MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 8TH DECEMBER, 2014

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

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

Chairman: Councillor Alison Cornelius,
Vice Chairman: Councillor Graham Old

Councillors

Philip Cohen	Gabriel Rozenberg	Amy Trevethan
Val Duschinsky	Caroline Stock	
Arjun Mittra	Barry Rawlings	

Substitute Members

Shimon Ryde	Maureen Braun	Laurie Williams
Daniel Thomas	Kath McGuirk	Vacancy

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

Andrew Nathan – Head of Governance

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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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	AGENDA ITEM 7 **Barnet Health Overview and Scrutiny Committee** **8 December 2014**
Title	**Surgery Branch Closure – Business Case from Dr Isaacson & Partners**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Appendix A - Business Proposal for the closure of a branch surgery in East Finchley
Officer Contact Details	**Anita Vukomanovic, Governance Team Leader** **anita.vukomanovic@barnet.gov.uk** **0208 359 7034**

Summary
Dr Isaacson & Partners have drafted a business case which has been submitted to NHS England with the intention of closing their branch surgery in East Finchley. NHS England have instructed that Dr Isaacson & Partners include the views of the Barnet Health Overview and Scrutiny Committee regarding the possible closure. The Committee are asked to consider the business case attached at Appendix A. Representatives from Dr Isaacson & Partners will be in attendance to present the business case to the Committee, and to respond to any questions from Members. Dr Isaacson & Partners will include the comments made by the Committee in their Business Case, which will be submitted to NHS England.

Recommendations
That the Committee consider the report attached at Appendix A, and provide Dr Isaacson & Partners with their views on the proposed closure.

1. WHY THIS REPORT IS NEEDED

1.1 NHS England have instructed that Dr Isaacson & Partners include the views of the Barnet Health Overview and Scrutiny Committee regarding the possible closure.

2. REASONS FOR RECOMMENDATIONS

2.1 The report provides the Committee with the opportunity to formally put on record their views on the proposed closure, which will be considered by NHS England.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 The views of the Committee in relation to this matter will be passed on by Dr Isaacson & Partners to NHS England.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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

5.3 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.

5.4 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.

5.5 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.6 None in the context of this report.

5.7 Legal and Constitutional References

5.71 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.

5.7.11 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

"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."

5.8 Risk Management

5.8.1 Not receiving this report would present a risk to the Committee in that they would not be kept up to date on issues surrounding the provision of GP services in the area, or have the ability to pass their views on via the business case to NHS England.

5.9 **Equalities and Diversity**

5.9.1 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.

5.9.2 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.

5.10 **Consultation and Engagement**

5.10.1 This paper provides an opportunity for the Committee to be engaged in the proposed planning of the branch, and for their views to be passed on to NHS England.

6 **BACKGROUND PAPERS**

None.

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Appendix A - Business Proposal for the closure of a branch surgery in EAST FINCHLEY

Submitted to the Barnet Health Overview and Scrutiny Committee by Dr Isaacson & Partners

Summary:

This case is to propose the closure of a branch surgery. The practice has sought the views of the patients, staff and Barnet CCG. We currently offer GP services from two sites, Colney Hatch Lane and East Finchley.

Rationale:

Condition of premises:

- It is not equipped to the same level as the main surgery. Not to CQC standards.
- The premises do not provide ease of access to wheelchair users. They do not comply with the Disability Act 2010.
- There are no nappy changing or baby feeding facilities.
- Considerable amount of building work needs to be carried out in order to bring the premises up to standard, which are not feasible in such premises as the landlord will not give permission for structural changes.

Economies for rationalising services onto one site:

- Greater range of clinical expertise available under one roof.
- Enhanced patient safety due to continuity of care.
- Larger team with the ability to provide essential primary care services more effectively.
- GPs (Male & Female) and a Nurse are available for personal and telephone consultations everyday.
- Online patient access to book/ cancel appointments online, and request repeat prescriptions.
- More continuity of care at on one site rather than waiting several days to see same GP at branch.
- Improved telephone access at main site with 4 telephone lines as opposed to only one at the branch surgery.
- Increased access by phone and face to face during core hours, i.e. **8:00am – 6:30pm Monday – Friday.**

Difficulties for sustaining the current provision:

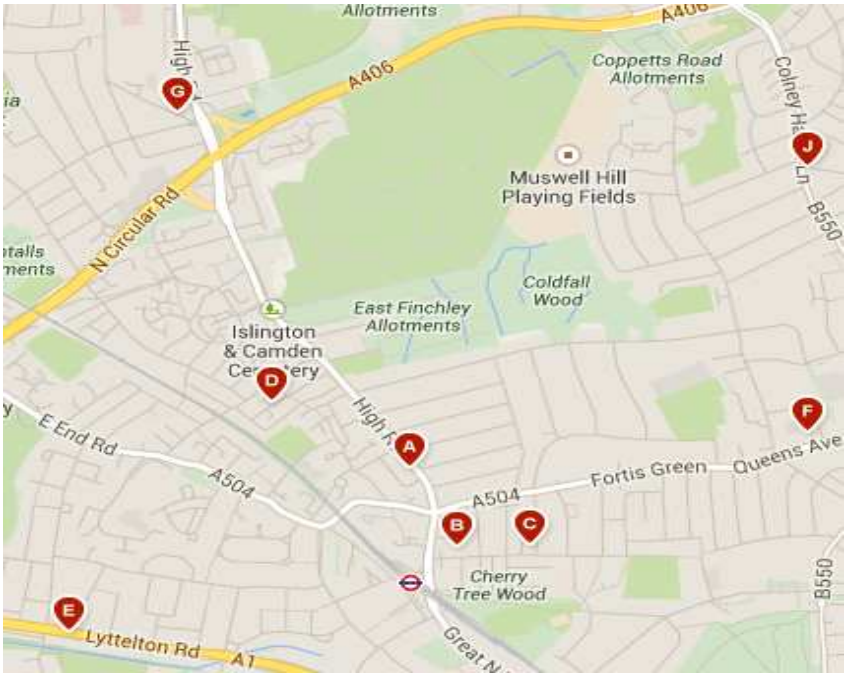
- Inability to provide high calibre services from branch surgery due to lack of staff and limited opening hours.
- Operating across two sites presents problems around communication and efficiencies of scale.
- Reduced clinical risk at main surgery due to the ability to conduct all necessary tests due to nurse and GP being on site together- therefore less delayed diagnosis.
- Vulnerability of lone worker (receptionist) at branch surgery.
- GP & nursing time is currently split on a rota basis between the two sites, resulting in inadequate & fragmented services on both sites, with patients not being able to see a full choice of doctors each day and infrequent nurse availability.
- Due to difficulties in sustaining 2 sites, opening hours and telephone access is currently very limited.

Patient views- from 71 letters received following 650 consultation letters sent to the households:

- They acknowledge the reasons for the proposed closure and agree that they are all valid.
- They do not want the surgery to close as for most of the patients, it is within walking distance.
- They like the idea of a “walk–in” surgery and feel they would have to wait much longer to see a GP if they had to make appointments.
- For some patients it is difficult to enter and exit the current building with buggies, however they do manage with the help of the practice staff.
- They sympathise that the GPs feel stretched with having 2 surgeries.
- Elderly patients feel as though they will be left stranded.
- Patients will register with another practice in East Finchley as they feel a bus ride to Muswell Hill will cause them inconvenience.

Patient Options:

1. Patients who use the branch surgery can remain registered with the practice though they will need to travel to Colney Hatch Lane to see a GP or Nurse.
2. The practice has stated that the GPs will still visit patients in their own homes if they are too ill or too frail to visit the surgery.
3. Patients who choose not to remain registered with the practice have a choice of 3 other practices within half a mile radius of the branch surgery and 3 further practices within a mile. The location of the branch surgery in the



context of other practices is shown below:

A – Current branch surgery at 91 High Road, East Finchley, London N2 8AG

	Name of Practice	Address	Telephone	Miles from branch surgery
B	Dr Twena & Partners	39 Baronsmere Road, London, N2 9QD.	0208 883 1458	0.20
C	Dr Decesare & Partners	Cherry Tree Surgery 26 Southern Road, East Finchley, London, N2 9JG.	020 8444 7478	0.29
D	Dr Dakin & Dr Ingram	54 Leopold Road, London, N2 8BG.	020 8442 2339	0.30
E	Dr Gibeon & Partners	8 Lyttelton Road, London, N2 0EQ.	020 8458 9262	0.74
F	Queens Avenue Surgery	The Surgery, 46 Queens Avenue, Muswell Hill, N10 3BJ.	020 8883 1846	0.75
G	Squires Lane Medical Practice	2 Squires Lane Finchley London N3 2AU	020 8346 3388	0.92

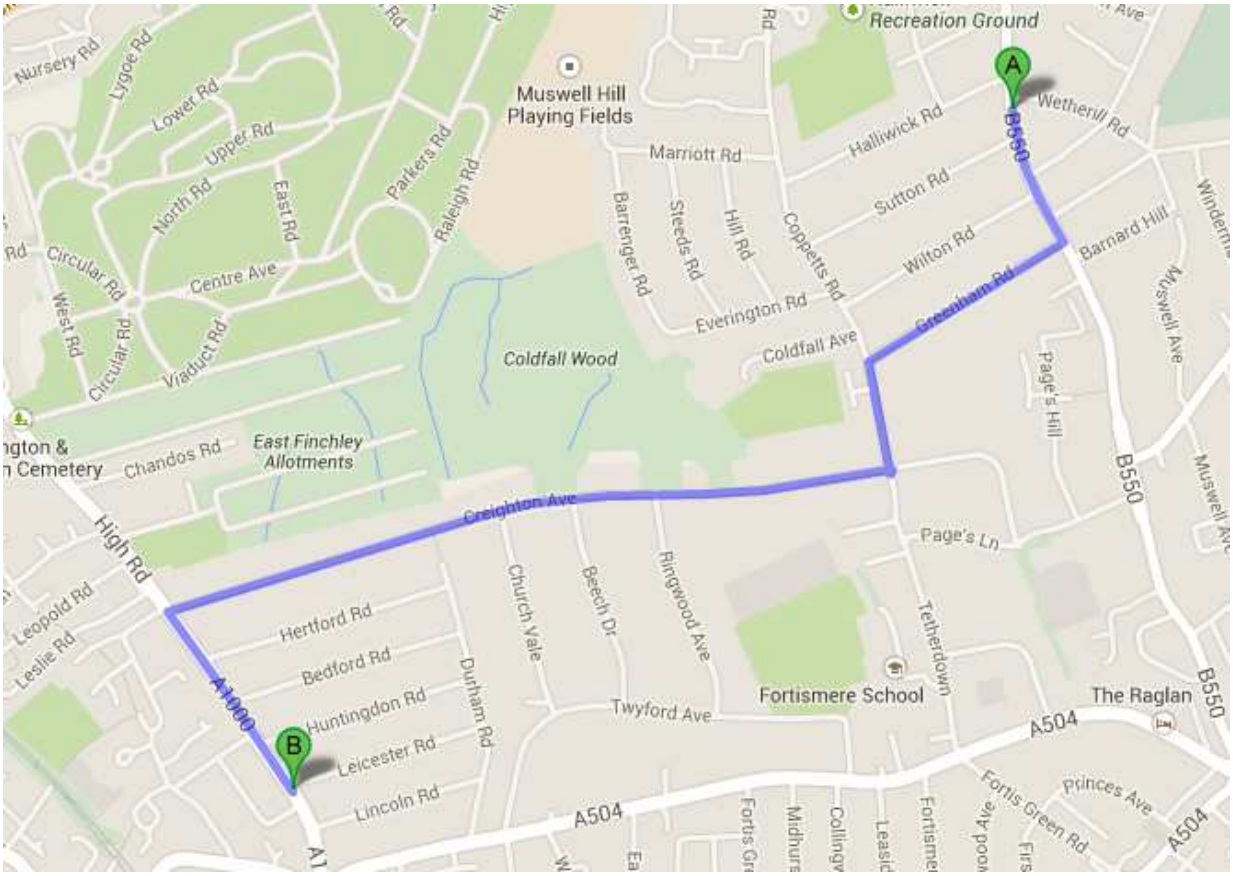
Introduction:

Dr Isaacson & Partners practice operates under a GMS contract. The practice currently has 3 GP partners. The main surgery has a list size of about 4607 patients and the branch surgery has a list size of about 1555 patients. Of the 1555 patients living closer

to the branch surgery, 1288 (83%) are under 65 years old, 136 (8%) are between 65 – 74 years and 127 (8%) are 75+ years.

The main site is located at 192 Colney Hatch Lane, Muswell Hill, London, N10 1ET and the branch site is located at 91 High Road, East Finchley, N2 8AG. The distance between the two sites is 1.5 miles which takes about 5 mins by car, 25 mins by public transport and 30 mins on foot.

Below is a map showing the directions from (A) Main surgery in Colney Hatch Lane to (B) Branch Surgery in East Finchley.



Core services provided at both sites are:

GP consultations: Appointments are made in advance at the main surgery. “Walk–In” type service at branch surgery. Services include antenatal clinic, baby clinics and family planning.

Home visits: This service can be arranged if an illness prevents patients from attending the surgery.

Practice nurse services: Asthma checks and advice, blood pressure monitoring, dressing and wound care, ear care, dietary advice, diabetic advice, immunisations, removal of stitches, sexual health advice and screening, smoking cessation advice, smear tests, travel advice and immunisations.

Health Care Assistant: phlebotomy clinic, new patient health checks. These services are only provided in the main surgery.

Main site:

GPs – 17 clinical sessions / week

Nurse- 6 clinical sessions/ week

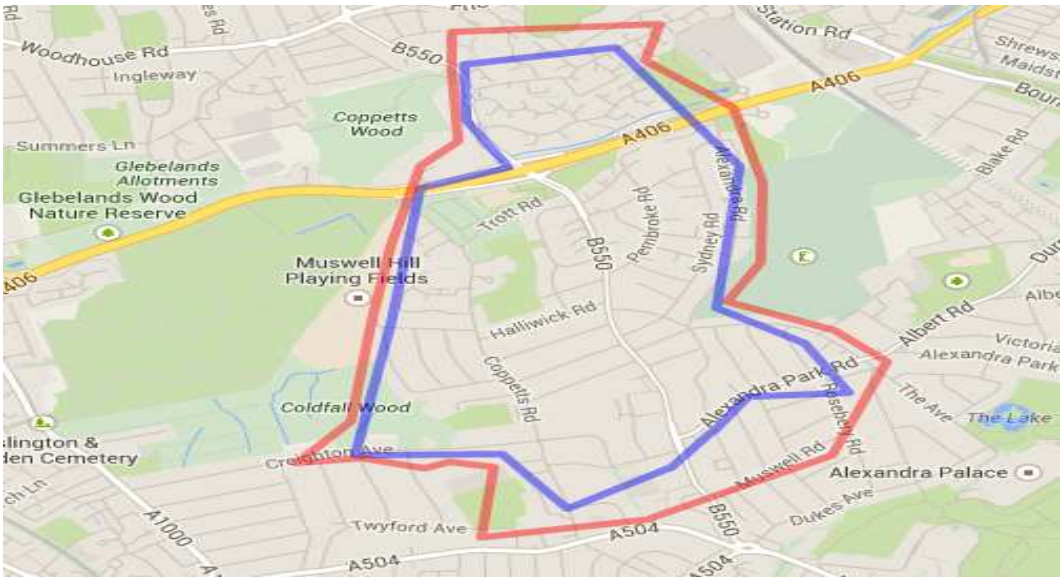
Admin staff- 4 Full time, 3 part-time staff

List size for main site- 4607

Branch Demography- The surgery is set up in a Victorian house on Colney Hatch Lane. It is very easy to find parking on the main road and near-by side roads as there is unrestricted parking. The surgery is very well suited for wheelchair users. There are 4 clinical rooms (3 GPs and 1 nurse), 2 admin rooms, a receptions room and waiting area for patients. The waiting area consists of various posters, leaflets and a video display unit which shows video information about different conditions that patients may have. The VDU also makes patients aware of services available within the practice. There is also a disabled toilet for patients.

Catchment area

Inner Boundary for patients wanting to register at our Surgery.
on B550 Colney Hatch Lane facing Halliwick Road



East Finchley:

GPs- 9 clinical sessions/ week

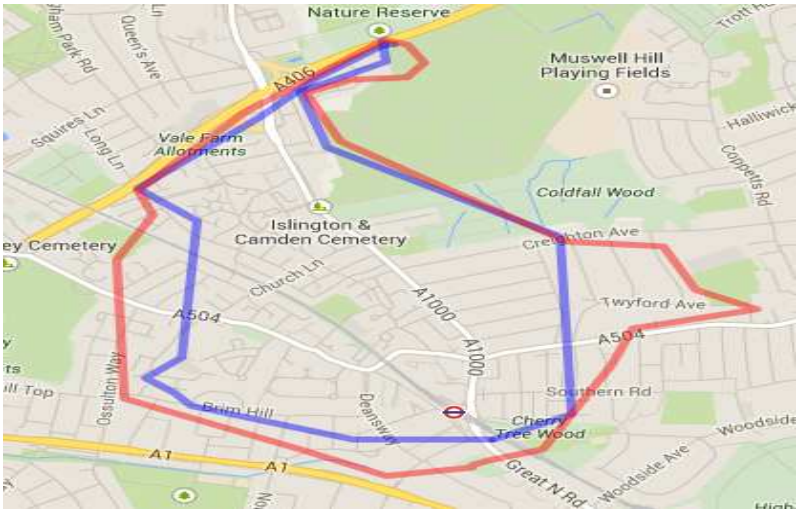
Nurse- 1 clinical session/ week

Admin staff- 3 part-time staff

List size for branch site- 1555

Branch Demography- the surgery is located on East Finchley High Road amongst various shops and cafes. It is very difficult to locate parking near the surgery as all the spots are for permit holders only at certain times. The GPs have a parking bay outside the surgery, which comes at a cost of £200 per GP per annum. The surgery is not suited for wheelchair users- some wheelchairs cannot get through the narrow entrance passage and doorway. There are 2 consulting rooms (1 doctor's room and 1 nurse's room), a reception room and a waiting area for patients. The waiting area consists of a few posters and leaflets but cannot hold much as the area is quite small. There is a patient toilet available for use, however it is not disable friendly. Wider wheelchairs cannot always get into the surgery.

Catchment area



Inner Boundary for patients wanting to register at our Surgery.
At 91 High Road, East Finchley, London N2 8AG (on A1000)

Outer Boundary for patients registered at our Surgery.

How the current practice works between the two sites and the constraints?

