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**

TO: MEMBERS OF HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)

Chairman: Councillor Alison Cornelius
Vice Chairman: Councillor Graham Old

Councillors

Maureen Braun	Arjun Mittra	Kate Salinger
Geof Cooke	Bridget Perry	Brian Schama
Julie Johnson	Barry Rawlings	

Substitute Members

John Hart	Kath McGuirk
Sury Khatri	Charlie O'Macauley

You are requested to attend the above meeting for which an agenda is attached.

Andrew Nathan – Head of Governance

Governance Services contact: Andrew Charlwood 020 8359 2014
andrew.charlwood@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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1.	Minutes	
2.	Absence of Members	
3.	Declaration of Members' Interests a) Disclosable Pecuniary Interests and Non Pecuniary Interests b) Whipping Arrangements (in accordance with Overview and Scrutiny Procedure Rule 17)	
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BARNET
LONDON BOROUGH

AGENDA ITEM 5

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Transport Services – Finchley Memorial Hospital**
Report of	Scrutiny Office
Summary	On 9 May 2013 the Committee considered a Members' Item from Councillor Geof Cooke on Transport Services at Finchley Memorial Hospital. The Committee received a full report on 4 July 2013 and resolved that a further update be reported to the next meeting.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	Woodhouse
Key Decision	N/A
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, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Committee consider the update on Transport Services at Finchley Memorial Hospital and make appropriate comments and/or recommendations.

2. RELEVANT PREVIOUS DECISIONS

2.1 North Central London Sector Joint Health Overview and Scrutiny Committee, 27 February 2012, Decision Item 6, Barnet, Enfield and Haringey Clinical Strategy – during discussion on this item, the Committee made the following comment:

"The need to address public transport when considering major service change was raised. It was the view of the Chair that there had been an inability on the part of TfL to engage effectively with the change programme. It was noted that the process for making transport link changes, even to move a bus stop, could never meet the pace of change required, even when TfL could see the need."

2.2 Health Overview and Scrutiny Committee, 9 May 2013, Decision Item 12, Any Other Items the Chairman Decides are Urgent (Members' Item) – the Committee considered a Members' Item from Councillor Geof Cooke in relation to bus services at Finchley Memorial Hospital. In presenting the item, Councillor Cooke requested an update on discussions between the relevant NHS body and Transport for London (TfL) regarding the need for a bus service calling at Finchley Memorial Hospital in view of the distance from existing stops, including the distance from the entrance in Granville Road to the hospital building. In particular, he requested that consideration be given to providing a service by a small hopper type bus similar to that operating elsewhere in the borough.

Councillor Cooke also requested an update on any previous consideration by the Health Overview and Scrutiny Committee on bus services in the context of reorganisation of health services between Barnet Hospital and Chase Farm Hospital, in particular the complete lack of any direct TfL service from any part of Barnet to Chase Farm.

The Committee resolved to receive a full report at the next meeting of the Committee on 4 July 2013 to include an update on any discussions between the GLA Member for Barnet and Camden (Andrew Dismore AM) and Transport for London on this issue.

2.3 Health Overview and Scrutiny Committee, 4 July 2013, Decision Item 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 on-going 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.

At the conclusion of the item the Committee resolved the following:

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 on-going discussions and possible options for transport services at Finchley Memorial Hospital.

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.

5.2 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.

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

6.1 None in the context of the 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 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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, the Committee have considered the issue of transport services at Finchley Memorial Hospital on a number of occasions.

9.2 In accordance with the resolutions outlined in section 2.3 above, a submission has been prepared to the Greater London Assembly Transport Committee. The Chairman has however requested that the submission be delayed until a meeting has taken place between the Council and TfL representatives on this issue. This meeting is scheduled to take place on 24 September 2013 and will be attended by the Chairman and Vice-Chairman of the Health Overview and Scrutiny Committee, the Cabinet Member for Public Health and council officers. The outcome of the meeting will be reported in writing in advance of the committee on 3 October 2013.

9.2 Representatives from TfL have been invited to attend the committee meeting to answer questions from Members on this issue.

10. LIST OF BACKGROUND PAPERS

10.1 None

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

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Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Barnet, Enfield and Haringey Clinical Strategy**
Report of	Overview and Scrutiny Office
Summary	The Committee will receive an update from the Barnet, Enfield and Haringey (BEH) Clinical Strategy Programme Director on the implementation of the BEH Clinical Strategy

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. RECOMMENDATIONS

1.1 That the Committee note the presentation by provided by the Barnet, Enfield and Haringey Clinical Strategy Programme Office and make appropriate comments and/or recommendations.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 11 December 2012, Decision Item 16, Barnet and Chase Farm NHS Trust – Maternity and Accident and Emergency Services Update

2.2 North Central London Sector Joint Health Overview and Scrutiny Committee, 17 January 2013, Decision Item 5, Barnet, Enfield and Haringey Clinical Strategy

2.3 Health Overview and Scrutiny Committee, 12 February 2013, Decision Item 6, Barnet, Enfield and Haringey Clinical Strategy – Ambulance Services

2.4 Health Overview and Scrutiny Committee, 4 July 2013, Decision Item 6, Barnet, Enfield and Haringey Clinical Strategy

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.

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

6.1 None in the context of this report. The update to be provided relates to the BEH Clinical Strategy being implemented by Enfield Clinical Commissioning Group. Following the dissolution of NHS North Central London, Enfield CCG has been given responsibility for overseeing implementation of the BEH Clinical Strategy on behalf of the boroughs of Barnet, Enfield and Haringey.

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 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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 At the Health Overview and Scrutiny Committee meeting on 4 July 2013, the Committee received an update on the Barnet, Enfield and Haringey Clinical Strategy with a specific focus on accident and emergency services. At the meeting, the Committee resolved to receive a further update at the 3 October 2013 meeting.

9.2 Representatives from Barnet, Enfield and Haringey Clinical Strategy Programme Office will be in attendance to make a presentation to the Committee.

10. LIST OF BACKGROUND PAPERS

10.1 None.

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

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Health and Social Care Integration**
Report of	Dawn Wakeling, Adults and Communities Director Dr Sue Sumners, Chair NHS Barnet Clinical Commissioning Group
Summary	This reports progress of Health and Social Care Integration projects, with specific reference to addressing delayed hospital discharges

Officer Contributors	Karen Spooner, Head of Joint Commissioning, Barnet Clinical Commissioning Group Rodney D'Costa, Head of Joint Commissioning Adults and Communities, LBB Mark Hourston, Programme Manager Health and Social Care Integration
Status (public or exempt)	Public
Wards Affected	All
Key Decision	No
Reason for urgency / exemption from call-in	Not applicable
Function of	Health Overview Scrutiny Committee
Enclosures	Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund Appendix 2: Barnet Health and Social Care Concordat
Contact for Further Information:	Dawn Wakeling, Adults & Communities Director Telephone 0208 359 4290 Email dawn.wakeling@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Health Overview and Scrutiny Committee considers the information set out in the report in relation to the following key areas and make appropriate comments and/or recommendations to the responsible Cabinet Member(s) and/or the Barnet Clinical Commissioning Group (CCG):

- **The Health and Social Care Integration programme and the progress of the projects.**
- **The work to develop a high level Health and Social Care integration target operating model to support Barnet's submission for the Integration Transformation fund.**
- **The work to date on national delayed transfer of care.**

2. RELEVANT PREVIOUS DECISIONS

2.1 Cabinet 4 April 2012, Health and Social Care Task and Finish Group – the Cabinet endorsed the recommendations which proposed a vision for integration; a shared governance structure and integration initiatives, and endorsed the initial commitment of £1.1m by Barnet Council to fund the delivery of a local health and social care integration work programme. A Strategic Outline Business Case for Integration was also endorsed by the Cabinet and by the Health and Wellbeing Board in May 2012.

2.2 Health and Well-Being Board, 31 May 2012, Health and Social Care Integration Strategic Outline Business Case and Investment Priorities report – the Strategic Outline Business Case for Integration was also endorsed by the Health and Wellbeing Board.

2.3 Health and Well-Being Board, 27 June 2013, Barnet CCG Integrated Care Plan for 2013/14 – the Board agreed the Barnet CCG proposals to further develop integrated care, and these were also endorsed by the Health and Social Care Integration Board on the 19th July 2013.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 Link to Sustainable Community Strategy

3.1.1 Health and Social Care Integration projects support the Council's Sustainable Community Strategy 2010-2020 which is committed to achieving its objectives through working "together to draw out efficiencies, provide seamless customer services; and develop a shared insight into needs and priorities, driving the commissioning of services and making difficult choices about where to prioritise them." The integration of Health and Social Care services embodies this approach to partnership working.

3.1.2 The Health and Social Care Integration Board, which brings together a range of local health and social care partners, has as part of its development work already developed and approved an integrated care concordat that sets out a shared vision for integrated care in Barnet.

3.1.3 Successful integration of health and Social care services should promote the Sustainable Community Strategy priority of "healthy and independent living".

3.2 Link to Health and Wellbeing Strategy

3.2.1 The Health and Wellbeing Strategy sets out the aspirations of the Health and Wellbeing Board and its member organisations. The Health and Wellbeing Board is responsible for promoting greater co-ordination of planning across Health, Public Health and Social care. This is recognised in the Health and Wellbeing Strategy. The Health and Social Care Integration Task and Finish Group recommendations which underpin the Health and Social Care Integration Programme, supports the Health and Wellbeing strategic intentions.

4. RISK MANAGEMENT ISSUES

4.1 The evidence base for health and social care integration continues to grow. However, there is a need to pull together the various strands of local evidence and data into one place to ensure that there is a comprehensive evidence base from which to make decisions about the use of an integrated care budget. To ensure sound decision making, this risk will be mitigated by the development of a target operating model for integration which will consider both the costs and the expected shifts across both health and social care activity ahead of operationalising any further projects in Barnet. This model will consider evidence of best practice and results from other integration projects, in order to inform its development.

4.2 Barnet CCG is recognised as one of the most financially challenged in the country. The CCG is likely to continue with a small number of conditions and directions in relation to financial plans. The CCG has a five year recovery plan which maintains spending levels in community and mental health services and reduces secondary care costs. The cost reduction is based on detailed analysis of activity and returning specific areas of over activity to expected norms. It is evidence based and has been accepted by NHS England. In addition it is recognised that Barnet and Chase Farm hospitals are not independently financially viable. Barnet and Enfield CCGs are considering a possible acquisition by the Royal Free Hospitals NHS Foundation Trust which will require commissioner transitional support for up to five years. There is a risk therefore that savings from Health and Social Care Integration will accrue more to the NHS than Social Care and that costs will be transferred from Health to Social Care.

4.3 Funding cuts to Local Government continue to present significant challenges. Planned 10% reductions to budgets in 2015-16 follow the 28% reductions in the period 2011-15. The planned cuts form the biggest part of the Public Sector funding reductions and, together with increasing demands due to an ageing population, present a number of challenges with regard to preserving Social Care in the Borough. The evidence base suggests that there is a risk therefore that local integration could carry demand or financial risks for the council. This will be mitigated by robust benefits modelling and measurement and the development of shared risk systems for the target operating model.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 The approach taken by the Programme is predicated on the principle that any integration of health and social care services and pathways should only be considered if there is clear evidence that this will substantially benefit Barnet's citizens by improving the experience and outcomes of people who use care. However, it is likely that the areas identified as opportunities for integration may focus on particular groups and communities, for example the care of frail elderly people and their carers and people with complex health and social care needs, as this is where most benefit can be realised for service users.

5.2 Recommendations from the Health and Social Care Integration Programme continue to be informed by an analysis of local and national evidence. Any subsequent work on integration will be informed by a clear understanding of local need identified in the Joint Strategic Needs Assessment (JSNA), and what has been proven to work elsewhere. Future recommendations should support the Council, CCG and partner organisations to identify effective ways of working together to deliver integration and address the needs of all people who use care.

5.3 The integration of health and social care services could have a differential impact on different groups of citizens and communities within Barnet. This could include people with protected characteristics as defined by the Equality Act 2010, such as older people and carers of older people or disabled people. An Equalities Impact Assessment will be undertaken for all health and social care projects to ensure that the approach and solutions are inclusive and the local authority discharges its duties under the Equality Act 2010.

5.4 The integration of health and social care services could also impact staff involved in the commissioning and delivery of local care services. The impact on staff will be included within the scope of all project Equalities Impact Assessments.

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

6.1 The Health and Social Care Integration update to the Health and Well-Being Board, 19th September 2013, outlined the work being undertaken to estimate the health and adult social care savings that integration across these services will bring, which will be completed in October 2013. These savings, once calculated, will be factored into the Quality, Innovation, Productivity and Prevention (QIPP) and CCG Recovery Plan in the NHS, and the Council savings requirements in the Medium-Term Financial Strategy and Priorities and Spending Review. Current spend to date on the Programme (since January 2012) is £282k which is a combination of programme support and project delivery.

7. LEGAL ISSUES

7.1 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now agreed two overarching section 75 agreements for the Health and Social Care Integration Programme, relating to Adults and Children's' services. These are in addition to the existing five section 75 agreements already in place.

7.2 Section 6c of the 2006 National Health Act now allows for local authorities to provide services which improve the health of the population.

7.3 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population.

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

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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.

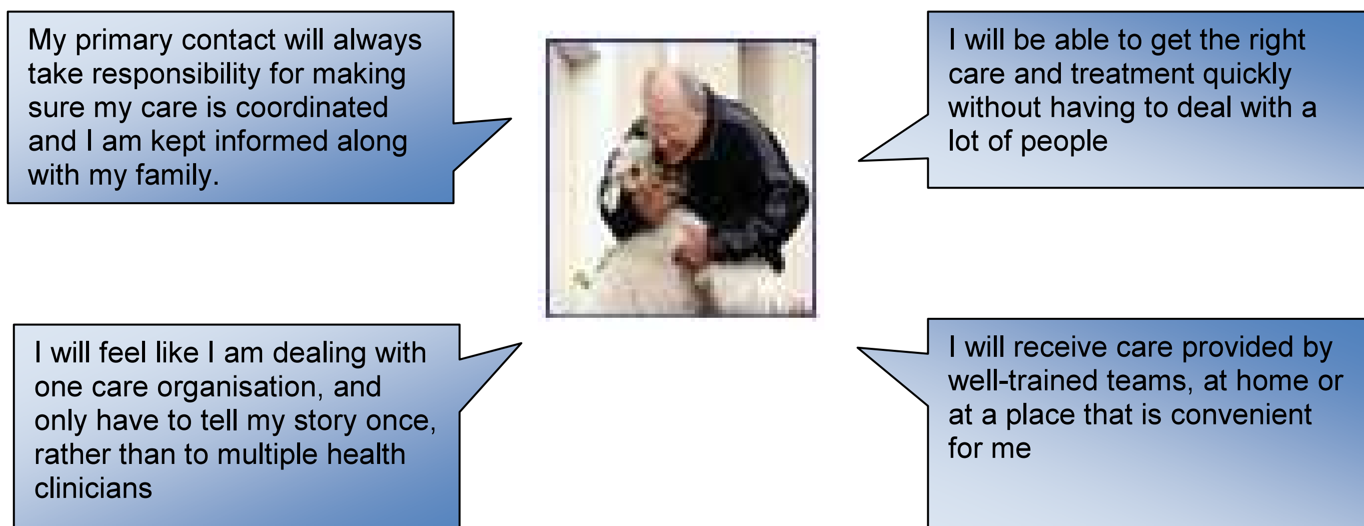
9. BACKGROUND INFORMATION

9.1 Local Health and Social Care Integration

9.1.1 The Council, CCG and Partner organisations have developed a shared vision and priorities for health and social care integration in Barnet and a firm commitment to achieve these through the Health and Social Care Integration Board.

"Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations."

The vision is articulated through the experience of the fictitious character of Mr Colin Dale and is outlined more fully in the Concordat, signed by all Health and Social Care Integration partners in Barnet, and shown in Appendix 2.
The statements below define how he experiences integrated health and social care.



9.1.2 Two projects have now been mobilised and the expected outcomes are:

- Improved quality of care and better quality of life for residents
- Reductions in safeguarding related incidents
- Reduction in unplanned and emergency admissions to hospital and A&E

9.1.3 The Older People Integrated Care Project (OPIC) seeks to achieve savings to health of over £1.26 million over 3 years by providing proactive care based on risk stratification to identify residents on the cusp of care.

