MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

THURSDAY 3RD OCTOBER, 2013

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
1.	a. Minutes of the Health Overview and Scrutiny Committee, 4 July 2013 b. Minutes of the North Central London Joint Health Overview and Scrutiny Committee, 19 July 2013	1 - 18
5.	Transport Services Finchley Memorial Hospital – Outcome from 24 September 2013 Meeting	19 - 20
9.	Dolphin Ward Update	21 - 38
12.	Members' Item - Breast Screening (Councillor Barry Rawlings)	39 - 42

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Decisions of the Health Overview and Scrutiny Committee

4 July 2013

AGENDA ITEM 1

Members Present:-

Councillor Alison Cornelius (Chairman)
Councillor Graham Old (Vice-Chairman)

Councillor Geof Cooke	Councillor Barry Rawlings
Councillor Julie Johnson	Councillor Brian Schama
Councillor Arjun Mittra	Councillor Sury Khatri
Councillor Bridget Perry	(In place of Maureen Braun)

Also in Attendance
Councillor Helena Hart – Cabinet Member for Public Health

Apologies for Absence

Councillor Maureen Braun Councillor Kate Salinger

1. MINUTES

The Chairman updated the Committee in relation to minute items from the 9 May 2013 meeting as follows:

i) Item 1 (Minutes) – Dr Rounce had now received a letter following her meeting on 21 March 2013 with three members of the Barnet and Chase Farm Hospitals NHS Trust management team. It was noted that a reply had been promised by 30 April 2013, but had not been received until June 2013.

ii) Item 10 (Quality Accounts) – the Committee were advised that Barnet, Enfield and Haringey Members had met on 28 May 2013 to agree a joint submission on the Barnet, Enfield and Haringey Mental Health NHS Trust Quality Accounts 2012/13 and that this had enlarged upon the Barnet submission agreed on 9 May 2013.

iii) Item 10 (Quality Accounts) – the Committee noted that it was hoped that scrutiny of the 2013/14 Quality Accounts of the Barnet, Enfield and Haringey Mental Health NHS Trust and Royal Free London NHS Foundation Trust would take place at the North Central London Sector Joint Health Overview and Scrutiny Committee,rather than at an individual borough level.

RESOLVED that the minutes of the meeting held on the 9 May 2013 be agreed as a correct record.

2. ABSENCE OF MEMBERS

Apologies for absence had been received from Councillor Maureen Braun who had been substituted for by Councillor Sury Khatri.

An apology for absence had been received from Councillor Kate Salinger.

3. DECLARATION OF MEMBERS' INTERESTS AND PREJUDICIAL INTERESTS

Member	Subject	Interest declared
Councillor Barry Rawlings	Agenda Item 12 (Healthwatch Barnet – Update and Response to the Francis Report)	Pecuniary interest as Councillor Rawlings worked for CommUNITY Barnet the Barnet Healthwatch host organisation
Councillor Alison Cornelius	Agenda Item 9 (NHS Quality Accounts)	Non-pecuniary interest by nature of being on the chaplaincy team at Barnet Hospital

4. PUBLIC QUESTION TIME

Details of the questions asked of, and the answers given by the Chairman, were circulated at the meeting, made available to the public questioners in advance of the meeting and published online with the agenda papers for the meeting. Verbal responses were given to supplementary questions asked at the meeting.

At the invitation of the Chairman, the Cabinet Member for Public Health advised the Committee that she had written to the Mayor of London regarding the issue of bus services at Finchley Memorial Hospital. She reported that she had received a response stating that the Mayor would look into the issue personally and the Committee would be updated on any progress.

5. MEMBERS' ITEM - DIABETES SCREENING

Councillor Geof Cooke presented his Members' Item which related to diabetes screening rates in Barnet. He reported that the Diabetes UK publication titled 'The NHS Health Checks Programme – Lets Get it Right' identified that the estimated percentage of undiagnosed diabetes patients in Barnet was 27.8%.

The Director of Public Health, Dr Andrew Howe, advised the Committee that the NHS Health Checks programme had been rolled out in Barnet approximately six months ago when responsibility for public health transferred to the Council. Members noted that targets for Q4 2012/13 had been met with 4,758 checks undertaken. Whilst the improved performance was welcomed by the Committee, there was a concern about the level of resources in place in GP practices to support second and third phase interventions.

A Member identified that private pharmacies were offering screening services and questioned whether these were linked into other areas of the health service. Dr Howe advised the Committee that diabetes screening was not offered universally in GP practices and other settings and was a targeted approach based on other risk factors. He undertook to investigate the pharmacy chain in question and its links to the Health Checks programme.

The Committee requested that performance information be presented as a moving annual total to allow meaningful comparisons to take place. It was noted that the Council had a new Corporate Plan target 'to increase the number of eligible people who receive an NHS Health Check to 7,200.' As a result, ongoing performance would be monitored by the Corporate Performance Team which would improve data quality.

RESOLVED that:

1. **The Committee receive the final report of the joint Barnet / Harrow NHS Health Checks Task and Finish Group at the 12 December 2013 meeting.**

2. **The Committee requested that the NHS Health Checks Task and Finish Group review give specific consideration to diabetes screening rates as referred to in the Members Item and the preamble above.**

The Chairman announced a variation in the order of the agenda. Agenda item 8 (Barnet, Enfield and Haringey Clinical Strategy) would be considered before agenda item 7 (GP Services). Agenda item 6 (Joint Health Overview and Scrutiny Committee – Minutes) would be considered after agenda item 10 (Update on NHS Transition).

Agenda item 11 (Maternity Services – Caesarean Births) had been withdrawn from the agenda at the request of Councillor Kate Salinger and would be considered at the next meeting of the Committee.

6. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

The Committee welcomed Dr Nick Losseff, Medical Director for the Barnet, Enfield and Haringey (BEH) Clinical Strategy, Siobhan Harrington, BEH Programme Director, and Fiona Smith, Director of Operations at Barnet and Chase Farm Hospitals NHS Trust who delivered a presentation on the BEH Clinical Strategy.

Dr Losseff advised the Committee that the BEH Clinical Strategy was a quality and safety programme which would improve standards across Barnet, Chase Farm and North Middlesex hospitals. Members were advised that Chase Farm hospital would not be closing, adding that a large majority of patients would continue to be treated there. The Committee were advised that the following services would continue to be provided: planned elective surgery (disaggregated from emergency surgery), outpatients, paediatrics and older people assessment units, blood tests, x-ray and pre and post-natal services. Chase Farm would have an urgent care centre, with accident and emergency services provided from Barnet Hospital. Responding to a question, it was clarified that the following services would be transferred from the Chase Farm site: maternity deliveries, accident and emergency, paediatric inpatients and complex operations. The greater specialisation on planned care at Chase Farm would ensure greater efficiency and less likelihood of cancelled appointments. The Committee noted that as part of the Clinical Strategy, modelling had been undertaken to assess where the 7,090 accident and emergency patients at Chase Farm would be disbursed to. It was expected that patients would present at the following hospitals for services instead: Princess Alexandra Harlow, Barnet, North Middlesex and West / North Hertfordshire.

The Committee were advised that staff consultation on the proposed changes were currently taking place, along with deep dives into clinical workstreams to ensure services

were fit for purpose. The BEH Clinical Strategy Programme Office had been working with NHS England in advance of presenting the final proposals to the Barnet, Enfield and Haringey Clinical Commissioning Groups in September, with implementation taking place in November.

As part of a drive to ensure that patients presented in the correct setting, an urgent care pilot was taking place at Barnet Hospital which was seeking to reduce the 30% of people presenting at accident and emergency incorrectly. As part of the pilot, audits would be undertaken to assess presentations at accident and emergency and urgent care. Members were advised that reception areas for accident and emergency and the urgent care centre receptions were now co-located. Patients would be triaged by staff when they presented at reception and would be referred to accident and emergency or the urgent care centre as appropriate. It was noted that as part of the pilot, extended GP cover would be provided a peak times to manage demand. The Committee noted that Barnet Hospital had missed the 95% target for seeing accident and emergency patients within four hours, with current performance at 86%. Members were informed that this was chiefly on account of the current building works to expand the unit which were scheduled to complete in August 2013. Fiona Smith acknowledged the issue and emphasised that the pilot scheme was seeking to address this issue.

The Committee referred to an article in the local media which alleged that a patient an accident and emergency patient at Barnet Hospital had not been seen for 16 hours. Fiona Smith identified that delays could be attributed to the different assessment phases that needed to be completed. She added that redesigned pathways and reconfigured services would mean that patients had a much quicker referral to a specialist that would have previously been the case.

Members commented that accident and emergency presentations could often be attributed to a lack of availability of GPs and noted that a whole systems approach was required to reduce admissions. The Committee expressed support for the Clinical Strategy and emphasised the importance of effective communications with patients regarding service reconfigurations. They were advised that an extensive marketing campaign was being planned and that there had already been a bus campaign about the maternity changes.