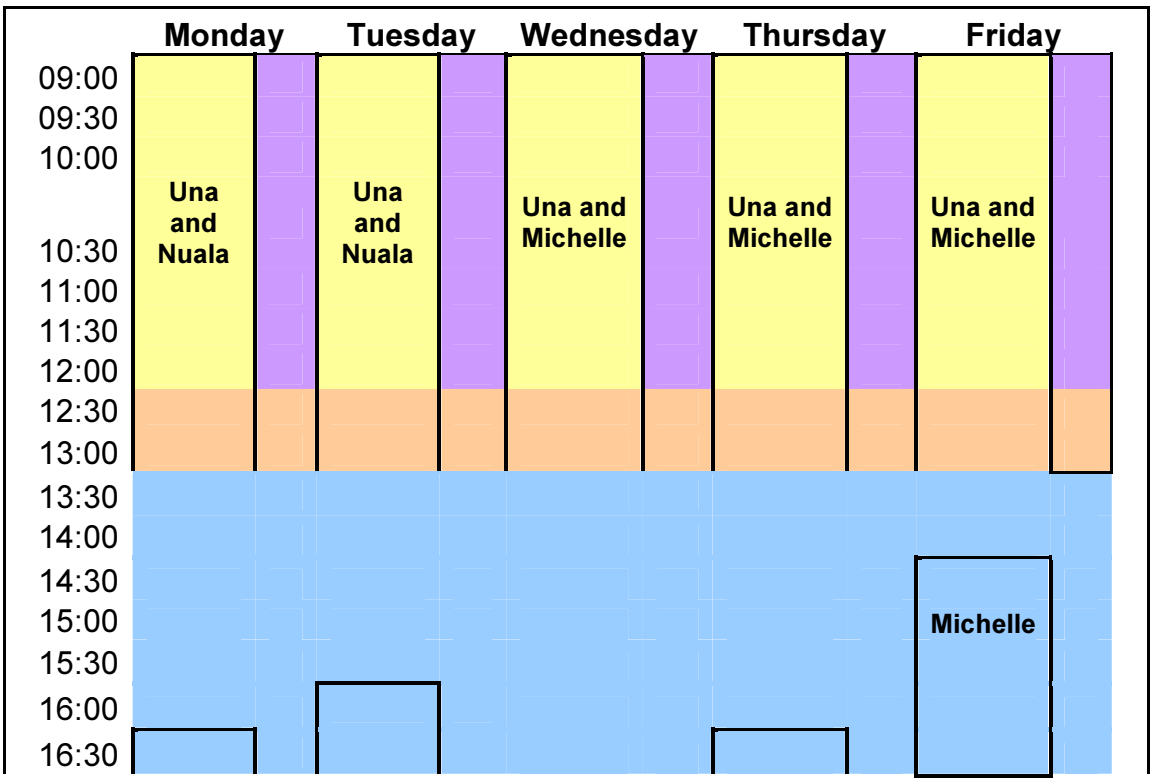
Our Practice continuously strives to provide high quality healthcare and we are very keen to maintain the best possible service to our patients. However, the two surgery sites, which are 1.5 miles apart, are maintained by 3 GPs, whose travelling time between sites reduces the appointment time available for patients. The most efficient way to improve services would be to offer them from just one site.

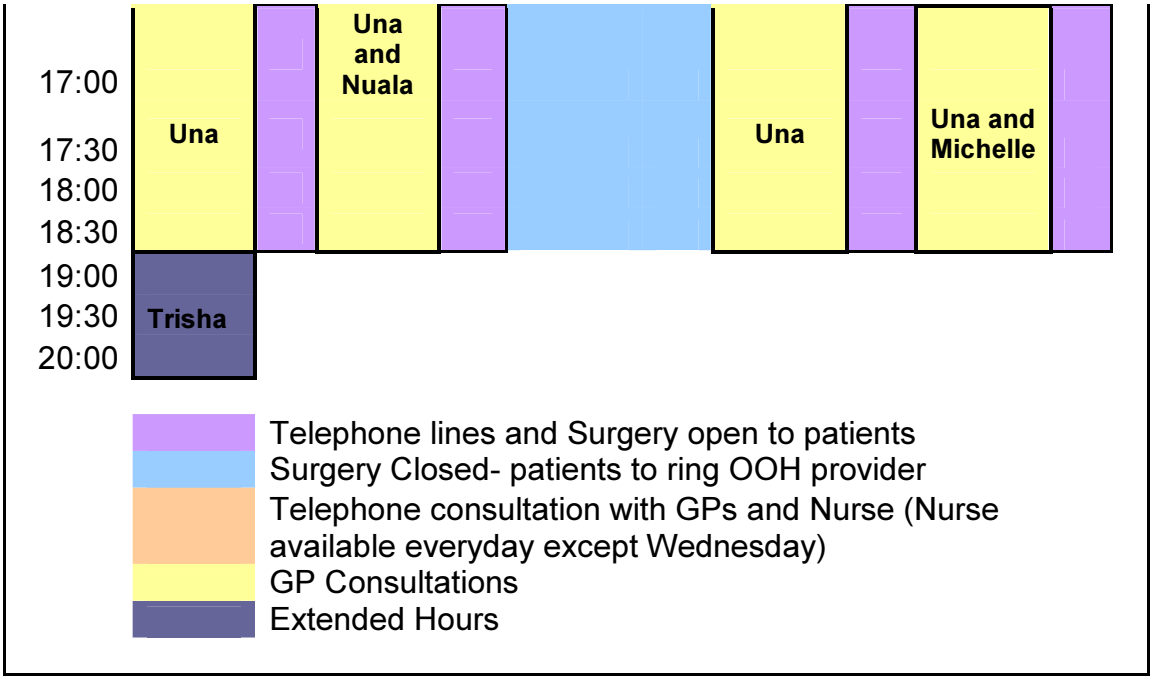
Currently the branch practice operates on reduced opening times, due to the time constraints. It is open for patients between 9-10am and 4:30 – 6pm. The telephones lines there are open from 9am-1pm and 5:00-6:30pm. This problem would be mitigated if the GPs were providing services from one site only, and patients would benefit through having a GP surgery that can remain open for longer.

The nature of care provided in general practice has been changing with more extensive management of chronic disease in practice, treatment of more complex cases, provision of a wider range of services by practices, availability of a wider range of staff working

with GPs. This change requires more equipment, extended staff range etc. and so cannot readily be provided in smaller premises by a single GP.

How does the practice team work now and how does it propose to work when on one site? The logistics of doing this, will there be reduction in staff?

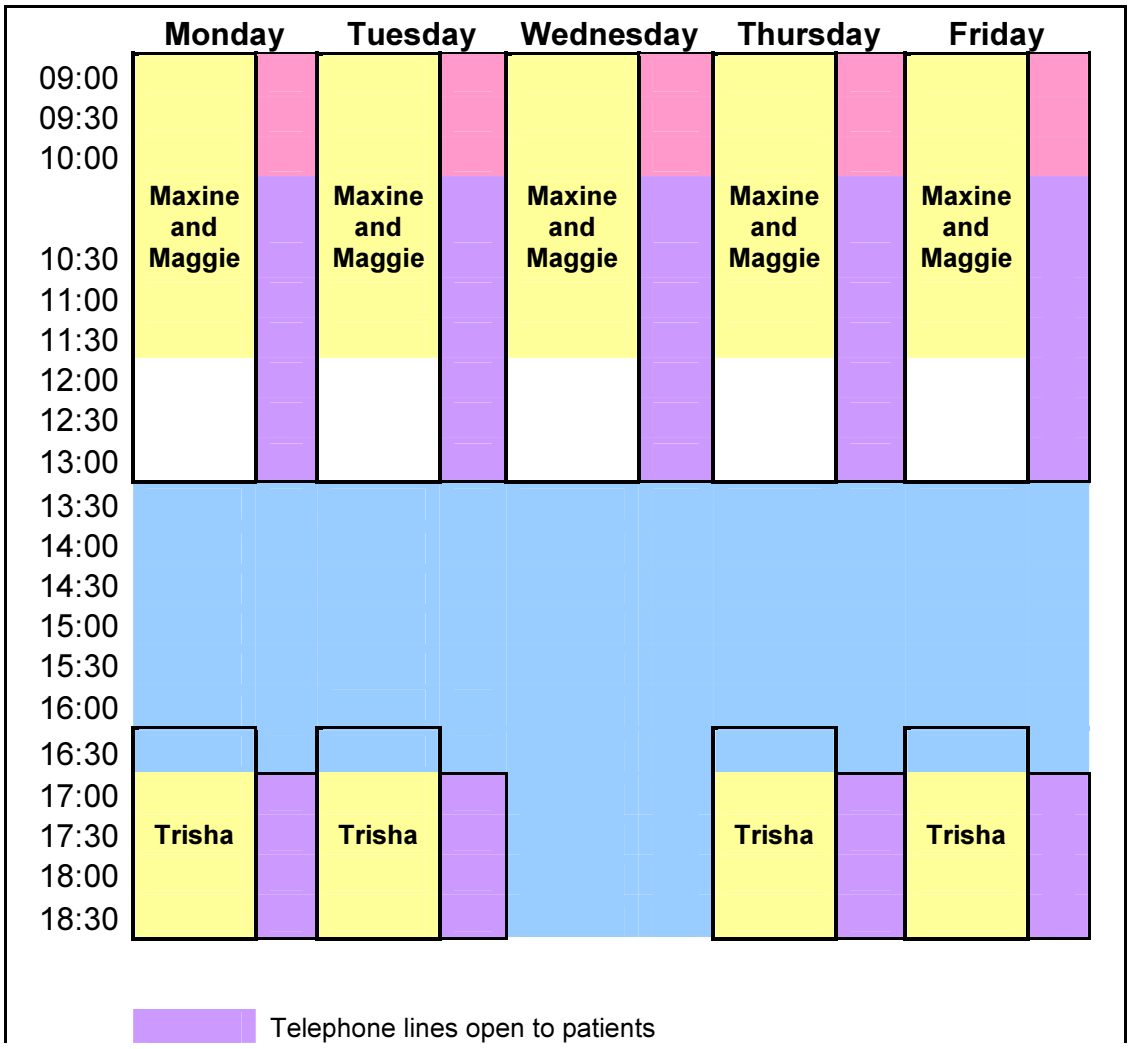


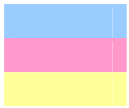


The table below shows how the practice team works at the main surgery.

As it can be seen in the table above, the reception team are there daily from 9am – 1pm. GPs start their consultations at 9am – 12pm and 4:50pm – 6:30pm daily. They then have telephone consultations from 12:30 – 1pm. We have a nurse on site on Mondays (9am – 1pm), Tuesdays (9am – 1pm, 4pm-6:30pm), Thursdays (9am – 1pm) and Fridays (9am – 1pm, 3:30pm-6:30pm). There is also a health care assistant on site who carries out the new registration health checks every Monday and Tuesday afternoons, and she holds a phlebotomy clinic every Wednesday morning 9am – 12pm. The surgery is closed between the hours of 1pm – 5pm. Any patients who need medical help between these times would need to contact Barndoc (OOH providers).

The table below shows how the practice team works at the branch surgery.





The above table of the practice team in the branch surgery shows that the reception team start at 9am – 1pm, and then 4:30pm – 6:30pm. There is always one GP on site who has consultations from 9am – 10am and 4:30pm – 6:30pm. They then deal with their admin (i.e. prescriptions, referrals etc). The GP would leave from the branch surgery at around 12pm, to go to the main surgery in time for the telephone consultations. A nurse is available at the branch surgery only on Thursday afternoons between 4:30pm – 6:30pm.

If the closure of the branch surgery is approved, then the staff that currently work in the branch surgery would be re-located to the main surgery and the **main surgery would stay open to all patients during core hours i.e. 8:00am – 6:30pm, Monday - Friday.** The GP appointment system would also be re-designed to accommodate for more patients. This will be easier as the surgery will have 3 full time/ equivalents GPs, and they will be able to fully concentrate on consulting from one site and therefore will be able to offer a wider choice of consultation sessions. This could be via telephone/ face-to-face consultations. The GPs being on one site full time will reduce costs (locum), and maintain continuity of care. This will be a benefit to the patients, as they will be able to see a GP or Nurse of their choice quicker than they used to before, therefore patient care will also improve. Locums will also be engaged as and when necessary.

This is not a training practice.

Case for Change:

The closure of the branch surgery will help the practice to address greater productivity gains and better access by offering the patients a wider choice of clinicians that they can see as opposed to just the one at the branch surgery. Having 3 full-time GPs and a nurse on site everyday will help in the management of long term conditions such as those supported by the QOF and the new DES- avoiding unplanned admissions. Our practice wants and needs to transform the way it provides services to reflect these growing challenges:

- An ageing population, growing co-morbidities and increasing patient expectations.
- Growing dissatisfaction with access to services.
- Registered lists: providing basis for coordination and continuity of care.
- Highly systematic use of IT: to support management if long term conditions, track changes in health status and support population health interventions like screening and immunisations.

The closure of the branch surgery means that the clinicians can solely concentrate on all of their patients from one site. When working from just one site, they can cut out wasted travelling time between the two practices. This then frees up more time for them to create an environment that enables the practice to play a much stronger role, as part of a more integrated system of out- of- hospital care, in:

- Pro-active coordination of care, particularly for people with long term conditions and more complex health and care problems.
- Holistic care: addressing people's physical needs, mental health needs and social care needs.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A & E attendances.
- Preventing ill health, ensuring a more timely diagnosis of ill- health, and supporting wider action to improve community health and wellbeing.
- Involving patients and carers more fully in managing their own health and care.
- Ensuring consistently high quality of care: effectiveness, safety and patient experience.

The patient views highlighted an impact on elderly patients and patients who indicated they had a disability in terms of access to services. The GPs are concerned and agreed that home visits would be carried out as necessary, where there were access difficulties to mitigate any impact on these patients.

It is acknowledged that the branch surgery provides ease of access to a GP for a number of patients who live close to the East Finchley surgery than the main surgery in Colney Hatch Lane. These include the elderly and disabled patients.

Based, however on the overriding need to ensure that the best quality care can be delivered to all patients, the fact that there are health and safety issues with the current branch surgery premises and taking into consideration that there are benefits to efficiently providing services from the main surgery only, to a larger number of patients, it is proposed that agreement is given to closure of the branch surgery.

Taking account of views expressed by the patients, and particularly concerns expressed by elderly and disabled patients, it is proposed that the GPs in the practice will be asked to ensure that any negative impact on these patient groups is mitigated.

Constraints in the current branch surgery premises do not enable the practice to increase or make changes to services. The space allowance at the main surgery will promote the ability for multi-disciplinary working and enable the introduction of new services.

As a result of the closure of the branch surgery, the clinicians will be able to focus on all their patients from one site. This will help address the strategic needs for primary care as:

- Patients will be helped in their goal to remain healthy and independent.
- Far more services will be delivered safely and effectively from the main surgery.
- Services will be integrated, built around the needs to patients, promoting independence and choice.
- Long standing inequalities in access and care will be tackled.

No changes would be required to be made to the current practice and branch IT systems as there is only one EMIS server between both sites that holds the patient list on EMIS Web and one Docman server, both of these servers are at the main surgery.

Patient communication and the use of IT etc. will improve following the proposed closure of the branch surgery through a range of contact systems such as telephone clinical triage, planned and urgent appointments, and home visits. The East Finchley patients who do want to stay with the practice in Colney Hatch Lane do not need to come to the surgery to pick up their repeat scripts. The surgery has been set up for

Electronic Prescribing Service- meaning the scripts are sent electronically to the patient's choice of nominated pharmacy.

Local factors: *from the Joint Strategic Needs Assessment, Primary Care*

Demographics

Barnet's rising local population (especially at the youngest and oldest extremes) will place pressure on all health and social care services, with a number of implications for health and wellbeing.

The projected growth in the child population, especially **5 to 9 year olds** will place significant demands on health, social care and education services. In addition to the general increase, improved survival rates also mean that there will be more children with complex needs which need supporting.

45-64 year olds – another expanding age group – are most at risk of developing long-term conditions, including obesity, raised cholesterol, high blood pressure, diabetes, stroke and heart failure. This may in turn lead to a rise in incidences of dementia further down the line.

While many **older people** are living independent lives, many will be dependent on care provided by family or public services. Over the next five years, there will be 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). Both of these increases are above the average growth rate (5.5%). In addition to the traditional health risks of old age, dementia is a particular issue that we can expect to see increase in prevalence as more people live into old age.

Ethnicity

Barnet is already a very diverse borough in 2011, with 33.1% of the local population belonging to non- white communities. Different ethnic groups have differing health needs and susceptibilities. Over the coming years, Barnet is forecast to become **increasingly diverse** (35.0% non-White by 2016), creating new and complex health

needs. It is vital that the unique health needs of these communities are properly understood and managed.

Deprivation

According to the latest release of the **English Indices of Deprivation**, Barnet is less deprived than it was three years ago, ranked as the 165th of 326 most deprived Local Authority Area. Barnet is a particularly diverse borough however, and although the Barnet average is averagely relatively deprived, there is a wide variance between different domains and different areas. No Lower Level Super Output Areas (LSOAs) in Barnet fall within the ten per cent most deprived nationally, six fewer than 2007. However 35 of 210 (16.67%) rank in the lowest ten per cent on at least one domain.

The two domains which have shown the greatest decrease in relative deprivation are Barriers to Housing and Services and Health Deprivation and Disability. In part the housing domain improvement is likely to be a change in the how data has been defined since the last release.7 No changes have been made to the methodology for the health domain, however this is a complex weighted measure in part based on prescription data.

The Barnet Local Development Framework (LDF) acknowledges the impact of access to good quality housing on public health and wellbeing. Among the priorities outlined in the document, there is a commitment to **providing quality homes and housing choice**, by developing wider choice in terms of tenures, types, size and affordability and a strategy for intelligent **distribution of growth in meeting housing aspirations**, which sets out the most sustainable locations for housing growth in the west of the borough together with the priority housing estates and town centres to avoid overcrowding.

Additional Health Indicators

Health inequalities can be thought of as potentially modifiable differences in wellbeing and in access to services of different types. Often, health inequalities are described in the context of deprivation, but avoidable disease is not something that only affects people in deprived areas, it simply occurs more often amongst those living in them.

Health inequalities in smokers (and between men and women)

A very large number of diseases are caused by, or worsened by, smoking and by inhaling second-hand smoke. Smoking-related diseases are more common amongst people living in more deprived areas because such people are, generally, more likely to smoke, but they affect people everywhere. It is noteworthy that deaths from chronic obstructive pulmonary disease in Barnet are dropping in men but have been relatively static in women until the last couple of years. This is probably because men and women have taken up smoking differently and have had different quit behaviours in past years.

Health inequalities in people who are obese

In Barnet, about 54,000 men, women and children are likely to be obese; a further 880 men and 3,100 women are likely to be morbidly obese.**10** Adults who are obese (i.e. who have a body mass index of 30 or greater) are at a greater risk of premature death and are more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders. Women who are obese are, generally, at greater risk than men of developing certain diseases. For example, obese women are nearly 13 times as likely to develop Type 2 (i.e. non insulin dependent) diabetes as obese men who are about five times as likely to do so.

In Barnet in 2010, 10.6% of children in reception and 17.5% in year six were found to be obese. For the reception age, the Barnet figure is slightly lower than the London average of 11.6 but slight higher than the England average of 9.8. The year six figure was lower than the London and England averages of 21.8% and 18.7% respectively.

The good news is that reducing weight reduces these risks. For example, if an obese person reduces their weight by 10% then their chance of dying prematurely is reduced by 20-25%, their blood pressure is likely to drop by 10-15mmHg,**13** the risk of developing diabetes can be reduced by more than 50%, and angina symptoms reduced by over 90%.

Health inequalities in people with mental health problems and people with learning disability

People with learning disabilities and those with mental health problems are much more likely to have significant health risks and major health problems: for those with learning disability this particularly includes obesity and respiratory disease, and for those with mental health problems obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke. People with severe and enduring mental illness are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population.

Health inequalities in people with diabetes mellitus

Whilst about 3% of the general population has Type 2 diabetes mellitus, some 20% of Asians and 17% of Black Africans and African Caribbean's do so. Diabetes principally damages blood vessels and thus compromises the blood supply to vital organs. It increases the risk of heart attack and death from heart attack, stroke, kidney failure, loss of sensation in the feet, foot ulceration and loss of toes and parts of the feet from dry gangrene. Diabetes is also the most common cause of blindness in people of working age. It is also noteworthy that diabetic complications such as heart attack, stroke and kidney failure are three-and-a-half times more likely to occur in people with diabetes who live in deprived areas.

The incidence of Type 2 diabetes is increasing, and the age of onset is decreasing, as more and more people in this country become obese. It is also five times more likely to develop in people with severe mental illness than in the general population.

Non Demographic Factors

Everything has to be paid for and the budgets available for both health and social care are finite. Public bodies are statutorily required to break even at the end of the financial year, i.e. not to spend more money than is available, and thus services have to be commissioned to provide the greatest benefit for the greatest number within available resources.

Most acute hospital services are charged at a national 'tariff' rate. Whilst this standardises the cost to commissioners for each activity there are still differences between hospitals because of

(i) Defining services differently, e.g. one hospital defining a procedure as an outpatient one and another as a day case one (the latter costing more), and

(ii) Differences due to a ‘market forces factor’, whereby hospitals sited closer to the centre of London uplift their prices because staff receive Inner London Weighting as part of their salaries.