OPIC consists of a Multi-Disciplinary Team service and Care navigation service which went "Live" on 1st July 2013. Two Care Navigators and two Case Managers have been recruited who are working with GPs and Social

Care to develop and implement personalised integrated health and social care support plans to meet the needs and outcomes of older people identified as at risk. Weekly Multi-disciplinary Team (MDT) meetings are taking place for multidisciplinary assessment and health and social care planning for people with very complex high risk needs who require specialist input. This will be enhanced by the use of risk identification software. A pilot has begun in the West of the Borough, with rollout across the Borough expected by the end of 2013.

9.1.4 The Care Home Improvement project aims to improve care in residential homes to reduce hospital admissions and safeguarding alerts from care homes. Activities include sharing good practice, buddying with homes with low rates of admissions, interventions to reduce pressure sores, improve foot care and reduce admissions due to dementia.

9.1.5 Training for care Home staff in pressure care and dementia has now been delivered. Feedback received from Care Home Managers has been very positive, staff have said that the training sessions have been exceptional, for example one said “the course has given me a better understanding of dementia and how I can better communicate with the residents”. One home has implemented pressure care strategies and has purchased specialist heel protectors as a result of the session.

9.1.6 The Health and Social Care Integration Programme is now developing an overarching target operating model for integrated health and social care for older people that supports the realisation of the vision for integrated care in Barnet and identifies the next steps for the local integration programme.

9.2 Update on national policies: Spending round health settlement 2015-16

9.2.1 The June 2013 Spending Round announced that the NHS, Department for Communities and Local Government and the Department of Health will pool £3.8bn of funds for investment in the integration of health and social care (the “Integration Transformation Fund”). However, there is very little new money being allocated to support integration. Appendix 1 contains the detail of this funding. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place

9.2.2 The funding is described as: “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”. This Integration Transformation Fund does not come into full effect until 2015/16; however a further £200m (in addition to the planned £900m transfer) is due in 2014/15 to be transferred to local government from the NHS to support transformation. To access the Integration Transformation Fund, a local plan must be developed by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum. Appendix 1 outlines the Integration Transformation Fund in more detail.

9.2.3 CCGs and Councils will need to jointly develop a two-year locality plan that details how the pooled budget will be spent. This plan will need to be assured and signed-off by the Health and Well-Being Board in early 2014 and by central government by March 2014. Plans must demonstrate how they meet the national conditions, set out below. At which point part of the funding for integration will be released. The second part will only be released once central government is satisfied with local performance achieved from use of the money.

Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- Protection for social care services (not spending);
- As part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- Better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- Ensure a joint approach to assessments and care planning;
- Ensuring that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- Agreement on the consequential impact of changes in the acute sector.

9.2.4 The broad timetable for the plans as set out in the London Councils briefing paper is:

- Initial local planning discussions and further work nationally to define conditions. August – October 2013
- NHS planning framework issued further development of local plans. November – December 2013
- Completion of local plans and local sign- off. December – January 2014
- Plans assured and signed off by Government. March 2014

9.3 Financial challenges

9.3.1 This national direction has been given at a time when there are significant financial challenges facing the local authority and CCG in Barnet, which will last until at least 2020. Both organisations have already recognised the role that the integration of health and social care will play, not only in improving health outcomes for people who live in Barnet, but also in driving financial efficiencies and securing economic sustainability, as documented in their core financial savings plans:

- The Council's Medium-Term Financial Strategy makes reference to the savings that can be realised through health and social care integration: the

Council needs to reach its c£75m savings target by 2015, before undertaking a further c£70m saving programme (known as the Priorities and Spending Review) between 2016 and 2020.
- The CCG financial recovery plan contains plans for integration in frail elderly; urgent care; and continuing care pathways: Barnet CCG needs to make up to £50m savings over the next 5 years to reach financial balance.

9.3.2 There is a risk that the financial savings plans set out above will not be achieved unless there is a focus on integrated commissioning and delivery, which will, among other areas, involve actively exploring estate rationalisation; the opportunities for sharing back-office functions; and the development of a shared care record.

9.4 The Health and Social Care Integration Programme

9.4.1 Barnet has already spent a substantial period of time developing its integration agenda between health and social care locally, which means there is information data and on-going work already available to support the development of the target operating model. For example, the Health and Social Care Integration Board, which brings together a range of local health and social care partners has, as part of its development work, already developed and approved an integrated care concordat that sets out a shared vision for integrated care in Barnet. A Joint Commissioning Unit has been established and is being operationalised so that it can deliver on the plans approved by the Integration Board. Existing Learning Disabilities and Mental Health Services are currently integrated in Barnet and the two spearhead projects for the Health and Social Care Integration programme have commenced.

9.4.2 The target operating model referred to in 9.1.4 will build on the existing projects that are already taking place as part of the Health and Social Care Integration programme. By being aware of national requirements in the plans to address A&E activity and 7 day working, the model is anticipated to have a positive impact on delayed transfer of care, and also promote a shift of healthcare activity from crisis to preventative responses.

9.4.3 Overarching Section 75 agreements for both Adults' and Children's health and social care services have also been developed between the Council and the CCG. This will provide a mechanism for the Council and the CCG to robustly manage and finance new integrated services. Specific arrangements for each integrated service will be covered in schedules that will be appended to the overarching agreement.

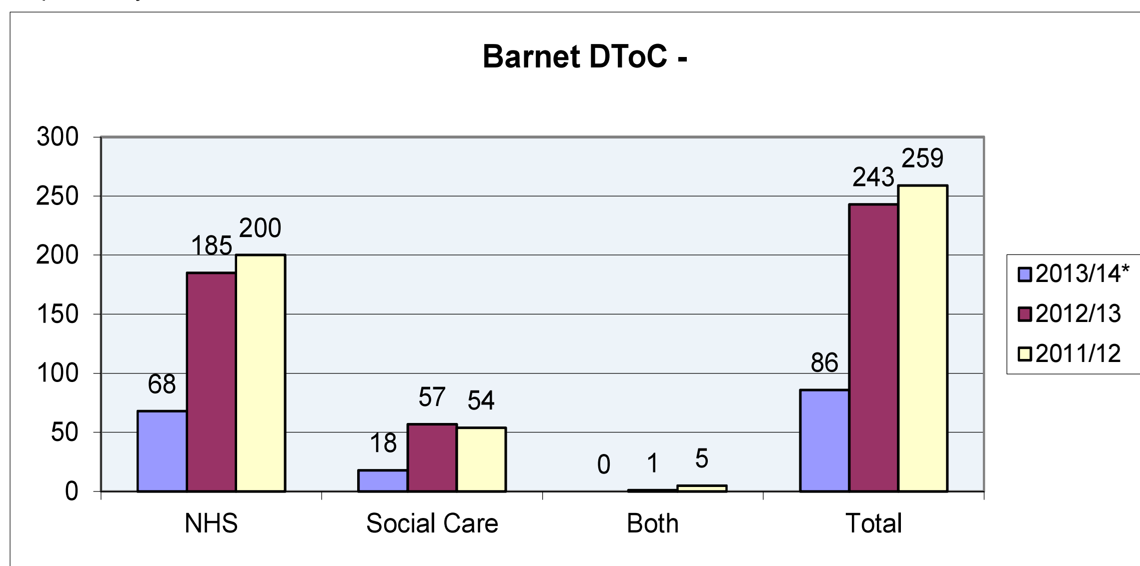
9.5 Delayed Transfers of care

9.5.1 A particular focus for the Integration Programme has been on delayed transfers of care. The following table illustrates the Barnet performance over the past three years and there are a number of initiatives underway to improve performance in this critical area.

Delayed Transfer of Care, NHS Organisations, Barnet

Year	NHS	Social Care	Both	Total
2013/14*	68	18	0	86
2012/13	185	57	1	243
2011/12	200	54	5	259

*April - July 13 data



This data represents performance across Barnet Hospital, Royal Free Hospital, Edgware Community Hospital and Finchley Memorial Hospital.

9.5.2 A workshop, focussing on Delayed Transfers of Care, was facilitated by Barnet and Chase Farm Hospital on the 20th June with attendance from senior officers in Health and Social Care from both Barnet and Enfield. Recommendations from the workshop will be progressed through the Urgent Care Network Board and the Health and Social Care Integration Board.

Part of this work includes inter-organisational approaches being developed to identify and address specific challenges and opportunities via integrated solutions. As mentioned previously, the target operating model will also incorporate the contribution to system-wide local priorities such as delayed transfer of care and winter pressures.

9.5.3 A Delayed Transfer of Care working group has been established, led by John Morton, Chief Officer Barnet CCG. This is attended by the Assistant Director of Social Care and meets on a monthly basis to action improvements to the service.

9.5.4 The Royal Free Hospital has for some time operated key services which facilitates rapid discharge and is called Post-Acute Care Enablement (PACE). PACE has now been reintroduced into Barnet from September. The PACE service will be provided by the same team which operates at the Royal Free Hospital. Patients selected for PACE will be discharged earlier and supported by the service for 3-5 days. The PACE team will work closely with the allocated social worker to provide support and monitor the person's functioning and care needs.

9.5.5 A vital part of preventing delayed transfers of care is also to prevent hospital admissions in the first place. A number of initiatives to prevent admissions into hospital are underway. The Royal Free Hospital has been operating a Triage and Rapid Elderly Assessment Team (TREAT) since 2011. The role of TREAT is to thoroughly assess elderly patients who have come to A&E, identifying those who are well enough to be discharged from A&E, and ensuring that support is put in place so that they can receive all of the care they require at home.

9.5.6 The recently established Integrated Quality in Care Homes Team is working towards improving the quality of care provided by the Borough's Care Homes and through this aim to prevent admissions into hospitals. A number of workshops have been arranged with Care Home staff to train them in areas such as pressure care management and other areas that lead to admissions into hospital.

9.5.7 The two spearhead Integration projects are also focussing on the prevention of admissions into hospital. The Older Persons Integration Project is introducing Care Navigators, risk profiling to identify those patients in need of complex care, and a Multidisciplinary team, which meets weekly to discuss the most complex cases and provide a holistic approach to patient care. This approach will help to ensure the most appropriate care is given to our residents in need, in a timely manner and therefore help prevent admissions into hospital. The Care Home pilot is similarly focussed on this aim. Working closely with the Integrated Quality in Care Homes Team, this is looking to improve the standards of care provision through training in areas such as pressure care and dementia.

10. LIST OF BACKGROUND PAPERS

10.1 None attached to this report

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

Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund

£3.8BN INTEGRATION TRANSFORMATION FUND 2015/16

LONDON COUNCILS BRIEFING NOTE

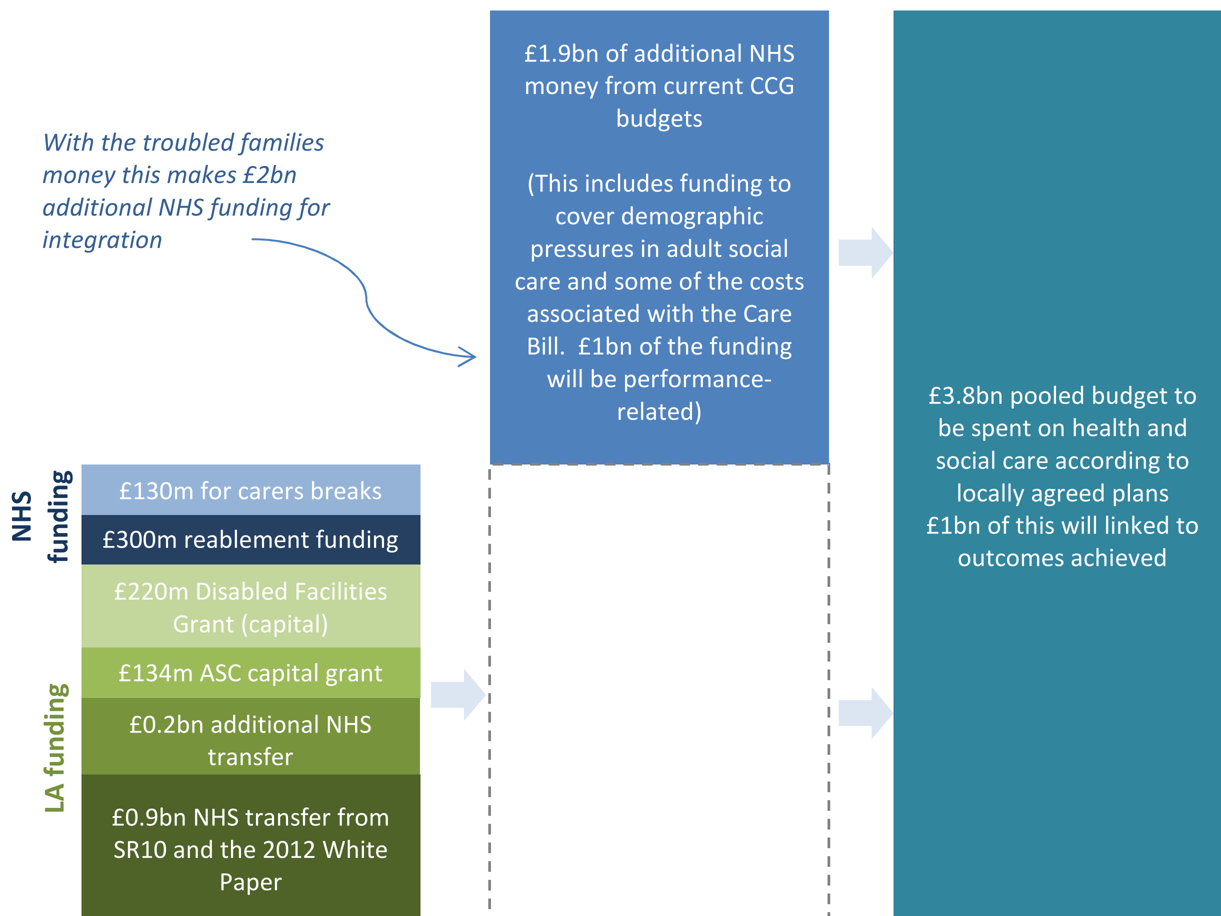
The Spending Round 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16. This is now being referred to as the "Integration Transformation Fund".

What is the Integration Transformation Fund for?

The government's stated goal is to get local health and care partners to work more closely, through creating a pooled budget in every area. This follows the publication of the National Vision on health and care integration, which defined integration from the perspective of the individual. The fund is intended to support an increase in the scale and pace of integration. It is clearly also a mechanism for promoting joint planning for the sustainability of local health & care economies.

Where does the money come from?

In reality, little of this is new money. The fund is made up as follows:



The additional £1.9 billion NHS funding will be drawn from current CCG budgets. Given existing demographic pressures & efficiency requirements, CCGs are likely to have to make cuts in existing services to release this money. Although the basis on which this will be taken from individual CCGs is not yet clear, as an initial rough planning guide CCGs have been advised to start considering how to free up around £10 million each.

In addition to this £3.8bn, DCLG have included in the overall grant settlement for local authorities £188m for pressures from the closure of the Independent Living Fund and £285m for the introduction of deferred payments from April 2015 and the transition to the capped cost funding policies flowing from the Dilnot report that will take effect from April 2016 once the Care Bill has been passed into law. The NHS has also contributed £70m to the Troubled Families programme.

The Spending Round also announced a further £200m transfer from the NHS to social care in 2014/15, in addition to the £900m already committed.

How the funding will come to local areas?

The 2015/16 funding will be a pooled budget between local authorities and CCGs. CCGs will use funds from their normal allocation to create it.

This means that there will be no automatic transfers of any funding to boroughs, as has been the case with the NHS c.£900m annual transfers in recent years (s256 transfers). However, it will be possible for money to be transferred to councils by local agreement, as part of local plans.

The basis for determining local shares of the £3.8bn has not yet been decided. However, it has been suggested that the same broad splits as used for the s256 allocations is a reasonable planning proxy for most of the funding.

DCLG are specifically considering how to handle the Disable Facilities Grant capital element of the fund allocations, in the light of local authorities' statutory responsibilities.

Local partners will be able to put additional funding into the pooled budget from their existing allocations if they want to do so.

Two year plans

Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. The plans will need to be agreed by March 2014.