In relation to delayed discharge, Fiona Smith reported that there were some systems issues which were being discussed with Barnet and Enfield Clinical Commissioning Groups and social care services which were seeking to reduce the length of stays and ensure that the right staff were in place to support the end of placements.

The Adults and Communities Director, Dawn Wakeling, updated the Committee on social care services at Barnet and Chase Farm Hospitals. Members were advised that social care teams from Barnet, Enfield and Hertfordshire were based at the hospital sites, adding Barnet social care has a good track record with hospital discharges. Members noted that there were approximately 117 discharges per month and during the last 16 months, there had only been 14 delayed discharges from Barnet and Chase Farm hospitals which were attributable to social care delays. Dawn Wakeling reported that there had been no delayed discharges from the Royal Free Hospital this year and advised the Committee that social services would learn from experiences and apply these practices in Barnet and Chase Farm hospitals.

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RESOLVED that:-

1. **The Committee note the update on the implementation of the Barnet, Enfield and Haringey Clinical Strategy as set out in the presentation and as referred to above.**

2. **The Committee receive a further update on the Barnet, Enfield and Haringey Clinical Strategy at the next meeting on 4 October 2013.**

3. **The Committee receive an update on delayed discharges and the ongoing work of social care services, clinical commissioning groups and NHS trusts as part of the report on Health and Social Care Integration at the next meeting of the Committee on 4 October 2013.**

7. GP SERVICES - BRUNSWICK PARK HEALTH CENTRE AND FINCHLEY MEMORIAL HOSPITAL

Councillor Andreas Ioannidis addressed the Committee in relation to GP services at the Brunswick Park Health Centre. He advised the Committee that he been in discussion with the Divisional Director of NHS Property Services, Tony Griffiths, who had advised him that services could be reinstated within four to six weeks of the lease being signed. He added that NHS England and NHS Property Services had been in discussions with the GP practices and their legal representatives regarding possible lease terms. He expressed disappointment at the length of time it was taking to reinstate services at the Medical Centre and the cost of providing security at the premises.

The NHS England Deputy Head of Primary Care – North Central and East London, Fiona Erne, and the NHS Property Services Associate Director Estates and Facilities, Martyn Hill, updated the Committee on GP services at Brunswick Park Health Centre and Finchley Memorial Hospital.

Brunswick Park Medical Centre

In relation to the Brunswick Park Health Centre, the Committee were advised by Ms Erne that there were two issues in relation to the reinstatement of services. Firstly, there was the issue of entering into a lease agreement with Dr Okonkwo. Secondly, there was the issue of the possible purchase of the Medical Centre by Dr Lakhani. Discussions had taken place regarding the property issues with both practices. The Committee were informed that Dr Okonkwo had concerns regarding the proposed fees and the financial viability of the practice following a move into Brunswick Park Health Centre. It was noted that financial assistance from NHS England had been discussed.

Mr Hill reported that there had been an initial meeting between Dr Okonkwo and NHS Property Services. Members were advised that the main issue was the financial impact on the practice, rather than the lease terms. It was noted that there may also be slight delays with the installation of the IT system and medical equipment.

Mr Hill advised the Committee that Dr Lakhani had withdrawn from negotiations with NHS England and NHS Property Services as he was primarily interested in purchasing the Medical Centre and was not interested in entering into a lease arrangement. Following this withdrawal, NHS Property Services had commenced discussions with another practice regarding a possible co-location.

The Committee received public comments from Mr Daniel Hope, Chairman of the East Barnet Residents Association, in relation to the Brunswick Park Health Centre.

Responding to questions from the Committee regarding the potential for part of the practice to be empty if Dr Okonkwo moved back into the premises, Mr Hill advised the Committee that following the fire in 2010, the premises had been expanded and enhanced with a view to increasing turnover, improving services, delivering economies of scale and developing synergies. He added that there was room for two or three practices on site, with Dr Okonkwo expected to be using between 33 – 40% of the available space.

Referring to lease charges, the Committee questioned whether Dr Okonkwo would be required to subsidise empty space in the practice. Mr Hill advised Members that the Clinical Commissioning Group (CCG) were being recharged for empty space. It was noted that NHS Property Services were paying for the cost of security at the building.

Finchley Memorial Hospital

Ms Erne updated the Committee on GP services at Finchley Memorial Hospital. The Committee were advised that a financial assistance package had been agreed and that a Task and Finish Group would be established to facilitate the two practices moving in. It was anticipated that services would commence operations in approximately six months time.

Mr Hill reported that NHS Property Services had been working with the Hospital on estates utilisation, adding that he was aware of the issues with void spaces. The Committee expressed disappointment that there had been no agreement before the hospital had been constructed regarding services that would be provided from the site.

Cabinet Member for Public Health – Submission on GP Services in Barnet

At the invitation of the Chairman, the Cabinet Member for Public Health, Councillor Helena Hart, addressed the Committee on all the work that had been undertaken to try and facilitate the re-opening of the Brunswick Park Health Centre and the proper utilisation of the GP space at Finchley Memorial Hospital. Councillor Hart emphasised that the failure to re-open the Brunswick Park Health Centre and to utilise the GP space at Finchley Memorial Hospital were Estates issues which needed to be resolved by NHS England and NHS Property Services. She added that both situations have significant implications for Barnet's residents and the CCG.

The Committee were advised that the Health and Well Being Board would be examining the progress being made to address Estates issues in the context of the CCG's Recovery Plan. It was noted that as both NHS England and the CCG were represented on the Health and Well Being Board, the Board was well placed to examine how the wider NHS Estate was used to support the delivery of the Health and Well Being Strategy and to deliver value for the taxpayer.

RESOLVED that:-

1. **The Committee note the update on GP services at Brunswick Park Medical Centre and Finchley Memorial Hospital as set out in the agenda and as detailed above.**

2. **The Committee encourage NHS England and NHS Property Services to continue efforts to reinstate GP services at the Brunswick Park Medical Centre as soon as possible.**

3. **The Committee note the financial impact to the Barnet Clinical Commissioning Group and request that the Health and Well Being Board monitor progress on the provision of GP services at the Brunswick Park Medical Centre and Finchley Memorial Hospital as part of their wider review of the estates issue.**

8. TRANSPORT SERVICES - FINCHLEY MEMORIAL HOSPITAL

The Committee considered a report which outlined issues with transport services at Finchley Memorial Hospital. The Vice-Chairman, Councillor Old, updated the Committee on discussions that had been held with Transport for London (TfL) where they had indicated that it was unlikely that any existing routes would be re-routed. He advised the Committee that the walk from the bus stop to the hospital entrance (approximately 400 meters) was an issue for patients and suggested that an interim measure should be sought while negotiations were ongoing with TfL.

The Cabinet Member for Public Health, Councillor Helena Hart, informed the Committee that she had written to the Mayor of London on this issue. In her representation she had stated that public transport links to Finchley Memorial Hospital were a key element of the redevelopment proposals. Her letter had also stated that there should be a firm commitment to equal and inclusive access to services. The Committee were advised that the Mayor had responded and had undertaken to personally look into this matter. Councillor Hart undertook to update the Committee on any response received from the Mayor's office.

It was noted that a number of other local politicians and groups had also been lobbying the Mayor and TfL on this issue.

A Member highlighted that executive responsibility for TfL rested with the Mayor of London and expressed disappointment at the lack of cooperation from TfL on this issue. It was suggested that re-routing a bus service into the site or providing a shuttle bus from the hospital entrance would address the problem.

RESOLVED that:-

1. **The Committee note the update on Transport Services at Finchley Memorial Hospital as set out in the report and as outlined above.**

2. **The Chairman be requested to submit a formal representation to the Greater London Assembly Transport Committee on this issue, with any feedback reported to the Committee in due course.**

3. **Officers be instructed to invite representatives from Transport for London to the next meeting of the Committee on 4 October 2013 to update the Committee regarding ongoing discussions and possible options for transport services at Finchley Memorial Hospital.**

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9. UPDATE ON NHS TRANSITION

The Committee welcomed the NHS Barnet Clinical Commissioning Group (CCG) Chief Officer, John Morton, who was in attendance to provide an update on the transition to new NHS structures. He reported that the CCG had been authorised on 1 April 2013 with nine conditions which were monitored every three months. He added that it was expected that five of the conditions would shortly be removed. The Committee noted that the budgets of the former primary care trusts had been distributed between CCGs, public health and NHS England. The Barnet CCG had a budget of approximately £430 million which was primarily for commissioning hospital, mental health and community services. Mr Morton identified that there had been underinvestment in mental health and community services in the past which the CCG were seeking to address. It was noted that there were financial challenges which were being addressed by the CCG.

Responding to a question, Mr Morton reported that the three legal directions were in place due to the scale of the budget challenge. He added that the CCG were taking a five year approach to addressing financial issues.

As referred to in minute item 7, the Committee expressed concern at the approximate £4 million annual cost to the CCG relating to under utilised estates. Mr Morton echoed these concerns and advised the Committee that the CCG were working to address these issues. Ongoing monitoring of estates issues would be taking place at the Health and Well Being Board.