This latter difference means that the same procedure, which should be provided with the same quality, will cost commissioners more if a patient is treated in an inner London hospital than an outer London one. In addition, there have been increases in the national tariff prices for a number of acute hospital services.

In order to ensure that care is provided in the most clinically and cost effective way, it is important that these changes in activity are understood more fully. Similarly, to ensure best value for money, it is also important to identify how safe and effective services can be provided in the most cost-effective way, which may necessitate shifts from acute hospitals to community-based care, including the provision of more services in a primary care setting, and changes in the pathway of care.

The care market then is a mix of well-established and immature markets and is shaped by commissioners, independent and voluntary sector providers, regulators, services users and their carers.

The care market in Barnet is dominated by residential care, with 121 care homes within Barnet offering 3,082 places, around a half of which are registered as ‘dementia beds’. Barnet social services purchases just over a quarter of available beds in Barnet, as well as buying a third of its provision from homes outside the borough. With NHS purchasing included, this proportion rises to around 50%. The remaining half of the market is made up of people funding their own care and people placed here by other local authorities.

Nearly a half of residential homes and beds within Barnet are located in the North cluster, although homes and beds with nursing facilities are concentrated in the South cluster.

Options Appraisal

Option 1: – To remain as is providing services from 2 sites

Detail	Constraints	Benefits
Patients	Ageing population and consequent demands upon healthcare providers.	Patients have the convenience to a walk-in surgery in East Finchley.
Premises	Branch surgery in East Finchley not fit for purpose- difficult for wheelchair users and buggies to enter and exit the branch surgery due to the structure of the building.	Main surgery is fully disabled friendly. Ease of access for wheelchair users and buggies.
Efficiency	Very time consuming for clinicians to travel between the two surgeries.	Plenty of parking available on the main and side roads near the main surgery.
Affordability	Very high costs (staff, locums, rent and rates)	
IT	The administration work for both surgeries is currently carried out from the main surgery. Slow IT connections at branch surgery.	One EMIS server and Docman server- both at the main surgery.

Option 2: - To rationalise services onto one site

Detail	Constraints	Benefits
Patients	East Finchley patients will have to travel to Colney Hatch Lane to see a GP or Nurse.	Patients will have the opportunity to consult with a GP of their choice and be offered a greater range of services.
Premises	Extra space will need to be created for	Premises at the main surgery are

	the Lloyd George patient records from the branch site, which is manageable.	fully disabled friendly.
Efficiency		Clinicians do not need to travel between the two sites, therefore can concentrate more on the patients.
Affordability		Reduced costs. (Locum and rates). No rent.
IT		No disruption to the servers.

Conclusion

As previously stated in earlier parts of the document, the current premises of the branch surgery is no longer fit for purpose. The proposal is for approval for the closure of the branch surgery and to provide services from the main surgery only. The branch surgery carries many underlying problems, such as inadequate parking facilities and due to the restriction of the size of the site, it is unable to expand ay further to allow for disabled access, furthermore the landlord will not give permission for structural changes.

The location of the main premises provides better access to the surgery and it is served by a frequent bus service. The location also allows for ample car parking space which is in contrast to the current provisions at the East Finchley site. The population of the area is growing and the needs of the patients are also increasing. With an ageing population, the main premise is proofed to be fit for purpose to continue to provide a sustainable service to all the patients. The main surgery premises will not only allow the practice to expand the provision of GMS services it currently provides, but also allow the practice to be able to help develop enhanced primary and community services.

The main benefit to patients would be that the surgery will be accessible during the core hours i.e. 8:00am – 6:30pm, Monday – Friday. At present both sites have limited accessible hours for patients.

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AGENDA ITEM 8

Health Overview and Scrutiny Committee
8 December 2014

Title	**Liverpool Care Pathway: Update from the North London Hospice**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Appendix A – Report from North London Hospice Appendix B – Extract from "One Chance to get it Right", by The Leadership Alliance for the Care of Dying People. Appendix B is available in full here: http://tinyurl.com/mad2kql
Officer Contact Details	Anita Vukomanovic, Governance Team Leader anita.vukomanovic@barnet.gov.uk 0208 359 7034

Summary

At their meeting in May 2014, the Barnet Health Overview and Scrutiny Committee considered the North London Hospice's Quality Account. During the consideration of this item, the Committee noted that the Liverpool Care Pathway was due to be phased out. The Health Overview and Scrutiny Committee requested that the North London Hospice attend the Committee at a future date to provide an update in relation to the phasing out of the pathway, and to be provided with an update on the new approach taken to care planning.

The report at Appendix A provides a short submission from the North London Hospice about the phasing out of this pathway.

The independent Neuberger review of the Liverpool Care Pathway (LCP) recommended that the Liverpool Care Pathway be phased out by 14 July 2014. Following this, The Leadership Alliance for the Care of Dying People (LACDP) produced a document called "One Chance to get it Right" which is attached (in part) at Appendix B.

Representatives will be in attendance on the evening to provide a further detail on the phasing out of the pathway, and to respond to questions from the Committee.

Recommendations

That the Committee note the report and update from the North London Hospice, and ask questions and make comments.

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health Overview and Scrutiny Committee have requested to receive this report, following their consideration of the North London Hospice Quality Account 2013-14.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the approach to care planning undertaken by the North London Hospice following the phasing out of the Liverpool Care Pathway.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Not applicable – the Committee is being asked to note the report.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

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

5.3 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.

5.4 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.

5.5 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.6 None in the context of this report.

5.7 Legal and Constitutional References

5.7.1 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

"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."

5.7.2 The LCP was not a single, simple medical procedure, and so there was no legal requirement for consent to be sought before it was used. However within the plan there were likely to be some aspects concerning treatment such as medication changes which would have required consent to treatment and for explanations to be given, and where issues may have arisen where the patient lacked the necessary capacity to give consent. There is an existing practice direction from the Court of Protection(Practice Direction (9E)) which requires decisions involving serious medical treatment for those lacking capacity to be referred to the court for decision. The Independent Review ' More Care Less Pathway' found that the LCP documentation was deficient in making distinct and clear where the need for consent and explanation existed.

5.7.3 The Independent Review recommended phasing out the pathway approach and moving to individual end of life care planning for patients.

5.8 Risk Management

5.81 Not receiving this report would present a risk in that it would remove an opportunity for the Health Overview and Scrutiny Committee to have an oversight in the work done in relation to care planning following the phasing out of the Liverpool Care Pathway.

5.9 Equalities and Diversity

5.5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the committee should consider:

- 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.

5.5.2 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 duties contained within legislation, most notably s149 of the Equality Act 2010; consideration of equalities issues should therefore form part of their reports.

5.10 Consultation and Engagement

5.10.1 None.

6 BACKGROUND PAPERS

None.

Appendix A – Briefing Note from the North London Hospice on the Phasing Out of the Liverpool Care Pathway

The independent Neuberger review of the Liverpool Care Pathway (LCP) recommended that the LCP be phased out by 14 July 2014. In response to the report, The Leadership Alliance for the Care of Dying People (LACDP) published 'One Chance To Get It Right' in June 2014. The document outlines a new approach to caring for people in the last few days and hours of life, that focuses on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be. The approach is based on five new Priorities for Care that will be the touchstone for every point of care for those in the last days and hours of life and their families – from frontline health and care staff to commissioners and regulators.

The Neuberger report identified that the pathway approach to end of life care was flawed, rather than the principles of care at end of life. The recommendation was removal of the pathway and implementing individualised care planning with patients and their loved ones in line with the five priorities of care.

The Five new Priorities for Care are:

1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
2. Sensitive communication takes place between staff and the person who is dying and those important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.
4. The people important to the dying person are listened to and their needs are respected.
5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place

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ONE CHANCE TO GET IT RIGHT

Improving people's experience of care in the last few days and hours of life.

Published June 2014 by the

Leadership Alliance for the Care of Dying People

Publications Gateway Reference 01509

Alliance members

This document has been developed by the Leadership Alliance for the Care of Dying People (LACDP), which was established following an independent review of the Liverpool Care Pathway for the Dying Patient (LCP). The LACDP is a coalition of 21 national organisations that was set up to lead and provide a focus for improving the care of people who are dying and their families. The Alliance members are listed below:

Care Quality Commission
College of Health Care Chaplains
Department of Health
General Medical Council
General Pharmaceutical Council
Health and Care Professions Council
Health Education England
Macmillan Cancer Support
Marie Curie Cancer Care
Monitor
National Institute for Health Research
NHS England
NHS Improving Quality
NHS Trust Development Authority
NICE (National Institute for Health and Care Excellence)
Nursing and Midwifery Council
Public Health England
Royal College of GPs
Royal College of Nursing
Royal College of Physicians
Sue Ryder

Marie Curie Cancer Care also represented Help the Hospices and the National Council for Palliative Care; Sue Ryder also represented the National Care Forum; Macmillan Cancer Support also represented the Richmond Group of Charities.

Throughout the development of the policies and processes cited in this document, the Leadership Alliance for the Care of Dying People has given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

Contents

Executive summary

This document sets out the approach to caring for dying people that health and care organisations and staff caring for dying people in England should adopt in future. The approach should be applied irrespective of the place in which someone is dying: hospital, hospice, own or other home and during transfers between different settings.

The approach has been developed by the Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations concerned to ensure high quality, consistent care for people in the last few days and hours of life.[1] The Alliance was established following an independent review of the Liverpool Care Pathway for the Dying Patient (LCP), which reported in July 2013.[2] The LCP was an approach to care developed during the 1990s, based on the care of the dying within the hospice setting, with the aim of transferring best practice to other settings. The review panel found evidence of both good and poor care delivered through use of the LCP and concluded that in some cases, the LCP had come to be regarded as a generic protocol and used as a tick box exercise. Generic protocols are not the right approach to caring for dying people: care should be individualised and reflect the needs and preferences of the dying person and those who are important to them.

The review panel recommended that use of the LCP should be phased out by July 2014; the Minister for Care and Support agreed this recommendation.[3] This document sets out the approach that should be taken in future in caring for all dying people in England, irrespective of whether organisations were previously using the LCP.

The approach focuses on achieving five Priorities for Care. These make the dying person themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person. The way in which the Priorities for Care are achieved will vary, to reflect the needs and preferences of the dying person and the setting in which they are being cared for. This approach is not, in itself, new. Where good care for dying people has been and continues to be given, it is typified by looking at what that care is like from the perspective of the dying person and the people who are important to them and developing and delivering an individualised plan of care to achieve the essentials of good care. Many health and care organisations and staff are already doing this and in some cases, as the review panel found, used the LCP to help them do so. However in other places, the LCP was associated with standardised treatment and care, carried out irrespective of whether that was right for the particular person in the particular circumstances. In some cases, the delivery of standardised treatment and care caused unnecessary distress and harm to dying people and those who were important to them. The risk of this continuing to happen is not tenable. Hence, the new approach set out in this document will replace the LCP.

1 Listed at Annex A.

2 *See More Care, Less Pathway. A Review of the Liverpool Care Pathway*, at: https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients

3 See Commons Hansard 15 July 2013 Cols 62-64 WS

Priorities for Care of the Dying Person

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours..

1. This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The variations in care for dying people found by the review panel highlight that where change is needed, it is in the practice of particular local organisations and staff. The role of national organisations is to require, encourage and support that change. In some instances where organisations are delivering poor care to dying people, the issue is not just about care in the last few days and hours of life. The Francis Inquiry[4] into the events at Mid Staffordshire NHS Foundation Trust highlighted an organisational culture that tolerated poor standards and a disengagement from managerial and leadership responsibilities. Where these sorts of failings occur it is very likely that their manifestation in poor standards of care will include poor standards of care for dying people. The programme of action being taken in response to the findings of the Francis Inquiry will, therefore, be a key element in ensuring consistent, high quality care for people in the last days and hours of life.

In addition, the 21 organisations in the Leadership Alliance for the Care of Dying People are committed, as appropriate to their individual roles, to requiring, encouraging and supporting the changes local organisations and individual staff need to make to deliver the five Priorities for Care of the Dying Person consistently for everyone in the last few days and hours of life in England. As well as setting out the five Priorities for Care of the Dying Person in detail, this document sets out what the members of the Leadership Alliance will do to require, encourage and support their adoption and delivery. Annex B relates these actions to the recommendations for national organisations made by the LCP review panel. The document is accompanied by a separate commitment statement and call to action by Alliance members. This sets out their collective and individual commitments to ensuring that all care given to people in the last days and hours of life in England:

- is compassionate;
- is based on and tailored to the needs, wishes and preferences of the dying person and, as appropriate, their family and those identified as important to them;

[4] See www.midstaffspublicinquiry.com

- includes regular and effective communication between the dying person and their family and health and care staff and between health and care staff themselves;
- involves assessment of the person's condition whenever that condition changes and timely and appropriate responses to those changes;
- is led by a senior responsible doctor and a lead responsible nurse, who can access support from specialist palliative care services when needed; and
- is delivered by doctors, nurses, carers and others who have high professional standards and the skills, knowledge and experience needed to care for dying people and their families properly.

Nothing less will do.

Background

The Liverpool Care Pathway

1. The LCP was an approach to care developed during the 1990s, based on the care of the dying within the hospice setting, with the aim of transferring best practice to other settings. The LCP provided guidance on a range of different aspects of care, including: comfort measures; anticipatory prescribing of medicines; discontinuation of interventions that were no longer necessary or in the patient's best interests; psychological and spiritual care; and care of the family (both before and after the patient's death).[5] A range of support materials and guidance was available to support the use of the LCP: these included template documents; training for health and care staff; and arrangements for audit and evaluation about how the LCP had been used and its outcomes.

The Independent Review

2. Following concerns expressed particularly by families during 2012, the Minister for Care and Support commissioned an independent review of the LCP in January 2013, under the chairmanship of Baroness Julia Neuberger. The terms of reference for the review are at Annex F. The review received 483 submissions from members of the public, 91 from health and care professionals, some of whom also had experience of the LCP in their personal capacities, and 36 professional bodies and other organisations. Members of the review panel made visits to health providers that were using the LCP in a range of care settings. The panel held sessions in Leeds, London, Preston and Bristol, where they met 113 members of the public to hear their experiences directly from them.[6] The panel published its report on 15 July 2013. Most of the panel's recommendations were for national organisations, reflecting the Panel's focus on creating strategic frameworks to deliver better care.

The Leadership Alliance for the Care of Dying People

3. In response to the panel's report, the 21 national organisations listed at Annex A came together to form the Leadership Alliance for the Care of Dying People. The starting point for the Alliance was the group of statutory/regulatory bodies to which the review panel addressed particular recommendations. This group invited other interested organisations, including charities, to develop, support and contribute to this work as members of the Alliance. The terms of reference and membership for the Leadership Alliance are at Annex A. The purpose of the Alliance was to take collective action to secure improvements in the consistency of care given in England

[5] Ellershaw J, Wilkinson S: *Care of the Dying: A Pathway to Excellence*, 2nd Ed. Oxford: Oxford University Press, 2011, Introduction

[6] See *More Care, Less Pathway. A Review of the Liverpool Care Pathway,* p. 13, paragraph 1.6 at: https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients

to everyone in the last few days and hours of life and their families. Its objectives were to:

- support all those involved in the care of people who are dying in responding to the findings of the review; and
- be the focal point for the system's response to the findings and recommendations of the LCP review.

4. The Alliance has now fulfilled these purposes and ceased to be as such. However, members of the Alliance, along with other bodies, will continue to work collectively to improve end of life care in England. This will include joint work to set and deliver future ambitions for end of life care. The joint working which has been done through the Alliance and which national organisations intend to do more widely to improve end of life care reflects the "national coalition" called for by the review panel. (Recommendation 39.)
5. The key part of the Alliance's work was the development of Priorities for Care, intended as the basis of care for everyone in the last few days and hours of life, irrespective of whether that care is provided in a hospital, hospice, the person's home (including care homes) or another place. Alliance members are committed to taking forward the Priorities for Care and have already taken individual and collective action to implement the Priorities for Care, in response to the review panel's recommendations and more widely.
6. The Alliance conducted widespread engagement on a draft version of the Priorities for Care (which were at that time called "outcomes and guiding principles"). The results of the engagement are reflected in the final version of the Priorities for Care.
7. The Priorities for Care reinforce that the focus for care in the last few days and hours of life must be the person who is dying. They are all equally important to achieving good care in the last days and hours of life. Each supports the primary principle that individual care must be provided according to the needs and wishes of the dying person. To this end the Priorities are set out in sequential order. The Priorities are that, when it is thought that a person may die within the next few days or hours of life:
   - This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
   - Sensitive communication takes place between staff and the dying person, and those identified as important to them.
   - The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
   - The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
   - An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

8. The Priorities for Care are supported by:
   - duties and responsibilities of health and care staff to deliver the Priorities for Care (see Annex D);
   - implementation guidance for service providers and commissioners (see Annex E).
9. The Priorities for Care are relevant and accessible to everyone. The supporting documents are not alternative forms of the Priorities for Care. They are articulations of the Priorities for Care intended to make clear what individuals and organisations should do to deliver good care for dying people.

Acknowledgements

10. During this work, the Alliance received an immense amount of support from organisations and individuals. Alliance members are grateful to all those who have contributed, including:

- those bereaved families and other individuals with experience of the care of dying people who attended workshops to discuss the draft "Outcomes and Guiding Principles", including families and individuals who had previously given evidence to the review panel;
- families and others with experience of receiving care for dying people who gave their views on-line and directly;
- Help the Hospices, Macmillan Cancer Support, Marie Curie, Sue Ryder and the National Council for Palliative Care, who hosted and supported 12 regional workshops for individual family members and clinicians to discuss proposed "outcomes and guiding principles" for care in the last days and hours of life and how to take them forward;
- Macmillan Cancer Support, for also funding a rapid review in relation to current advice on caring for people in the last few days and hours of life and Help the Hospices for supporting the analysis through the provision of a researcher;
- health and care staff who attended the workshops, commented on the proposals on-line or otherwise put forward their views;
- members of the Alliance's Clinical Advisory Group and Guidance, Education and Training Advisory Group;
- other individuals who attended additional meetings and workshops and contributed from their personal and professional experience; and
- the Royal College of Physicians for providing the Secretariat to the Clinical Advisory Group.

11. Finally, Alliance members wish to thank the independent review panel members for their work in producing the report *More Care, Less Pathway*, and for their commitment to ensuring that dying people and their families receive the best care possible.

Priorities for Care of the Dying Person

12. Alliance members believe the starting point for ensuring excellent care for everyone in the last few days and hours of life should be a common description and understanding, between health and care staff and the dying person and those important to them and between staff themselves, of what such care looks like. This is in the form of five Priorities for Care of the Dying Person. Alliance members will monitor the situation as the Priorities for Care are implemented and expect to modify them in the light of feedback from dying people and their families and health and care staff, and as new research evidence becomes available. This will be done through an NHS England-initiated working group, which is being formed to support strategic work on the broader aspects of end of life care.
13. The Priorities for Care provide a new focus for caring for people in the last few days and hours of life, which involves assessing and responding to the holistic and changing needs of individual dying people and their families. Those providing such care, in whatever setting, including the person's home, will need to demonstrate (e.g. as part of CQC inspections) how they are achieving the Priorities for Care, not in a generic way, but by reference to the particular person. It will not be sufficient to demonstrate delivery of particular protocols or tools. Staff and service providers will need to be able to show that the Priorities for Care the Alliance has developed, through widespread engagement, are being met.
14. The Priorities for Care express the common principles of good palliative care. The duties and responsibilities of health and care staff to deliver them, which have also been set out by the Alliance, are consistent with standards of practice set out in GMC good practice guidance, *Treatment and care towards the end of life: good practice in decision-making*, the NMC's Code and competency standards for nursing practice, the HCPC's Standards of conduct, performance and ethics and the General Pharmaceutical Council's *Standards of conduct, ethics and performance*. (Panel recommendation 36 refers.)