As well as covering the way in which the Integration Transformation Fund will be used locally in 2015/16, the plans will also need to set out how the £200m additional transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

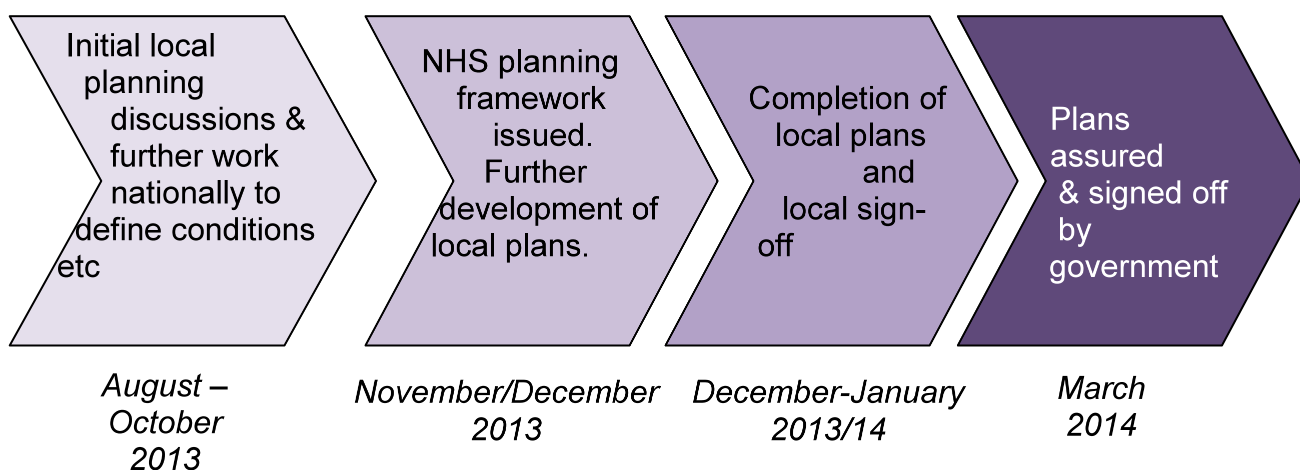
The plans will need to be jointly agreed between key partners – as well as local authorities and CCGs, this will include local clinicians. Health & Well-Being Boards will have to sign off the plans.

As well as being locally agreed, Ministers have decided that they will oversee and sign off the plans (DH, DCLG and HM Treasury Ministers all have an interest in this). The LGA and NHS England are developing proposals about how this can be done in an efficient and proportionate way. NHS England's role in either local or national agreement has not yet been clarified.

Joint LGA/NHS England guidance has been published clarifying that the plans should be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term – currently expected to be 3-5 years – strategic plans as part of the NHS Call to Action);
- the announcement of integration pioneer sites in October, and forthcoming integration roadshows.

The broad timetable for the plans is:



Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- ensure a joint approach to assessments and care planning;
- ensuring that, where funding is used for integrated packages of care, there will be an accountable professional (ref. Jeremy Hunt's recent request for views on improving care for the vulnerable elderly, that will culminate in some announcements expected in October)
- risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

How will the £1bn performance-related element work?

As part of their plans, local areas will need to set outcome goals and monitor delivery against these during 2014/15 and 2015/16. £1bn of the total fund will be based on achievement of these goals. This funding is likely to be unlocked in two tranches – half in April 2015 on the

basis of performance in 2014/15, and the second half in autumn 2015 on the basis of performance in the first part of the financial year.

The outcome measures will be a mix of national requirements and local choice. The national requirements are yet to be determined, but early discussions include e.g. delayed discharges.

Issues that still need to be resolved

There are a range of issues that still need to be clarified on which the government, LGA , NHS England and other national partners are working – and which London Councils will continue to seek to influence. These include:

- allocation of funds;
- national conditions, including definition, metrics and application (including whether the performance-related element of the funding will be based on 'all-or-nothing' achievement of outcomes);
- risk-sharing arrangements;
- assurance arrangements for national sign-off of the plans and subsequent monitoring;
- analytical support, e.g. shared financial planning tools and benchmarking data packs.

Action that boroughs and their partners can start to take now

Given the timescale for the preparation and agreement of plans on which this will all hang, and the aspirations for the strategic ambition of these plans, the earlier local thinking and discussions start the better.

Some of the issues that boroughs should start considering with their partners are:

- the basis that existing local plans and priorities – joint and individual – provide as a starting point for their Integration Transformation Fund plan, and early identification of further analytical needs and joint strategy development so these can be got underway as soon as possible;

- the implications of the way the fund has been drawn together on current planning and budgeting intentions e.g. in CCGs the need to free up the additional money to put into the fund and for local authorities the need to recognise that the s256 monies will no longer form an automatic transfer;

- the process for developing the plan and securing local sign-off, including through the Health & Well-Being Board;

- how to handle engagement with clinicians and acute trusts – particularly given that in most parts of London individual trusts will need to engage in several local area plans;

- what community and patient engagement to include as part of the development of the plan.

* * * * *

London Councils policy contacts:

Sarah Sturrock, Interim Strategic Lead Health & Adult Services
sarah.sturrock@londoncouncils.gov.uk
020 7934 9653

Anastasia Lungu-Mulenga, Policy & Projects Manager
anastasia.mulenga@londoncouncils.gov.uk
020 7934 9809

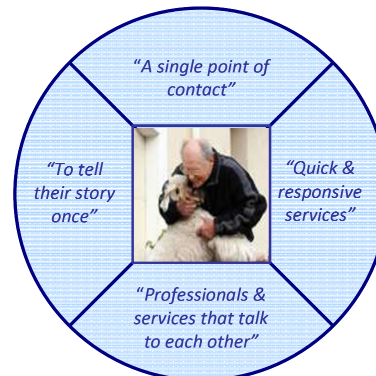
Appendix 2: Barnet Health and Social Care Concordat

Barnet Health and Social Care Integration: our vision
A concordat to guide the integration programme

Mr. Dale is an 82 year old gentleman living in Oakleigh. He has multiple needs and medical conditions and is receiving a range of services and support from health, social care and the voluntary sector. He has been admitted to hospital twice in the last year and on both occasions his family have felt that the system has not worked very well together and that the responsibility for his overall care and support is not properly co-ordinated and they find it difficult to know who is responsible for what. Mr. Dale's wife died 10 years ago and he lives alone with his dog, Sally. His daughter, Louise and her family live in East Finchley.

What do Mr. Dale and his family want for him when he needs help?

- A single point of contact
- Quick and responsive services
- To tell their story once
- Professionals and services that talk to each other.



We will work together tirelessly to deliver the Barnet vision of integrated care so that Mr. Dale and others like him enjoy better and easier access to services. This is our vision for integrated care:

Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.

What does this mean for Mr. Dale?

Mr. Dale deserves the best care, at the right time and the right place. When Mr. Dale needs treatment, support or care, he will cross organisational boundaries effortlessly, supported by professionals who take responsibility for his whole care and treatment journey, regardless of who they work for. Services offered to Mr. Dale will be personalised to his individual needs and will promote his independence. Mr. Dale and his family can expect to be at the heart of what we offer.

We want to deliver excellence for everyone through integrated care. These are our integrated care commitments:

- People in Barnet will feel like they are dealing with one care organisation
- They will have access to accurate information which will enable them to make informed choices and take responsibility for their health and wellbeing
- They will be able to get the right care and treatment quickly without having to deal with lots of people

- Personal information will only have to be provided once and will be shared securely with other organisations involved in the person's care
- Care will be provided safely by well-trained teams, at home or at a place that is convenient for them
- Someone will always take responsibility for making sure care is coordinated and the person being cared for, their family and carers, are kept informed
- People will be supported to be as independent of public services as possible through a local care system that encompasses prevention, self-care and supportive communities

How will we ensure we deliver on these commitments?

We, the leading organisations of the health and social care system in Barnet are committed to working together through the Barnet Integration Programme to make a difference to Mr. Dale, his family and others like them. Through the Programme, we aim to deliver the vision for integration in Barnet and through this, create substantially improved outcomes for patients, service users and their families and carers.

We commit to remove the barriers and to develop momentum and pace for health and social care integration in Barnet for the benefit of patients, service users and their families and carers.

All the undersigned organisations have committed to participate in the leadership and delivery of integration in Barnet and to strive for the best solution, so that Barnet offers Mr. Dale and his family world class care and support.

Agreement

The following Organisations have agreed to work together within the terms of this Concordat and adhere to its principles:

Organisation	Signatory Name And Position	Signature
Barnet and Chase Farm Hospitals NHS Trust		
NHS Barnet Clinical Commissioning Group		
Barnet Council		
Central London Community Health NHS Trust		
Community Barnet including Barnet Link		
Enara		
Housing 21		
Personnel and Care Bank		
Barnet Enfield and Haringey Mental Health Trust		
Royal Free London NHS Foundation Trust		
London Care		

Singed: October 2012
Review date: October 2013.

AGENDA ITEM 8

Meeting	Health Overview & Scrutiny Committee
Date	3 October 2013
Subject	**Maternity Services – Caesarean Births**
Report of	Overview and Scrutiny Office
Summary	For the Committee to consider the information provided by Barnet Clinical Commissioning Group, the Barnet / Harrow Public Health Team, the Royal Free London NHS Foundation Trust and Barnet & Chase Farm Hospital NHS Trust in relation to Maternity Services (Caesarean Births)

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	Committee
Enclosures	Appendix A – Public Health Intelligence Report
	Appendix B – Barnet CCG Submission
	Appendix C – Maternity Data from the Royal Free London NHS Foundation Trust and Barnet & Chase Farm Hospital NHS Trust
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Committee consider the information set out in the appendices and make comments and/or recommendations to health partners.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny committee, 12 February 2013, Decision Item 11, Members' Item – Maternity Services (Caesarean Births) – Councillor Kate Salinger presented a Members Item which requested the following information:

1. In 2012 how many Caesarean operations were performed in:
a) Barnet Hospital:-
b) Chase Farm Hospital
c) Royal Free Hospital

2. In 2012 how many of these Caesarean operations were elected by the patient in:-
a) Barnet Hospital
b) Chase Farm Hospital
c) Royal Free Hospital

3. In 2012 how many of these Caesarean operations were recommended by medical staff PRIOR to the patients admittance to give birth at:-
a) Barnet Hospital
b) Chase Farm Hospital
c) Royal free Hospital

4. How many inductions were performed at:-
a) Barnet Hospital
b) Chase Farm Hospital
c) Royal Free Hospital

5. How many of these inductions led to a caesarean operation at:-
a) Barnet Hospital
b) Chase Farm Hospital
c) Royal Free Hospital

Following consideration of the item, the Committee resolved that the Director of Public Health be requested to investigate the issues outlined above and prepare a report for the next meeting of the Committee on 9 May 2013 detailing: comparative London statistics; any abnormal trends; and reasons for inductions (local and national). At the request of the Chairman, this item was deferred for consideration until the 4 July 2013 meeting

2.2 Health Overview and Scrutiny committee, 4 July 2013, Decision Item 11, Members' Item – Maternity Services (Caesarean Births) – the Committee withdrew the item for consideration at the meeting on 3 October 2013.

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.

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 NHS Act 2006 as amended by S190 and S191 of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 make

provision for local authorities to review and scrutinise matters relating to the planning, provision and operation of the health service in their area.

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

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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 section 2.1, the Committee requested that the Director of Public Health be requested to investigate the issues outlined above and prepare a report for the next meeting of the Committee on 9 May 2013 detailing: comparative London statistics; any abnormal trends; and reasons for inductions (local and national). The submission from the Director of Public Health is attached at **Appendix A**. The Children's Commissioning Manager for Barnet Clinical Commissioning has also made a submission to the Committee which is attached at **Appendix B**. Data received from the Royal Free London NHS Foundation Trust and Barnet & Chase Farm Hospital NHS Trust is attached at **Appendix C**.

9.2 A report was included with the agenda of the 4 July 2013 meeting but the item was deferred to the 3 October 2013 meeting.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Cleared by Finance (Officer's initials)	**JH**
Cleared by Legal (Officer's initials)	**HP**

Appendix A – Public Health Intelligence Request

Request Number (please quote for further queries)	PHIR-2013-0006
Request from	Andrew Charlwood Overview & Scrutiny Manager Assurance Directorate Barnet Council
Request Date	8th April 2013
Details of request	Maternity Services (Caesarean Births) To consider a report from the Director of Public Health on caesarean births to include detail on: comparative London statistics; any abnormal trends; and reasons for inductions (local and national)
Response by	Carole Furlong

Summary

The data on caesarean section shows that rates in Barnet are slightly higher in the two local NHS hospital Trusts that serve Barnet than the national rate. The national guidelines introduced in 2011 mean that actions to interventions aimed at reducing the number of caesarean births are limited as women have the right to make an informed choice about whether to have a caesarean section or not. Available data does not identify the reason for planned caesarean sections.

Data on induction of the start of labour are unreliable and no conclusion can be drawn from them.

Caesarean Section - definition

Caesarean section (CS) is a surgical operation in which in which an obstetrician makes an incision through a woman's abdomen and uterus to deliver her baby. CS may be planned (elective) where there is a known risk e.g if the baby is in a position that makes normal delivery problematic or unplanned (emergency or non-elective) where a complication arises either during the pregnancy or during labour.

National Guidelines

The National Institute for Health and Clinical Excellence (NICE) has developed guidelines (CG132) to help ensure consistent quality care for women who:

- have had a caesarean section (CS) in the past and are now pregnant again or
- have a clinical indication for a CS or
- are considering a CS when there is no other indication.

These guidelines provide evidence-based information for healthcare professionals and women.

The guidelines do not cover the risks and benefits of caesarean section when it is used for specific medical conditions that arise during pregnancy, such as pre-eclampsia, where the mother or baby have a rare or complex condition such as a severe heart condition or any extra care that might be needed if mother or baby develop specific medical conditions in the course of the pregnancy or labour.

The guidelines say that women considering a CS should be information about risk (see Fig 1)

Figure 1 Planned caesarean section compared with planned vaginal birth for women with an uncomplicated pregnancy and no previous caesarean section

Planned caesarean section may reduce the risk of the following in women:

- perineal and abdominal pain during birth and 3 days postpartum
- injury to vagina
- early postpartum haemorrhage
- obstetric shock.

Planned caesarean section may increase the risk of the following in babies:

- neonatal intensive care unit admission.

Planned caesarean section may increase the risk of the following in women:

- longer hospital stay
- hysterectomy caused by postpartum haemorrhage
- cardiac arrest.

The NICE guidelines were updated in 2011 and now include guidance on maternal requests for CS. The guidance states that

- When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her

anxiety in a supportive manner.

- If after this discussion and offer of support (whether the offer was taken up or not), a vaginal birth is still not an acceptable option, offer a planned CS.
- If the obstetrician is unwilling to perform a CS, they should refer the woman to an obstetrician who will carry out the CS.

Implication of the guidance

The NICE guidelines mean that previous attempts by commissioners to limit the number of caesarean sections due to personal preference are no longer possible. A woman has the right to choose to have her baby by CS if she understands the risks and is making an informed choice.

Birth data – availability and limitations of data

This report has been compiled using the publicly available data as the Public Health Intelligence team do not currently have access to the maternity episodes files. These data are available to the Barnet Clinical Commissioning group through the North East and Central London Commissioning Support Unit. The nationally published data is by provider rather than commissioner grouping. The CSU should be able to extract and analyse this data for maternity episodes of women registered with Barnet GPs and possibly for those resident in Barnet.

As the data is by provider Trust, where there are multiple maternity units within the Trust, data is amalgamated. For example, the data for Barnet and Chase Farm Hospitals will include both the Barnet Consultant-led services and the Chase Farm consultant-led services as well as the birthing centres and midwifery led services.

Without access to the case level data, we have made an assumption that the majority of women in Barnet give birth in one of two hospital Trusts: Barnet and Chase farm NHS Trust and The Royal Free Hospital NHS Trust. The following information is based on the available data for these two trusts with comparator data for all Trusts in London and the England average. A summary of all routinely available statistics for the local trusts and for London is included in the appendix.