RESOLVED that the Committee note the update from Barnet Clinical Commissioning Group on the transition to new NHS structures as set out in the report and above.

10. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - MINUTES

The Committee considered the minutes of the North Central London Sector Joint Health Overview and Scrutiny Committee (JHOSC) which had taken place on 6 June 2013 and the minutes of the informal meetings held on 24 April and 28 May 2013.

The Chairman highlighted that on 6 June 2013, the JHOSC had received an update in relation to the 111 service and had received assurance that an additional 202 spaces would be provided at the Barnet Hospital site. She added that the JHOSC would be holding a workshop in October 2013 on the Francis Report to which all Health Overview and Scrutiny Committee Members would be invited to attend.

RESOLVED that the Committee note the minutes of the meeting of the North Central London Sector Joint Health Overview and Scrutiny Committee held on 6 June 2013 and the minutes of the informal meetings held on 24 April and 28 May 2013.

11. MATERNITY SERVICES (CAESAREAN BIRTHS)

Item withdrawn for considered at the next meeting of the Committee on 4 October 2013.

12. BARNET HEALTHWATCH

The Committee welcomed the Chief Executive of CommUNITY Barnet, Julie Pal, who was in attendance to present a report to the Committee on Healthwatch Barnet. She referred the Committee to the activities undertaken during the Healthwatch start-up period (section 9.2.1) and active projects which included an Enter and View programme and introduction of the Information, Advice and Signposting Service (section 9.2.4).

Members emphasised the importance of the Enter and View programme and questioned whether there were a sufficient number of trained volunteers to undertake the visits. Ms Pal highlighted that the change from the LINk to Healthwatch had been a major transfer. Whilst some volunteers had transferred over from LINK to Healthwatch, others were newly recruited and required training before undertaking visits.

The Committee requested that the members of Barnet LINk, particularly Gillian Jordan, be commended for their work.

RESOLVED that the Committee note the Healthwatch Barnet update and response to the Francis Report as outlined in the report and detailed above.

13. FRANCIS REPORT - IMPLICATIONS FOR THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE

The Overview and Scrutiny Manager presented a report which provided a detailed response to the recommendations in the Francis Report which related to the Health Overview and Scrutiny Committee.

RESOLVED that:-

1. **The Committee endorse the detailed responses to the recommendations in the Francis Report which relate to the Health Overview and Scrutiny Committee.**

2. **An item be added to the Forward Work Programme detailing the performance of NHS Trusts against the NHS Outcomes Framework (to be reported bi-annually).**

14. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME

RESOLVED that:

1. **The Health Overview and Scrutiny Committee Forward Work Programme be noted.**

2. **The Committee receive the following reports at future meetings:**

   - **Barnet, Enfield and Haringey Clinical Strategy – to receive an update from the BEH Clinical Strategy Programme Office on the progress of the BEH Clinical Strategy (4 October 2013)**
   - **Finchley Memorial Hospital Transport Services – to receive an update on progress made and to receive a submission from TfL (4 October 2013).**

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- **Maternity Services (Caesarean Births) – to consider the item deferred for consideration at this meeting (4 October 2013)**
- **Diabetes Screening – to receive a report from the Director of Public Health on diabetes screening (12 December 2013)**
- **NHS Health Checks Task and Finish Group (TFG) – to consider the report of the NHS Health Checks TFG (12 December 2013)**
- **NHS Trusts Performance – to receive a report on the performance of NHS Trusts against the NHS Outcomes Framework (12 December 2013)**

3. The Committee request that the item on Health and Social Care Integration due to be considered at the 4 October 2013 make specific reference to hospital discharges as detailed in minute item 6.

15. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

None.

The meeting finished at 9.50 pm

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North Central London Sector Joint Health Overview and Scrutiny Committee
Friday 19th July 2013

Minutes of the meeting of the **NCLS Joint Health Overview and Scrutiny Committee** held at 10:00a. m on **Friday 19th July 2013** at London Borough of Camden Town Hall, Council Chamber, Judd Street , London WC1H 9JE

Present:

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
John Bryant (Vice Chair)	LB Camden
Peter Brayshaw	LB Camden
Alison Cornelius	LB Barnet
Jean-Roger Kaseki	LB Islington
Martin Klute	LB Islington
Graham Old	LB Barnet
Anne-Marie Pearce	LB Enfield

Support Officers

Harvey Collins	LB Camden
Rob Mack	LB Haringey
Linda Leith	LB Enfield
Leah Mooney	LB Enfield

1. WELCOME AND APOLOGIES

Councillor Bryant (Vice Chair) welcomed everyone and advised that he would be chairing the meeting until Councillor Bull (Chair) arrived.

Apologies for absence were received from Councillor Alev Cazimoglu and apologies for lateness had been received from Councillors Bull and Cornelius.

2. DECLARATION OF INTEREST

There were no declarations made.

3. URGENT BUSINESS

There was no urgent business

4. MINUTES

The minutes of the meeting held on 6th June 2013 were agreed as a correct record.

5. THE WHITTINGTON HOSPITAL- TRANSFORMATION PROGRAMME AND FOUNDATION TRUST STATUS UPDATE

The JHOSC received the briefing presentation that had been included in the agenda papers for the meeting and a further presentation on the Whittington Health Clinical Strategy. The presentations provided information on the transformation programme and progress towards foundation trust status.

Members thanked the Whittington for the very detailed information that had been provided in the presentations and raised the following points:

- Members were pleased to note that the clinical strategy was driving the estate strategy but wanted further information on the timescales for the renewed bid for foundation status.
- There was significant discussion in the documents about delivering more services in the home and members expressed some concern that this would result in local authorities being relied on to provide additional services.
- What examples were there of technological innovations in health care working?
- What progress had there been on reducing agency staff?
- How effective had smoking cessation programmes been?
- Was the Whittington working with other hospitals as a training provider?
- Would GPs be taking over the clinical care of patients when they were discharged from hospital?
- Not everyone had computers, how would patients without them access information?
- How many Community Matrons were there?
- The strategy was very discursive but did not include a great deal of information about bed numbers and staffing levels which made it difficult to make any assessment of the implications of the strategy. When would more detailed information be available about the number of beds and staffing levels?

The following information was provided in response to the above points:

- A great deal of work had taken place at the Whittington to extend best practice and develop an integrated care model across all aspects of the hospital's work. There was a new timetable from the National Trust Development Authority with more focus on quality and operational excellence. There would be an assessment of the hospital's position with the aim of being on track for Foundation Status at the end of 2014.
- These were challenging times but the Whittington would be working with partners on a strategy for community engagement, an equalities impact assessment and a clinical strategy.
- There would be close working with CCG colleagues to ensure that current services would continue to be provided by the health service and would aim to deliver them more strategically.
- Best practice on the use of patient portals would be shared and its introduction at the Whittington would be revolutionarily transformational in the provision of care. The system being introduced would link social care, the Whittington, the community and GPs and be known as Whittington Health. The aim was that there would be a carers portal at a later stage.
- Targets on smoking cessation were not monitored for individual effectiveness

- A bank of agency staff was used to ensure standardisation and a quality of service and had proved to be financially beneficial.
- Partnership in education was key in the relationship with UCLH and Middlesex University Hospital and the Whittington wanted to continue to be a top training provider in London.
- The models of care were being redefined and the individual patient needs in each case would be assessed and adjustments made.
- Information on the number of community matrons was not to hand but would be made available.
- The clinical strategy was still at the development stage and so detailed figures were not yet available. In the next 18 months there would be a reduction in beds and there would be a further review of bed numbers after the ambulatory care arrangements had been in place. Changes in procedures had already resulted in a reduction in the length of stay in hospital but the JHOSC was assured that there would always be enough beds in the hospital to meet the demand for them and that there would be a report back from the Whittington in the Spring on the implementation of the ambulatory system.
- The Whittington would be developing an engagement plan that would be considered by the hospital's trust board in the autumn and it was agreed that draft plan would be considered by relevant health scrutiny committees

RESOLVED

1. That the engagement plan for the transformation programme be submitted to relevant health overview and scrutiny committees in the area during the Autumn;

2. That the Whittington Hospital Trust be asked to provide further information on community matrons, including how were employed; and

3. That a further report be submitted to the JHOSC in Spring 2014 by the Whittington on progress with the transformation programme.

(Councillor Bull Chaired the meeting from this point.)

6. LEADERSHIP OF SERVICE CHANGE IN THE NEW NHS

Consideration was given to a briefing that provided details about structure and leadership of service change in the NHS were organised at local and London level. The interface between the NHS and the Health Overview and Scrutiny committees was also described was well as the role of NHS England in Direct Commissioning and the interface with Public Health England and Clinical Commissioning Groups. There was also a presentation in support of the briefing, with a further explanation of:

- Planning and system leadership in the new NHS
- Role of NHS England in planning and system leadership in the new NHS
- Other stakeholders who would play an important role
- To enable the public to be involved
- Building a stronger relationship with health overview and scrutiny

The previous leadership models were more dispersed and unclear and it was hoped that these arrangements would provide more clarity.