Implementing the Priorities for Care

15. Key elements of the work Alliance members have done and will do to take forward the Priorities for Care of the Dying Person include:
    - The Priorities for Care are aligned with the existing NICE Quality Standard for End of Life Care.
    - NICE will take account of the Priorities for Care and accompanying Duties and Responsibilities of Health and Care Staff in drawing up a new Clinical Guideline on the care of dying adults, which it expects to publish in 2015.
    - The Priorities for Care and the accompanying Duties and Responsibilities of Health and Care Staff and Implementation Guidance for Service Providers and Commissioners are informing and will continue to inform CQC's new approach to hospital inspections, under which end of life care will be one of eight core service areas to be inspected.
    - They will also inform the inspection of end of life care in hospices, adult social care, community health services and general practice. They will also be taken into account as CQC undertakes a themed inspection focusing on end of life care, in 2014/15.
    - The NHS Trust Development Authority will support NHS Trusts to implement the Priorities for Care and Implementation Guidance for Service Providers to enable them to provide high quality end of life care.
    - The Priorities for Care and the Duties and Responsibilities of Health and Care Staff are aligned with the General Medical Council's good practice guidance, *Treatment and care towards the end of life: good practice in decision-making*, the Nursing and Midwifery Council's professional code of conduct, *The Code: Standards of conduct, performance and ethics for nurses and midwives*, the Health and Care Profession Council's *Standards of Conduct, Performance* and Ethics and the General Pharmaceutical Council's Standards of Conduct, Ethics and Performance, breach of any of which can endanger professional registration.
    - The forthcoming reviews of professional standards by the Nursing and Midwifery Council, the General Pharmaceutical Council and the Health and Care Professions Council (HCPC) will consider whether nursing standards, standards for pharmacy professionals and standards for HCPC-registered professionals respectively need to be strengthened in the light of the development of the Priorities for Care and the Duties and Responsibilities of Health and Care Staff.
    - The GMC will promote the Priorities for Care and the Duties and Responsibilities of Health and Care Staff as part of its work in 2014 to raise the profile of its guidance.

- Health Education England and other Alliance members will initiate work that guides health and care staff and educators in the use of the e-learning programme, e-ELCA[7], as a resource to support education and training.
- The Alliance has initiated work that will make existing advice to health and care staff on care for dying people, including the advice that already exists in relation to specific diseases and conditions, more accessible, through the creation of a central repository.
- The National Institute for Health Research (NIHR) has commissioned updates of Cochrane Reviews of evidence on medically assisted nutrition and on medically assisted hydration for palliative care patients, and these were published by the Cochrane Collaboration in April 2014. The NIHR has also commissioned a mapping of evidence requirements flowing from the Priorities for Care.
- The Alliance will use the outcomes from the results of the mapping and the recently established James Lind Alliance Priority Setting Partnership, which will work with families and others to find out what palliative and end of life care research is important to people who are likely to be within the last years of life, their families and those identified as important to the dying person, and the health and care staff who work with them, to inform the programme of future research around care for people in the last few days and hours of life.

16. Alliance members also agree with the foreword of the independent review panel's report and believe that it is essential that there should be a "proper National Conversation about dying". They take this to mean that everyone, members of the public, health and social care staff and the media should have opportunities to participate meaningfully in discussions about dying to raise awareness and understanding of this important part of life that everyone will experience, and to help ensure that people's care and experience is as good as it can be. Alliance members commit to working together and with all these groups to generate and promote this conversation.

[7] e-ECLA (End of Life Care for All) is a series of over 150 highly interactive sessions of e-learning on end of life care, which aims to enhance the training and education of health and social care staff involved in delivering end of life care to people.

The Priorities for Care of the Dying Person

17. The Priorities for Care reinforce that the focus for care in the last few days and hours of life must be the person who is dying. They are all equally important to achieving good care in the last days and hours of life. Each supports the primary principle that individual care must be provided according to the needs and wishes of the dying person. To this end the Priorities are set out in sequential order.
18. If it is established that a person lacks capacity at the relevant time to make the relevant decision, then a decision must be taken in their best interests in accordance with the Mental Capacity Act 2005. The person making the decision must, if it is practicable and appropriate to do so, consult:
    - anybody named by the person as someone to be consulted on either the decision in question or similar issues;
    - anyone engaged in caring for the person, close relatives, friends or others who take an interest in the person's welfare;
    - any holder of a lasting power of attorney or enduring power of attorney; and
    - any deputy appointed by the court to make decisions for the person.

    This is referred to below as a 'best interests decision'. Further guidance on how this decision should be made is provided in the Mental Capacity Act Code of Practice. If the person lacks capacity and there is a person with a registered lasting power of attorney who has the power to make the relevant decision, then the attorney should make the decision in the best interests of the person. It is also important to respect valid and applicable advance decisions.

Priority 1

This possibility [that a person may die within the next few days or hours] is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

19. When a person's condition deteriorates unexpectedly, and it is thought they may die soon, i.e. within a few hours or very few days, they must be assessed by a doctor who is competent to judge whether the change is potentially reversible or the person is likely to die. If the doctor judges that the change in condition is potentially reversible, prompt action must be taken to attempt this, provided that is in accordance with the person's wishes or in their best interests if it is established that they lack capacity to make the decision about treatment at that time. If the doctor judges that the person is likely to be dying, taking into account the views of others caring for the person, this must be clearly and sensitively explained to the person in a way that is appropriate to their circumstances (if conscious and they have not indicated that they would not wish to know), and their family and others identified as important to them. The person's views and preferences must be taken into account, and those important to them must be involved in decisions in accordance with the person's wishes. A plan of care must be developed, documented, and the person must be regularly reviewed to check that the plan of care remains appropriate and to respond to changes in the person's condition, needs and preferences.

Recognising 'dying'

20. Alliance members are concerned that there are misperceptions about the point at which a person becomes a 'dying person', at which treatment might end and care become palliative and about the level of certainty surrounding such judgements. Alliance members do not think that it is always possible or helpful to people who may be dying and their families to seek to make a definitive diagnosis of 'dying'. Care for people who are potentially in the last few days and hours should be a continuum, focusing on continually assessing their condition, needs and wishes and responding appropriately. However, professionals must make clear to the dying person and those who are important to them when it is thought that the person is likely to be dying and they should explain to them why they think this, what it is likely to entail and the uncertainties round this. Where a person's condition changes, this should be a 'trigger' for making decisions to change care and treatment (or review the position again later, e.g. when the senior clinician is next available). Even if it has been determined that someone may be dying, health and care staff must continue to offer them food and drink, provided eating and drinking would not harm the person. If the person wants this and needs help to eat and drink, health and care staff must provide that help.

21. The Alliance's approach creates a focus on recognition of patients who are clinically unstable and may not recover despite medical treatment, so that those patients and those important to them are as involved as much as possible in decisions being made about their care, rather than focusing on a 'diagnosis of dying', as occurred with the LCP. Alliance members themselves will adopt the approach of focusing on changes in the condition of someone who is likely to be dying, rather than diagnosing dying only. They will also stress the importance of ensuring that if someone is likely to be dying, this is clearly explained to the dying person (if conscious) and those important to them. They consider that this approach will deliver the intention behind the review panel's recommendation that definitions of time frames relating to end of life decision-making should be embedded firmly into the context of existing policies and programmes. (Panel recommendation 1 refers.)
22. The Alliance has considered the various prognostic tools that may help clinicians assess whether someone is in the last few days and hours of life, but has concluded that at the moment, there is insufficient evidence base for any specific tool to be endorsed by the Alliance (Panel recommendation 8 refers.)

Communicating about dying

23. The review panel noted that: "A common theme among respondents was that they were simply not told that their loved one was dying; this clearly contributed to a failure to understand that the patient was dying, compounded their distress and subsequently their grief, after what they perceived to have been a sudden death. It appears in these cases that conversations with relatives or carers to explain the diagnosis or prognosis had simply not taken place, or that doctors had used euphemisms such as 'making comfortable'. In other cases, discussions about the fact that the patient was regarded as dying took place hurriedly and inappropriately…" [8]
24. This is not acceptable practice. The Alliance's statement of the Duties and Responsibilities of Health and Care Staff includes that:

"If the doctor judges that the person is likely to die soon, s/he must clearly and sensitively communicate this to the dying person (if conscious). This includes explaining when and how death might be expected to occur and the basis for that judgement, acknowledging and accepting any uncertainty about the prognosis, and giving the dying person the opportunity to ask questions. The same communication must take place with those important to the dying person and others involved in that person's care"; and

"The goals of treatment and care must be discussed and agreed with the dying person, involving those identified as important to them and the multidisciplinary team caring for the person. These discussions must be clearly documented and accessible to all those involved in the person's care, taking into account the person's wishes about sharing their confidential information. Doctors and nurses must acknowledge, accept and communicate uncertainty that exists about the prognosis."

[8] *More Care, Less Pathway. A Review of the Liverpool Care Pathway,* p. 24, paragraph 1.49, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

Priority 2

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

25. Open and honest communication between staff and the person who is dying, and those identified as important to them, including carers, is critically important to good care. Clear, understandable and plain language must be used verbally and in all other forms of communication with the dying person and those important to them. If the dying person needs additional support to understand information, communicate their wishes or make decisions, these needs must be met. Communication must be regular and pro-active, i.e. staff must actively seek to communicate, not simply wait for the person or those important to them to ask questions. It must be two-way, i.e. staff must listen to the views of the person and those important to them, not simply provide information. It should be conducted in a way that maximises privacy. Communication must be sensitive, respectful in pace and tone and take account of what the dying person and those important to them want and feel able to discuss at any particular point in time. Staff must check the other person's understanding of the information that is being communicated, and document this.
26. The Alliance's statement of the duties and responsibilities of health and care staff includes that:

"Health and care staff must make time to talk with dying people, their families and those identified as important to them, including carers. They must listen, respond sensitively to their issues and concerns, provide information in a way that meets their communication needs and check that explanations and information are understood."

"The content and outcome of all discussions must be documented and accessible to all those involved in the person's care. This includes conversations about prognosis, goals of treatment and care plans at each point in time, and particular concerns that the person, their family and those identified as important to them have expressed."

(Panel recommendations 29, 30 and 31 refer.)

Priority 3

The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

27. Individuals vary in the extent to which they wish to be involved in decisions about their own treatment, though most would want to make or influence decisions about the care they receive, and the way this is delivered. This includes day to day decisions about food, drink and personal care, as well as clinical and treatment decisions. Individuals also vary in the extent to which they wish their families and those important to them to be involved in decision-making. Sensitive communication is needed to ascertain the wishes of the dying person and their wishes must be respected. The person, and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care. Where it is established that the dying person lacks capacity to make a particular decision, the decision made or action taken on their behalf must be in their best interests, and they should still be involved as far as possible in that decision.

Involvement of families in decision-making

28. The NHS Constitution pledges: "You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers."[9] The NHS Constitution Handbook includes more detail on what this right means and its legal underpinning.[10]
29. Involving families and carers in decisions about a dying person's treatment and care can be a very difficult and sensitive area: as the review panel noted: "It is clear that one of the central issues causing difficulty [with the LCP] seems to be some misunderstanding and uncertainty over whether deciding to implement the LCP is a treatment decision that requires the patient's consent (if the person has capacity) or requires the decision to be taken in the patient's best interests (if the person lacks capacity). In some cases, relatives and carers incorrectly consider they are entitled to decide what treatment their relatives receive, and in others clinicians fail to seek consent or consult the relatives and carers in a 'best interests' assessment when they should."[11] Alliance members agree that it should be made clear to dying people and those who are important to them whether they are being informed about, consulted about, involved in or taking particular decisions about treatment and care.

9 NHS Constitution, p. 9 www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf
10 NHS Constitution Handbook, pp. 70-71. www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf
11 *More Care, Less Pathway. A Review of the Liverpool Care Pathway*, p. 23, paragraph 1.44 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

Professional responsibility for decisions about care and treatment

30. An area of particular concern to the review panel was decisions to withdraw or not to start potentially life-prolonging treatments. They were concerned about the timing of such decisions, including when they were made overnight. Where this happens, there is likely to be less scope to involve people whom the dying person has indicated they would like to be involved in such decisions. The review panel was also concerned that in some cases, such decisions were being taken by staff without the requisite training and competence. The Alliance's statement of the duties and responsibilities of health and care staff sets out that: "Doctors, nurses and other healthcare professionals must carefully consider which decisions need to be made on-the-spot to ensure the person's comfort and safety, and which can and must wait for a review of the person's condition by the senior doctor who has responsibility for the person's treatment and care (who may know the person better and/or have relevant competence and information to inform treatment decisions) or a clinician with the appropriate training and competence to whom the responsibility has been delegated".
31. This is consistent with and reinforces that, in line with the Government's response to the Francis Inquiry[12], every hospital patient should have the name of a responsible consultant/clinician and nurse above their bed. The Care Quality Commission will include the latter in its inspection of the quality of end of life care experienced by people in acute hospitals. (Panel recommendations 13 and 14 refer.)

Communicating professional responsibility for care and treatment

32. If the dying person does not know which professionals are in charge of their care at any point in time, it is very difficult for them to make clear how far they want to be involved in decisions about their treatment and care and then, insofar as they want, be involved in them. If people who are important to the dying person are to be involved in those decisions, they also need to know who the senior doctor responsible for the dying person's care and the lead nurse are, including when this changes, e.g. at the end and beginning of shifts. The review panel said: "From experiences described to the Review panel, it is clear that patients, their relatives and carers need to know better who is the senior responsible doctor in their care…"[13] The Alliance's statement of the duties and responsibilities of health and care staff make it clear that the dying person and, as appropriate, those important to them, should always know who is in charge of the dying person's treatment and care. (Panel recommendations 14, 15, 26 and 27 refer.)

Capacity and advance decisions

33. Professionals must ensure that they comply with legal requirements in relation to representation or advocacy for people who lack capacity to consent. The Mental Capacity Act 2005 provides that in certain circumstances where the person lacks capacity to make a decision, arrangements for an independent mental capacity advocate, to represent and support the person, should be made. When considering

[12] *See Hard Truths The Journey to Putting Patients First - Volume Two of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: Response to the Inquiry's Recommendations,* p.195, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270103/35810_Cm_8777_Vol_2_accessible_v0.2.pdf

[13] *More Care, Less Pathway. A Review of the Liverpool Care Pathway,* p.36, paragraph 2.9, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

a person's capacity to make a particular decision, all practical steps to help the person to make a decision should be taken and it should be established whether the person has capacity. A person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to a matter because of an impairment of, or a disturbance in the functioning of the mind or brain. A person is unable to make a decision for themselves if they are unable to understand the information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision or to communicate the decision (whether by talking, sign language or any other means).

34. Professionals must also ensure they respect advance decisions that are valid and applicable to the circumstances. Where there is a person with a registered lasting power of attorney to make the particular decision, then the attorney should make a best interests decision for the person. Professionals are held accountable for best interests decisions primarily through professional standards and regulation. (See response to Panel recommendation 32.)

Priority 4

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

35. Families and those important to the dying person, including carers, have their own needs which they, and others, can overlook at this time of distress. They are often tired, both physically and emotionally, and may be anxious and fearful, especially if they are the dying person's main caregiver at home. Even those who may appear to be coping well appreciate an acknowledgement that the imminent death of somebody they love is hard and that they have a role in ensuring that their loved one receives a good standard of care as they near the end of life. Where they have particular needs for support or information, these must be met as far as possible. Although it is not always possible to meet the needs or wishes of all family members, listening and acknowledging these can help. If a person who is dying lacks capacity to make a decision, the decision-making process should be explained to those people who are supporting the person and they should be involved as much as possible.

Priority 5

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

36. A plan for care and treatment must be developed to meet the dying person's own needs and wishes in relation to how their care should be managed and any treatment preferences they may want to express. This plan must include attention to symptom control (e.g. relief of pain and other discomforts) and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. The person must be supported to eat and drink as long as they wish to do so, and their comfort and dignity prioritised. There must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this. This plan of care must be documented so that consistent information about the person's needs and wishes is shared with those involved in the person's care and available at the time this information is needed.

Planning care

37. Unless a death is sudden and could not reasonably have been foreseen (for example if someone suffers a fatal injury), it is part of good care for a dying person to plan ahead as much as possible, if they wish this, involving them as much as possible and making best interests decisions for people who lack capacity. The care plan should be reviewed as circumstances, including the dying person's preferences, change. The care plan or, as a minimum, key elements of it, should be immediately available to health and care staff who are or might become involved in caring for the dying person, (including ambulance services, social care services and 'out-of-hours' general practitioners), so that the person's preferences are known and can be taken into account across the range of services they receive.
38. As noted above, some people will deteriorate and die unexpectedly and the Priorities for Care should be applied in such circumstances. However, in many cases people will already be receiving care and the care plan for their last few days and hours of life will be part of a planning process that started days, weeks, months or even years before. For example, people with long-term conditions and vulnerable older people should have care plans in place, if they so wish, well before the last few days and hours of life. The process of planning for dying should be part of these and other care planning processes, with the pace and timing of discussions about dying reflecting the person's and, where appropriate, their families' and friends' readiness to discuss particular aspects.

39. Where a person is being cared for by NHS or care staff, current arrangements strongly encourage the creation of a care plan. All the support materials the Alliance is aware of encourage health and care staff to ensure dying people and, as appropriate, their relatives and friends, are involved in the planning process. However, there is evidence, from the review of the Liverpool Care Pathway and elsewhere, that plans for the last few days and hours of life are not always developed with the dying person and their loved ones, nor are they always transparent. Hence the Alliance's Priorities for the Care of the Dying Person make clear that there must be an individual plan of care. (Panel recommendation 38 refers.)

Food and drink

40. The review panel noted that most of the submissions it received from families that were critical of the LCP referred to hydration and nutrition. Food and drink can be important to people's comfort and psychological wellbeing, even where their physical needs for hydration and nutrition are met through other means.

41. The GMC guidance on *Treatment and care towards the end of life: good practice in decision-making 2010*[14] sets out clearly the need for patients to be offered food and drink orally, provided that it would not harm them (e.g. by causing choking). Specifically, it includes: "All patients are entitled to food and drink of adequate quantity and quality and to the help they need to eat and drink. Malnutrition and dehydration can be both a cause and consequence of ill health, so maintaining a healthy level of nutrition and hydration can help to prevent or treat illness and symptoms and improve treatment outcomes for patients. The doctor must keep the nutrition and hydration status of the patients under review. The doctor should be satisfied that nutrition and hydration are being provided in a way that meets patients' needs, and that if necessary patients are being given adequate help to enable them to eat and drink." It also states: "The offer of food and drink by mouth is part of basic care (as is the offer of washing and pain relief) and must always be offered to patients who are able to swallow without serious risk of choking or aspirating food or drink. Food and drink can be refused by patients at the time it is offered, but an advance refusal of food and drink has no force." Detailed guidance on assessing and meeting people's hydration and nutrition needs is also part of the guidance. Failure to follow the guidance may call into question a doctor's fitness to practise and endanger their registration. (Panel recommendation 17 refers.)

42. Similarly, the essential skills clusters for nutrition and fluid management as set out in the NMC's Standards for pre-registration education[15] have the effect that registered nurses must be able to assess and monitor nutritional and fluid status and, in partnership with patients and their carers, formulate an effective plan of care to ensure people receive adequate food and fluid. This includes identifying when nutritional status worsens or there are signs of dehydration and acting appropriately to correct these. They must also ensure that appropriate assistance is available to enable people to eat and drink and to ensure that people unable to take food by mouth receive adequate fluid and nutrition to meet their needs. In April 2014, the NMC published the standards for nursing practice, including the essential skills clusters on hydration and nutrition, as a separate document from the education standards, so that they are more easily accessible and to make it clear that they apply to all nurses, not just student nurses.[16] Nurses who fail to comply with the *NMC*

[14] *Treatment and care towards the end of life: good practice in decision-making 2010,* p.52, available at: www.gmc-uk.org/End_of_life.pdf_32486688.pdf
[15] http://standards.nmc-uk.org/Documents/Annexe3_%20ESCs_16092010.pdf
[16] The NMC's *Standards for Competence for Registered Nurses (2014)* document is available on the NMC website at: www.nmc-uk.org/Documents/Standards/Standards%20for%20competence.pdf

Code: Standards of conduct, performance and ethics, may call into question their fitness to practise and endanger their registration. There are similar duties on other health and care professionals and pharmacists. (Panel recommendations 18, 20 and 21 refer.)

