre provision

Highbury New Park is a day care centre for people living with dementia run by Care UK. The day centre is funded via a Council funded block contract. Each person who is referred by social care is financially assessed, and the outcome of the assessment determines how much of a contribution the person attending the day centre makes. The pathway into the day centre is only through a social care referral.

Each person living with dementia has a care plan developed by social care. These care plans differ to the care plans developed in the home.

The home had noted that the average age of person coming into the day centre has increased, and therefore this has presented its own set of issues. Most people will not meet the eligibility criteria (mainly around mobility as you need to be mobile for the service) and therefore the uptake of the service is low.

Enhance Reablement

Enhanced Reablement is a core part of Islington's Reablement offer. Enhance Reablement works with service users to maximise their own independence and confidence. It does this through an 'enabling' model of care, whereby service users are supported to co-create health and well-being with specific input. This model involves a short period of support and care working towards service user led goals. Reablement is funded by the Intermediate Care Pooled Budget, held between Islington Council and Islington CCG.

Enhanced Reablement provides specific skills and capacity within Reablement to allow for assessment and case management of people with cognitive problems, including dementia. It started as a pilot project in August 2011 and was made a core part of the Reablement service in April 2013.

Enhanced Reablement has been shown to be effective in supporting people to be discharged from hospital, and in decreasing use of care homes.

Telecare

Islington's Telecare offer is an in house service. It is known that people with dementia are receiving Telecare but currently there is no formal record of the diagnosis and of the services offered through Telecare. Telecare can offer a range of services that can help people live with dementia to remain independent.

The Islington Telecare service provides a service for 1,155 service users who are funded by adult social care. There are about 160 additional private clients who pay for the service themselves. This means that the majority of the telecare service is funded by adult social care.

Home treatment team

The home treatment team is a service run by C & IFT and commissioned by the CCG. The service is for both Camden and Islington residents who have an acute mental health illness, over the age of 70 and or for people of any age who live with dementia.

The service is designed to reduce the need for an admission to either a mental health hospital or acute hospital admission if the individuals mental health deteriorates. The service also help support early discharge from Highgate Mental Health Unit and frail people under 70 who are care coordinated by the Service for ageing mental health team.

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**

REPORT TITLE
North Central London Joint Health Overview and Scrutiny Committee: Work Planning 2017-18

REPORT OF
Committee Chair, North Central London Joint Health Overview & Scrutiny Committee

FOR SUBMISSION TO: NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 22nd September 2017

SUMMARY OF REPORT

This paper provides an outline of the 2017-18 work programme of the North Central London Joint Health Overview & Scrutiny Committee

Local Government Act 1972 – Access to Information

The following document(s) has been used in the preparation of this report:

No documents that require listing were used in the preparation of this report

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

- Note the contents of the report
- Agree the work programme for the remainder of 2017-18

1. Introduction

1.1. This paper provides a summary of the work undertaken by the North Central London Joint Health Overview and Scrutiny Committee (JHOSC) during the current municipal year and provides an outline of key areas of interest for the 2017-18 work programme.

2. Terms of Reference

2.1. The Committee has been set up with the following terms of reference:

- To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;
- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;
- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the area of Barnet, Camden, Enfield, Haringey and Islington;
- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities,
- although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;
- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and
- The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

3. Meeting dates for 2017-18

3.1. The following dates have been scheduled for the committee's meetings in 2017-18

- Friday, 7th July 2017 (Haringey) 10am
- Tuesday, 19th September 2017 (Camden) 6:30pm
- Friday, 22nd September 2017 (Barnet) 10am
- Friday, 24th November 2017 (Enfield) 10am
- Friday, 26th January 2018 (Camden) 10am
- Friday, 23rd March 2018 (Islington)10am

Appendix A: Committee agenda

Friday, 7th July 2017 (Haringey)

Item	Lead Organisation
NCL Sustainability and Transformation Plan: Final plan including finance; Lead - Councillor Alison Kelly	NCL STP Project Management Office
NCL Sustainability and Transformation Plan: CCGs Joint Committee; Lead - Councillor Alison Kelly	NCL STP Project Management Office

Tuesday, 19th September 2017 (Camden)

Item	Lead Organisation
Camden and Islington NHS Foundation Trust Estates Strategy Lead - Councillor Alison Kelly	Camden and Islington NHS Foundation Trust
St Ann's Hospital Estates Strategy Lead – Councillor Pippa Connor	Barnet, Enfield and Haringey Mental Health NHS Trust

Friday, 22nd September 2017 (Barnet)

Item	Lead Organisation
Royal Free London financial update	Royal Free London NHS Foundation Trust
NCL Sustainability and Transformation Plan: Staffing and workforce Lead - Councillor Alison Kelly	North London partners
NCL Sustainability and Transformation Plan: Engagement Update	North London partners
North Central London approach to commissioning procedures of limited clinical effectiveness	North Central London CCGs
Dementia Pathway: To report following a meeting between borough commissioners to share good practice on provision within each borough including relevant statistics and work with acute providers*;* Lead – Councillor Graham Old	Borough CCGs and joint commissioners;

Friday, 24th November 2017 (Enfield)

Item	Lead Organisation
NCL Sustainability and Transformation Plan: Estates Strategy Lead – Councillor Pippa Connor	North London partners
NCL Sustainability and Transformation Plan: Working together in North London to address social care challenges Lead – Councillor Pippa Connor	North London partners
NCL Sustainability and Transformation Plan: Devolution and Implications for North Central London Lead - Councillor Alison Kelly	North London partners
NCL Sustainability and Transformation Plan: Strategic Risk Management Lead - Councillor Alison Kelly	North London partners

Appendix B: Additional areas of interest suggested at previous meetings for future consideration:

- NCL Sustainability and Transformation Plan:
    - CAMHS
    - Individual Workstream engagement and working together with local people
    - Equalities
    - CCGs joint commissioning committee – 6 month update requested at July 2017 meeting (due Jan 2018)
    - Mental health
- Health devolution
- Patient safety
- NMUH – Achievement of Foundation Status
- 7 day NHS
- Stop Gap Services (Maternity)
- Sexual Health Services
- NHS Providers
- Whittington Hospital – Development of Estates: Update; Lead – Councillor Martin Klute
- Health Tourism at the Royal Free; Lead – Councillor Alison Cornelius
- LAS including handover procedures and times following trial in A&E; NHS England; and changes to LAS targets for reaching patients
- Ambulance private providers
- Out of hours
- 111
- GP service in care homes
- Screening and immunisation follow up including working with local authorities
- Missed GP Appointments
- Accountable Care Organisations
- Congenital Heart Disease Surgery national changes