The following points were made in response to the briefing:

- Were these new arrangements essentially the creation of a strategic health authority?
- NHS England was still in the process of appointing staff, was there capacity there to support all this work?
- Health needs in London were very different to the rest of the country, was this being addressed in the strategy?
- It was key to these new arrangements that the changes were implemented with more momentum. There did not appear to be any specific new pathways proposed and no significant initiatives.
- Who was responsible for the strategic overview of health areas? There were a number of networks but how do these transfer into action?
- Councillors had seen a number of housing development proposals where it was not clear if they had been linked to any strategic look at health provision
- What is the role of Patient Participation Groups in these new arrangements and was there any information that could be provided to members?
- What were the governance arrangements and what transparency was there around board accountability and decision making?
- There was concern from JHOSC members that £500m was a large sum for an individual to be able to make a budgetary decision on.
- What opportunities were there for comments from the public to be heard?

In response the JHOSC was advised that:

- The new organisational structure and leadership had resulted in changes in responsibilities to those previously but were a much more strategic approach and there was accountability within the new structures.
- NHS England was aware of large planned developments. The specialist community role within NHSE would ensure that CCGs fulfilled their roles to provide hospital and GP services that were responsive to the needs of their communities. There would also be a key role for Health and Wellbeing Boards in this work.
- Information on Patient Participation Groups was being collated and would be available in the next few months.
- It was advised that under the new arrangements there was a main board for NHS England and a regional London team. Processes for decision making were being established and all governance arrangements were not yet in place. Regional directors had been delegated authority to manage contracts up to £500m.
- The London region was structured differently with one Area Director responsible for the North Central and East London Areas, with three sub regional areas sitting below the NC/EL areas.
- The new arrangements had only been in place for fifteen weeks and there would be opportunities for the public to participate and for their voices to be heard.

RESOLVED

That the briefing and presentation be noted

7. FAILING GP PRACTICES

The JHOSC received a presentation about the arrangements to address failing GP practices, which looked at the following:

- Background information
- GP contracts in this part of NCEL
- Managing GP Performance
- How do we identify poor performance?
- New national arrangements being developed - what had been produced and was in place contractually for the individual performer
- Position from GPOS Summary (Dec 2012 data)
- GP Live Performance Cases Summary (July 2013)
- Individual Performance
- Contractual or practice matter?
- Absolute failure of a practice
- Changes between the old and new practices

The following points were then made in response to the presentation:

- The huge demand on Accident and Emergency Services was an indication of the lack of access to GPs. The need for more services had been identified by the CCGs as the route of a number of health service problems. Primary care service should be more responsive to the public need for the service.
- A potential strength of the new structure was that it would be able to look locally at the needs of each CCG
- A particular issue in Enfield had been the transport links between primary care services.
- In work that it was undertaking, Islington HOSC had identified a huge diversity in appointment systems at GP practices and people in the borough were struggling to navigate the appointment processes. With little common ground in the systems, trying to scrutinise the issues for patients had raised more questions than had been answered. Islington members of the JHOSC were asked to share their findings on this issue.
- Quality, performance and the mechanisms to generate improvement were issues that needed to be reviewed
- Out of hours services was another area generating complaints from users who were unclear about the provision and dissatisfied with the service being provided.

RESOLVED

That the presentation and the points raised by the JHOSC be noted.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS

The JHOSC considered a report that provided information on the:

- Engagement on urological cancer surgical services
- Background to the cancer proposals
- Cancer pathways
- Cardiovascular Services and conclusions.

Following on from the responses that had been received as part of the Engagement, NHS England had agreed that the proposals would benefit from a formal consultation exercise, which was expected to be launched later in the year along with further development of the proposals for specialist cancer services across North East and North Central London. No significant changes to the location of services would take place without further consultation.

During consideration of the report the following points were made:

- The cross party working taking place at scrutiny committees had worked but there was some concern about party politics coming into play in the run up to the local elections in May 2013. It was advised that the consultation would be taking place late November to late February and so would be completed well before the local elections in May 2013.
- Consideration would need to be given as to how health overview and scrutiny committees would feed into to consultation process. Whilst there was a statutory requirement to set up a joint committee to respond to NHS consultations, it was possible that the three joint committees covering north and north east London could fulfil this function. Legal guidance would be taken on this issue and liaison would take place between the JHOSC and the joint committees for inner and outer north east London.

RESOLVED

That a meeting be arranged between the Chair and the Chairs of the Inner North East London (INEL) and Outer North East London JHOSCs, relevant support officers and NHS Officers to discuss the consultation process and engagement with health overview and scrutiny committees.

9. WORK PLAN AND DATES FOR FUTURE MEETINGS

Consideration was given to the work plan report that outlined proposed items for discussion.

In addition, the issue of women not entitled or eligible for maternity care accessing services was raised. In response it was requested that further information be sought about what period of residency in the UK was required in order to receive care. Also what reciprocal arrangements were there between member states of the European Union and was it the case that pre-existing conditions had to be treated in the patient's home country?

Members of the JHOSC agreed that they would be mindful of the dates and items that would be considered at the scheduled meeting close to the local council elections in May next year and to purdah period restrictions.

The following meeting dates were also noted:

- 29th November 2013 (Barnet)
- 7th February 2014 (Enfield)
- 28th March 2014 (Islington).

RESOLVED

That a briefing be submitted to a future meeting of the Committee on the arrangements for reimbursement of costs incurred in NHS treatment of non UK residents.

Minutes End

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LB Barnet / Transport for London
Meeting to Discuss Transport Services at Finchley Memorial Hospital
Tuesday, 24 September 2013

AGENDA ITEM 5

Present:
Councillor Alison Cornelius – LB Barnet Health OSC Chairman
Councillor Graham Old – LB Barnet Health OSC Vice-Chairman
Councillor Helena Hart – LB Barnet Cabinet Member for Public Health
John Barry – TfL, Head of Bus Network Development)
Peter Howarth – TfL, Borough Engagement Manager (North)
Martin Cowie – LB Barnet, Development and Regulatory Services
Andrew Charlwood – LB Barnet, Overview & Scrutiny Manager

Andrew Charlwood outlined that the purpose of the meeting was to investigate with Transport for London (TfL) possible options to address the issue of bus services not stopping at the entrance of new the Finchley Memorial Hospital. Existing services stopped outside the hospital site meaning that patients had to walk approximately 400 metres from Granville Road to the hospital entrance. Councillor Hart added that failing to provide a transport link between the TfL bus stops and the hospital main entrance was an accessibility issue which affected certain groups of patients, primarily the elderly and infirm.

Councillor Hart reported that a meeting had taken place earlier in the summer between Mike Freer, MP for Finchley and Golders Green, Councillor Hart, Isabel Dedring, Deputy Mayor for Transport at the Greater London Authority and Clare Kavanagh, Performance Director London Buses at TfL.

John Barry reported the following were reasons for TfL not diverting a bus on to the FMH site:

1. The hospital site was only suitable for a suitable single deck bus; the only single deck route in the area was the 382 route.
2. Diverting the route onto the hospital site would cost £180,000
3. Diverting the route onto the hospital site add five minutes to the route; and
4. Diverting the route onto the hospital site would affect up to 1,500 passengers per day (non-hospital users).

TfL had to take into consideration the cost and demand elements of any service changes. It was highlighted that the current hospital forecourt could not accommodate a bus on the site.

It was suggested that an alternative vehicle could be used to ferry passengers from the bus stops located close to the hospital and that local community transport services was an option that could be explored. The main issue related to funding the service (both the procurement of a vehicle and the on-going revenue costs). TfL reported that there was no funding available for community transport services, but assistance could be provided in terms of stops, timetables etc. It was noted that at the meeting which had taken place earlier in the summer

that it had been suggested that Barnet Community Transport may be able to provide the service.

It was questioned whether extending dial-a-ride to serve the hospital could be an option. John Barry reported that there was no additional funding available to meet the additional costs of a community transport service. He suggested that section 106 funding which had been allocated as part of the Finchley Memorial Hospital redevelopment could be redirected to fund a bus service on the hospital site. Martin Cowie undertook to investigate this option and to identify any restrictions on the use of the S106 funding.

Members highlighted that site accessibility might be one of the issues that was preventing GP practices relocating into the hospital site.

Actions:

John Barry / Peter Howarth

1. Provide detailed costings and other impacts of diverting the 382 route in to the Finchley Memorial Hospital site

Martin Cowie

2. Investigate the possible use of section 106 funding for transport initiatives allocated as part of the Finchley Memorial Hospital redevelopment to fund the capital cost of a vehicle.
3. Provide an outline of actions required to accommodate a bus stop on the hospital site (physical reconfigurations), liaising with NHS Property Services as necessary (to include changes to road layout and removal of parking spaces)
4. Provide an indicative cost of providing a passenger shelter at the entrance of the Finchley Memorial Hospital.
5. Liaise with LB Barnet Passenger Transport to ascertain an indicative cost of a vehicle (both hopper bus and electric vehicle).

Councillor Alison Cornelius

6. Contact Peter Cragg to investigate the feasibility of the Friends of Finchley Memorial Hospital providing volunteers to drive a shuttle bus.