Use of sedatives and pain relief

43. The review panel found a mixed picture in relation to the use of sedatives and pain relief, with some examples of exemplary and appropriate management. However, the panel also took evidence that opiate pain killers and tranquillisers had been used inappropriately and was concerned that, in some cases, these drugs were given as a matter of course, rather than from a need for symptom control. The panel noted that the previous focus of work on symptom management at the end of life had been based on patients with advanced cancer in hospices who were inevitably going to die in days to weeks, with no chance of recovery. The panel suggested that new research was needed on the use of drugs at end of life, and in particular on the extent to which sedative and analgesic drugs themselves contribute to reduced consciousness, and perceived reduction of appetite and thirst.
44. The Alliance is concerned that such research would not address directly the issue of ensuring that pain killers and tranquillisers are given appropriately for symptom relief, rather than as a matter of course. It also notes that what drugs do is well-known – it is the way in which they are used that can lead, amongst other effects, to reduced consciousness. (Panel recommendation 24 refers.)
45. A particular area of concern for the independent review panel was the use of syringe drivers with sedative drugs. (Panel recommendation 23 refers.) Syringe drivers are used typically when a person is un able to take medication orally. They are pumps, which provide regular doses of the particular drug. The review panel noted that, in some cases where syringe drivers were initiated, patients did not communicate again. This was distressing for families who had not been made aware that a syringe driver was going to be used, nor understood the effects of the drug being administered in such a way. The Alliance's statement of the duties and responsibilities of health and care staff includes that:

"All medications, including anticipatory medicines, must be targeted at specific symptoms, have a clinical rationale for the starting dose, be regularly reviewed, and adjusted as needed for effect."

"The reason for any intervention, including the use of a syringe driver, must be explained to the dying person and to those important to the dying person. Other than in exceptional circumstances, this should be done before it is used."

"The likely side effects of specific interventions, especially those that may make the person sleepy, must be discussed with the dying person to enable them to make informed decisions, and explained to those important to the dying person if the person wishes."

Advice from specialist palliative care teams

46. In many situations where people are in the last days and hours of life, the health staff caring for them will find it helpful to seek advice from palliative care teams. Hence Priority for Care 5 includes: "There must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this." The Alliance's implementation guidance for service providers and commissioners includes that service providers must: "Work with commissioners and specialist palliative care professionals to ensure adequate access to specialist assessment, advice and active management. 'Adequate' means that service providers and commissioners are expected to ensure provision for specialist palliative medical and nursing cover routinely 9am - 5pm seven days a week and a 24 hour telephone advice service. Where this service does not already exist, service providers and commissioners should formulate an action plan and commit to provision of such services within defined timelines. This should ensure the provision of specialist cover over 24 hours, including face to face assessment in the exceptional circumstances where this is necessary." (Panel recommendation 33 refers.)

Documenting treatment and care

47. It is part of professional practice that health and care staff keep clear and accurate records about all treatment and care given. The Priorities for Care do not cover this issue explicitly, because it is not specific to end of life care. However, the Review Panel received reports of incomplete and wrongly completed forms in relation to care given on the Liverpool Care Pathway. (Panel recommendation 7 refers.)
48. For nurses and midwives, the NMC Code currently states that nurses must:

"Keep clear and accurate records

- You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.
- You must complete records as soon as possible after an event has occurred.
- You must not tamper with original records in any way.
- You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.
- You must ensure any entries you make in someone's electronic records are clearly attributable to you.
- You must ensure all records are kept securely." [17]

49. Where these requirements are breached deliberately, as would be the case if a nurse or midwife sought to falsify records, this would be a disciplinary breach and could be cause for referral to the Nursing and Midwifery Council. The NMC's consultation on the draft revised Code was launched in mid-May 2014 and will run until mid-August 2014. The revised Code will be published in December 2014. It will consider the issue of falsification of records further in this context, with a view to

[17] See the NMC Code, p. 6 at: www.nmc-uk.org/documents/standards/the-code-A4-20100406.pdf

making it even clearer that falsifying documents for any reason, not just to deflect criticism of a failure of care for a dying person, is a serious fitness to practise matter.

50. The NMC frequently reminds people on their register that they must adhere to the Code and that falsification of records is a serious breach and may result in a referral and investigation into their fitness to practise. Details of the outcomes of hearings are published on the NMC website. A number of hearings have related to the falsification of records for which a sanction was applied. Where there are concerns that nurses might have falsified records, these should be raised with the NMC.

51. Similarly, *Good Medical Practice, 2013* (GMP 2013)[18] makes clear that doctors must keep clear and accurate records and that any documents they write or sign must not be false or misleading. GMP 2013, published in March 2013 and updated in April 2014, was sent to all doctors on the Medical Register. It reminds doctors that serious or persistent failures to follow the guidance will place their registration at risk. The GMC's guidance to panellists who consider doctors' fitness to practise says: "Dishonesty, especially where persistent and/or covered up, is likely to result in erasure". The GMC continues to deliver a programme of work to promote the advice in GMP 2013, which is described in the GMC commitment statement that accompanies this document.

52. The HCPC's Standards of Conduct, Performance and Ethics require registrants to "keep accurate records" (standard 10); and "behave with honesty and integrity" to ensure that their behaviour does not damage the public's confidence in the registrant or their profession (standard 13).[19] Behaviour contrary to these standards would be cause for referral to the HCPC and dishonesty is an issue considered very seriously by its fitness to practise panels. The HCPC will continue its ongoing engagement with those on its Register to ensure that these expectations are explored and understood. As part of its forthcoming review of its Standards of Conduct, Performance and Ethics, the HCPC will consider strengthening its expectations of registrants with reference to their responsibility to identify and be open about failures in care, and to take steps to put right any failures. The HCPC will consider strategies for the promotion and dissemination of its new standards as part of this review.

53. The GPhC's standards of Conduct, Ethics and Performance state that registrants must keep full and accurate records of the professional services they provide in a clear and legible format (standard 1.8) and be honest and trustworthy (Principle 6).[20] GPhC will consider the issue of falsification of records further in the context of its forthcoming review of the standards of Conduct, Ethics and Performance.

54. In response to the Francis Report[21], the Government announced that the existing professional duty of candour on individuals will be strengthened through changes to professional guidance and codes[22]. The General Medical Council, the Nursing and Midwifery Council, Health and Care Professions Council and other professional regulators are working to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors and nurses, and other health professions, to be candid with patients when mistakes occur, whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities. The

18 See *Good Medical Practice,* 2013, paragraph 71, available at: www.gmc-uk.org/guidance/news_consultation/20477.asp

19 See HCPC Standards of Conduct, Performance and Ethics, pp13-14 which is available online at: www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics

20 See GPhC Standards of Conduct, Ethics and Performance, p8, p14 which is available online at: www.pharmacyregulation.org/standards/conduct-ethics-and-performance

21 www.midstaffspublicinquiry.com/report

22 *Hard Truths: the journey to putting patients first. Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry,* Executive summary, paragraph 15 – available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Professional Standards Authority will advise and report on progress with this work.

55. The NHS standard contract for 2014/15 includes a duty of candour in relation to patient safety. In addition, the Government has recently consulted on the proposal to introduce a statutory duty of candour as a CQC registration requirement in secondary legislation. This will also be a major step towards implementing a key recommendation from the Francis Report. The registration requirement will require all CQC registered providers to inform people if they believe treatment or care has caused significant harm, and provide an explanation and, where appropriate, an apology. CQC will decide when to take enforcement action for a failure to meet the duty of candour, including whether to bring a prosecution. Providers will be expected to establish the duty throughout their organisation.

Phasing out the LCP

56. Insofar as the LCP provided an approach to those caring for people in the last few days and hours of life, the Priorities for Care and the supporting documents will take its place. (Panel recommendation 3 refers). In order to implement the Priorities for Care effectively, organisations and staff will want to use alternative support materials, including easy-to-use reference documents and prompts; and templates for records. In future, these should be consistent with and support achievement of the Priorities for Care. Leaders of organisations or groups of organisations in individual localities will want to consider and advise their staff and organisations what support materials are most appropriate for their particular circumstances.

57. In developing its programme of action in response to the report by the independent panel, the Alliance has spent considerable time debating the pros and cons of developing either a single, recommended set of support materials, or a process for endorsing such products. This would save organisations having to develop their own materials and potentially 're-invent the wheel'. However, one of the key issues with the LCP was the way in which some organisations and health and care staff came to regard it as an end in itself, rather than using it to pro-actively engage with the needs of individual patients and their families. Alliance members therefore consider that a key part of ensuring effective care for all people in the last few days and hours of life is that organisations work out for themselves, using the Priorities for Care and the supporting documents, how they can deliver the best outcomes for dying people and their families, bearing in mind their own particular circumstances. The Alliance is also very conscious of the fact that in some cases, the effectiveness of different support materials will depend on the setting in which care for the dying person takes place.

58. Ideally, all the various organisations in a particular locality from whom a person in the last few days and hours of life might receive services would work out together how to deliver the best care. This would include hospitals, hospices, 'out-of-hours' GP services, ambulance services, social care, voluntary care services and others. They may want to consider using or developing particular support materials. There might be scope for some of these to be used across service providers (e.g. forms in relation to preferences about care and treatment). In many cases, however, the care will need to be supported by different support materials, depending on the setting in which the care takes place. Whilst the support materials are important, it is the way they are used and the other elements that contribute to the care of dying people coming together which are important in delivering appropriate care to individual patients. It is how - not whether - particular support materials are used which should be assessed.

Education, training and professional development

59. The issues raised by the review panel's report require substantial action on education, training and professional development. It is clear from the report that some staff caring for dying people do not have the skills and knowledge required to deliver care to high standards; and in some cases, they are not putting into practice the values that underpin such care.

60. Particular members of the Alliance have specific responsibilities for ensuring that initial training[23] for particular groups of staff equips them to carry out their roles effectively. This document describes action Alliance members have taken and will take to ensure this happens. Individual providers of health and care are responsible for ensuring their staff have the experience and competence they need to do their jobs well. This includes making time and other resources available for staff to undergo professional development. Staff themselves have responsibilities to ensure that they have the necessary skills to do their jobs and to keep those skills up-to-date. This document also describes action Alliance members have taken and will take to support service providers and individual health and care staff to deliver their responsibilities in relation to education and training on caring for dying people.

Training for doctors

61. Many of the competencies that are needed to deliver effective care for people in the last few days and hours of life are generic: i.e. they are also relevant to caring for other people. The Shape of Training Review, which reported to the GMC on 29 October 2013, stressed that future postgraduate curricula would need to encompass the generic professional capabilities that all doctors should possess (or be able to develop) to ensure the delivery of good quality care across all specialties. The GMC is working with the Academy of Medical Royal Colleges to identify what these are. They will include some fundamental areas of practice such as the need to communicate effectively, empathise, lead, follow and be diligent and conscientious as well as those more related to end of life care such as partnership and team working.

62. Further support for doctors' ongoing professional development is available through a document being produced by the Specialty Advisory Committee for Palliative Medicine of the Royal College of Physicians, the Joint Royal Colleges Postgraduate Training Board and the Association for Palliative Medicine of Great Britain and Ireland. This outlines how physicians training in a range of medical specialties can gain the required competences in palliative care. (Panel recommendation 10 refers to training for doctors.)

[23] Including post-graduate training required for qualification.

Ongoing education and training for all health and care staff

63. Alliance members are clear that all staff who have contact with dying people must have the skills to do this effectively and compassionately. This includes clinical and support staff (e.g. porters, reception staff and ward clerks.) Those organisations that deliver such care have the prime responsibility for ensuring that the people they employ are competent to carry out their roles effectively, including facilitating and funding ongoing professional development, where this is appropriate. The Alliance's Implementation Guidance for Service Providers and Commissioners includes advice to help those organisations ensure they are carrying out their responsibilities to ensure staff have the necessary training and skills in this area. This advice includes desired characteristics of programmes of education and training for staff who care for people in the last days and hours of life. The desired characteristics include taking an educational approach which employs evaluation methods that can demonstrate achievement of outcomes and, ideally, extend beyond the immediate end of the training course or event. The Alliance is creating a mechanism for sharing practice, and enabling evidence of its effectiveness, to be shared. The Alliance intends that those who fund, commission or provide training for health and care staff should use the 'desired characteristics' it has developed and its mechanism for sharing good practice, to help them develop specifications for specific training, education, professional development and learning packages that include care in the last few days and hours of life. On content, the Alliance's advice includes that such education and training cover:

- Specific attention to the topics of nutrition and hydration: assessment, discussion and shared decision-making with the person (where possible), and those important to them and other health and care team members.
- Symptom management: assessment, communication and shared decision-making wherever possible about use of medication (including route of delivery), physical measures (including repositioning) and safe and accurate prescribing.
- Communication skills, including empathy and recognising emotional response to stress and distress, discussing uncertainty, conversations about limits of treatment including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR), withholding and withdrawing treatment, preferred place of care and death, etc.

(Panel recommendations 11, 16, 19 and 22 refer.)

64. Alliance members consider there is scope for those arranging training for health and care staff who care for dying people and their families to make greater use of Health Education England's e-Learning for Health e-learning programme on end of life care (e-ELCA). e-ELCA[24] is a library of over 150 highly interactive sessions of e-learning on end of life care, which aims to provide a resource for enhancing the training and education of health and care staff involved in delivering end of life care to people. The sessions are arranged in four core modules (advance care planning; assessment; communications skills; and symptom management, comfort and wellbeing), with three additional modules (social care, bereavement and spirituality) and one 'integrating learning' module which helps to consolidate and apply understanding in different situations.

[24] Further information on End of Life Care for All (e-ELCA) is available at: www.e-lfh.org.uk/projects/end-of-life-care

65. Despite its high regard, soundings taken by the Alliance suggest that the use of e-ELCA to support education and training remains patchy in some parts of England. The Alliance notes that the breadth of e-ELCA can make it difficult for busy practitioners to make choices and that its potential to be used as part of a blended approach to learning is not fully realised. Hence, it will seek to provide guidance on factors that maximise the effectiveness of e-ELCA. GMC will consider the possibility of including information about e-ELCA in its wider work to enable doctors to identify and access learning opportunities on end of life care; and its work to promote its guidance on *Treatment and care towards the end of life: good practice in decision-making, 2010*[25].

66. Individual Alliance members are keen to run joint education and training days throughout England to support care in the last few hours and days of life. For example, the RCGP, Marie Curie, Macmillan and the GMC are exploring the possibility of a collaboration to deliver one-day educational workshops on excellent personalised care and symptom control in 2014. The RCP is also considering plans to produce a toolkit on care for people in the last few days and hours of life to identify current problems and suggest ways of improving quality.

67. Training for the assessment and meeting of spiritual needs of dying people, their relatives and carers in any setting can be accessed from chaplaincy departments. Training can support the use of a variety of approaches, including FICA (The acronym FICA refers to: F - Faith and Belief, I - Importance, C - Community and A - Address in Care). Further details of this are at Annex I.

Assessment and evaluation of training, education and learning to support health and care staff caring for dying people

68. The Alliance has produced Implementation Guidance for Service Providers and Commissioners. This states that education and training programmes for care in the last hours of life should take an educational approach which includes how to apply learning to practice and evaluation methods that can demonstrate achievement of outcomes and will, ideally, extend beyond the immediate end of the training course or event. (Panel recommendation 22 refers.)

69. Health Education England will work with stakeholders to influence training curricula as appropriate, although the content and standard of clinical training is ultimately the responsibility of the professional bodies. Education and training of the existing workforce is primarily an employer responsibility. (Panel recommendation 35 refers.)

[25] Available at: www.gmc-uk.org/End_of_life.pdf_32486688.pdf

Advice

Terminology relating to death

70. In the national End of Life Care Strategy (2008), the term 'end of life care' was defined as the last year of life. However, for some people, including health and care staff, the term 'end of life' is understood to mean the last few days of life, in other words when death appears to be imminent. The Alliance agrees that this terminology is confusing. The Social Care Institute for Excellence, the National Council for Palliative Care and NHS England have undertaken a joint piece of work to generate and facilitate understanding about the terms 'palliative care' and 'end of life care' with the aim of developing greater clarity in the use of these terms.
71. In the meantime, the Alliance has agreed a glossary of terms in relation to care in the last few days and hours of life. This is at Annex G.

Terminology relating to guidance

Pathways

72. The term 'pathway' is used widely in health and care. For example, NICE (National Institute for Health and Care Excellence) Pathways are interactive topic-based diagrams which aim to provide users with a way to quickly view and navigate all NICE guidance recommendations on a particular topic. A NICE Pathway starts with a broad overview of a topic and allows the user to explore NICE recommendations and advice in increasing detail. Relevant topics are linked together forming a network of NICE information. A NICE Pathway provides a useful starting point for new users to a topic while giving specialists easy access to NICE recommendations. NICE Pathways do not provide a comprehensive management pathway for individual patient care.
73. A 'clinical pathway' generally refers to a standardised set of actions aiming to optimise care for a particular clinical problem, in line with evidence or guidelines. The process of dying should not be regarded as a "clinical problem" and hence the development or use of clinical pathways for the last few days and hours of life can cause confusion.
74. A 'care pathway' has been defined broadly as "a set of quality measures that together describe a care pathway for a particular population or group of patients." As the review panel noted, the Marie Curie Palliative Care Institute Liverpool (MCPCIL) described care pathways differently i.e. "a care pathway is a complex intervention for the mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period." [26]
75. The review panel went on to say that: "Due to … [a] lack of clarity, the LCP is being perceived by some of its users – doctors and nurses – not as a document, nor as a

[26] See https://lcp.mcpcil.org.uk/modules/page/page.aspx?pc=registrationint

guideline, but most frequently as a set of instructions and prescriptions, that is to say a protocol."[27]

NICE

76. NICE uses the term 'protocol' in the context of research. The glossary on the NICE website defines a protocol as "A plan or set of steps that defines how something will be done. Before carrying out a research study, for example, the research protocol sets out what question is to be answered and how information will be collected and analysed."[28]

77. NICE uses the terms 'guidelines' and 'guidance' interchangeably, with specific definitions depending on the type of guideline / guidance it is discussing. At their most generic, they can be defined as: "evidence-based recommendations on the most effective and cost-effective treatment and care of people with specific diseases and conditions, and recommendations for populations and individuals on interventions that can help prevent disease or improve health." The definition used in the NICE accreditation manual is "systematically developed statements to guide decisions about appropriate health and social care to improve individual and population health and wellbeing."[29] NICE does not use the terms 'standard operating procedures' or 'best practice models'.