Rate of Caesarean Section Births

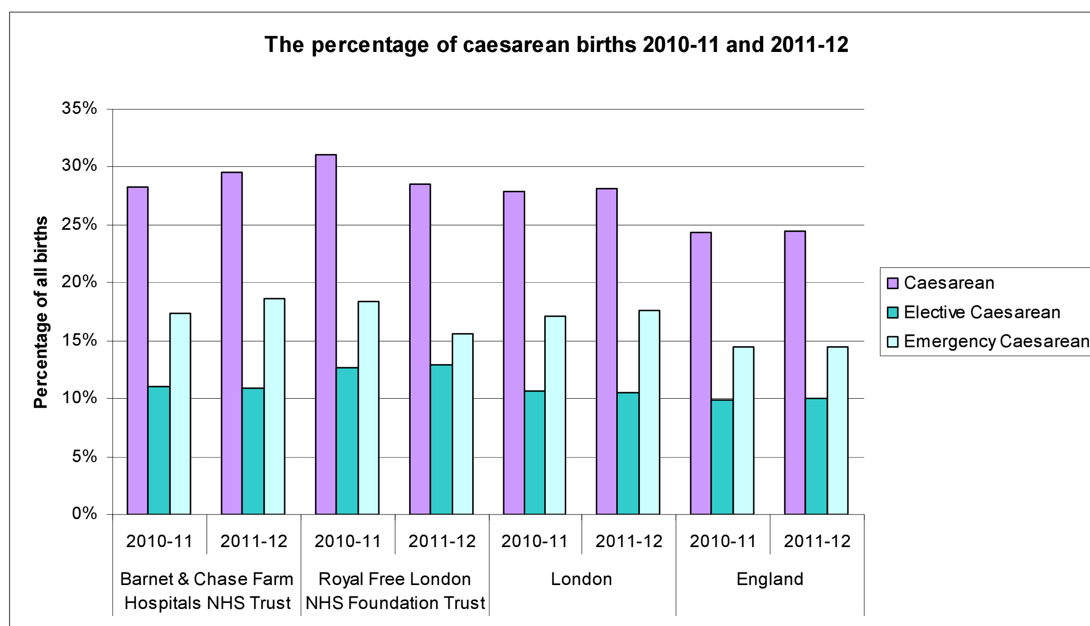
Across England 24.5% of births are by caesarean section, with 10% being elective (planned) and 14.5% emergency. The total CS rates in London are

around 3% higher than those for England as a whole. This is almost all due to a higher rate of emergency CS.

In both of the individual Trusts the rates are higher than those for London as a whole. In the Royal Free, the rates of both elective and emergency CS were higher than London. There was a drop in the rate of emergency CS in the Royal Free between 2010-11 and 2011-12 which was due to reduced number of emergency CS. This coincides with a drop in the total births in the Trust and suggests a change in referral patterns rather than in Trust practice.

In Barnet and Chase Farm, the rates of elective CS was slightly higher than those seen nationally but there was a 4% higher rate of emergency CS which had increased from the 2010-11 rate.

The following table shows that the rate of caesarean births occurring in the two named Trusts, London as a whole and England as a whole.



The data we have available does not give reasons for either the elective or the emergency CS. This analysis would need to be requested from the CCG and/or individual Trusts.

Induction – Definition and guidelines

Induction is a method of artificially starting labour. There are NICE guidelines concerning induction (CG70) It may be offered or recommended to women for a number of reasons but the most common is that the pregnancy is overdue

(usually over 41 or 42 weeks). Other reasons include

- If the membrane have ruptured (waters broken) but spontaneous labour hasn't started within a day or so. This can lead to increased risk of infection;
- If the woman has a medical condition requiring early labour e.g. due to diabetes or an acute condition, such as pre-eclampsia or kidney disease, that threatens either the woman's or the baby's health;
- Occasionally, personal reasons can be considered e.g. if a partner in the armed forces is due to be posted abroad and would otherwise miss the birth; or
- If the woman is concerned about complications or has had a previous baby that was stillborn

Induction often results in a more painful labour with a higher chance the need for intervention e.g. forceps or ventous.

NICE recommends membrane sweeping (detaching the membranes from the cervix) to promote spontaneous labour. If labour does not start, vaginal prostaglandin E2 (PGE2) is recommended. Surgical rupture of the membranes and intravenous syntocin are not recommended as first line treatments unless there are contraindications.

Local and National Data

The available data is again at NHS Trust level. The summary data gives the method of onset of labour but does not give a cause for those that were induced. The table below shows that spontaneous labour was the most common onset. With the local Trusts having higher rates than those of London or England as a whole. However, this data is incomplete. Nationally, 10% of electronic records submitted to the NHS Information Centre do not specify the method of onset of labour. The data for Barnet and Chase Farm hospitals appears to show that one fifth of labours were surgically induced and none medically induced. Similarly, the Royal Free appears to have one sixth of births both surgically and medically induced. A quick look at other Trust in England shows that this is a problem of coding. The data on method of induction must be considered unreliable. Although the rate of total inductions is probably correct no further inference can be made.

Method of onset of labour	**Barnet and Chase Farm**		**Royal Free**		**London**		**England**	
Spontaneous	65%	64%	69%	69%	58%	59%	59%	59%
Caesarean	16%	15%	13%	14%	10%	11%	10%	11%
Surgical Induction	20%	20%	**	<1%	3%	3%	4%	4%

Medical Induction	0%	0%	**	<1%	10%	10%	10%	11%
Surgical and Medical Induction	0%	0%	17%	16%	3%	3%	5%	5%
Total Inductions	20%	20%	17%	17%	16%	16%	19%	19%
Unknown	<1%	<1%	<1%	1%	16%	12%	12%	10%

The CCG could be asked to report on this but given the apparent poor quality of the data, it is unlikely that it would provide any more information. The individual Trusts could be asked about induction and the reasons for it but looking at the information we have, it is unlikely that this would uncover any systematic problems.

Annex

Barnet and Chase Farm Hospitals NHS Trust

In 2011-12

- There were 6,493 recorded deliveries representing a decrease of 300 from the previous year (2010-11), when there were 6,793 deliveries.
- 3,883 (66.2%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 624 (9.6%) women had their first antenatal assessment within an unknown time period.
- 3,664 (62.4%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 4,712 (76.0% where known). Gestation length is unknown for 294 (4.5%) deliveries.
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 4,155 (approximately 64.2% where the method of onset is known). 24 (0.4%) deliveries had an unknown method of onset.
- Where known, there were 1,317 deliveries where the method of onset of labour was induction (approximately 20.4%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 3,727 (approximately 57.9% where known). Caesareans account for 1,921 (approximately 29.9%) deliveries where the delivery method is known.
- Of the 3,727 deliveries where the method of delivery was spontaneous; 305 (8.2%) involved an episiotomy.

Royal Free London NHS Foundation Trust

In 2011-12

- There were 3,070 recorded deliveries representing a decrease of 105 from the previous year (2010-11), when there were 3,175 deliveries.
- 1,511 (55.2%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 331 (10.8%) had their first antenatal assessment within an unknown time period.
- 1,856 (67.8%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 2,146 (70.6% where known). Gestation length is unknown

for 31 (1.0%) deliveries.
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 2,117 (approximately 69.4% where the method of onset is known). 19 (0.6%) deliveries had an unknown method of onset.
- Where known, there were 518 deliveries where the method of onset of labour was induction (approximately 17.0%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 1,778 (approximately 58.2% where known). Caesareans account for 875 (approximately 28.6%) deliveries where the delivery method is known.
- Of the 1,778 deliveries where the method of delivery was spontaneous; 146 (8.2%) involved an episiotomy.

London Strategic Health Authority

In 2011-12

- There were 128,320 recorded deliveries representing a decrease of 4,133 from the previous year (2010-11), when there were 132,453 deliveries.
- 53,663 (54.6%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 30,091 (23.4%) had their first antenatal assessment within an unknown time period.
- 66,416 (67.6%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 73,209 (65.5% where known). Gestation length is unknown for 16,496 (12.9%) deliveries.
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 75,667 (approximately 67.3% where the method of onset is known). 15,895 (12.4%) deliveries had an unknown method of onset.
- Where known, there were 22,313 deliveries where the method of onset of labour was induction (approximately 19.8%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 72,812 (approximately 57.5% where known). Caesareans account for 36,051 (approximately 28.5%) deliveries where the delivery method is known.
- Of the 72,812 deliveries where the method of delivery was spontaneous; 6,826 (9.4%) involved an episiotomy.

Ceaesarean and Induced Labour Rates

Supplementary Report

NHS Barnet Clinical Commissioning Group

Introduction

1. The Director of Public Health has submitted a report to the Health Overview and Scrutiny Committee, outlining the rate of births by caesarean section and induced labour at Barnet and Chase Farm Hospitals and the Royal Free Hospital. That report provides data at NHS trust level. This supplementary report provides the data for those patients who are the responsibility of NHS Barnet Clinical Commissioning Group.

Caesarean Sections 2012/13

	All Barnet CCG Deliveries	Barnet CCG Deliveries at BCF	Barnet CCG Deliveries at RFH	Barnet CCG Deliveries at UCL	Barnet CCG Deliveries at other Trusts
No of deliveries	5071	2427	1224	561	859
No (%) of deliveries by C-Section	1555 (31%)	764 (31%)	349 (29%)	160 (29%)	282 (33%)
No (%) of deliveries by planned (elective) C-Section	615 (19%)	271 (11%)	149 (12%)	80 (14.5%)	115 (19.5%)
No (%) of deliveries by emergency C-section	940 (12%)	493 (20%)	200 (17%)	80 (14.5%)	167 (13.5%)

2. Although the NICE Clinical Guidance relating to caesarean section where this is not clinically indicated effectively establishes a mother's right to choose a caesarean delivery, policy within the NHS stresses the importance of birth as a normal part of life for most women. This is reflected in 'Maternity Matters: Choice, access and continuity of care in a safe service' (2007), the most recent Department of Health strategy for maternity services. The NHS Institute for Innovation has also carried out a detailed review of the use of caesarean sections and published a toolkit to support maternity services to promote normal births.

3. Mandatory payment by results tariffs were introduced nationally for 2013/14. Maternity services providers will receive the same payment for a birth without complications, and for a birth with complications, regardless of whether it is a normal or caesarean delivery. This provides maternity services providers with a financial incentive to review their use of caesarean sections and reduce this where clinically appropriate.

4. The Clinical Commissioning Group and providers recognise that the caesarean section rates at both Barnet and Chase Farm Hospital (BCF) and the Royal Free Hospital (RFH) are above the London average. Key performance indicators have been included in 2013/14 contracts to reduce this to 28% and 29% respectively. The slightly higher target for RFH reflects a significant and sustained decrease from the position at March 2011.

5. It is the emergency caesarean section rate at BCF which commissioners are focussing on as an area of service improvement. This was identified as an outlier by the Care Quality Commission, who asked BCF to undertake a case note review of at least 30 randomly selected cases. Initial conversations with BCF suggest that this may be linked to the clinical rota. Representatives of the Clinical Commissioning Group are meeting with BCF in May 2013 to review the findings from the case note review and the Trust's action plan to address these. This approach is part of BCF's Service Improvement and Development Plan for 2012/13, which has been agreed through the contracting process.

Induced Deliveries 2012/13

	All Barnet CCG Deliveries	Barnet CCG Deliveries at BCF	Barnet CCG Deliveries at RFH	Barnet CCG Deliveries at UCL	Barnet CCG Delivers at other Trusts
% of deliveries which were induced	27%	27%	31%	26%	24%

6. As stated in the Director of Public Health's report, the data on induced labour is problematic and it appears that inductions may not be coded appropriately. At this stage, the Clinical Commissioning Group does not have a view on this data. Performance on inductions will be part of a suite of quality indicators which are discussed with maternity providers on a regular basis.

Howard Ford
Children's Commissioning Manager
NHS Barnet CCG
April 2013

Maternity Services – Caesarean Births

Data received from the Royal Free London NHS Foundation Trust and Barnet & Chase Farm Hospital NHS Trust:

1. In 2012 how many Caesarean operations were performed in:
a) Barnet Hospital **1,163**
b) Chase Farm Hospital **1,003**
c) Royal Free Hospital **889**

2. In 2012 how many of these Caesarean operations were elected by the patient in:
a) Barnet Hospital **32**
b) Chase Farm Hospital **40**
c) Royal Free Hospital **46**

3. In 2012 how many of these Caesarean operations were recommended by medical staff PRIOR to the patients admittance to give birth at:
a) Barnet Hospital **424**
b) Chase Farm Hospital **350**
c) Royal Free Hospital **401**

4. How many inductions were performed at:
a) Barnet Hospital **672**
b) Chase Farm Hospital **749**
c) Royal Free Hospital **542**

5. How many of these inductions led to a caesarean operation at:
a) Barnet Hospital **185**
b) Chase Farm Hospital **230**
c) Royal Free Hospital **160**

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AGENDA ITEM 10

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**NHS Health Checks Scrutiny Review**
Report of	Scrutiny Office
Summary	This report provides the Committee with an update on the joint Barnet / Harrow NHS Health Checks Scrutiny Review.

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 A – Barnet / Harrow NHS Health Checks Scrutiny Review Project Plan
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 The Committee note the Barnet / Harrow NHS Health Checks Scrutiny Review Project Plan attached as Appendix A to this report and make appropriate comments and/or recommendations to refer to the Member Working Group.

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 In relation to the **NHS Health Checks Task and Finish Group**, the following outcomes and targets are relevant to the work of the Group:

"To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and

"We will work with the local NHS to encourage people to keep well by increasing the availability of health and lifestyle checks for those aged between 40 and 74, and promoting better use of green space and leisure facilities to increase physical activity."

"Increase the number of eligible people who receive an NHS Health Check to 7,200"

4. RISK MANAGEMENT ISSUES

4.1 As set out in the attached Project Plan, it is intended to commission an external facilitator to engage with residents and patients as part of the review process. Detailed costings for this activity will be developed as part of the Consultation Plan. Funding for this engagement activity will be drawn from the existing Public Health budget and procurement of the external facilitator will be in compliance with the Contract Procedure Rules.

4.2 As part of the bid to the Centre for Public Scrutiny, the review will be receiving five days of Expert Advisor support. Funding for the Expert Advisor will be provided by the Centre for Public Scrutiny who are in turn being funded by the

Department for Health.

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 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution).

The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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 In April 2013, the Centre for Public Scrutiny (CfPS) launched a programme to support local authority scrutiny functions to review their local approach to NHS Health Check and improve take up. A bid for support was made by the London Boroughs of Barnet and Harrow (who have a shared Public Health function) and the bid was successful. Work on this project will take place between June and November 2013. This project will be managed by scrutiny officers from Barnet and Harrow and will link directly to each council's overview and scrutiny committees. Support for the project will primarily be provided a CfPS Expert Adviser and the Joint Director for Public Health. In accepting the support offer, Barnet and Harrow have committed to the following:

- Completing the review by November 2013
- Using the CfPS Return on Investment (ROI) model
- Participate in Knowledge Hub online discussions
- Keep an action log which will be utilised to co-produce a case study
- Participate in Action Learning Events

9.2 NHS Health Checks are a mandatory service which local authority public health functions have been required to deliver from 1 April 2013. Participation in the CfPS Health Checks programme provides both Barnet and Harrow with an opportunity to:

- Review previous performance;
- Consider the budget envelope, planned approach and commissioning strategy for both authorities;
- Utilise the support of an independent expert advisor;
- Enable engagement with commissioners, health service professionals (particularly GPs) and service users to understand perceptions of Health Checks;

- Enable Scrutiny Members to assist health and wellbeing boards, clinical commissioning groups and the Director of Public Health to develop the strategic approach Health Checks; and
- Identify the potential impact of improved uptake of the Health Checks by applying the CfPS ROI model to the review.

9.3 The Task and Finish Group review is seeking to:

- Identify ways in which NHS Health Checks can be promoted within each borough under the leadership of the Joint Director of Public Health;
- Explore the extent to which NHS services promote the NHS Health Checks to eligible residents;
- Consider the capacity of GPs, local pharmacies or other suitable settings to undertake Health Checks;
- Determine the extent to which secondary services are available to those who have been identified as having undetected health conditions or identified as being at risk of developing conditions without lifestyle changes;
- Identify examples of best practice from across England to inform the approach of Barnet and Harrow to commissioning and monitoring the NHS Health Checks Programme; and
- Utilise the CfPS ROI model to undertake an analysis of the cost/benefit of the NHS Health Checks Programme. The outcomes from this will influence the review recommendations.
- Explore whether GPs could be organised on a cluster basis to deliver NHS Health Checks in each borough.

9.4 The joint Barnet / Harrow Task and Finish Group met on 18 September 2013 to receive a summary of activity to date, review and agree the project plan, receive the results of a data mapping exercise undertaken by the public health team and to agree the approach to engaging with key stakeholders and residents / patients.

9.5 The Barnet Members of the Task and Finish Group are Councillors Alison Cornelius, Graham Old and Barry Rawlings.

9.6 The Committee will receive a verbal update on any further progress with the review at the meeting.

10. LIST OF BACKGROUND PAPERS

10.1 None.

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

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Project Plan: Barnet and Harrow Scrutiny Review: NHS Health Check

Author:	**Andrew Charlwood**
Date:	11th September 2013
Service / Dept:	Governance Service, Assurance Group, LB Barnet

Approvals

By signing this document, the signatories below are confirming that they have fully reviewed the Project Plan for the Barnet and Harrow Scrutiny Review: NHS Health Check project and confirm their acceptance of the completed document.