Andrew Charlwood

7. Collate evidence regarding the demand for a shuttle service from TfL bus stops to the hospital entrance (to include hospital staff, hospital service providers, older peoples forums, Age UK etc) to develop a case for usage and demand.
8. Contact NHS Property Services to investigate whether the existing footpath from Granville Road can be re-routed to provide a more direct link from TfL bus stops to the hospital main entrance.

All attendees to receive an update in one month (24 October 2013) on the outcome of the actions detailed above (Action: Andrew Charlwood)

AGENDA ITEM 9

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Dolphin Ward Update**
Report of	Overview and Scrutiny Office
Summary of Report	The Committee have requested to receive an update on the status of the former residents of the Dolphin Ward at the Springwell Centre on the Barnet Hospital site.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	All
Key Decision	No
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	None
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, andrew.charlwood@barnet.gov.uk, 020 8359 2368

1. RECOMMENDATION

1.1 That the Committee note the update on the former patients of the Dolphin Ward (Older Adults Admissions Unit) at the Springwell Centre on the Barnet Hospital site as provided by the Barnet Clinical Commissioning Group / Barnet, Enfield and Haringey Mental Health Trust (Appendix A) and make appropriate comments and/or recommendations.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 12 September 2012, Any Other Items the Chairman Decides are Urgent – the Committee were notified by Barnet, Enfield and Haringey Mental Health Trust that the Dolphin Ward had been closed due to clinical concerns and that patients had been moved to the Chase Farm Hospital site. The Committee noted that the former Napsbury patients had already been subject to a transfer from Elysian House to the Springwell Centre in September 2011 and assurances had been sought at that time that no further transfers would take place.

2.2 Health and Well-Being Board, 4 October 2012, Barnet, Enfield and Haringey Clinical Strategy Update – the Board received an update on the BEH Clinical Strategy and were advised that they would be informed of developments regarding the future of the Dolphin Ward at the Springwell Centre.

2.3 Health Overview and Scrutiny Committee, 11 December 2012, Any Other Items the Chairman Decides are Urgent – the Committee received an update from Barnet Clinical Commissioning Group on the relocation of former residents of the Dolphin Ward.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Overview and Scrutiny Committees must ensure that the work of Scrutiny is reflective of the Council's priorities.

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.
- The Council is required to give due regard to its public sector equality duties as set out in the Equality Act 2010 and as public bodies, health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.

5.2 See also Appendix A, at 2.1.2 and page 11 which highlight some positive and some negative effects which have been identified in the Equalities Impact Assessment and Analysis which is attached to the Report at Appendix A.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of this report.

7. LEGAL ISSUES

7.1 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 As set out in Section 2 (Relevant Previous Decisions), the Committee have received a number of updates on the former patients of the Dolphin Ward (Older Adults Admissions Unit) at the Springwell Centre on the Barnet Hospital site. The Committee have requested to receive an update from Barnet Clinical Commissioning Group and Barnet, Enfield and Haringey Mental Health Trust on the status of the former patients. The update received is set out in **Appendix A**.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Cleared by Finance (Officer's initials)	**JH/AD**
Cleared by Legal (Officer's initials)	**LC**

Briefing paper on Older People's Mental Health Services in Barnet and the closure of Dolphin Ward in the Springwell Unit, Barnet Hospital.

1.0 Introduction

This briefing paper outlines the existing inpatient and community mental health care pathways for older people in Barnet and provides an update to the Overview and Scrutiny Committee since the last update provided in May 2012. It also makes the proposal to formally close Dolphin Ward which has been temporarily closed since 2011.

The existing model for older people's mental health services in Barnet is described below. All community and outpatient services are based at the Springwell Building at Barnet Hospital and inpatient services are based on the Chase Farm Hospital site.

Barnet Older People's Mental Health Services consists of:

- Community Mental Health Teams: supporting patients in the community with functional mental illness or dementia who are subject to CPA
- Day Hospital Provision: functional (sessional only) and dementia (full-day attendance)
- Memory Treatment Clinics: a nurse-led service monitoring patients on anti-dementia medication
- Acute In-patient Care: patients with a functional mental illness are admitted to The Oaks Ward; people with dementia are admitted to Silver Birches Ward (applies to Barnet, Enfield and Haringey).
- Home Treatment Teams: providing acute care for adults of all ages in the community with a functional mental illness

1.1 Background

The last paper to the OSC on Barnet's older peoples mental health services in May 2012 outlined a review of the temporary changes that had occurred to the acute in-patient pathway for older people in 2011. On the 5th of July 2011, Dolphin Ward (Based in Springwell Unit, Barnet Hospital) was temporarily closed and all activity transferred to Cornwall Villa based at Chase Farm Hospital. This was an urgent service change in response to a safeguarding and disciplinary investigation on Cornwall Villa. Cornwall Villa was a 25 bed acute admission ward for older people with a functional illness e.g. depression, schizophrenia or dementia. At the time, there was a consistent number of vacant beds, that allowed the Trust to temporarily close Dolphin ward and move the in-patient activity to Cornwall Villa. As Dolphin Ward was only 12 beds, the Trust could not close Cornwall (25 beds) and only use the smaller unit as there would not have been sufficient capacity. Since this initial move, patients have been moved to the Oaks Unit on the Chase Farm Hospital site that provides a more appropriate environment.

Since then, the Trust has managed in-patient demand effectively with only one older patient (Enfield patient) admitted to the private sector due to bed pressures during the last two years. However, there have been concerns within the Trust about the complexity of managing acutely ill patients with functional mental illnesses and those with dementia within the same environment (The Oaks). The consolidation of acute provision and increasing complexity in demand has resulted in rising levels of mental health acuity on The Oaks unit. It is considered too large at 25 beds.

A compounding issue is the mixed pathology on the unit. More vulnerable and elderly patients with dementia can, on a fairly frequent basis, become involved in altercations and incidents with younger (e.g. age 65-70) patients with functional illness such as people in the manic stage of a bi-polar illness.

A compliance inspection of The Oaks by the CQC in March 2013 found areas of non-compliance related to care plans not being updated in a timely manner and also that patients were not always having their capacity to make significant decisions assessed under the Mental Capacity Act (2005). During the last year there were also several safeguarding alerts raised by The Oaks and an increase in the number of complaints from patients and their families about care on the ward. These various problems highlighted the increased operational pressure the service was under in trying to manage and care for patients with functional mental illness and severe dementia within the same environment. In response to the above concerns, a providers concern process for The Oaks was initiated and led by the London Borough of Enfield with a robust improvement plan developed by the Trust and its partners.

In June 2013, as an agreed way forward during the provider concern review, the Trust proposed to move all acute admissions for people with dementia to Silver Birches Ward on the Chase Farm Hospital site. This new pathway for Barnet, Enfield and Haringey older people was established in August 2013. The plan aims to reduce the bed numbers on The Oaks from 25 to 21 (currently 22 beds). These actions intend to reduce the size of the unit and the complexity of provision by separating functional and dementia care pathways which could not be achieved when units were geographically based and borough focussed. There will be no corresponding reduction in staff resources resulting in a further increase in the staff to patient ratio on The Oaks.

The improvement plan, which has almost been fully implemented, included the following key elements:

- Reduce the size of The Oaks from 25 to 21 beds
- Separate out functional and dementia patient pathways through utilising Silver Birches Ward as the main acute assessment ward for people with dementia
- Improve the structure and layout of The Oaks unit through improving reception and creating two smaller 6 bed and 15 bed units within the footprint of the standalone unit
- Enhance clinical leadership on the unit through the introduction of a new dedicated Consultant Psychiatrist for the unit and an additional charge nurse
- Further increase medical staffing through the introduction of a new specialty doctor
- Introduce a standard induction process for agency workers
- Review and implement revised clinical review processes
- Continue to deliver our inpatient staff development programme
- Increase our quality assurance processes around the care and treatment provided on the Oaks
- Review and enhance the therapeutic activity programme
- Improve working with informal carers
- Review the physical health care needs of patients on the Oaks and address any identified gaps
- Deliver additional safeguarding training to staff
- Closely monitor practice in relation to Trust policy and guidelines on restraint
- Improve falls screening, assessment and care planning

1.2 Brief commentary on what we want to achieve.

The following outlines the key areas of priority for Barnet Mental Health Services for Older People:

- To strengthen acute care and avoid unnecessary admissions to hospital
- To further integrate community provision to support a managed network of services across a wide spectrum of care for example, the new MDT elderly frail networks
- To continue to support residential and nursing homes by helping to maintain placements and avoid unnecessary admissions to acute general and mental health hospital care
- To support carers especially carers of people with dementia.
- To work with commissioners to develop a Barnet Memory Service that will form the central part of a Dementia Hub for Barnet
- To develop an enhanced Psychiatric Liaison service at Barnet Hospital based on the RAID model
- To integrate with community services in managing people with long-term conditions (LTC)

Trust Strategy

The BEH Trust's discussion document, 'Changing for Good', published in October, 2009 reflected key elements contained in the healthcare policy framework at that time and are further developed in the Trust's Clinical Strategy published in 2013. A key focus of the Strategy is:

- to maintain the majority of care in the community enabling people to live independently at home,
- to develop alternative options for acute care (e.g. Home Treatment Teams) and
- to reduce unnecessary admissions to hospital.