General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), General Pharmaceutical Council (GPhC)

78. The GMC publishes a range of guidance in fulfilment of its regulatory duties. This includes guidance for providers of undergraduate and postgraduate education and training and continuing professional development; guidance for its fitness to practise decision-makers; and guidance to doctors on the professional values and standards of ethical practice expected of all those on the medical register.[30]

79. The NMC is required to establish standards of education, training, conduct and performance for nurses and midwives and to ensure maintenance of those standards. The NMC sets the standards for pre-registration nursing and midwifery education programmes and these contain the minimum requirements by which programme providers determine the programme content, learning outcomes and assessment. They also contain the competency standards for nursing and midwifery practice. These standards must be achieved by all students completing those programmes and are the standards which must be maintained by nurses and midwives on the NMC register. In addition, nurses and midwives must adhere to the standards of conduct, performance and ethics, known as "The Code". The Code sets out in broad terms the standards of conduct and performance which society and the profession expect of nurses and midwives throughout their careers. The Code applies to all registered nurses and midwives, regardless of their role, their specialty, grade or area of work. Failure to comply with the Code may bring a nurse or midwife's fitness to practise into question and endanger their registration. The NMC may also publish guidance where there is evidence that guidance is required to set out how the standards set out in the Code should be met. For example, NMC has recently published updated guidance on raising concerns for nurses and midwives.[31]

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[27] See *More Care, Less Pathway. A Review of the Liverpool Care Pathway*, p.16, paragraph 1.18, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf
[28] www.nice.org.uk/website/glossary/glossary.jsp?alpha=p
[29] www.nice.org.uk/media/886/95/NICEAccreditationProcessManual.pdf
[30] Details of GMC guidance are available on the GMC website at: www.gmc-uk.org
[31] See NMC Code at: www.nmc-uk.org/documents/standards/the-code-A4-20100406.pdf

80. The HCPC is required to establish and maintain standards of education, training, conduct and performance for the professions it regulates, in order to protect the public. One such set of standards is the HCPC's standards of conduct, performance and ethics, which set out the behaviour expected from professionals on the HCPC Register. To help registrants meet these standards, the HCPC produces guidance, such as its guidance on confidentiality.[32]

81. The GPhC regulates pharmacists, pharmacy technicians and registered pharmacies. One of the ways by which it does this is to set the standards of conduct, ethics and performance for pharmacy professionals. The GPhC also produces guidance to assist pharmacy professionals in meeting the standards of conduct, ethics and performance. Guidance covers topics such as consent and raising concerns.[33]

The Alliance's approach to terminology

82. The Alliance agrees with the review panel that there is a lack of clarity about the status of different documents relating to care for people in the last few days and hours of life. It also agrees with the review panel's recommendation that it is not appropriate to use the term 'pathway' in relation to care for people in the last few days and hours of life, because of the possible concern that if someone was on a pathway for those approaching the end of life, the treatment and care they received would be 'standardised', rather than personalised. The Alliance has produced a glossary which includes definitions of, amongst other things, 'clinical pathways', 'protocols', 'standard operating procedures', 'guidelines/ guidance' and 'best practice models'.[34] Alliance members, will respect these definitions, and in relation to care in the last few days and hours of life, will reserve the terms 'guidance/ guidelines', as well as 'quality standards' for use by NICE and the professional regulators (GMC, NMC, HCPC and GPhC), who will continue to produce regulatory guidance on how professional standards should be achieved. The only exception will be that the Alliance has produced implementation guidance for service providers and commissioners on delivering the Priorities for Care of the Dying Person. (Panel recommendation 2 refers.)

Extent of existing guidance relevant to care in the last few days and hours of life

83. In response to the review panel's report, the Alliance commissioned a rapid review of existing guidance on caring for people in the last few days and hours of life. The report of the review is at Annex J. Its key findings include:

    - there is extensive existing advice on caring for people who are approaching the end of their lives, including technical guidance relating to caring for people with diabetes, heart failure, neurological conditions, Parkinson's disease, advanced kidney diseases and dementia;
    - much of the advice is robust, developed by reputable sources; but
    - some of this advice is difficult to find and it is not in a single standard format.

84. Specific Alliance members will therefore undertake work to make particular advice, including that on specific disease groups, more easily accessible. The NHS will work

[32] See HCPC *Standards of Conduct, Performance and Ethics* at: www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics
[33] See GPhC *Standards of Conduct, Ethics and Performance* at: www.pharmacyregulation.org/standards/conduct-ethics-and-performance
[34] The Alliance's Glossary of Terms can be found below at Annex G.

with organisations with an interest in specific diseases and conditions to consider whether new advice is needed. (Panel recommendation 37 refers.)

85. The main current NICE guidance in relation to dying people is *Improving supportive and palliative care for adults with cancer*, published in 2004. NICE is currently developing new Guidance on the management of care for dying adults which it hopes to publish in 2015. It will also, a little later, update its existing guidance on palliative care and end of life service guidance as part of its ongoing surveillance and updating programme. The new guidance on the organisation of services for people who are dying will update some parts of the cancer service guidance on supportive and palliative care. NICE also intends, shortly, to develop separate guidance for End of Life Care in children. Its recently redrafted Quality Standard on End of Life Care will be revised following the publication of this new Guidance.

86. In the meantime, the NICE Quality Standard sets out what care and treatment for dying people should seek to achieve, as do the Alliance's Priorities for Care. (Panel recommendation 12 refers.)

Advice on decision-making

87. The GMC guidance on decision-making for doctors can be found in *Treatment and care towards the end of life: good practice in decision-making*, in place since May 2010.[35] It is highly regarded and plays an important role in establishing the principles of good practice in this area. During 2014, the GMC's work to promote improved standards of patient care will be prioritising activities to raise awareness of the guidance, especially the advice on oral nutrition and hydration, advance care planning and decision-making around cardiopulmonary resuscitation (CPR), as set out in its commitment statement. For nurses, the competency standards for nursing practice are stated within the Standards for Pre-registration nursing education.[36] Nursing practice and decision-making is one of the four domains within the standards for all nurses. This includes decision-making required in caring for people who are dying either as a consequence of old age or due to progressive or terminal illness and providing therapeutic nursing interventions to people, their families and carers. In April 2014, as part of the review of the Code and developing guidance for revalidation, the NMC published these standards for nursing practice separately to the pre-registration education standards, so nurses, patients and the public can access them more easily.[37] (Panel recommendation 13 refers.)

88. As part of developing the revised Code, the NMC will consider whether it should include specific guidance on caring for people at the end of life, including specific guidance about decision-making in relation to such care. In doing so, it will take account of the findings of the "rapid review" on guidance carried out on behalf of the Alliance, responses to public consultation and the impact of any system-wide guidance on this subject that may be issued by the Alliance or any other cross-regulatory bodies. The review of the Code will strengthen requirements in the areas of decision-making and end of life care on a more general basis for all nurses and midwives. It will also reinforce the NMC's position on the nurse's professional duty of candour, as will the guidance the NMC is working on alongside the GMC and other healthcare regulators on the professional duty of candour. (Panel recommendations 13 and 34 refer.)

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35 www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

36 http://standards.nmc-uk.org/Pages/Welcome.aspx

37 The NMC's *Standards for Competence for Registered Nurses* (2014) document is available on the NMC website at: www.nmc-uk.org/Documents/Standards/Standards%20for%20competence.pdf

Implementing the new Priorities for Care

Inspection and regulation

89. The Care Quality Commission (CQC) consulted on proposals to make significant changes to its inspection approach in 2013. The new inspection approach is being implemented in 2014 and will examine whether the service is safe, effective, caring, responsive to people's needs and well-led for all the sectors they regulate. This includes acute hospitals, primary care, adult social care, hospices and community health services.

90. This new approach to inspection is designed to get to the heart of people's experience of care. The role of health and care staff cuts across the five domains of care[38] and the role of health professionals in planning and delivery of care will be a key component of the judgements CQC inspection teams make. For example, in considering whether the care delivered is effective, inspection teams will look for evidence that services, treatment and care are delivered by qualified, competent staff who are supported in their development and in their role. In terms of end of life care, this will mean inspection teams consider the role health and care staff play in care in the last few days and hours of life as well as care provided after death, including the support provided to bereaved families and carers.

91. The introduction of the new approach has started with the acute sector, led by the Chief Inspector of Hospitals. All inspections of acute hospitals under the new approach include an inspection of end of life care services as one of eight core service areas which the inspection team routinely consider. (See response to panel recommendation 40.) Inspections look at palliative and end of life care across the hospital and are not limited to specialist services. Inspection teams gather views from people who use services, their families, carers and advocates; observe care; interview key members of the senior management team and staff at all levels; and may visit certain services out of hours and unannounced. Inspections of community health services under the new approach include a specific focus on end of life care.

92. CQC's Chief Inspectors of Adult Social Care and General Practice are also incorporating end of life care services in the inspection approach in their sectors. The proposed approach to inspection of care homes includes end of life care as a key inspection area. In inspecting services which deliver end of life care in any setting, CQC will review whether people receive care in line with the Alliance's Priorities for Care. CQC inspections of particular hospitals and care homes will include whether care is delivered by qualified, competent staff, who are supported in their development and in their roles. CQC inspection teams will gather views from people who use services and their families, carers and advocates. (Panel recommendation 4 refers.)

[38] The NHS Outcomes Framework, which sets out the high-level national outcomes that the NHS should be aiming to improve, is structured around the following five domains:
- Domain 1: Preventing people from dying prematurely;
- Domain 2: Enhancing the quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill-health or following injury
- Domain 4: Ensuring that people have a positive experience of care; and
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

93. The Care Quality Commission also undertakes thematic work on prioritised topics across the sectors it regulates in addition to its regulation of registered providers of care. Thematic work enables CQC to look at the quality of care across registered providers and sectors, and to focus on integrated care and the patient's journey through services by listening to what users, carers and staff say about care quality.

94. CQC will undertake a themed inspection focusing on end of life care in 2014/15, and will publish a national report presenting its findings. The themed inspection is in addition to the ongoing programme of inspections of hospitals, care homes, hospices, GPs and community services, which will reflect end of life care as a priority, and it will build on the inspection programme. The themed inspection topic will focus on an area with significant implications for people's experience of care at the end of life, and where CQC can use its unique position as the regulator of health and social care to achieve the maximum impact. The scope of the inspection will include all settings where people experience care at the end of their lives, and will consider issues such as integration, inequity, vulnerabilities and access across the whole community. (See response to panel recommendation 41.)

95. The CQC works closely with Monitor and the NHS Trust Development Authority to identify where improvement is needed, whilst ensuring their approaches are coordinated and that regulatory activity is not duplicated. Hence, if the CQC has a concern about the quality of care being delivered at an NHS foundation trust or if a foundation trust is failing to meet its registration requirements, it will inform Monitor, and the two organisations will work together to ensure that appropriate and joined-up regulatory action is taken. If CQC has a concern about the quality or safety of care provided by an NHS trust, it will inform and work closely with NHS TDA.

96. For NHS trusts, the NHS Trust Development Authority has included in its Planning Guidance 2014-15 an expectation that the forthcoming recommendations from the Alliance will be adopted and it will use the Priorities for Care and the three supporting statements as part of the process to support NHS Trusts to deliver high quality end of life care.

Commissioning

97. The review panel recommended that "payments 'per person implemented on the LCP, or equivalent approach' should cease." Alliance members agree that such financial incentives are inappropriate. In a written statement to Parliament on 15 July 2013,[39] the Minister for Care and Support "said: "I am asking NHS England to work with clinical commissioning groups to implement this [recommendation] immediately." There are no longer any such national incentives and NHS England agrees that any such payments from clinical commissioning groups should cease. (Panel recommendation 25 refers.)

98. NHS England and the NHS Commissioning Assembly have also jointly established a 'Task and Finish Group' to look at how to embed the Alliance's Priorities for Care within commissioning processes. (See response to panel recommendation 42.)

[39] Commons Hansard, 15 July 2013, Col 64WS.

Organisational leadership and governance

99. Local leadership will be an important part of securing improvements in the overall care of people in the last few days and hours of life and ensuring that the Alliance's proposed Priorities for Care are successfully implemented and embedded. Across England, thousands of different organisations are responsible for providing that care. Each one of them needs to have leadership that is committed to ensuring that those people to whom it provides services who are dying receive high-quality, compassionate care, focused on the needs of the dying person and their family. As many of those who are in the last few days and hours of life receive services from a range of local providers, a powerful driver for improving services in a particular locality could be for relevant service providers to come together with a common goal of providing excellent, seamless services for people approaching the end of their lives. The Alliance calls on local organisations to commit to the Priorities for Care.

100. The Minister for Care and Support wrote to the chairs and chief executives of individual NHS Trusts and NHS Foundation Trusts on 15 July 2013 about the report of the independent review into the Liverpool Care Pathway. Amongst other things, he asked them to appoint a Board member with the responsibility for overseeing any complaints about end of life care and for reviewing how end of life care is provided.

101. CQC's new inspection approach looks at whether a service is well-led, and specifically includes end of life care in acute hospitals. Inspection teams will look at whether individuals at all levels are clear about their responsibilities and how effectively they are held to account. Individual responsibility for end of life care at board level is integral to this. CQC is also undertaking a themed inspection focused on end of life care in 2014/15 (see paragraph 91). This will focus on people's experience of end of life care across sectors and develop understanding of why some groups of people experience poor care. In carrying out this review, CQC will consider governance and leadership issues. (Panel recommendation 28 refers.)

A priority for NHS England in the Mandate

102. The current Mandate to NHS England includes five priority areas, one of which is ensuring that people have a positive experience of care. Within this, improving the experience of care for people at the end of their lives is identified as one of the nine areas where progress will be expected. Progress will be measured by assessing bereaved carers' views on the quality of care given to their relatives in the last three months of life through an annual survey. There are a number of questions which relate specifically to the last two days of life.

103. This is an important area and so the Government will continue to keep under review the need to include anything further in the annual refresh of the NHS England Mandate and the second edition which will run from April 2015. (Panel recommendation 43 refers.)

	AGENDA ITEM 9 **Health Overview and Scrutiny Committee** **8 December 2014**
Title	**Update Report: Royal Free Hospital Acquisition of Barnet and Chase Farm Hospitals NHS Trust**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Appendix A – Update from Royal Free London NHS Trust
Officer Contact Details	Anita Vukomanovic – Governance Team Leader anita.vukomanovic@barnet.gov.uk – 0208 359 7034

Summary

In July 2012 the Barnet and Chase Farm Board concluded that it was not likely to become a Foundation Trust alone and invited competitive proposals from potential partners to create a larger Foundation Trust. The Royal Free NHS FT was subsequently formally accepted as its preferred partner.

The Health Overview and Scrutiny Committee have requested to receive an update from the Royal Free London NHS Trust on the acquisition of Barnet and Chase Farm Hospitals NHS Trust. In addition to the update provided in Appendix A, representatives from the Royal Free Hospitals NHS Trust will be in attendance on the evening to provide a verbal update to the Committee and to respond to any questions.

Following a request from the Health Overview and Scrutiny Committee, this report focuses on the following aspects of the acquisition:

- A financial update
- The redevelopment of Chase Farm Hospital, including the planning application
- An update on dementia training at the Trust

The Chairman has also requested that representatives from the Trust provide an update in respect of blue badge parking at the Chase Farm Hospital site.

Recommendations

1. **That the Committee note the update from the Royal Free London NHS Trust on the acquisition of Barnet and Chase Farm Hospitals NHS Trust and ask questions of the representatives of the Trust .**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health Overview and Scrutiny Committee have requested to receive an update on from the Royal Free London NHS Trust following the acquisition of Barnet and Chase Farm Hospitals NHS Trust.

2. REASONS FOR RECOMMENDATIONS

2.1 Receiving this report will provide Members of the Health Overview and Scrutiny Committee with the opportunity to question senior Officers from the Royal Free London NHS Foundation Trust on the outcome of the decision of the proposed acquisition.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1 This report is an update report. It is up to the Committee to determine if they wish to receive any future updates or request any additional information on this matter.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.11 The Health Overview and Scrutiny Committee must ensure that its work is reflective of the Council's priorities.

5.12 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.

5.13 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.

5.2 **Legal and Constitutional References**

5.2.1 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.

5.2.2 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.

5.2.1 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

"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."

"To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents."

"To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships in the public, private and voluntary sectors."

5.3 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.3.1 None in the context of this report.

5.4 **Risk Management**

5.4.1 To not receive this update report would present the Committee with a risk of not being kept abreast of the current status of the acquisition by the Royal Free London NHS Foundation Trust. This could in turn hinder the Committee's ability to conduct effective scrutiny of this service.

5.5 **Equalities and Diversity**

5.2.1 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 comply with its public sector equality duty as set out in the Equality Act 2010 which is to give due regard to the matters set out in s149:

- the need to—
- (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- The relevant protected characteristics are—
- age;
  disability;
  gender reassignment;
  pregnancy and maternity;
  race;
  religion or belief;
  sex;
  sexual orientation

- And as public bodies, health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.
- This duty must be borne in mind in considering the Report at Appendix A

5.6 **Consultation and Engagement**

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

Appendix A

Update Report on the Acquisition from the Royal Free London NHS Foundation Trust

Financial update

Barnet and Chase Farm Hospitals NHS Trust had a deficit of circa £16m in 2013/14 which reflected the part year impact of the BEH strategy. In 2014/15 the BCF forecast reflected the full year effect of the BEH strategy which moved the trust from circa £16m deficit to £38m deficit. This was included within the transaction agreement and the deficit is funded by the Department of Health (DH).

The funding to be received in 2014/15 is £111m broken down into:
Integration funding (£13m)
BCF transformation funding (£27m for nine months)
Capital investment (£26m)
Historic deficit (£45m)

The Chase Farm Hospital redevelopment outline business case (OBC) is currently being developed. The trust is going through a detailed exercise which includes defining the clinical model, designing the clinical and non-clinical space, submitting the planning application and developing the workforce/cost model. The OBC will be submitted to the trust board in January 2015 in advance of submission to the Treasury for funding. It will include the proposed sale of land which in part funds some of the new build.

Chase Farm Hospital redevelopment

Following the acquisition of Barnet and Chase Farm Hospitals NHS Trust the trust announced its intention to redevelop the Chase Farm Hospital site to create a modern hospital that will provide clinically-led services. The surplus land on the site will be used to create new housing, which will fund construction of the new hospital, and a primary school, to be delivered by the local authority to help address the shortage of school spaces in the local area.

There has been support for the trust's plans to redevelop the site. Throughout the pre-application stage, the trust has worked with local residents and engaged with the local community to ensure the proposals are understood. The trust has undertaken a series of consultation events with stakeholders and the local community.

- Meetings with councillors from both LB Enfield and LB Barnet
- Regular master planning meetings (every two to three weeks) with Enfield Council
- Continuing engagement with Enfield Clinical Commissioning Group, Barnet Enfield and Haringey Mental Health Trust, Transport for London
- Establishment of a stakeholder group that meets every eight weeks – meetings held so far in July, September and November 2014
- Regular residents' drop-in sessions – meetings held so far in July, September and November 2014 (invitations sent to around 5,000 local households)
- Presentations to existing tenants of trust-owned staff accommodation on the site – held in July, September and November 2014

- Following submission of the outline planning application the trust will publish a newsletter, advertise in the local papers and also hold events/exhibitions and open days/evenings. Displays and signage to them will able available at Chase Farm Hospital.
- Details of the redevelopment are available on the trust website

The trust has worked to address key concerns raised at these events (including timescale, local traffic and parking levels, density of housing, availability of keyworker housing, impact on infrastructure, trees, future of the Clocktower building and possibility of future expansion) and incorporate suggestions in the outline planning application.

Proposed timescales:

November 2014:	outline planning submission
January 2015:	outline business case to trust board and DH
March 2015:	enabling works/site assembly
Early 2015:	surplus land sold in phased parcels
May 2015:	reserved matters planning
Summer 2015:	full business case to trust board and DH
January 2016:	main works start
Spring 2018:	new hospital opens
Autumn 2018:	potential for school to open

The trust will present its application to invited members of the public and interested council members on 7 January 2015 at the development panel. The application will then be discussed at the planning committee hearing on 24 February 2015.

Dementia training

More than 4,900 trust staff received dementia training in 2013/14.

All staff receive dementia awareness training as a one-hour session within the trust induction. This session aims to raise awareness of symptoms of dementia and its increasing prevalence. It uses a film created by Guy's and St Thomas's Hospital called "Barbara's Story" which offers a chance for reflection. The session also highlights the trust's aim to always be positively welcoming, actively respectful, clearly communicating and visibly reassuring.