Name	Role	Signature	Date	Version
Felicity Page	Project Team			
Brenda Cook	Project Team			

DOCUMENT CONTROL

Version History

Version	Date	Author(s)	Summary of Changes
V1.1	11/09/13	A Charlwood	Initial draft for review by F Page and B Cook
V1.2	13/09/13	A Charlwood	Amendments incorporated following review by F Page

1. Introduction

This project plan summarises the actions needed to enable councillors and officers from LB Barnet and LB Harrow to work together to scrutinise the uptake of the Health Check within the two boroughs. The project plan also incorporates processes and activities developed by the Centre for Public Scrutiny (CfPS) to enable scrutiny reviews to identify the return on investment of an issue that impacts on health inequalities. Following the submission of an expression of interest by Barnet and Harrow to become an NHS Health Checks Scrutiny Development Area, both councils have been provided with additional support from a CfPS Expert Adviser. As part of the support offer, the review must incorporate the Return on Investment (ROI) model to measure the cost-benefit of the review. The Expert Adviser support is part of a national initiative between Public Health England and CfPS that aims to improve the awareness of the NHS Health Check programme and to help councils to understand the benefits of investing in upfront preventative actions to improve health.

Objectives of the CfPS National Programme

- Demonstrate the role of council scrutiny in assessing a local approach to NHS Health Check; ensuring programmes are fit for purpose and sustained over the transition and beyond.
- Use CfPS' ROI model to assist council scrutiny functions and the National NHS Health Check programme to understand the wider public health benefits and the return on investment of NHS Health Check programmes on other areas of the public sector (such as social care), not just savings in primary or secondary care.
- Use scrutiny to identify local barriers to take up of NHS Health Check and use an appreciative inquiry approach to suggest how take up could be improved locally.
- Share learning with Health and Well Being Boards to promote the proactive role of scrutiny in Joint Strategic Needs Assessments and Joint Health and Well Being Strategies.
- Support scrutiny to develop political leadership of Public Health action within councils.
- Demonstrate how scrutiny can be a bridge between councillors and clinicians

The following outcomes are anticipated from the review:

- Understand the benefits of the NHS Health Check programme within Harrow and Barnet (costed and consequential benefits)
- Understand the barriers to take up
- Understand how local take up can be improved
- Make recommendations that will improve local take up

2. Strategic Context

Public Health Functions

Following the implementation of the Health and Social Care Act 2012, local authorities have taken over responsibility for public health functions from the NHS which include:

- tobacco control and smoking cessation services
- alcohol and drug misuse services

- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks

NHS Health Checks

The NHS Health Check is a health screening programme which aims to help prevent heart disease, kidney disease, stroke, diabetes and certain types of dementia. Everyone between the age of 40 and 74 who has not already been diagnosed with one of these conditions or have certain risk factors will be invited (once every five years) to have a check to assess their risk and advice to help them reduce or manage that risk.

Local authorities are now responsible for commissioning the NHS Health Check risk assessment. However, the programme requires collaborative planning and management across both health and social care. Health and Well Being Boards are therefore vitally important in the local oversight of this mandated public health programme (Source: www.healthcheck.nhs.uk).

As part of the Health Checks programme, local authorities will invite eligible residents for a health check every five years on a rolling cycle. Health checks can be delivered by GPs, local pharmacies or other suitable settings.

The tests comprise a blood pressure test, cholesterol test and Body Mass Index Measurement. Following the test, patients will be placed into one of three categories of risk: low; medium; and high. Patients are offered personalised advice based on the outcome of their check.

LB Barnet and LB Harrow Health Check Budget:

Barnet

- November 2012 - 31 March 2013 – £150,000
- 1 April 2013 – 31 March 2014 – £465,000

Harrow

- 1 April 2012 – 31 March 2013 – £456,000
- 1 April 2013 – 31 March 2014 – £456,000

Budgets including funding for health checks invitations, health checks completed, training, publication costs, a risk management programme (such as exercise on referrals) and software licenses. The NHS Health Check Programme has been running since 2009 and was previously managed by the now abolished Primary Care Trusts.

In Barnet, there has been a large increase in the NHS Health Checks budget due to this being identified as a priority investment area by the Health and Well Being Board.

The final cost of delivering the Health Checks programme in each borough will depend on negotiations with providers on the unit cost of the health check element of the budget.

Project Background

In April 2013, the Centre for Public Scrutiny (CfPS) launched a programme to support local authority scrutiny functions to review their local approach to NHS Health Check and improve take up. A bid for support was made by the London Boroughs of Barnet and Harrow (who have a shared Public Health function) and the bid was successful. Work on this project will take place between June and November 2013. This project will be managed by scrutiny officers from Barnet and Harrow and will link directly to each council's overview and scrutiny committees. Support for the project will primarily be provided a CfPS Expert Adviser and the Joint Director for Public Health.

In accepting the support offer, Barnet and Harrow have committed to the following:

- Completing the review by November 2013
- Using the ROI model (see further information in Project Approach section)
- Participate in Knowledge Hub online discussions
- Keep an action log which will be utilised to co-produce a case study
- Participate in Action Learning Events

Link to Corporate Priorities

In Barnet, the Corporate Plan 2013 – 2016 has a corporate priority "To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health" and priority outcome of working with the local NHS to encourage people to keep well by increasing the availability of health and lifestyle checks for those aged between 40 and 74, and promoting better use of green space and leisure facilities to increase physical activity.

In Harrow, the Corporate Plan 2013 – 2015 has a corporate priority of "Supporting residents most in need, in particular, by helping them find work and reducing poverty" and a outcome of delivering an efficient public health service with the resources available, to positively influence residents' health and wellbeing.

3. Rationale

NHS Health Checks are a mandatory service which local authority public health functions have been required to deliver from 1 April 2013. Participation in the CfPS Health Checks programme provides both Barnet and Harrow with an opportunity to:

- review previous performance;
- consider the budget envelope, planned approach and commissioning strategy for both authorities;
- utilise the support of an independent expert advisor;
- enable engagement with commissioners, health service professionals (particularly GPs) and service users to understand perceptions of Health Checks;
- enable Scrutiny Members to assist health and wellbeing boards, clinical commissioning groups and the Director of Public Health to develop the strategic approach Health Checks; and
- Identify the potential impact of improved uptake of the Health Checks by applying the CfPS ROI model to the review.

The Public Health funding allocation is ring-fenced, only to be spent on public health functions. In Barnet, the current contractual liabilities do not cover all of the mandatory functions for Councils in respect of Public Health. Historically in Barnet there has been no permanent budget line to cover NHS Health Checks. In Barnet and Harrow the 2013/14 commissioning plans allocate approximately £0.5m towards the provision of NHS Health Checks in each of the boroughs.

Health Checks are only provided by GPs via Local Enhanced Service (LES) contracts. LES contracts supplement the GPs core General Medical Services (GMS) contracts and provide an opportunity for GPs to earn additional income. LES contracts are open to local negotiation.

Year One (2013/14) – existing contracts transferred from PCTs. Year 1 activity to primarily focus on base-lining and cleansing data, contract monitoring and refining processes. Steps are being taken to introduce a standard LES contact which would be based on a model developed within the West London Alliance

Year Two (2014/15) – existing contracts are likely to be extended for an additional six or 12 months. The year 1 activity referred to above and the findings from this Scrutiny Review are likely to be used to inform commissioning intentions for future years (2015/16 onwards).

This review will seek to:

- Identify ways in which NHS Health Checks can be promoted within each borough under the leadership of the Joint Director of Public Health;
- Explore the extent to which NHS services promote the NHS Health Checks to eligible residents;
- Consider the capacity of GPs, local pharmacies or other suitable settings to undertake Health Checks;
- Determine the extent to which secondary services are available to those who have been identified as having undetected health conditions or identified as being at risk of developing conditions without lifestyle changes;
- Identify examples of best practice from across England to inform the approach of Barnet and Harrow to commissioning and monitoring the NHS Health Checks Programme; and
- Utilise the CfPS ROI model to undertake an analysis of the cost/benefit of the NHS Health Checks Programme. The outcomes from this will influence the review recommendations.

- Explore whether GPs could be organised on a cluster basis to deliver NHS Health Checks in each borough.

4. Project Definition

Expected and Required Deliverables

- Time limited joint review into the NHS Health Checks Programme supported by CfPS Expert Adviser
- SMART (Specific, Measurable, Achievable, Realistic and Timely) recommendations to the Barnet and Harrow Executives, Health and Well Being Boards, Joint Director for Public Health and other stakeholders of both authorities relating to potential process/procedural improvements which can be monitored to track outcomes
- Forum for key stakeholders (local authority, GPs, health professionals, patient groups and residents) to discuss the NHS Health Checks Programme and its benefits (or otherwise)
- Participate in CfPS promotional activity relating to the review and wider CfPS Health Checks Programme and share knowledge/insight with other local authorities and health partners

Return on Investment Model

The CfPS have previously utilised the ROI model in supporting scrutiny reviews in a number of other local authorities. Details of the model can be found in the June 2012 publication, 'Tipping the scales! A model to measure the return on investment of overview and scrutiny[1]' and the May 2013 publication 'Valuing inclusion: Demonstrating the value of council scrutiny in tackling inequalities[2]'.

This review will be based around the ROI model and will seek to identify an ROI question drawn from the data collection activities which will be aimed at identifying improvements. Data sources for the ROI question will be drawn from the following sources:

- National Strategy – consider approach of Public Health England and NHS England to NHS Health Checks[3]
- Performance Review – review performance data relating to NHS Health Checks Programme over recent years in Barnet and Harrow. Specific reference is to be made to performance over the whole programme (since 2009) both prior to LA transfer and post transfer, rather than performance in individual years
- Review Existing Programme – review approach during year 1 (2013/14) when responsibility for Health Checks transferred from NHS (PCTs) to Barnet and Harrow
- Commissioning Strategy – explore plans for Barnet and Harrow's investment strategy for year 2 (2014/15), development of KPIs and monitoring arrangements. Review findings to support Public Health team in defining Health Checks investment strategy.

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[1] http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_379_tipping_the_scales_v4.pdf

[2] http://www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L13_30_CfPS_Valuing_inclusion_v5_Web_final_amends.pdf

[3] https://www.gov.uk/government/publications/nhs-health-check-implementation-review-and-action-plan

- Stakeholders Engagement – GPs, CCG, Public Health, health services, patient and public involvement groups and residents
- System Capacity – review the capacity of the system to provide support to those identified as being at risk or with undiagnosed conditions. Specific reference is to be made to the ability/capacity of GPs to deliver Health Checks programme health services to follow-up and monitor patients results.
- Benefits Analysis – consideration to be given to the cost/benefits of the programme and quality of life indicators. Specific reference to be made to CfPS Return on Investment model and Barnet's early intervention approach. Undertake some analysis of prevention and financial benefits for the NHS
- Role of GPs and Other Providers – identify best practice in Barnet and Harrow and explore barriers to improving the service.
- Inequalities – are all sectors of the community aware of Health Checks and how to access and the benefits/positive impact that they may have.
- Diabetes Screening – specific consideration to be given to diabetes screening as part of the review in accordance with the resolution of the Barnet Health OSC on 4 July 2013.
- Consider whether there is scope to analyse a cohort of the population to identify any underlying factors behind positive and negative lifestyle choices and their impact on health
- Consider the population make-up and take-up of health checks in both Boroughs (ethnicity, socio-economic breakdown etc) whether there are any additional risk factors to assist in refining priority areas for review.

Constraints

- Officer Resources – LB Harrow and LB Barnet Scrutiny have officer capacity issues. Proposed to be mitigated by LB Barnet officers providing project support.
- Public Engagement – obtaining view of residents eligible for Health Checks will be important in understanding barriers to take-up. Engaging with this group of stakeholders is expected to be more problematic than for other stakeholders (i.e. commissioners and providers).
- Finance – review to be aware of budget constraints facing Public Health and NHS in making recommendations. As part of the review, the financial benefits of Health Checks is to be considered in detail in considering the ROI question. Any assumptions used in the financial modelling will be verified by finance officers from LB Barnet and/or LB Harrow.

Resources

- Project management will primarily be led by LB Barnet Scrutiny Office, with strategic input from LB Harrow Scrutiny Office.
- Additional resources may be required to undertake consultation activity with residents. Detailed financial implications will be explored in a separate Consultation Plan.
- LB Barnet/Harrow Public Health team, supported by LB Barnet and LB Harrow Scrutiny Officers, to provide relevant data, undertake research and identify best practice examples (local and national).
- CfPS Expert Advisor – 5 days support available. LB Barnet and LB Harrow Scrutiny Members and Officers to provide a steer on how this should be utilised.

5. Business Case

NHS Health Check is a national prevention programme to identify people at ‘risk’ of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. The term that covers all these conditions is ‘vascular disease’. Everyone between the ages of 40 and 74 in England (almost 15 million people) who has not been diagnosed with vascular disease or already being managed for certain risk factors should be offered an NHS Health Check once every five years to assess their risk. The risk assessment involves a face to face meeting with a trained person such as a nurse, public health worker or pharmacist and uses questions about family health history and checks such as weight, blood pressure and cholesterol. From April 2013, NHS Health Check also identified alcohol risk assessment and, with people aged 65 to 74, will raise awareness about dementia. Overall, this programme will dramatically increase the potential for improving health and care.
Each year NHS Health Check on average:

- Prevents 1,600 heart attacks and saves at least 650 lives.
- Prevents over 4,000 people from developing diabetes.
- Detects at least 20,000 cases of diabetes or kidney disease allowing people to manage their condition and prevent complications.

These are national figures and provide evidence that improved uptake of the Health Check in Barnet and Harrow could reduce the incidence of life limiting conditions and consequently the cost of treating these.

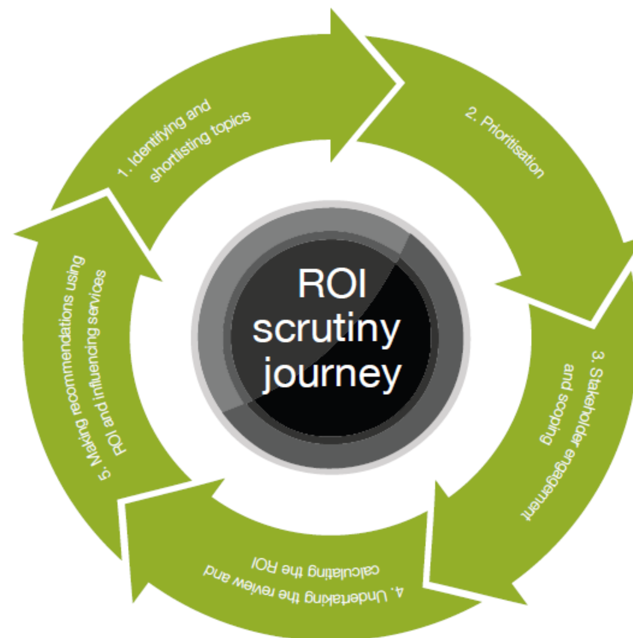
CfPS’ ROI Model of Scrutiny

The model was developed in 2011 and piloted with five councils. The reason for developing the model was to:

☑ Make scrutiny more robust focusing on impacts, outcomes, measurements and costs.
☑ Integrate the policy objectives of the Marmot review in to a review and the local authority.
☑ Have a focus on the wider determinants and their impact on health.
☑ Have the ability to forecast the impact (financial and non-financial) of the scrutiny recommendations.

Whilst the model is depicted as a cycle (see below) the 5 different stages can be applied at different times as appropriate to the delivery of the review.

This review will be based on the ROI model and will utilise the following stages:



1. **Identifying and Short Listing Topics**

   NHS Health Checks has already been agreed as a priority area for Public Health England and NHS England. The CfPS have been commissioned by Public Health England to support five NHS Health Checks Scrutiny Development Areas. Barnet and Harrow have been successful in obtaining that support and the review has been endorsed by the relevant lead Members in each authority. As a consequence, the identifying and shortlisting topics stage is not necessary for this review and the topic has been self-selected.

2. **Prioritisation**

   The prioritisation stage has three steps:

   - Producing an Impact Statement
   - Using a "Scoring Matrix" to choose the topic for the focus of the review
   - Developing the Considering what to measure

   The CfPS Impact Statement template has been developed to encompass the six policy objectives of the Marmot Review of Health Inequalities.

   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - Strengthen the role and impact of ill health prevention

The three main policy objectives which relate to this review are ‘Ensure healthy standard of living for all’, ‘Create and develop healthy and sustainable places and communities’ and ‘Strengthen the role and impact of ill health prevention’

In the context of this review, local prioritisation will take place with elected Members in mid-September following a data mapping exercise. The data mapping exercise is to use the following format on a Barnet and Harrow borough map:

- Total population;
- Types of GP surgeries (health or medical centres with multiple GPs, or single handed);
- GP clusters;
- Population diversity (ethnicity, gender, disability etc)
- Deprivation indicators;
- Morbidity / mortality indicators;
- Health checks delivered by area (GP surgery, post code, ward or super output area)

Analysis of this data should assist Members and officers to identity trends and enable priority areas to be identified for more detailed exploration with stakeholders (commissioners, providers and residents) during the later stages of the review.