To achieve these, mental health services will work more closely with primary and social care services to manage the growing demand for healthcare in the local population.

Older People's Services Model

An effective older people's mental health service requires a managed network of services across a wide spectrum of care. The expertise of older people's mental health services lies in the care and treatment of people with complex psychological, cognitive, functional, behavioural, physical and social problems usually related to ageing. Older people benefit from an integrated approach with social care services as most patients in older age mental health services have complex social needs (Joint Commissioning Panel for Mental Health 2013)[1]. In addition to complex social needs, older people often have a combination of mental and physical health problems. Significantly more older people suffer from functional illnesses, depression and psychosis, than dementia and there is significant cross-over between the two categories of illnesses. This latter point means that if is often very difficult to completely separate out provision for functional illnesses and dementia. Provision

[1] Joint Commissioing Panel for Mental health (2013) Guidance for commissioners of older people's mental health services. Published May 2013

can be separated and this now forms a requirement from the Trust's Clinical Strategy with regards to our older people's in-patient care.

Community Mental Health Teams (CMHTs)

These services are integrated health and social care teams that manage older people with complex needs related to functional illness and dementia under the Care Programme Approach. Their purpose is the active treatment and management of patients in the community in order to improve the individual's mental health and maintain independence in the community. Treating people in their own homes to maintain independence and avoid unnecessary admission to hospital for treatment is a key function of these teams. Carer burden can be significant and particularly for carers of people with dementia. Specialist support is required to improve and maintain carer health and avoid the potential breakdown of a person with dementia's support network at home. In addition to this, CMHTs provide a critical role in supporting patients in residential and nursing homes and helping to prevent placement breakdown and avoid unnecessary hospital admission.

In-Patient Services

In-patient services are essential components of the care pathways, dementia and acute care, that help to manage clinical risk and placement breakdown. The purpose of in-patient care is to provide more intensive, safe support to the person who requires assessment or stabilising of their mental health before returning to community living or step-down care.

In BEH we have a clear plan in place to improve acute care for older people within **The Oaks and Silver Birches Wards**. The Trust has made significant investment in resources for these units and, with the recent changes to the overall model, has now applied for AIMS (Accreditation for In-patient Mental Health Services) accreditation with the Royal College of Psychiatrists to support our continuous improvement and achievement of a recognised standard for in-patient care.

Memory Services

The Trust is working closely with commissioners to develop a dedicated **Barnet Memory Service** that will form part of a Dementia Hub in Barnet working closely with the Alzheimer's Society and other agencies. Referrals to older people's services in Barnet increase by approximately 7.5% per annum and we have seen a marked increase in the number of people referred in the early stages of dementia requiring assessment, diagnosis and treatment. The Trust has already achieved accreditation for Memory Services in Enfield and Haringey.

2.0 Service Development

The consolidation of the sectorised acute care pathway has enabled re-investment to enhance staffing in Barnet community services and the remaining specialist in-patient units based on the Chase Farm Hospital site. Recent and future developments are outlined below including the development of an enhanced Psychiatric Liaison service for Barnet Hospital based on the successful RAID model of liaison.

The main changes include:

- The move from geographically-based sectorised wards with mixed pathology (functional illness and dementia) to centralised and better resourced units separately focussed on a primary pathology (e.g. functional illness or dementia) and based on the Chase Farm Hospital site.
- Increased staff enhancements to community services including Consultant Old Age Psychiatry, Therapy staff and the introduction of Admiral Nurse provision (trained mental health nurses whose clients are the family carers of people with dementia)
- New service developments including a new Memory Service team for Barnet and a new Psychiatric Liaison team for Barnet Hospital
- The intention to develop a proposal for a rapid assessment service for people with dementia aimed at preventing unnecessary hospital admissions

Triage, Crisis and Home Treatment Services

The Trust is transforming the way it responds to both routine and urgent care referrals. The service transformation and re-design proposals set out an organizational structure that allows for the services to be delivered through three borough teams with an overarching streamlined management and clinical structure for both the new Triage Service and the Crisis Resolution & Home Treatment Team (CRHT). These changes will create three new integrated Triage services and CRHT's in Barnet, Enfield and Haringey based locally to provide mental health assessments and advice. The service recognises a need to manage risk effectively but also engage in positive risk taking to ensure that the care offered is designed around service user need rather than service need.

Response targets are guided by NICE guidelines: 2 hour response for urgent and crisis referrals, 3 working weeks for routine and non-urgent referrals. These services are for all adults including older people. Senior clinical staff will lead at the front of the pathway through undertaking all initial assessments. This will support better decision making, signposting and appropriateness of onward referrals and also help to avoid unnecessary admissions.

Anticipated advantages of the changes include

- Improved quality of care and patient experience
- Equitable and fair access to services
- A modernised approach to care emphasising the need for a timely and clinically appropriate response and assessment.
- Integrated bed management structure for all services.

- Changes to the way staff work to ensure the right skills are in the right place with skilled staff available to provide supervision and support as needed.
- Increased flexibility
- Ability to respond more effectively to the challenging economic climate.

Carers Strategy

The Trust recognise and value the crucial role that carers play. Over the past two decades there has been a progressive shift in the provision of care for people with health problems from hospital based services to more community focused care and whilst this brings many positive outcomes, the provision of day to day care frequently lies with their carers, who take on the task of caring alongside other responsibilities. The Trust are currently consulting on a new Carers Strategy that outlines the expectations placed on the Trust in recognising and supporting carers to stay healthy. The strategy provides a framework for carer engagement at individual, team and service development levels, in line with Trust objectives.

Amongst all carers, the carers of people with dementia are one of the most vulnerable, suffering from high levels of burden and mental distress, depression, guilt and psychological problems[2]. The behavioural and psychological symptoms of dementia patients, such as aggression, agitation and anxiety, are particularly difficult for carers and are a common cause for institutionalisation of dementia patients in care homes. The roll out of Admiral Nurses across the three boroughs has been a welcome addition to the existing service model. During the last year, two new Admiral Nurse posts have been established to work with carers from Barnet. A senior band 7 Admiral Nurse has been appointed to support the Oaks, Silver Birches and Cornwall Villa and the new Admiral Nurse position (Band 6) within Barnet's community services for older people.

2.1 In-patient Provision

Mental Health in-patient care is highly specialised, focussed on the most vulnerable, those with the greatest need and complexity. It requires specialist expertise, with intensive levels of assessment, monitoring and treatment that is not possible in other settings. Inclusion of a wide range of disciplines as part of the multi-disciplinary clinical and management team is essential. The Royal College of Psychiatrists (2011)[3] recognises that practically, in order to deliver such high-quality specialist units, people may have to travel further to more centralised and well-resourced in-patient areas although it recognises that this may be potentially problematic for some older people.

Since the temporary closure of Dolphin Ward in 2011, the Trust has made significant re-investment in the acute care pathway. This has included:

- Increasing nursing staff on The Oaks shift plan to 6 during daylight hours and 4 at night (Previously 4:3). In addition to this there is a full time supernumerary ward manager.
- Creation of a full time Nurse Consultant post for The Oaks since December 2011 (in addition to the above shift plan)

[2] University of Oxford (2010) Dementia 2010: The economic burden of dementia and associated research findings in the United Kingdom. Health Economics Research Centre, University of Oxford.
[3] Royal College of Psychiatrists (2011) In-patient care for older peple within mental health services. April 2011

- Creation of a senior inpatient Admiral Nurse post (Band 7) to support carers of people with dementia
- Creation of an additional full time OT post to support rehabilitation and facilitate discharge
- Increased medical consultant time by 0.4wte to 1.0 dedicated full-time Consultant Psychiatrist for The Oaks
- Further increase of medical support with a full-time specialty grade doctor for The Oaks.

Table 1 below outlines the number of Barnet admissions since April 2010 to the acute care pathway. This shows a range of between 2 and 11 admissions per month with an average of 6.3 admissions per month and a small rise in trend during the last 12 months. On average, Barnet accounts for almost 50% of all admissions with 28% from Enfield and 19% from Haringey (3% from other boroughs). Barnet incurs more admissions proportionally than would be expected based on its population but the high number of residential and nursing home facilities in Barnet increases the number of older people with significant morbidity and this is likely to be a factor. During the last year, 39% of Barnet admissions were for people with dementia.