Other dementia training:

- new nursing assistant induction includes a 1.5 hour dementia training session
- one-hour training for all new FY1's held annually
- one-hour training on dementia and delirium for FY2'2 and Registrars held annually
- one-hour training for core medical training held annually
- core dementia skills training and advanced dementia skills training held monthly
- a recently completed nursing assistant monthly training programme
- supporting older people with complex needs training (also offers reflective practice in line with the healthcare assistant core competencies
- bespoke training offered to departments throughout the hospital sites eg porters, security, out-patients, admin and clerical staff and volunteer services
- patient safety days at Barnet Hospital and Chase Farm Hospital include dementia modules

- three e-learning modules of varying levels
- in support of the national Dementia Friends Campaign the trust holds training sessions to encourage all staff (particularly non-clinical staff) to become dementia friends.

20 November 2014

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	AGENDA ITEM 10 **Health Overview and Scrutiny Committee** **9 December 2014**
Title	**Healthwatch Barnet Enter and View and Update Report**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Appendix A- Healthwatch Barnet Highlight Report Appendix B – Healthwatch Barnet Enter and View Meal Summary Report Appendix Bi - Healthwatch Barnet Enter and View Meal Report
Officer Contact Details	Anita Vukomanovic – Governance Team Leader anita.vukomanovic@barnet.gov.uk – 020 8359 7034

Summary

The report at Appendix A provides the Barnet Health Overview and Scrutiny Committee with an update report on Healthwatch Barnet's performance and key activities for Year 2.

In January 2014, Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. The reports provided at Appendix B and Appendix Bi provides an outline of the Enter and View Meal-Time Review visits to 6 wards at Barnet Hospital that were undertaken by the Enter and View team during the period mid-March to June 2014.

Representatives from Healthwatch Barnet will attend the meeting to respond to questions.

Recommendations
1. That the Committee note the reports and make appropriate comments and/or recommendations to Officers from HealthWatch Barnet.

1. WHY THIS REPORT IS NEEDED

1.1 The consideration of Enter and View reports provides the committee with an oversight of the quality, care and safety in residential and health care settings from the view of a lay-person.

1.2 The report at Appendix A also deals with Health Watch's performance/key activities.

2. REASONS FOR RECOMMENDATIONS

The recommendation provides the Committee with the opportunity to highlight issues of interest and concern, and to make recommendations on any arising matters to Healthwatch Barnet.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Any recommendations made by the Committee will be followed up by the Governance Service with Healthwatch Barnet., with any requests for information being disseminated as appropriate.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

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 for the objectives in the Health and Well Being Strategy 2012-15 and in the Corporate Plan 2012-13, specifically under 'Sharing Opportunities and Responsibilities'.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 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 commenced on 1 April 2013 and expires 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.

5.2.2 There are no direct resource implications arising from this report.

5.3 Legal and Constitutional References

5.3.1 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.

5.3.2 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

"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."

"To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, Health Watch and/or other health bodies."

"To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships in the public, private and voluntary sectors.

5.4 Risk Management

5.4.1 Healthwatch Barnet has a group of Authorised Representatives. The 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 and View and Safeguarding training prior to participating in the programme.

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

5.5 Equalities and Diversity

5.5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the committee should consider:

- 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.

5.5.2 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 duties contained within legislation, most notably s149 of the Equality Act 2010; consideration of equalities issues should therefore form part of their reports.

5.6 Consultation and Engagement

5.6.1 None.

6 BACKGROUND PAPERS

6.1 None.

HEALTHWATCH BARNET HIGHLIGHT REPORT
For Barnet Council Health Overview and Scrutiny Committee Monday 8th December 2014

This report provides the Health Overview and Scrutiny Committee with details of Healthwatch Barnet's performance and key activities for Year 2.

YEAR 2 PERFORMANCE

Healthwatch Barnet is on track to meet its contractual targets for Year 2 as follows:

REACH (promotion of health and social care issues and raising awareness of Healthwatch Barnet to local residents.)
Target: 12,000.
Achieved at end Q2: 17,756.

ENGAGE (residents are provided with the opportunity to actively express their views on an individual basis.)
Target: 1200.
Achieved at end Q2: 506.

VOLUNTEER ROLES
Target: 105.
Achieved at end Q2: 110

YEAR 2 PRIORITIES AND ACTIVITY

Through a series of community engagement events, Healthwatch Barnet consulted with local residents on its key priorities and activities for Year 2, as follows:

- Consultation on year 2 priorities with community organisations and Partnership Boards took place in May and June 2013.
- Consultation on Year 2 priorities with the public took place through an open meeting for local residents in June, with 63 people attending. 13 evaluation forms were completed, of which 3 said the event was excellent, 7 said it was good and 2 said it was average. 11 said they found out new information. There were 15 recorded follow-up actions, where participants said they would take further action as a result of the meeting, such as making contact with health and social care services, or volunteering.

The information below provides an update on
- activities undertaken to date to meet these priorities
- future activity
- key issues arising.

Priority	Activity	Progress
Older Adults	Enter and View to hospitals. Enter and View to care homes.	E+V to care homes is continuing. The planning group is exploring how a Kings Fund tool that summarises good dementia care, could be used to review

	Consultation with older adults on dementia care and hospital discharge and hospital transport, in liaison with charity partners Advocacy in Barnet, Age UK Barnet, and Jewish Care.	the quality of care to residents in care homes. The E+V meal time review at Barnet Hospital also included visits to and reports on geriatric wards. The Hospital Discharge Report engaged with 136 local residents. It found that many patients and carers had experienced good quality services, but a significant minority (25%) had not. The report is currently with the providers, Royal Free Hospital and Central London Community Healthcare for comment. Healthwatch Barnet Engagement Group and staff are currently exploring, with commissioners and key charities, the general quality of dementia services in Barnet and whether more detailed community consultation should be undertaken on particular aspects of social care or community, primary or secondary health services. Healthwatch Barnet is represented on the new Barnet Council Transport Group which will explore the quality of services in the Borough.

Mental Health	Enter and View to mental health community and hospital settings. Charity partner BCIL will review BEH Mental Health Trust complaints process, to develop a person-centred approach. Liaison with Mind in Barnet and Barnet Voice and MH Partnership Board on effective patient engagement by the Barnet Enfield and Haringey Mental Health Trust. Liaison with the CQC about any key issues as required.	An Enter and View visit has taken place at Thames Ward to review whether recommendations from our visit in summer 2013 have been implemented and sustained. Further visits to wards for patients with mental health conditions are planned for winter 2014/2015. Barnet CCG commissioned Healthwatch Barnet to deliver a focus group on the quality of mental health services. The CCG was pleased that the focus group included those that do not usually attend such fora, different ethnic groups and also young people under 24. Our report and recommendations were submitted to and endorsed by the CCG Board, specifically in relation to investment in primary and community care services to avoid demand on secondary and acute care. This project is due to start in December 2014. Quarterly meetings take place with the CQC and Barnet Council Care Quality Team.
Learning Disability	Led by charity partner Barnet Mencap, potential consultation on the quality of services for people with autism or Asperger Syndrome.	This project is due to start in November 2014. BCCG has a working group to implement the recommendations of the HWB-Barnet Mencap report, Talk To Me (March 2014), to provide summary of appointment letters in Easy Read and double appointment times for

		people with learning disabilities.
Young parents and parents of young families.	Led by charity partner Home-Start Barnet, consultation on parents' experiences of and barriers to childhood immunisation.	This project started in September 2014 and the report will be submitted to the Health and Wellbeing Board in March 2015.
Carers	Led by charity partner Barnet Carers Centre, TBC.	
Children and Young People	Potential Youth Board and/or further consultation with young people.	The first meeting of the Youth Health Forum took place in November 2014. There were ten participants from the ages of 15 to 19. The Forum is keen to carry out projects relating to mental health. In addition Public Health will consult with the group over the development of sexual health services for young people.
Engagement with key communities.	Healthwatch Barnet to undertake an equality analysis to review reach and engagement in year 1 and to identify any potential further engagement and activities with key communities.	Community Barnet's Parenting Consortium will undertake specific consultation with some of Barnet's key ethnic communities and will potentially undertake consultation on sexual health services and alcohol usage. Multi-Lingual Wellbeing Service has been invited to become a charity partner to Healthwatch Barnet to help engage with and disseminate information to key ethnic communities in the Borough.

Effective patient engagement	Promote effective patient engagement with Barnet CCG and Royal Free Hospital over acquisition of Barnet and Chase Farm Hospital and redefined healthcare pathways.	On-going meetings are taking place with RFH Directors and senior staff at Barnet CCG to develop patient workshops on the re-design of pathways, in early 2015. Three volunteers contributed to the initial high-level clinical workshops in June 2014.
	Promote effective patient engagement with Barnet CCG in its development of the Patient Reference Group, including with key communities and under-represented groups.	Healthwatch Barnet Engagement Group gave guidance and feedback to Barnet CCG on developing its Patient Reference Group, including the format, structure and topics for meetings and effective communications. BCCG positively welcomed these recommendations which will be implemented going forward.
	Promote effective patient communication and engagement with the Health and Social Care Integration Programme.	Two Healthwatch Barnet volunteers are part of the Shared Care Record Governance and Information Management project teams for the HSCI Programme.
Primary care services	Healthwatch Barnet Primary Care Group to formulate Year 2 work plan, potentially including dental services, GP access and information, promotion and involvement of Patient Participation Groups.	The Primary Care Group is currently defining the community research that it will undertake on dentistry. Through Healthwatch England and Which?, this potentially will be part of a national project to explore the quality of services, particularly around charges for treatment. The Primary Care Group and Barnet CCG are currently planning an event to promote Patient Participation Groups, for patients, GPs and Practice Managers, due to be held in early 2015.
OTHER ACTIVITY		

Social Care	The Care Act Domiciliary Care Review	Ongoing liaison with Barnet Council to contribute to the consultation on The Care Act and raise awareness of Act. Liaison with Barnet Council on its project to review standards of domiciliary care.
Community Consultation		Event with the Gypsy, Roma, Traveller community to raise awareness of diabetes and to gather their feedback on using diabetes/health services took place in June 2014. Community consultation with homeless people and the adult safeguarding group to gather their experiences of health and social care services took place in June and July 2014. From this, a report was sent to Healthwatch England for their Special Inquiry into Hospital Discharge.

healthwatch Barnet

Healthwatch Barnet Enter and View Meal-Time Review

Summary Report

Healthwatch Barnet 2014

Part 1

Healthwatch Barnet Enter and View Meal-Time Review

Summary Report

Introduction

In January 2014 Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration are well documented as being a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients, to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet had received some feedback from members of the public about concerns around the quality of support given at mealtimes at Barnet Hospital.

The project was led by Healthwatch Barnet Volunteer and Projects Officer, Lisa Robbins. A small team of Healthwatch Barnet volunteers, provided a significant amount of expertise, and led on the research for and the design of the project. A wider team of volunteers, who are all fully trained Enter and View Authorised Representatives, were then briefed on the protocols and background information. The Enter and View visits were undertaken predominantly by Enter and View volunteers, as named in the individual reports, and Lisa Robbins.

To fully understand the process, the Team undertook the following background research.

- Meeting with the Contract Director from Medirest, the Company which holds the catering contract at Barnet Hospital, and the Facilities Manager at Barnet Hospital, to fully understand the contract and responsibilities of the Medirest/Steamplicity staff and the hospital staff. The team also had the opportunity to see the kitchen area, and to sample some of the food served to patients.
- Meeting with Head of Patient Experience at Barnet and Chase Farm Hospital to discuss the project.
- Meeting with the Director of Nursing at Barnet and Chase Farm Hospital to discuss the visits and to agree the timescales and protocols to be followed during the visits.

Background Information

The catering at Barnet Hospital is currently provided by Medirest who operate a system of prepared meals called Steamplicity. This system cooks food under steam pressure aiming to retain the taste and nutritional value of the food. Meals are prepared off-site by Steamplicity and are delivered chilled to the hospital where 2/3 days supply is stored in a chilled environment. A range of different types of meals catering for a range of specialist diets are available (for example, kosher, vegetarian, gluten–free meals). An extensive menu (available in a variety of formats) is available for patients to choose from for both the midday and evening meals. Orders are taken a few hours before the mealtime by a hostess. Supplies of meal options are kept chilled on-site, and are delivered to the ward where they are heated using specifically programmed microwaves, and served to the patients. The system is very flexible and allows for food to be heated/served only when the patient is ready, and also offers a wide range of choices (there are 32 main meal choices).

Hostesses also clear up after the meals have been finished. They work from either a small kitchenette on the ward, or a large mobile serving unit.

Breakfast is served from a trolley which is taken around the ward, with a choice of breakfast cereals and bread. No hot options other than porridge are available at this time.

Methodology

There are 18 wards at Barnet Hospital. The team agreed to visit 6 wards during the period mid-March to June. The reasons for this were as follows:

- To visit a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the patients, their relatives, friends and carers.
- To avoid visiting critical hospital services, such as children's wards and acute/ assessment wards.

The Enter and View teams consisted of two trained volunteers/staff for each ward. Each of these teams aimed to visit the ward on more than one occasion and where possible at different times of the day, for example, lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week. The dates of the visits were notified to the Director of Nursing, but not the wards

that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they could not anticipate the actual date a visit was to take place.

The Teams did not approach any wards that had notification of infections.

Each visit comprised two distinct parts. Phase 1 was to observe activity from start to finish of mealtime. To minimise the risk of our presence affecting behaviour, our observers took care to be as unobtrusive as possible.

In Phase 2, when mealtime was over, as many as possible patients and their carers/visitors were approached, again using a standardised questionnaire. Thus, the team's observations could be compared, for consistency, with patient feedback. Some discussions with staff and volunteers also took place.

In total we observed 206 patients at mealtimes, and spoke to 67 patients /friends/relatives.

This information was then summarised into a structured report for each ward, which was sent to the Director of Nursing to check for factual accuracy and any responses to the recommendations. Unfortunately due to the acquisition of Barnet and Chase Farm Hospitals by the Royal Free, there was a change in personnel in this post which resulted in a delay in concluding the hospital's response to the reports. However meetings took place with the outgoing Director of Nursing and the new incumbent, and the Matron at Barnet Hospital with responsibility for this area, to discuss the findings of the reports and these have all been very constructive. These reports for each ward are contained in Appendices 1 to 6. This final report has been collated summarising the findings of all of the visits and the overall recommendations of the team.

<u>Findings:</u>

Cleanliness and hygiene:

Across all of the wards visited, none of the patients who were immobile were observed having the opportunity to clean their hands in any way before they ate. Mobile patients were able to wash their hands if they wished but those unable to do this of their own accord were not encouraged or enabled to do so.

Support:

The majority of patients were assisted into a comfortable position to eat. All had jugs of water and a glass of water available when we visited. All those who were able to eat by themselves were supported to ensure that they could open all containers and sachets, and the food was left within reach. This support was either provided by the nursing staff or the hosts who delivered the meals to the patients.

The red tray system (a red tray is used to identify a patient needing additional support with eating) was being used and most of the time this appeared to work well with patients getting assistance in a timely way. There were a small number of cases observed where the meals were delivered to the patient's bedside before there was a member of staff was available to assist with feeding, so the meals were left to go cold. We observed this happening on 7 occasions (out of 206) during our visits with one patient having to wait for 45 minutes to be assisted.

We observed several cases where very impressive care was given to patients who needed support with eating, with staff being very supportive and caring in trying to encourage patients to eat and to find food that would be appetizing for them.

We observed one situation where the patient was fed by a member of staff 'on automatic pilot' without any interaction with the patient, and without making any attempt to talk to or encourage the patient, but this was the exception.

Protected Meal Time

We found that protected meal time was very erratic in its use. It was used effectively in the Larch, Spruce, Walnut and Juniper wards at lunchtime, but was not used at all in Willow ward. However in general in the wards that we visited, it operated much less effectively at evening meals which were much less focused and took a much longer period of time.

There were four situations where medical treatments were continued, or even started, while patients were eating. In a number of cases we felt that the mealtimes could really have benefitted from a more managed and focused approach, to ensure that sufficient emphasis was placed on the importance of

nutrition. In several cases particularly in the evening we observed several staff involved in other tasks while patients were needing support with eating.

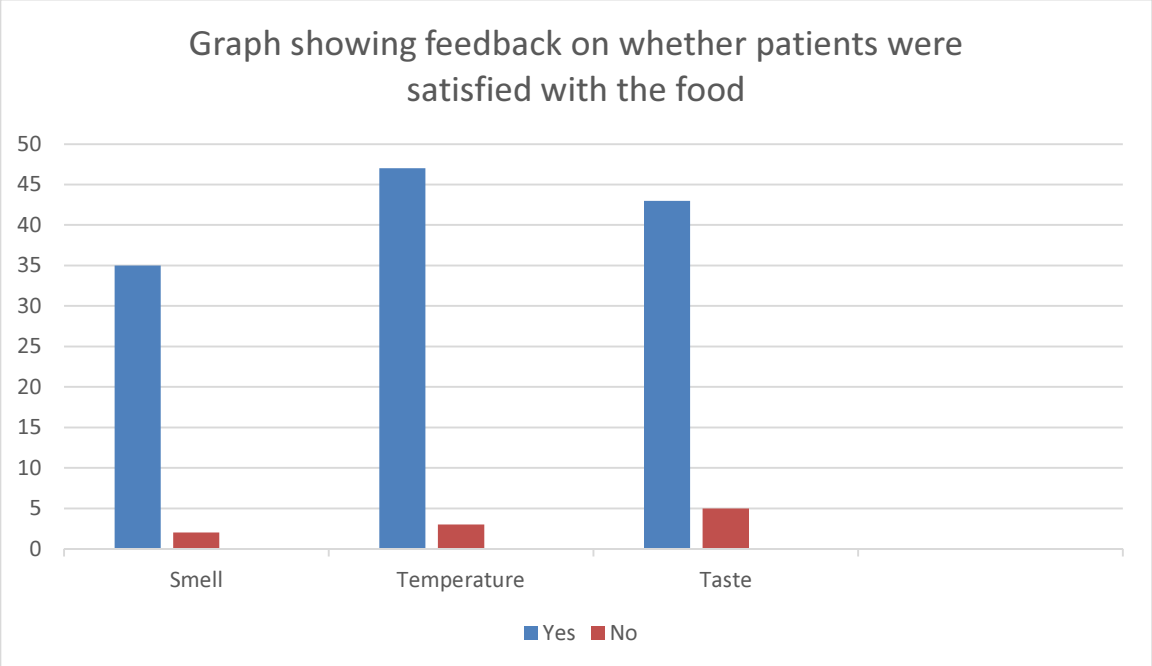
Clearing up after Meals

All trays were cleared efficiently by the hosts within reasonable timescales. Concerns were raised by relatives and the Healthwatch volunteers about whether the nursing staff were aware of the amount of food that the patients were eating, when the trays were cleared by the hosts.

All patients were given plenty of time to eat and we did not see anyone being rushed. Water jugs in some wards were replenished at this point.

Quality of Food

The feedback about the smell, taste and temperature of the food was generally good and are shown below:



All patients felt that the portion size was generous and some felt it was too large.

The exception to the general satisfaction with the food was around the Kosher and Halal options. We spoke to 3 patients who ate Kosher food which they felt was very poor and that all of the advertised options were not always available. We also spoke to 2 patients eating halal food who both found it very bland and unappetising.

Complaints

We only spoke to two patients who had made complaints about the food and the circumstances of one of these were quite specific to their situation. Although some others told us of some relatively minor issues they had not felt that they merited making a complaint.

Ordering

The vast majority of patients found the ordering system to be effective and easy to use. However we spoke to two sets of relatives who told us the patient was not able to read the menu due to visual impairments and had therefore continued to order the same things for some time. The hosts told us that relatives were welcome to order food on behalf of the patient by leaving a note with the menu, but this was not generally known by relatives.

Availability of Additional Food.