Scrutiny Officers, Public Health and Performance / Insight Teams will be required to input into this mapping exercise with the work substantially completed by **12th September 2013**.

A Member prioritisation meeting will take place on **18th September 2013**.

3. **Stakeholder Engagement and Scoping the Review**.

There will be two parts to the stakeholder engagement and scoping stage of the review:

Stage 1

Commissioners, providers and patient groups Stakeholder Event (to take place in w/c 7 October or w/c 14 October 2013, date TBC) to include the following key groups:

- Cabinet Members (Barnet and Harrow);
- GPs – Locality Cluster Leads (Barnet and Harrow);
- Joint Director for Public Health;
- Public Health England;
- NHS England;
- Patient Representatives (Health Watch, CCG Patient Groups and GP Patient Groups)

This wider stakeholder meeting will use the wider determinants of health to develop a whole systems response to the topic chosen. Participants will consider the following:

☑ What works, and what doesn’t and what’s the evidence?

☑ What more can be done to tackle the issue and by whom?

☑ What appears important to you?

☑ What actions would make the most difference?

- o Radical difference
- o Small incremental steps

The Stakeholder Event will be organised by the LB Harrow and LB Barnet Scrutiny Officers and facilitated by the CfPS Expert Adviser. It is proposed that the Stakeholder Wheel will be used as the primary tool at this meeting. The meeting will also seek to determine the Return on Investment question.

Stage 2

Following the Stakeholder Event, a further round of engagement will take place with residents. Options for facilitating this engagement are to be defined in a detailed Consultation Plan.

The aim is to engage with residents (such as patient groups, specific groups (ethnicity, sex, age etc) or the eligible cohort) with low take-up in both boroughs (as identified in the mapping exercise) that should or have been offered an NHS Health Check.

The Consultation Plan will need to be evaluated to ascertain whether there are any additional resources implications. It is expected that structured engagement with residents and patients will have additional resource implications; the Director for Public Health has indicated that there may be some funding available to support this activity across Barnet and Harrow.

Stage 3

Following the Stakeholder Event and Resident Engagement, a further meeting of the Task and Finish Group will be convened to review the data and evidence from the prioritisation stage and stakeholder event. This information and evidence will be used to help Members consider the following areas:

- ☑ Review what works?
- ☑ What could the review influence?
- ☑ Consider investment / disinvestment decisions
- ☑ Review access to services

4. **Undertaking the Review** (Designing and Measuring Impact – Processes and Outcomes)

Detailed stages in completing the review have been outlined in the sections above. These can be summarised as:

Stage 1 – Stakeholder Event

Stage 2 – Resident / Patient Engagement

Stage 3 – Task and Finish Group Findings and Recommendations

The review has agreed to use the CfPS Return on Investment Model in undertaking the review; in support of this the Project Plan has been structured around the ROI model. CfPS publications have identified that the ROI stages are as follows:

- Estimating ROI – challenging to obtain valid cost information, difficult to quantify intangible benefits and hence make recommendations *(Stage 1)*
- Process Measures – relating to the stage between ROI and making recommendations
- Impact Statements – challenge to obtain valid cost information and to quantify intangible benefits, so difficult to make recommendations *(Stage 3)*

It is proposed that the ROI question is defined in the Stakeholder Engagement meeting. Data provided by Public Health should highlight trends on:

- Health Checks offered / take-up; and
- Deprivation, ethnicity and other socio-economic data and prevalence of conditions (heart disease, diabetes etc) in specific geographic locations

5. Making Recommendations and Influencing Services

The ROI review stages outlined above, supplemented by academic research, will provide a comprehensive overview of the NHS Health Checks programme in Barnet and Harrow. Evidence will be used to develop specific SMART recommendations that will be used by Barnet and Harrow to inform the NHS Health Checks commissioning strategy for 2015/16. Findings from the review will link into the wider CfPS body of work on NHS Health Checks.

Developing and testing the ROI question will be essential in demonstrating the cost / benefit of the review to ensure that scrutiny review delivers outcomes (costed and consequential) that can shape the delivery of local services.

Return on Investment Model – Review Actions

Review Activity	ROI Model Involvement
Project Planning – detailed planning with LB Barnet and LB Harrow Scrutiny Officers and Public Health	Clarifying topic Starting to discuss **prioritisation**
Develop Project Plan – update Project Briefing and create Project Plan using LB Barnet standard project management documentation	Scoping and planning
Data collection by public health Officer analysis against the impact assessment template	Officer analysis against the impact assessment template
Member Level TFG Meeting, 18 September 2013 – to present priority areas to elected Members and gain approval for Stakeholder Event and Community Engagement approach	**Agree priorities and where review can have impact**
Stakeholder Event, w/c 7 October or w/c 14 October – to facilitate event utilising the CfPS ROI model for detailed scoping and defining the ROI question	**Stakeholder engagement and identifying ROI question**
Consultation with community representatives/groups	**Stakeholder engagement and identifying data to support ROI**
Remaining review activity – TBC	**Identifying ROI through review**
Making recommendations	**Stage 5 of model - influencing**

Each of the above actions is seen a milestone to be achieved jointly by Councillors and Officers and with the support of the CfPS Expert Adviser. The activities will also be supported by staff within the Public Health Team who can provide valuable data about the commissioning, provision and take-up of the Health Check, as well as the public health benefits to local people and communities.

It is anticipated that the outcomes from the review will identify ways in which offering and take-up of the Health Check may be improved.

Risks

1. **Resources –** lack of officer resources at LB Harrow (currently 1.7 FTE to support scrutiny function)
2. **Resources –** the need for staff or additional resources to undertake focused community consultation.
3. **Timing –** summer breaks at both authorities may constrain progress and limit Member input.
4. **Timing –** it may be challenging to arrange the stakeholder meeting and consultation events and analyse the outcomes during the timescale.
5. **Engagement –** lack of engagement by LB Barnet / Harrow Members, officers and NHS and GP stakeholders currently responsible for delivering the Health Check
6. **Focus –** for the ROI model to be effective the review needs to remain focused on a clear ROI question that can be quantified. This may be challenging for councillors if a variety of issues are raised through the stakeholder engagement and consultation.

Reporting

Regular status reports will be produced and include: progress against key milestones, status against key success criteria, key issues and any proposed changes to the project. Status reports will be reported to the Project Team and elected Members as part of a regular update process.

The involvement in the CfPS requires regular sharing of information through its Knowledge Hub. It also requires a commitment to share the outcomes of the review and the ROI identified more widely through an Action Learning meeting in early 2014 and the production of a document incorporating the learning from all scrutiny development areas, of which this is one, by CfPS staff.

The project will close down in a structured way showing whether it has achieved its objectives and identify any lessons learned.

An agreed set of documentation and information will be held by LB Barnet and LB Harrow Scrutiny Officers

AGENDA ITEM 11

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Healthwatch Barnet Enter and View Reports**
Report of	Healthwatch Barnet
Summary	Members are requested to consider the Enter and View reports from Healthwatch Barnet as set out in the Appendix.

Officer Contributors	Selina Rodrigues, Head of Healthwatch Barnet 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 A: Thames Ward, Edgware Community Hospital, Barnet Healthwatch Enter and View Report
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Committee note the Enter and View Reports for Thames Ward at Edgware Community Hospital and make appropriate comments and/or recommendations to Barnet Healthwatch or the service provider.

2. RELEVANT PREVIOUS DECISIONS

2.1 Safeguarding Overview and Scrutiny Committee, 10 December 2012, Barnet LINk Enter and View Reports and the LINk Annual Report.

2.2 Cabinet Resources Committee, 25 February 2013, the HealthWatch Contract was awarded to CommUNITY Barnet

2.3 Safeguarding Overview and Scrutiny Committee, 20 March 2013, Barnet LINk Enter and View Reports

2.4 Safeguarding Overview and Scrutiny Committee, 9 September 2013, Barnet LINk Enter and View Reports

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.

3.4 Healthwatch will be the primary vehicle through which users of health and care in the Borough will have their say and recommend improvements. These should lead to improved, more customer focused outcomes and will assist in meeting the objectives in the Health and Well Being Strategy 2012-15.

4. RISK MANAGEMENT ISSUES

4.1 Healthwatch Barnet has a group of Authorised Representatives. The Authorised Representatives are selected through a recruitment and interview process. Reference checks are undertaken. All representatives must complete a Disclosure and Barring Service check. All Authorised Representatives are required to undergo Enter & View and Safeguarding training prior to participating in the programme.

4.2 Ceasing to carry out the visits removes the opportunity for an additional level of scrutiny to assure the quality of service provision.

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 The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet. The Healthwatch contract value is £197,361 per annum. The contract will commenced on 1 April 2013 and will expire on 31 March 2016; the contract sum received is £592,083. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

7. LEGAL ISSUES

7.1 Sections 221 to 227 of the Local Government and Public Involvement in Health Act 2007, as amended by Sections 182 to 187 of the Health and Social Care Act 2012, and regulations subsequently issued under these sections, govern the establishment of Healthwatch, its functions and the responsibility of local authorities to commission local Healthwatch.

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

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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 Healthwatch Barnet delivers 'Enter and View' visits, which are review visits by lay-people of the quality, care and safety in residential and health care settings. The Healthwatch Enter and View team are given the legal right to do this and have all been well trained in their role. The most important aspect of Enter and View is that it is intended to add value by working in collaboration with service providers, residents, relatives, carers and those commissioning services.

9.2 The Enter and View reports are written by the Enter and View team and sent to the care provider to check for factual accuracy and to respond to the report recommendations. The Reports are reviewed and authorised at each stage by Healthwatch Barnet staff, and once finalised are uploaded to the Healthwatch Barnet website. The reports are then sent to the Care Quality Commission and the Head of Safeguarding, Adults and Communities at Barnet Council and either the Safeguarding Overview and Scrutiny Committee (for social care settings) or the Health Overview and Scrutiny Committee (for health care settings).

9.3 A report which provided a detailed analysis of the Barnet Healthwatch Enter and View programme was reported to the Safeguarding Overview and Scrutiny Committee on 9 September 2013.

9.4 The Committee are requested to consider the Enter and View report attached at **Appendix A** and the responses from the health care provider as detailed below and make appropriate comments and/or/recommendations to Barnet Healthwatch or the service providers:

10. LIST OF BACKGROUND PAPERS

10.1 None.

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

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healthwatch Barnet

Enter and View – Visit Report

Name of Establishment:	Thames Ward Dennis Scott Unit Edgware Community Hospital Edgware, HA8 0AD
Staff Met During Visit:	Ms Ana Basheer, Ward Manager Healthcare worker (– Bank staff working more often on Avon Ward) Student Nurse
Date of Visit:	24 April 2013
Purpose of Visit:	This is part of a planned strategy in response to concerns Barnet LINk received, prior to Healthwatch, about the treatment of Mental Health patients in various locations in the borough. Each Healthwatch has the statutory powers to enter health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services. The principal role of Healthwatch is to consider the standard and provision of services, how they may be improved and how good practice can be disseminated. Subsequent to any visit a report is prepared, agreed by the manager of the facility visited, made public via the website and then made available to interested parties, such as the Health and Well Being Board. As part of our preparation for the visit we reviewed the Care Quality Commission (CQC) report of December 2011, particularly the areas of concern. It should be noted that the CQC report covered four wards at the Dennis Scott Unit and their report did not always distinguish between them. Where Thames Ward had been specifically named in the CQC report we discussed these

	comments with Ms Basheer, ie meals, medicine management, consent to treatment, weekend activities, and replacement staff. These are discussed below and are not seen as current issues for Thames Ward
Healthwatch Authorised Representatives Involved:	Stewart Block Janice Tausig Nahida Syed (Christina Meacham could not attend owing to illness)
Introduction and Methodology:	**DISCLAIMER:** ***This report relates only to the service viewed on the date of the visit, and is representative of the views of the staff, visitors and residents who met members of the Enter and View team on that date.*** Thames Ward is one of four mental health units in the Dennis Scott Unit at Edgware Community Hospital. It is a mixed acute admissions ward with 20 beds. Patients are admitted via a doctor's referral or a home treatment gatekeeper. Although patients generally stay for about 6 weeks, some may stay longer. Many, according to Ms. Basheer, come back more than once. There is a description of the ward on http://www.beh-mht.nhs.uk/mental-health-service/mh-services/thames-ward.htm We spoke to Ms. Basheer to establish the current situation, then to some of the other staff and also to patients where possible. It was possible to speak with the patients in private on only one occasion as Ms. Basheer felt that it would be inappropriate for us to be alone with patients. The tone of calm and professional

	manner of the unit is set by the Manageress, Ms. Basheer. At the time of the visit there were 17 male and 3 female patients. Sleeping accommodation is in individual rooms (not en-suite) with separate areas for men and for women. The women's area is very close to the Manageress's rooms and well observed. There are also separate lounge areas for men and for women though communal areas are shared. This was not seen as a problem by the E&V Team as the ward area generally was very well managed and no communal area was visually shut off from staff passing by. The unit is always full. The Manageress has twice daily teleconferences with other units in the Trust to assess the current availability for new admissions. We used a prepared prompt list of questions to find out relevant facts, made observations and spoke to staff and patients. The notice advertising our visit was displayed on a notice board. We wanted to observe a meal time and so planned a morning visit and were also able to spend a little time with 2 of the Kitchen staff during lunch. During our visit we walked through the unit and patients (and staff) were free to approach and talk to us. There were no patients' visitors for us to talk to since visiting times are Monday to Friday: 16:00 to 20:00 and Weekends & Bank Holidays10:00 to 20:00. The communal areas had been recently decorated.
General Impressions:	Entry was through an air-lock system of double doors after our identity and purpose of visit had been identified. We were asked to sign the visitor's book and to use the disinfectant hand gel dispenser.

	The communal rooms are all light, airy and well-ventilated, although patients did not always use them, sometimes preferring to sit in the corridor on the floor. There were no odours and Ms. Basheer said that it was her policy to open windows and keep the unit well ventilated. The individual rooms are adequately furnished for the intended relatively short-stay patients and have nothing in them that could be used for self-harm. Even the curtains, necessary for privacy, came down - if any weight or pressure had been applied to them. Staff were all engaged in a variety of activities and frequently communicated with the Manageress to confirm decisions they had made, kept her up to date as events unfolded or asked for assistance where necessary.
Policies & Procedures:	Apart from a mental health assessment patients on admission are given a physical health check and regularly monitored during their stay. Planning starts for their release destination, home, recovery house, social housing. "Bed-blocking" is not said to be an issue. Specialist Interpreter support is available, especially for clinical evaluations. Care Plans were shown to us with names removed. They are updated weekly on the system and are available for staff. Some patients are aware of their plan. The staff would discuss the Care Plan with the family if asked. It was noted that if there is conflict between two patients, one may be moved to another unit. We were assured that the criticism from CQC regarding the way in which medication was noted had been complied with. The Ward Manager confirmed that the required response had been sent to CQC.