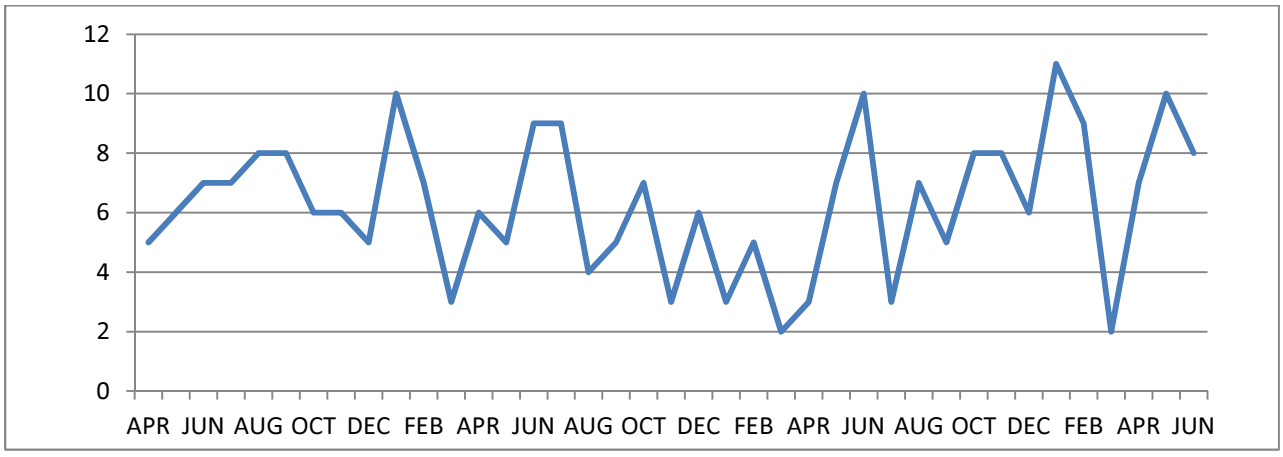

Table 1: Barnet monthly admission rate from April 2010 to June 2013

For comparison across boroughs, Haringey's admission rate has remained fairly stable with 38 admissions in 2010/11 and 39 admissions over the last 12 months (average 3.2 admissions per month). In contrast, Enfield has seen a significant reduction in admissions over the last few years with 80 admissions in 2010/11 and only 59 admissions during the last 12 months (average 4.9 admissions per month).

The average length of stay (ALoS) on The Oaks is 42 days for people with dementia and 50 days for people with a functional illness. Barnet's average length of stay is better than average across the three boroughs with a total ALoS of 42 days in Q1 this year and the last three quarters of 2012/13 showing 46(Q4), 35(Q3) and 33(Q2).

Table 2 below shows the number of Barnet patients in an acute bed on the 1st of each month. There is some variation with a range of between 7 and 16 patients and an overall average of 11.6 patients at any one time. In line with the small increase in average admissions per month during the last year there has been a slight increase in the number of Barnet patients at any one time.

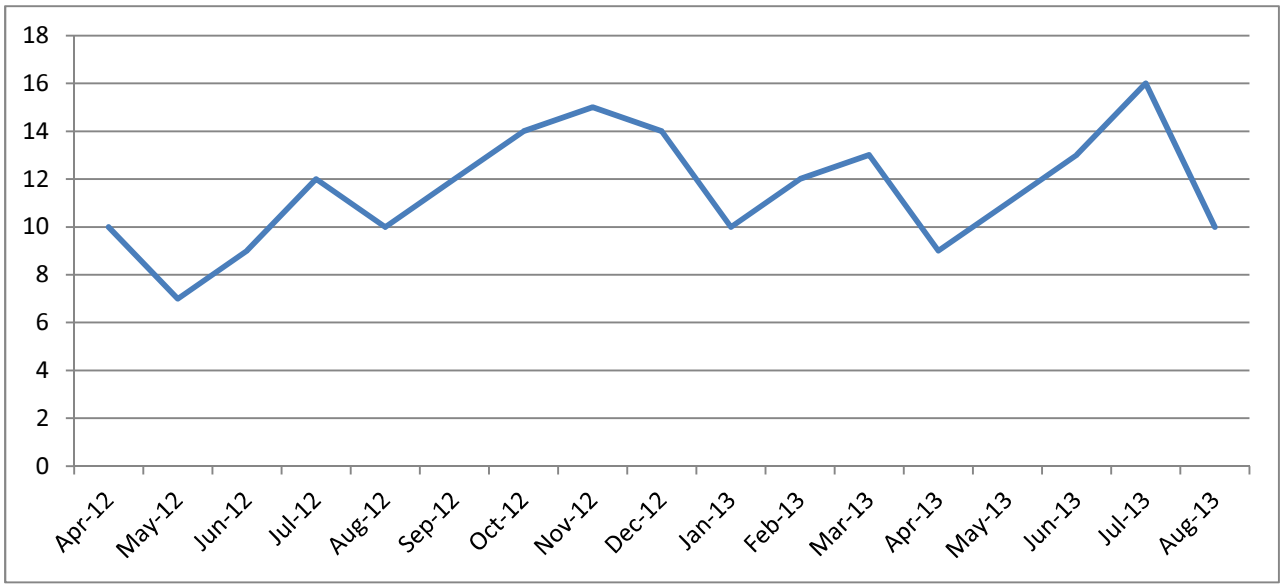

Table 2: Barnet patients in acute care on 1st of month from April 2012 to August 2013

Barriers to Discharge from In-Patient Care

The Royal College of Psychiatrists (2011) recognises the negative impact that prolonged admissions have on all agencies and the need to address the significant numbers of mental health beds that are occupied by people whose discharge is delayed. A national survey by the Faculty of Psychiatry of Old Age[4] found 13.3% of functional mental illness beds and 28.6% of dementia assessment beds were filled by patients whose discharge had been delayed. Delayed transfers of care (DToC) locally usually relate to patients who are waiting for residential placements and the necessary agreement regarding continuing care eligibility (CHC), funding or placement approval. Although there are efficient processes in place to address these issues between the Trust, Barnet LA, and Barnet CCG, the focus tends to be on patients who have already been admitted to hospital rather than the need for multi-agency intervention prior to admission. This is particularly the case for people with dementia and the need to respond to challenging behaviour (e.g. wandering, behavioural problems, aggression) that invariably increase with disease progression.

Although not yet quantified, a proportion of admissions to hospital could be managed by alternative models to hospital care. The person with dementia can, for example, present to A&E, after having been found wandering, and is then admitted out of hours. In these circumstances, vulnerable adults require immediate and supportive care plans at home or emergency respite in a residential setting rather than admission to an acute admission ward as the changes in their behaviour are expected and should be planned for via effective multi-agency arrangements. In light of this, commissioners

[4] Barker, A & Bullock, R (2005) Delayed Discharge in older peoples' mental health beds. Old Age Psychiatrist Newsletter, Autumn:9.

and the Trust plan to develop a future proposal around the development of a joint, multi-agency rapid assessment service to prevent unnecessary admissions, particularly for people with dementia.

2.1.1 Benefits of changes to the acute care pathway

The changes made to the acute care pathway provide benefits for patients, service providers and commissioners. The Trust's shift from more traditional geographically sectorised in-patient models to a centralised model based on primary pathology supports significant benefits to patients and services by providing expert interventions that are timely and appropriate.

Increased specialism helps to improve delivery within a particular unit e.g. focussed on functional mental illness or dementia. This also includes benefits in simplifying training and education of staff and consolidation of in-patient provision has enabled the appointment of additional staff and senior clinicians for the services e.g. dedicated Consultant Psychiatrist, Nurse Consultant and senior Admiral Nurse to improve clinical leadership. Improved service delivery and care leads to shorter rehabilitation periods and subsequent shorter lengths of stay on wards.

Having separate in-patient beds for dementia and functional beds has been consistently regarded as good practice (Audit Commission 2002, Care Services Improvement Partnership 2005, Royal College of Psychiatry 2006, The Mental Welfare Commission for Scotland 2010). The Mental Welfare Commission for Scotland paper highlighted the problems with mixed-provision: people with dementia invade the personal space of other people. Also, providing activities that are stimulating and meet the needs of each individual was cited as challenging. The RCPsych's paper from the Centre for Quality Improvement in 2008 highlighted that violence and aggression is higher in mixed pathology units than in in-patient units providing care separately. This is an important finding. Another issue, highlighted by the National Collaborating Centre for Mental Health in 2006, was that good palliative care is more difficult to deliver in mixed pathology units.

At a ward level, the artifacts of these changes are providing substantial benefits for patients and include:

Improved Clinical Decision Making

The Oaks has moved away from the traditional and long weekly multi-disciplinary ward rounds to a more agile and frequent daily review process where senior clinicians can assess and adjust plans together more quickly as new information is received. The older more traditional model was to a large extent dictated by the fact that the consultant psychiatrists were not ward-based and worked across various services including the Oaks. Care Programme Approach (CPA) meetings tended to occur during the weekly ward rounds, organised around the consultant psychiatrists availability, and this meant that it wasn't unusual for ward rounds to last 4-5 hours. The new clinical review process supported by the full time Consultant Psychiatrist and Nurse Consultant means that CPA meetings are organised around the availability of the family, where appropriate, and other key professionals and do not happen during the professionals daily clinical review process. It also means that the relevant named nurse or nurse-in-charge is not removed from clinical duties for extended periods of time but for shorter and more manageable time periods.