Staff:	The unit had 5 staff on duty during the day and 4 at night. In the event of staff shortages, bank staff are used in preference to Agency Staff where this is possible, as Ms. Basheer prefered to use staff familiar with the unit. She felt this promoted the best possible care for patients. All staff are Mental Health qualified Nurses. 24 hour support is available for staff. Ms. Basheer told us that Staff received regular clinical and non-clinical training covering all legislation required. Safeguarding training was mentioned in particular. During our visit it was sometimes difficult to distinguish between staff and patients. Staff did not wear uniforms. Ward staff were not clearly identifiable by patients, visitors and other staff.
Staff Views:	The Manageress was well aware of the need for more activities, especially physical activities for the younger men. Please also see "Activities section" below. Ms Basheer said she spoke five languages – and a smattering of others, she tended to use interpreters for important meetings but relied on her own knowledge for day to day communication with patients. She was much in demand whilst we were there! On the whole, staff commented very little when we were with patients and let the patients speak for themselves. Other staff thanked us for the conversation we had with a particular patient, which had lasted nearly ten minutes. The ward was so busy that there was not the opportunity to talk at any length with the other staff.
How the Hospital Gets Patients' Views:	There are open meetings run by the Ward Manager for all staff. There are also anonymised

	Service User Surveys, we were given two copies. The feedback was generally positive. There is also an electronic system used by the patients to record their views. We did not see this. The team felt that it was important to cross-check comments by other means - observation, feedback, etc. Ms Basheer told us that verbal complaints to her were dealt with, usually on the spot; though no written record was kept. Written complaints were handled by a peer group review process with the Health Authority. There appeared to be no ward records kept of complaints, their resolution and the timing.
How the Home Gets Relatives' / Carers' Views:	Staff are available to chat with relatives when they come in – although it is unclear how this impacts on their time with other patients.
Privacy and Dignity:	Patients were shown respect, with staff knocking before entering rooms. No smoking was allowed in the unit and was actively discouraged but provision was made for smokers to go outside, accompanied, to smoke. Patients were also encouraged to take some responsibility by, for example, making their own beds. Patients were generally well presented.
Environment:	Light and airy; patients moved about or sat, interacting with staff.
Furniture:	Reasonable condition, clean. Perfectly acceptable for short term stays.
Food:	Meals are served in a well-ventilated dining room, patients collecting their meals from a serving hatch. We were told that staff went round the unit just before each meal reminding patients of the meal time and checking any who hadn't turned up. There was a reasonable choice of pre-ordered meals with the various religious/cultural groups catered for. The patients we spoke to, generally had no complaints about the quality or quantity

	of food. This was reinforced by what we saw. The food, prepared elsewhere, is served by kitchen staff.
Activities:	A TV room is available; patients can have radios in their rooms. Games room and newspapers available with a variety of games available. Ms**.** Basheer commented that there was a garden where the patients could play football. We understood there were also regular visits by psychologists, who discussed with patients individually how they were feeling and what progress they were making and pharmacists, who discussed drugs and their side effects with patients. It was clear from talking to two of the patients that they were well informed about their medication. One of the notice boards listed engagement time in the afternoons. This is time when staff talk with patients 1:1 to establish how they are feeling and the progress they are making. As our visit was due in the morning, we were unable to see this in action. There were no computers for the patients to use at the hospital. Nor were there any TVs in individuals' rooms. This was Ms**.** Basheer's policy as she wanted patients to talk and engage with others.
Feedback from Residents and Relatives/Visitors:	Several patients approached and talked to us. Unfortunately, it was impossible to ascertain whether their conversation would have been any different had they not been surrounded by Staff. One patient asked for an Advocate and said that when he had been there before an Advocate was available everyday. The patient was referred to one of the Nurses who said he would make arrangements for him to see an Advocate; One team member had the opportunity to speak at some length with a

	patient undisturbed by staff and this proved a positive experience for both of them with no issues arising. No relatives or other visitors were available.
Recommendations:	1. Clearly visible and legible name badges for all staff 2. Web links to latest CQC reports and responses should be readily available. 3. Investigate the possibility of more physical exercise. 4. The Ward manager should keep a ward record of written and oral complaints, their resolution and dates.
Conclusion:	A well-run unit. A manageress well aware of the need to set boundaries so that the patients feel safe but with a very human touch, showing understanding of people as individuals who need care, attention, independence and support.
Signed: Stewart Block Janice Tausig Nahida Syed	
Date: 16 August 2013	

RESPONSE RECEIVED FROM THAMES WARD:

Response from Ana Basheer – Ward Manager, Thames Ward

In response to Recommendations

1. All staff now have Identity Badges which should be visible at all times.

3. Weather permitting we are able to spend long periods out in the garden area, playing football, basketball and tennis.
4. Re Complaints – a record folder has been made up for complaints.

Also noted that the patients are able to use computers under the supervision of staff. There are now two TV areas in the ward.

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Members' Item – Breast Screening**
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 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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.

8.3 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 Alison Cornelius has requested that a Member’s Item be brought to the Committee in relation to the breast screening services at Finchley Memorial Hospital (FMH). In particular:

- Why the mobile breast screening unit has been removed from FMH and letters were sent out to patients without any prior discussion/consultation with partners;
- The reason why breast screening services have been transferred from FMH to Enfield.

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**

Health Overview and Scrutiny Framework
Effective Scrutiny for Better Outcomes

This framework was originally presented to and discussed by members at the Aging Well Scrutiny Framework workshop on 30 January 2012 and is designed to aid Scrutiny members in deciding and scoping their future work programme. It is based on four principles:

- Issues chosen for Scrutiny should be recognised as being of sufficient importance to the community to warrant expending scarce resources in investigating it.
- There should be a clear understanding by everyone concerned of what is being investigated.
- The investigation should be asking questions that have not been asked before. That is to say the issue has not been replicated elsewhere (even if in a slightly different form). This includes other Overview and Scrutiny committees.
- The outcomes from this investigation will make a real difference to the community.

The framework takes into account Barnet's Ageing Well Strategy, the Centre for Public Scrutiny's work on health and health scrutiny and good practice guidelines for Overview and Scrutiny.

Stage 1: Scoping Your Review

The first point of consideration for considering an item for scrutiny should be whether or not something has already been identified as an issue. Ideally an issue should not be considered unless it is "exceptional".

What constitutes "exceptional"- why are we embarking on this review?

When considering if something is exceptional we should consider the following points:

- Is the issue relevant or important?

- Is it supported by robust evidence and judged against strict principles?

- Exceptionality could be judged on the basis of whether the issue is referenced in past and current strategies, for example, the Joint Strategic Needs Assessment (JSNA) or Health and Well-being Strategy, national and local research and policy data.

- Exceptionality identifies either fault lines in the construction of these strategies and documents which have led to "gaps" in identifying need and risk, or highlights a new issue that has subsequently arisen.

- As members use the Cabinet Forward Plan, the Corporate Plan and the strategies of local health partners' and other sources such as petitions, and Council motions to construct long and short-list for work programmes, the majority of these would not be considered exceptional.

Therefore in identifying exceptionality members should consider:

- Issues that have a high public interest or where there is severe press/public pressure to investigate an issue not identified within the Corporate Strategies and documents (whether this be as a result of an individual's experience or the failure of a whole service). However, the argument for exceptionality still has to be made.

- Is the level of need/risk exceptional compared to datasets elsewhere?

- Are the conditions within the community exceptional compared to a similar community elsewhere?

- When considering a new or existing service would it/does it differ significantly from a comparable service (either within the Council or elsewhere) in terms of outcomes or benefits to the community?

If these questions can be answered positively then you have a case for exceptionality.

Note: Whenever an issue is put forward for consideration, it is expected that members are already aware of the existing evidence which supported the original identification of the issue (for example, ward deprivation indices, morbidity statistics, level of complaints).

Stage 2: Defining your Question

Once the issue has been identified then *the question* needs to be defined. A common failing of previous scrutiny reviews is that the terms of reference are too broad or that the investigation is complex, lengthy and poorly focused. The resulting recommendations frequently lack robustness, are easily misinterpreted and equally easily rejected.

Your proposed question should clearly identify specific *key lines of enquiry* (KLoE).

Example: Complaints about the provision of dementia nursing care at home, in care and in hospital are rising significantly.

Sample question:

How could the patient journey for dementia sufferers be improved?

Are there specific steps that the Council and its health partners need to make to ensure that early stage dementia sufferers and their carers are adequately supported in the borough?

Sample KLoEs

- What support do sufferers and their carers really want?
- Have organisations, agencies, community, voluntary sector considered provision of this in their operations strategy?
- How could the quality of life be improved and what longer-term savings could be made as a result of adequately supporting this target group?

Stage 3: Is the Health Overview and Scrutiny Committee the Best Means of Investigating the Issue?

HOSC is not always the best route when investigating an issue. It may be that other organisations such as LINk (soon to be healthwatch), Citizen's Advice etc are better placed to collate individuals' concerns and bring them to the attention of the relevant organisation.It could be that the issue has already been considered and addressed by the Acute Health Trust for example, or revised guidelines issued to GPs by the BMA.

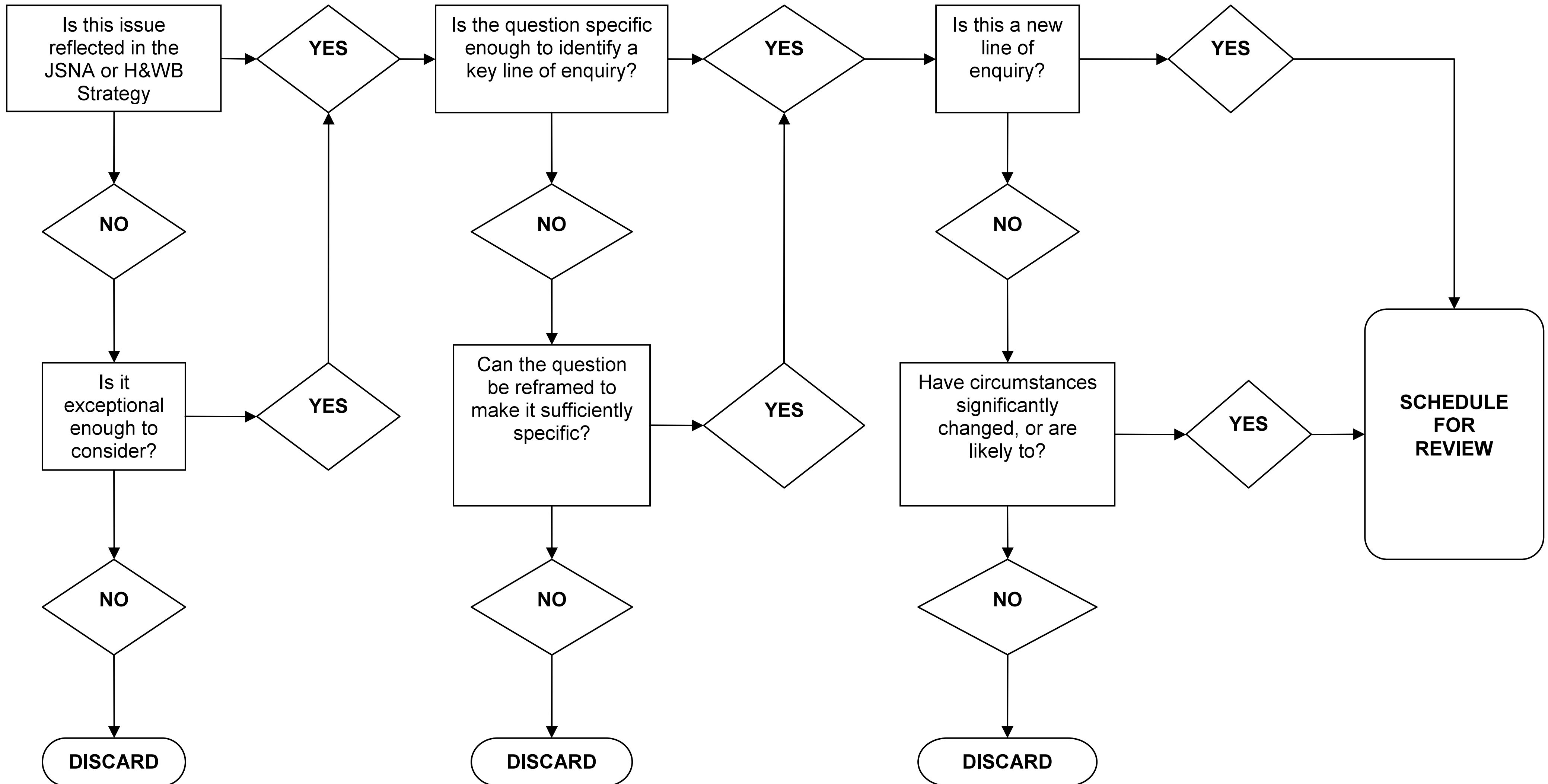
Your time and resources are limited so focus on questions that have not been asked before either by the Council or its partners. That way you can be sure that you will make a difference.

The flow chart below provides a visual guide for helping you evaluate the appropriateness of issues to be taken forward to Scrutiny.

Stage 4: Start Your Review

By following this process you would have already done a significant amount of the groundwork required for good scoping of your investigation. You will be presenting issues and topics for scrutiny that have not been duplicated elsewhere and help ensure that the council delivers one of the key corporate objectives of delivering better services with less money.

Issue Evaluation Flow Chart



Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Members' Item – Sexually Transmitted Diseases**
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 Sexually Transmitted Diseases 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;
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4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

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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.

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9. BACKGROUND INFORMATION

9.1 Councillor Julie Johnson has requested that a Member’s Item be brought to the Committee in relation to sexually transmitted diseases as follows:

“The national press seems to suggest that there has been an increase in the number of people seeking treatment for sexually transmitted diseases (STD's):

1. Have Barnet's figures increased in the last two / three years and, if so, by how much?

2. Does Barnet have sufficient resources to deal with any extra demand?

3. As education about STD's is part of the national curriculum, can we have some feedback and how this is managed in our schools (including academies and free schools), including Barnet's looked after children?”

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**

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Note: Whenever an issue is put forward for consideration, it is expected that members are already aware of the existing evidence which supported the original identification of the issue (for example, ward deprivation indices, morbidity statistics, level of complaints).

Stage 2: Defining your Question

Once the issue has been identified then *the question* needs to be defined. A common failing of previous scrutiny reviews is that the terms of reference are too broad or that the investigation is complex, lengthy and poorly focused. The resulting recommendations frequently lack robustness, are easily misinterpreted and equally easily rejected.

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Example: Complaints about the provision of dementia nursing care at home, in care and in hospital are rising significantly.

Sample question:

How could the patient journey for dementia sufferers be improved?

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Stage 3: Is the Health Overview and Scrutiny Committee the Best Means of Investigating the Issue?

HOSC is not always the best route when investigating an issue. It may be that other organisations such as LINk (soon to be healthwatch), Citizen's Advice etc are better placed to collate individuals' concerns and bring them to the attention of the relevant organisation.It could be that the issue has already been considered and addressed by the Acute Health Trust for example, or revised guidelines issued to GPs by the BMA.

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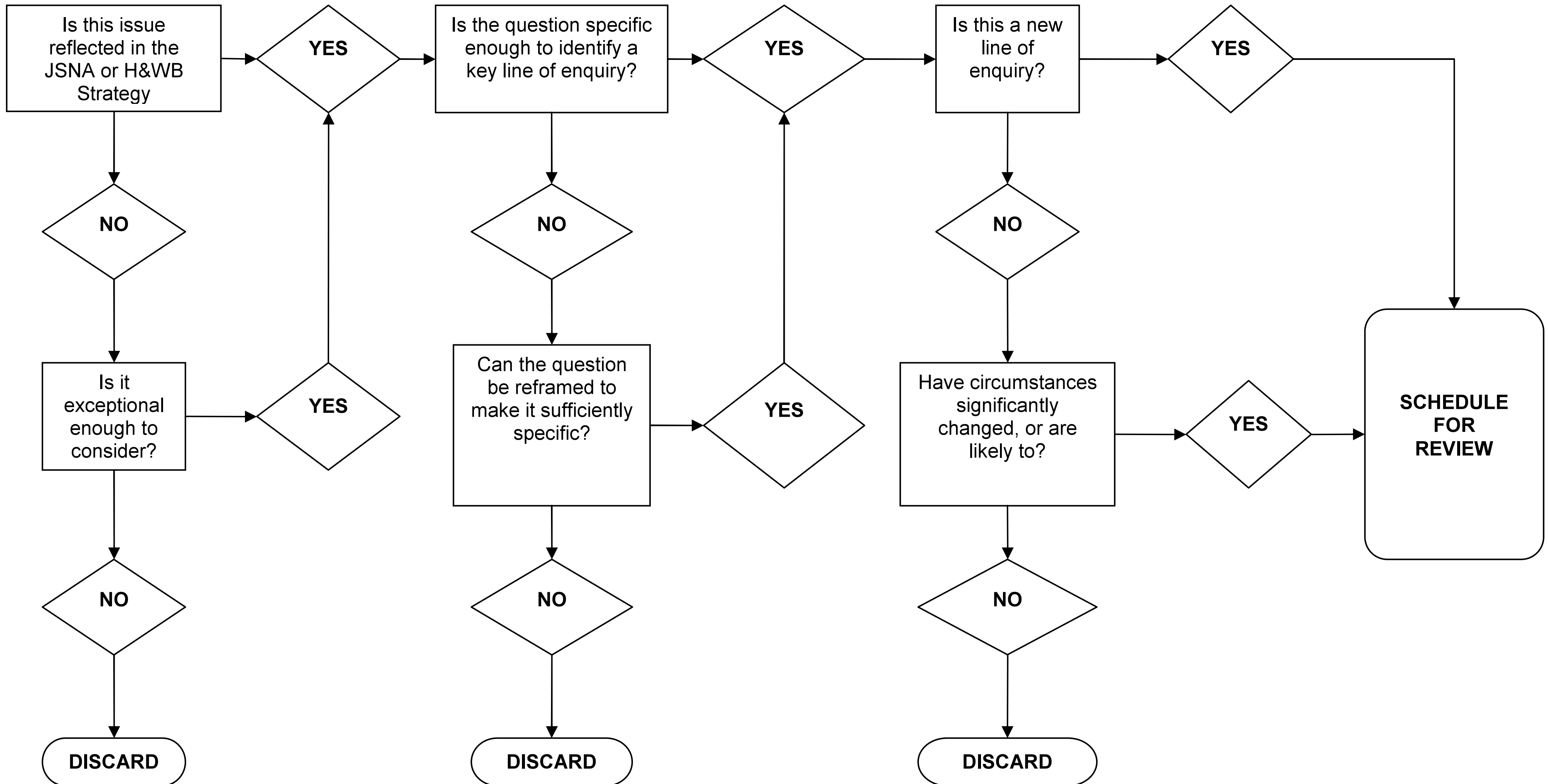
Issue Evaluation Flow Chart



AGENDA ITEM 14

Meeting	Health Overview and Scrutiny Committee
Date	3 October 2013
Subject	**Members' Item – GP Services in Barnet**
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 Sexually Transmitted Diseases 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 Health Overview and Scrutiny Committee, 9 May 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital – the Committee received an update on steps being taken to provide GP services in both locations.

2.2 Health Overview and Scrutiny Committee, 4 July 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital – the Committee received a further update on from NHS England and NHS Property Services and referred this issue to the Health and Well-Being Board.

2.3 Health and Well-Being Board, 19 September 2013, Use of Estates – Referral from the Health Overview and Scrutiny Committee to the Health and Well-Being Board

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 Detailed financial considerations will be addressed by health partners should the committee resolve to bring a substantive item to the next meeting on 12 December 2013.

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.

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8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

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.

8.3 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 Geof Cooke has requested that a Member's Item be brought to the Committee which requests a briefing on the provision and location of GP surgeries in Barnet, and the rent and service charge costs to GPs for delivering services in NHS facilities like Finchley Memorial Hospital and Brunswick Park Health Centre, and others.

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**

Health Overview and Scrutiny Framework
Effective Scrutiny for Better Outcomes

This framework was originally presented to and discussed by members at the Aging Well Scrutiny Framework workshop on 30 January 2012 and is designed to aid Scrutiny members in deciding and scoping their future work programme. It is based on four principles:

- Issues chosen for Scrutiny should be recognised as being of sufficient importance to the community to warrant expending scarce resources in investigating it.
- There should be a clear understanding by everyone concerned of what is being investigated.
- The investigation should be asking questions that have not been asked before. That is to say the issue has not been replicated elsewhere (even if in a slightly different form). This includes other Overview and Scrutiny committees.
- The outcomes from this investigation will make a real difference to the community.

The framework takes into account Barnet's Ageing Well Strategy, the Centre for Public Scrutiny's work on health and health scrutiny and good practice guidelines for Overview and Scrutiny.

Stage 1: Scoping Your Review

The first point of consideration for considering an item for scrutiny should be whether or not something has already been identified as an issue. Ideally an issue should not be considered unless it is "exceptional".

What constitutes "exceptional"- why are we embarking on this review?

When considering if something is exceptional we should consider the following points:

- Is the issue relevant or important?

- Is it supported by robust evidence and judged against strict principles?

- Exceptionality could be judged on the basis of whether the issue is referenced in past and current strategies, for example, the Joint Strategic Needs Assessment (JSNA) or Health and Well-being Strategy, national and local research and policy data.

- Exceptionality identifies either fault lines in the construction of these strategies and documents which have led to "gaps" in identifying need and risk, or highlights a new issue that has subsequently arisen.

- As members use the Cabinet Forward Plan, the Corporate Plan and the strategies of local health partners' and other sources such as petitions, and Council motions to construct long and short-list for work programmes, the majority of these would not be considered exceptional.

Therefore in identifying exceptionality members should consider:

- Issues that have a high public interest or where there is severe press/public pressure to investigate an issue not identified within the Corporate Strategies and documents (whether this be as a result of an individual's experience or the failure of a whole service). However, the argument for exceptionality still has to be made.

- Is the level of need/risk exceptional compared to datasets elsewhere?

- Are the conditions within the community exceptional compared to a similar community elsewhere?

- When considering a new or existing service would it/does it differ significantly from a comparable service (either within the Council or elsewhere) in terms of outcomes or benefits to the community?

If these questions can be answered positively then you have a case for exceptionality.

Note: Whenever an issue is put forward for consideration, it is expected that members are already aware of the existing evidence which supported the original identification of the issue (for example, ward deprivation indices, morbidity statistics, level of complaints).

Stage 2: Defining your Question

Once the issue has been identified then *the question* needs to be defined. A common failing of previous scrutiny reviews is that the terms of reference are too broad or that the investigation is complex, lengthy and poorly focused. The resulting recommendations frequently lack robustness, are easily misinterpreted and equally easily rejected.

Your proposed question should clearly identify specific *key lines of enquiry* (KLoE).

Example: Complaints about the provision of dementia nursing care at home, in care and in hospital are rising significantly.

Sample question:

How could the patient journey for dementia sufferers be improved?

Are there specific steps that the Council and its health partners need to make to ensure that early stage dementia sufferers and their carers are adequately supported in the borough?

Sample KLoEs

- What support do sufferers and their carers really want?
- Have organisations, agencies, community, voluntary sector considered provision of this in their operations strategy?
- How could the quality of life be improved and what longer-term savings could be made as a result of adequately supporting this target group?

Stage 3: Is the Health Overview and Scrutiny Committee the Best Means of Investigating the Issue?

HOSC is not always the best route when investigating an issue. It may be that other organisations such as LINk (soon to be healthwatch), Citizen's Advice etc are better placed to collate individuals' concerns and bring them to the attention of the relevant organisation.It could be that the issue has already been considered and addressed by the Acute Health Trust for example, or revised guidelines issued to GPs by the BMA.

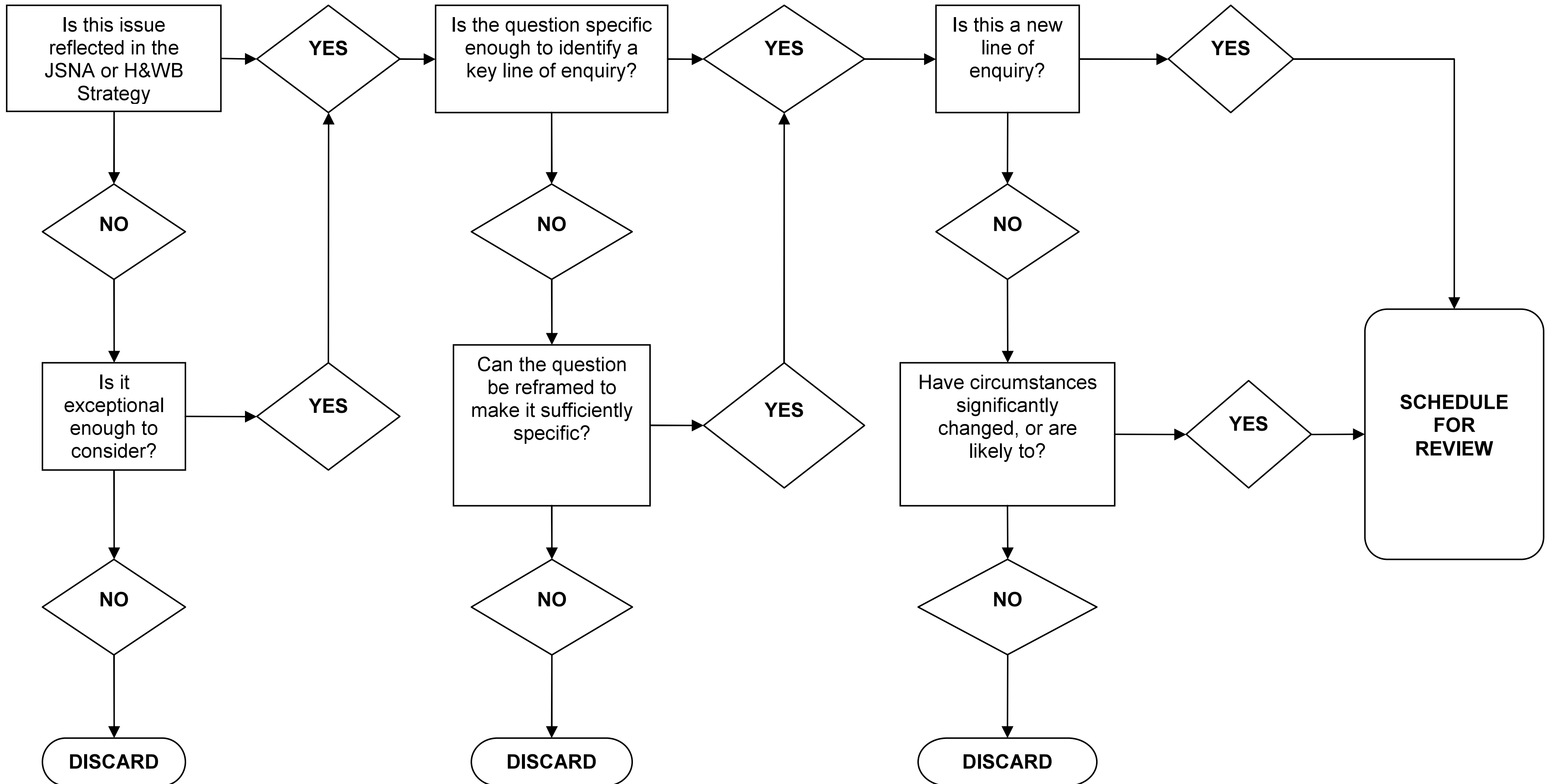
Your time and resources are limited so focus on questions that have not been asked before either by the Council or its partners. That way you can be sure that you will make a difference.

The flow chart below provides a visual guide for helping you evaluate the appropriateness of issues to be taken forward to Scrutiny.

Stage 4: Start Your Review

By following this process you would have already done a significant amount of the groundwork required for good scoping of your investigation. You will be presenting issues and topics for scrutiny that have not been duplicated elsewhere and help ensure that the council delivers one of the key corporate objectives of delivering better services with less money.

Issue Evaluation Flow Chart



BARNET
LONDON BOROUGH

AGENDA ITEM 15

Meeting	Health Overview & Scrutiny Committee
Date	3 October 2013
Subject	**Health Overview and Scrutiny Committee Forward Work Programme**
Report of	Overview and Scrutiny Office
Summary	This report provides Members with the Health Overview and Scrutiny Committee Forward Work Programme.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards affected	All
Enclosures	Appendix A – Health OSC Forward Work Programme
Reason for urgency / exemption from call-in	Not applicable
Key decision	N/A

Contact for further information: Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014

1. RECOMMENDATION

1.1 That the Committee consider and agree the Health Overview and Scrutiny Committee Forward Work Programme attached at Appendix A.

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 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.

5.2 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.

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

6.1 None in the context of the report.

7. LEGAL ISSUES

7.1 None in the context of the report.

8. CONSTITUTIONAL POWERS

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 Under the current overview and scrutiny arrangements, the Health Overview & Scrutiny Committee are required to ensure that the work of Scrutiny is reflective of Council priorities, as evidenced by the Corporate Plan and the programme being followed by the Executive. The Committee are requested to consider and agree the items contained within the work programme.

9.4 Future meeting dates for 2013/14 are:

12th December 2013
12th March 2014
12th May 2014

10. LIST OF BACKGROUND PAPERS

10.1 None.

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London Borough of Barnet

Health Overview and Scrutiny Committee

May 2013 – May 2014

Contact: Andrew Charlwood Tel: 020 8359 2014 email: andrew.charlwood@barnet.gov.uk

Subject	Decision requested	Cabinet Member	Author
3 October 2013			
Barnet, Enfield and Haringey Clinical Strategy	Update on the progress of the Barnet, Enfield and Haringey Clinical Strategy	N/A	Barnet, Enfield and Haringey Clinical Strategy Programme Office
Transport Services – Finchley Memorial Hospital	Update on developments since the 4 July 2013 meeting and to receive a representation from Transport for London on transport services at Finchley Memorial Hospital.	N/A	Scrutiny Office / Transport for London
Health and Social Care Integration	To consider a report on the progress of Health and Social Care Integration projects with specific reference to addressing delayed hospital discharges	Cabinet Member for Public Health / Cabinet Member for Adults	Director for People / Adults and Communities Director / Barnet Clinical Commissioning Group
Maternity Services (Caesarean Births)	To consider a report from the Director of Public Health, Barnet Clinical Commissioning Group and NHS Trusts on caesarean births to include detail on: comparative London statistics; any abnormal trends; and reasons for inductions (local and national)	N/A	Barnet CCG / NHS Trusts / Director of Public Health
Dolphin Ward Update	Update on any progress or developments in relation to the Dolphin Ward at the Springwell Centre.	N/A	Barnet Clinical Commissioning Group / Barnet, Enfield and Haringey Mental Health Trust
NHS Health Checks Task and Finish Group	Update on the joint Barnet / Harrow NHS Health Checks Task and Finish Group	Cabinet Member for Public Health	Scrutiny Office

Subject	Decision requested	Cabinet Member	Author
Members' Item – Breast Screening	To receive a Members' Item in the name of Councillor Alison Cornelius in relation to Breast Screening services in Barnet, with particular reference to Finchley Memorial Hospital	N/A	Scrutiny Office
Members' Item – Sexually Transmitted Diseases	To receive a Members' Item in the name of Councillor Julie Johnson in relation to sexually transmitted diseases	N/A	Scrutiny Office
Members' Item – GP Services in Barnet	To receive a Members' Item in the name of Councillor Geof Cooke in relation to GP services in Barnet.	N/A	Scrutiny Office
Healthwatch Enter and View Report	To receive an enter and view report from Barnet Healthwatch on the Thames Ward at Edgware Community Hospital.	N/A	Barnet Healthwatch
12 December 2013			
NHS Quality Accounts	NHS Partners to provide a six-monthly update on actions taken by NHS Trusts to respond to comments and/or recommendations made by the Committee in relation to Quality Accounts 2012/13	N/A	NHS Trusts
NHS Trusts Performance	To receive a report on the performance of NHS Trusts providing services to Barnet residents against the NHS Outcomes Framework	N/A	Scrutiny Office / NHS Trusts
Diabetes Screening	To receive an update on the Members' Item considered at the 4 July 2013 meeting in relation to diabetes screening performance.	Cabinet Member for Public Health	Director of Public Health

Subject	Decision requested	Cabinet Member	Author
12 March 2014			
Items TBC			
12 May 2014 (NHS Quality Accounts)			
Barnet and Chase Farm Hospitals NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Barnet and Chase Farm Hospitals NHS Trust for 2013/14	N/A	NHS
Barnet, Enfield and Haringey Mental Health NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Barnet, Enfield and Haringey Mental Health NHS Trust for 2013/14	N/A	NHS
Central London Community Healthcare NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Central London Community Healthcare NHS Trust for 2013/14	N/A	NHS
North London Hospice Quality Accounts	To receive and comment upon the Quality Accounts from North London Hospice for 2013/14	N/A	North London Hospice
Royal Free Hospital NHS Foundation Trust Quality Accounts	To receive and comment upon the Quality Accounts from Royal Free Hospital NHS Foundation Trust for 2013/14	N/A	NHS
Unallocated Items			
Barnet Local Involvement Network (LINk) Annual Report 2012/13	To consider and review the final annual report of Barnet LINk for 2012/13	N/A	Barnet LINk Host (CommUNITY Barnet)

Subject	Decision requested	Cabinet Member	Author
Foundation Trust Status updates	To receive updates on the attainment of Foundation Trust status from NHS partners: • Barnet and Chase Farm Hospitals NHS Trust • Barnet, Enfield and Haringey Mental Health NHS Trust • Central London Community Healthcare NHS Trust	N/A	NHS
Health and Wellbeing Strategy	TBC	Cabinet Member for Public Health	Director for Public Health
Public Health Commissioning Intentions	TBC	Cabinet Member for Public Health	Director for Public Health
Physical Activity and Older people	TBC	Cabinet Member for Public Health	Director for Public Health
Schools Programme	TBC	Cabinet Member for Public Health	Director for Public Health
Public Health Programmes	TBC	Cabinet Member for Public Health	Director for Public Health
Director of Public Health Annual Report	TBC	Cabinet Member for Public Health	Director for Public Health

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