The daily review meeting also enables the care team to plan and implement actions in a more timely way which aids in reducing unnecessary delays to tasks and processes related to patient discharge.

Improved Support for Carers

Re-investment within the Oaks has supported the establishment of a senior Admiral Nurse for our inpatient services. The Admiral Nurse works directly with family and carers of people with dementia. A new initiative within the Oaks and Silver Birches has been to have a 'family meeting' with relatives/carers (where appropriate) within the first week of the patient's admission. There is a structured format to the meetings and where possible includes the patient's named nurse and/or ward doctor. The aim of the meeting is to gather a richer picture of the patient's needs, offer a carers assessment and give information about the ward and any aspect of care and treatment. The Admiral Nurse documents the discussion in the meeting and any other additional information and a copy of this is provided to the carer/family member. The Nurse Consultant carries out the same role for carers/family members of patients admitted to the Oaks with a functional illness

Improved Staff Development and Supervision

One of the key areas of responsibility for the Nurse Consultant position involves staff development. The Nurse Consultant leads on and delivers an innovative staff development programme for qualified and unqualified nurses across the older people's wards. This consists of a programme of formal study days and ward based 'team days' that are planned up to a year in advance. Senior clinicians from all disciplines lead on each of the 24 days delivered each year and some of the experiential training has been supported by using actors.

2.1.2 Equality Impact Assessment

The attached Equality Impact Assessment and Analysis form for this ward consolidation initiative has been completed and identifies possible minor positive impacts and some negative impacts related to the protected characteristics of age, disability and ethnicity. The change affects a small number of patients and their families with around 80 admissions per annum and with an average length of stay on the ward during the last four quarters of 33, 35, 46 and 42 days.

2.2 Community Provision

A substantial part of community mental health service provision for older people in Barnet is aimed at providing support to the high number of residential and nursing care homes within the borough. Following the closure of Dolphin Ward, reinvested Consultant Psychiatrist sessions (0.5wte) have assisted in maintaining and developing support to key homes in the borough, including: Apthorp Lodge, Elmstead House, Clore Manor, Candle Court, Clara Nehab House and Lady Sarah Cohen House. Medical and non-medical staff provide regular 'clinics' within these homes on either a weekly

or monthly basis depending on need. Community and Day Hospital nursing and therapy staff have also been re-focussed, having previously input to Dolphin Ward, and who now spend more of their client contact time within the community and outpatient settings. In addition to this, the Trust have created an Admiral Nurse post in Barnet to provide support for carers of people with dementia, who can experience significant carer burden, and this has been operating well since the start of the financial year.

A new development for Barnet has been the recent agreement to establish a new service for the Memory pathway in Barnet. The new service will form part of a centralised dementia hub that will include key partner agencies including the Alzheimers Society. The service will provide assessment, diagnosis and treatment for all referrals of people with suspected dementia. This will be an exciting new development for Barnet. Early diagnosis of dementia is a government priority and the National Dementia Strategy 2009[5] describes the value of early diagnosis and intervention. The following positive impacts are listed: early provision of support at home can decrease institutionalisation by 22%; even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6%; older people's mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care.

The Prime Minister[6] is committed to ensuring that memory clinics are established in all parts of the country and are accredited according to the standards outlined by The Royal College of Psychiatrists, Memory Service National Accreditation Programme (MNSAP) standards. Key commitments listed in the Prime Ministers Pledge 2012 include:

- increasing diagnosis rates through regular checks for over - 65s
- better information for people with dementia and their carers
  promoting local information on dementia services e.g. by rolling out web information for local areas.

Nationally, only about one third of people with dementia receive a formal diagnosis and the Department of Health's National Dementia Strategy[7] aims to ensure that effective Memory Clinic services for early diagnosis and intervention are available nationally. With an expanding older people population, Barnet can expect a 21% increase in the number of older people during the next decade. Local services have seen a 15% increase in demand during the last two years, mainly as a result of the incremental drivers to diagnose people in the early stages of their dementia.

The National Dementia Strategy provides evidence that such services are cost effective. Once established, such services can release substantial funds back into health and social care systems. The evidence available indicates that:

- Early provision of support at home can decrease institutionalisation by 22%
- Even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6%

[5] Department of Health (2009) Living well with dementia: A National Dementia Strategy
[6] Department of Health (2012) Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015
[7] Department of Health (2009) Living well with dementia: A National Dementia Strategy.

- Older peoples mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care
- Carer support and counselling at diagnosis can reduce care home placement by 28%
- Early diagnosis and intervention improves quality of life for people with dementia and;
- Early intervention has positive effects on the quality of life of family carers

(Summary of benefits taken from DoH National Dementia Strategy 2009)

2.3 Liaison Psychiatry

Although not the full RAID model, the Trust will be delivering an enhanced Psychiatric Liaison service to Barnet Hospital in this year. The service will be evaluated with a view to considering what level of liaison services is required for 2014/15 onwards.

The Rapid Assessment, Interface and Discharge (RAID) model provides an innovative liaison psychiatry service which will improve quality of care, drive down lengths of stay and reduce readmission rates across the whole spectrum of mental health co-morbidities in the acute hospital including dementia, self-harm and substance misuse. This is the model that was developed and implemented at Birmingham City Hospital, and has been thoroughly evaluated and accepted nationally as a benchmark platform for acute hospital liaison services. There are two key components:

- direct assessment and treatment of patients presenting with overt mental health problems, allowing the existing Barnet hospital pathways to function smoothly and reduce unnecessary delays, similar assessment and treatment of patients who present with co-morbid mental health problems such as dementia
- high quality education & support for the Barnet Hospital staff through both formal teaching and informal techniques, to rapidly skill up NMUH staff in identification of patients who might benefit from RAID input and improve their own care of such patients.

3.0 Summary and conclusion

Since the temporary closure of Dolphin Ward in 2011, The Trust has been able to satisfactorily manage in-patient demand and is continuing to reduce total bed numbers with further reductions planned to The Oaks which is going from 25 beds to 21 beds this year. No further bed reductions are planned at this stage.

The in-patient pathway consolidation and a move away from geographically based wards with mixed pathology to separate in-patient units for people with functional illness and dementia has resulted in re-investment within community services including the introduction of Admiral Nurses, increased specialisation within in-patients and improved clinical leadership with a dedicated Consultant Psychiatrist and Nurse Consultant for the Oaks ward.

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AGENDA ITEM 12

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Members' Item – Breast Screening (Cllr Barry Rawlings)**
Report of	Scrutiny Office
Summary	This report informs the Committee of a Member's Item and requests instructions from the Committee.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	All
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	Appendix – Health Overview and Scrutiny Framework Effective Scrutiny for Better Outcomes
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 The Committee's instructions on the Members' Item on Breast Screening Services are requested taking into account the Health Overview and Scrutiny Framework Effective Scrutiny for Better Outcomes attached in the Appendix when determining the most appropriate route for this request.

2. RELEVANT PREVIOUS DECISIONS

2.1 None.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Overview and Scrutiny Committees must ensure that the work of Scrutiny is reflective of the Council's priorities.

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 Equality and diversity issues are a mandatory consideration in decision-making in the council pursuant to the Equality Act 2010. This means the council and all other organisations acting on its behalf must have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their

duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.2 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of this report.

7. LEGAL ISSUES

7.1 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

8.2 Council Constitution, Overview and Scrutiny Procedure Rules, Paragraph 8.1 states that "Any member of an Overview and Scrutiny Committee shall be entitled to give notice to the Head of Governance that he/she wishes an item relevant to the functions of the Committee to be included on the agenda for the next available meeting of the Committee. On receipt of such a request, the Head of Governance will ensure that the item is included on the next available agenda".

9. BACKGROUND INFORMATION

9.1 Councillor Barry Rawlings has submitted a Members' Item be brought to the Committee in relation to the breast screening services at Finchley Memorial Hospital (FMH) with the following supporting information:

"To receive a report at the meeting of HOSC on the 3rd October as to the situation regarding routine Breast Screening in Barnet, and in particular the situation at Finchley Memorial Hospital. In addition;

- To be informed of the charges imposed by Community Health Partnerships for all the services at FMH and whether decisions regarding the Breast Screening service were based on clinical or financial criteria.
- What the projected figures for attendance were, what the effect has been on actual attendance and what the likely consequences are of any reduction in attendance at the screening service.
- Which partners were informed of the decision to cease the service at FMH.
- To be given a list of sites that are now managed by Community Health Partnerships - what increases in charges have been made and whether other services have ceased at those sites, or are under threat from any such increases.
- To add to the work programme a request for both Community Health Partnerships and NHS Property Services to attend the committee to explain their charging policies and how it assists in achieving better clinical outcomes for Barnet residents."

9.2 The Committees instructions are requested in relation to the request outlined at 9.1 above. Members are requested to take into account the Health Overview and Scrutiny Framework Effective Scrutiny for Better Outcomes attached in the Appendix when determining the most appropriate route for this request.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Cleared by Finance (Officer's initials)	**JH/AD**
Cleared by Legal (Officer's initials)	**LC**