There was some confusion about this. Medirest had informed us that snack boxes are kept on the wards at all times containing snacks such as cereal bars, biscuits and dried fruit, and that these could be accessed as needed for patients. However none of the patients were aware of this, and most of the staff were also unaware. The staff felt that this could be very useful. The vast majority of patients said that they did not feel the need for any additional food but one or two commented that the time gap between lunch and dinner was quite long and that they may appreciate something in between.

On some wards tea and coffee was available from a machine at all times. Not all patients knew about this and several people told us that they would like to have more hot drinks during the day. The acknowledged that they always had fresh water to drink, but were accustomed to having more tea, and missed that.

Only those patients who were already familiar with the hospital layout knew about the coffee shop and restaurant and that they could buy food there if they choose to.

Many patients said that their friends and family brought in food for them However only three said that they needed this as a main source of food, as in all the other cases they felt the hospital food was sufficient. One of these cases was where the patient had specific dietary preferences, and the other two were due to poor quality of Kosher food.

Any Occasions where Meals have been Missed.

There were three patients who told us that they had missed meals when they were admitted through A&E. They had not known how to request food whilst going through the process of being admitted and had therefore not ended up eating, though they were hungry. This was resolved once they had reached the ward.

Several other patients and staff told us that meals were missed due to medical procedures but due to the flexibility of the Steamplicity system they were kept in the ward kitchen and heated up when the patient was ready for them.

Key Recommendations

As the result of our visits we have drawn together a list of key recommendations based on the feedback we have received and our observations. Some of these are in response to individual situations/circumstances detailed in the 6 ward reports.

We alerted the Director of Nursing where we noticed individual situations, with specific staff, which we felt were inappropriate or where we felt care was not given adequately. The Director of Nursing gave us assurance that these would be followed up with the staff and their managers. These points have not been included in the reports, as they relate to individual staff.

- More closely manage mealtimes to ensure that support with eating is available when the food arrives and that patients don't have to wait while food goes cold.
- Ensure that all patients who are not mobile have the opportunity to wash/clean their hands prior to eating.
- Reinforce the principles of 'Protected mealtime' to ensure meals are not interrupted for treatment.
- Explore the range of options and the method of delivery of breakfast to offer a wider range of food and faster delivery of food.
- Ensure those who are admitted through A&E are offered food/drinks as appropriate.
- Improve the quality of Halal and Kosher food options, including diabetic options for each of these.
- Ensure that uneaten food is monitored appropriately in all cases.
- Ensure that where needed advice on appropriate food, following operations, is available to patients.
- Ensure there is a mechanism in place to support patients who are not able to read the menu, for example for staff or relatives/friends/carers to order food for the patient.
- Ensure there is sufficient communication between the catering staff and ward staff to arrange timely cover for absent catering staff.
- Clarify the position on availability of snacks between meals for patients, ensuring staff as well as patients are aware of what is available.
- Make information available to all about where else on the premises food/drinks can be purchased.

<u>Final Comments</u>

Overall the Healthwatch Volunteers observed well run wards with a pleasant atmosphere. Most care and support that was observed was of a high standard and most patients and relatives that we spoke to were happy and complimentary about the care. Most felt that the food was good and met their needs. However there were a number of areas where we felt improvements could be made. We have already fed these back to the hospital and look

forward to seeing these changes implemented and to continue working together with the staff, thus improving the experience of patients at the hospital.

We would like to thank the hospital management and their staff for their support in designing and carrying out this investigation, and for welcoming the Healthwatch volunteers and supporting their work. Thank you also to those patients and their relatives who participated and gave us their feedback.

This report relates only to the services viewed on the dates of the visits, and is representative of the views of the staff, visitors and patients who met members of the Enter and View team on that date.

Royal Free London NHS
NHS Foundation Trust

Royal Free Hospital
Pond Street
London
NW3 2QG

Tel: 020 3758 2000

Lisa Robbins
Volunteer and Projects Officer
Healthwatch Barnet
CommUNITY Barnet
7th Floor
Barnet House
1255 High Road
Whetstone
N20 0EJ

14 November 2014

Dear Lisa

I would like to extend, on behalf of the trust, my thanks to Healthwatch Barnet for the time, effort and insight given into the enter and view mealtime visits at Barnet hospital. The reports have been extremely helpful to us in our determination to improve the experience of our patients at mealtimes.

I thought it might be useful to outline the work that has been undertaken under the leadership of Kay Gilsenan, senior matron. Kay set up a working group comprising of the ward sisters and charge nurses and matrons who have developed a 'Mealtimes Matter' action plan. The key elements of the plan are:

- Relaunch protected mealtimes at Barnet hospital. This includes, amongst other things, moving the lunchtime meal to 13.00 instead of 12.00 to allow clinical teams more time to complete their morning clinical work thereby not having to encroach on patients' meal time. There will also be clearer signage on the wards indicating that protected mealtime is in progress.
- Each meal time will be led by a senior nurse with a registered nurse being allocated each day to lead the mealtime and ensuring that staff are available to support patients with their nutritional needs.
- Setting out roles and responsibilities of all staff at mealtimes.
- Reintroducing nutrition link nurses on each ward.
- Introduction of hygienic hand wipes on each meal tray

You may be interested to know that the CQC recently carried out an unannounced inspection at Barnet hospital and in the **draft** report (we have not yet received the final report) the following was said about food and meal times which I hope demonstrates that we have made improvements since the Healthwatch visit:

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We observed that there was a good variety of food which was well cooked and presented. We spoke to one patient who said that he was very happy with the kosher food that had been prepared for him. This patient told us, "I had the option of going private but what's the point?"

We observed that patients were regularly offered hot drinks such as tea, coffee and hot chocolate.

We observed a lunch period and found that patients who needed it were given support in eating and drinking. The hospital uses a 'Red Tray' to identify patients who need additional support at mealtimes

Once again thank you very much for your reports and I look forward to a return visit from Healthwatch to see our progress.

Yours sincerely

Deborah Sanders
Director of Nursing

healthwatch Barnet

Healthwatch Barnet Enter and View Meal-Time Review

Summary Report

Healthwatch Barnet 2014

Part 2

Appendix 1

Appendix 1

Individual Ward Enter and View Meal-Time Observation Reports

The following wards were visited and the individual reports are shown below as follows:

1. Juniper Ward
2. Larch Ward
3. Olive Ward
4. Walnut Ward
5. Spruce Ward
6. Willow Ward

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Juniper Ward: Medical and Respiratory

1 bays of 5 beds, and 1 bay of 6 beds (1 male, 1 female), 2 bays of 4 beds (1 male, 1 female), 5 single rooms (24 in total)

Healthwatch Authorised Representatives:

Melvin Gamp, Jill Smith, Tina Stanton, Alan Shackman

Dates of Visits: Thursday 10 April and Saturday 17 May

Patients spoken to: Number of patients/visitors spoken to: 4 patients on the first visit and 2 patients on the second visit.

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients and to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet has also been alerted to concerns raised by patients and residents about the care and support to patients at mealtimes.

The project was developed by a small team of volunteers and staff from Healthwatch Barnet. To fully understand the process, the Team undertook the following research.

- Meeting with the Contract Director from Medirest, the Company which holds the catering contract at Barnet Hospital, and the Facilities Manager at Barnet Hospital, to fully understand the contract and responsibilities of the Medirest/Steamplicity staff and the hospital staff. We also had the opportunity to see the kitchen area, and to sample some of the food served to patients.
- Meeting with Head of Patient Experience at Barnet and Chase Farm Hospital to discuss the project.
- Meeting with Terina Riches, the Director of Nursing at Barnet and Chase Farm Hospital, to discuss the visits and to agree the timescales and protocols to be followed during the visits.

The team of volunteers, who are all fully trained Enter and View Authorised Representatives, were then briefed on the protocols and background information.

Methodology

There are 18 wards at Barnet Hospital. The team agreed to visit 6 wards during the period mid-March to mid-May. The reasons for this are as follows:

- To visit a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the public.
- To avoid visiting critical hospital services, such as children's wards and acute/ assessment wards.

The Enter and View teams consisted of two trained volunteers for each ward. Each of these teams aimed to visit the ward on more than one occasion and at different times of the day, for example, lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week. The dates of the visits were notified to the Director of Nursing, but not the wards that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they could not anticipate the actual date a visit was to take place.

The Teams did not approach any wards that had notification of infections.

Each visit comprised two distinct parts. Phase 1 was to observe activity from start to finish of mealtime. To minimise the risk of our presence affecting behaviour, our observers took care to be as unobtrusive as possible and not to interact with staff and patients. In Phase 2, when mealtime was over, as many as possible patients and their carers/visitors were approached with a standardised questionnaire. Some discussions with staff and volunteers also took place Thus, observations could be compared for consistency with patient feedback.

This information was then summarised into a short report for each ward, and a full report will be produced for the whole hospital on conclusion of the visits. The draft ward reports were sent to the ward managers via the Director of Nursing, for their comments and to check for factual accuracy. The overall summary report and the final versions of the ward reports are available to the public via the Healthwatch website. They are also sent to the Care Quality Commission, Barnet Clinical Commissioning Group and the Council's Health Overview and Scrutiny Committee.

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 patients who met members of the Enter and View team on that date.

Findings

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

The team sought advice on the first visit about any areas we should not visit and were advised so long as the curtains were back, it was fine to approach all patients. However we discovered some of those in single rooms were clearly very ill and some were on the end of life pathway. We felt we should have been advised not to disturb these patients.
Several patients were severely ill and some were being fed via PEG Feed (Percutaneous Endoscopic Gastrostomy) and several had nasal cannulas and required pureed food.

Cleanliness and Hygiene: There was no hand-washing prior to meals, nor any "wipes" provided on the trays. All beds had gel, but there was no encouragement to use this before meals. Mobile patients were able to get to the sink themselves.

Support: We noted that patients were assisted to move to a suitable position to eat according to their condition, but some patients were only put into a suitable position to eat once the meal actually arrived.
One of the patients receiving a red tray meal was only got ready to eat 5 minutes after the meal arrived.
Food trays were placed within reach of those able to feed themselves.
One patient received the wrong meal and then had to wait for 20 minutes until the correct meal arrived.
We observed several situations where nurses were encouraging patients to eat and offering alternatives.
Although all staff appeared to be involved in the lunch service there did not appear to be enough staff to help everyone.
We observed notes being made on patients' records for those with red trays, about how much had been eaten etc and were told that matters of concern are passed on to a nutritionist/dietician.

Protected Meal Time
On the first visit the bell for lunch rang at 12 o'clock and at 12.15 on the second visit. The doors to the female bay were shut at 12.40 on the second visit.
There was a notice board which indicated that there were 5 red trays on the ward.

There were no facilities to sit around a table e.g. a day room, only at the bedside.

One patient had medical staff around the bed when the meal arrived who continued speaking to her for at least 10 minutes before she started eating (this patient ate very little but said she was not hungry).
Another patient had observations taken whilst eating, but the nurse commented that this was because she was receiving a blood transfusion.

We were told that patients receiving red trays have the amounts of food consumed noted on a nutritional chart. We were also told that hostesses alert staff if significant amounts of food are left by all patients, but we did not observe this.

Clearing Up after Meals: All meals were cleared up efficiently after the patients had finished.

Phase 2: Feedback from Patients

Due to the severity of their illnesses it was only possible to talk to 4 patients at the first visit and 2 patients at the second visit. Two others gave a couple of comments during the first visit, but were not able to answer all our questions.

Length of Stay
All patients we spoke to had been in hospital for between 2 and 7 days.

Support with Eating: All patients said they were helped to get ready for their meals (if needed) but two felt the drinks and meals were not always left where they could easily eat/drink them. However four of the people we spoke to said they did not get the help they needed with eating.

Quality and Choice of Food and Drink: All of the patients felt they had sufficient choice of food and drinks and that the food was good and tasty. All said the food was hot when they received it.
Two said they would like to have more access to hot drinks during the day between meals.

Complaints: None of the patients we spoke to had complained.

Ordering System: All found the ordering system good, and easy to use. One patient had received the wrong meal but after a wait it had been rectified.

Dietary and Cultural requirements: All patients we spoke to, said the food met their dietary/cultural requirements.

Portion Size: All found the portion size sufficient – some found the portions too big.

Availability of additional snacks: Three of the patients said they had been made aware of snacks being available and also where else in the hospital food is available.

Need for Friends and family to bring in food: Several patients had friends and relatives who brought in food but that was not because it was needed – there is plenty of food.

Any occasions when meals have been missed: No-one reported having missed any meals.

General Comments

'All pretty good'

'Don't always fancy the food because I am feeling down '

'I miss out on my tea if the nurse is seeing to me in the morning – the tea goes cold'

'Two types of crumble desert would be good as it is very popular.'

'The soups are delicious'

One patient who was very tired and couldn't answer all the questions wanted to say: 'service is excellent – I don't have to wait. No complaints – the salmon was lovely but too much to eat. Water available for me'

Recommendations:

- To reduce the potential for things going wrong, mealtimes would benefit from being more tightly managed and with greater leadership and supervision of staff, thus ensuring that staff are available to support all patients who need help to eat and drink sufficiently.
- A procedure should be in place to ensure that all patients are prepared to eat before the meal arrives and be given the opportunity to clean their hands before eating.
- Evidence of a protocol to ensure that the amount of food being consumed, or left, is being monitored for all patients, not just those receiving a red tray.
- To ensure that patients are aware that they can access hot drinks at any point during the day.

- To ensure that clear, sensitive information about which patients are able to be approached, is passed on to visitors such as ourselves.

Conclusions:

We were able to observe the mealtime experience on this ward, however there were very few patients who were well enough for the volunteers to talk to. The feedback that we did gather, indicated that patients felt that they did not receive sufficient help with eating or drinking. Whilst the volunteers were in the ward they observed good care, but the staff were at times very aware of their presence and the feedback from the patients suggested that there was a lack of sufficient support to enable patients to eat.

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Larch Ward – Older People/General Medicine and Care of the Elderly

22 Beds, (3 bays and 6 single rooms)

Healthwatch Authorised Representatives:

Melvin Gamp, Alan Shackman, Lisa Robbins

Dates of Visits: 12 March 2014 and 3 April 2014

Patients spoken to: Number of patients observed: Visit 1, 3 Bays observed (16 beds) Visit 2, 2 bays observed (12 beds)

Number of patients/visitors spoken to: 7 patients and 2 visitors on behalf of the patient

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients and to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet has also been alerted to concerns raised by patients and residents about the care and support to patients at mealtimes.

The project was developed by a small team of volunteers and staff from Healthwatch Barnet. To fully understand the process, the Team undertook the following research.

- Meeting with the Contract Director from Medirest, the Company which holds the catering contract at Barnet Hospital, and the Facilities Manager at Barnet Hospital, to fully understand the contract and responsibilities of the Medirest/Steamplicity staff and the hospital staff. Also

had the opportunity to see the kitchen area, and to sample some of the food served to patients.

- Meeting with Head of Patient Experience at Barnet and Chase Farm Hospital to discuss the project.
- Meeting with Terina Riches the Director of Nursing at Barnet and Chase Farm Hospital to discuss the visits and to agree the timescales and protocols to be followed during the visits.

The team of volunteers, who are all fully trained Enter and View Authorised Representatives, were then briefed on the protocols and background information.

Methodology

There are 18 wards at Barnet Hospital. The team agreed to visit 6 wards during the period mid-March to mid-May. The reasons for this are as follows:

- To visit a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the public.
- To avoid visiting critical hospital services, such as children's wards and acute/ assessment wards.

The Enter and View teams consisted of two trained volunteers for each ward. Each of these teams aimed to visit the ward on more than one occasion and at different times of the day, e.g. lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week. The dates of the visits were notified to the Director of Nursing, but not the wards that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they could not anticipate the actual date a visit was to take place.

The Teams did not approach any wards that had notification of infections.

Each visit comprised two distinct parts. Phase 1 was to observe activity from start to finish of mealtime. To minimise the risk of our presence affecting behaviour, our observers took care to be as unobtrusive as possible. In Phase 2, when mealtime was over, as many as possible patients and their carers/visitors were approached with a standardised questionnaire. Some discussions with staff and volunteers also took place. Thus observations could be compared for consistency with patient feedback.

This information was then summarised into a short report for each ward, and a full report will be produced for the whole hospital on conclusion of the visits. . The draft ward reports were sent to the ward managers via the Director of Nursing, for their comments and to check for factual accuracy. The overall summary report and the final versions of the ward reports are available to the public via the Healthwatch website. They are also sent to the Care Quality Commission, Barnet Clinical Commissioning Group and the Council's Health Overview and Scrutiny Committee.

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 patients who met members of the Enter and View team on that date.

Findings

Appendix Bi

This was the first ward visited by Healthwatch Barnet's Enter and View Authorised Representatives at Barnet Hospital.

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

Cleanliness/hygiene: None of the patients we observed who were immobile were given the opportunity to clean their hands in any way before they ate. Those who were able to get up themselves did this at their own instigation.

Support: All patients observed were either able to get themselves into a suitable position or were assisted to get into a suitable position to eat, before their meal was served. All were able to reach their food and any containers that needed opening were done so for the patients. All patients had filled water jugs within reach beside their beds.

Those patients with red trays were offered assistance though not all needed it, and some just needed help getting started and were then left to continue themselves which is what they wished.

Where patients were not interested in eating, the staff were very supportive in looking at alternatives that could be offered and tried hard to encourage the patients to eat. At the lunchtime visit we saw two particular examples where the staff were very encouraging and thoughtful in trying to support patients, even though they did not succeed in the end.

When we visited in the evening we felt that although the care was still good, the mealtime was less focused and stretched for a much longer period of time. Most staff helped with supporting patients to eat but some went on to other duties before everyone had eaten. No patient requiring assistance failed to receive it eventually but some certainly had to wait. The nurse in charge had finished work before the meal was finished so perhaps there was a loss of focus due to this. We observed one staff member openly making a personal telephone call of some length during mealtime.

Protected Meal Time

When we visited the ward at lunchtime a hand bell was rung at 11.50am to indicate the start of protected mealtime. We did not see any notice at the entrance indicating that it was starting but the bell was rung throughout the ward. The team of doctors on the ward were seen to withdraw from the ward when meals started arriving, leaving patients the opportunity to eat uninterrupted.

In the evening the bell was rung at 6.05pm and the first meals were served shortly after this. We did not see any sign indicating protected meal time. No medical staff were working with patients on the wards at this time. The last meals were not served until 6.45pm

Clearing Up after Meals:

When we visited at lunchtime we felt that the mealtime hostess coped very well with a busy session and was very efficient in delivering meals as quickly as possible and following up where late orders needed extra attention. The plates were cleared away in a timely manner.

In the evening the process was a lot slower, which may not have been the fault of the hostess, but it took a long time for all patients to receive their meals. (protected meal time started at 6.05 and the last meal was served at 6.45pm). The trays were cleared away after that but were therefore left for some time for some patients.

Phase 2: Feedback from Patients

Length of Stay

We spoke to a total of 9 patients and visitors.

4 had been in hospital between 2 to 7 days

4 for between 8 and 14 days

1 for more than 30 days

Support with Eating: All patients that we spoke to felt that they received sufficient support with eating, and getting into position to eat, and that all food and drinks were left in suitable positions where they could easily reach them when they wished to.

Quality and Choice of food and drink: The majority of people felt the choice of food options was very good and they enjoyed the variety. Most said they had consistently received the meal that they ordered though two had experienced some issues with this, one in respect of main courses and one with deserts.

Complaints: No one we spoke to had made a complaint about the food. Some had relatively minor complaints which they told us about but did not feel it merited making a complaint. Eg. One patient felt that the porridge was more like 'Ready Brek' than porridge and it was not pleasant.

The kosher food was reported as being very poor but the patients concerned had not actually complained about it.

Ordering system: All of the patients we spoke to found the ordering system very straightforward and easy to use, though one relative of a patient with sight problems felt that he was ordering the same thing every day as he was not able to see the menu and didn't want to make a fuss.

Dietary/cultural requirements: Most people felt that the food met with their dietary/religious requirements. The exception to this was kosher food which we discussed with two patients/visitors. They both felt the quality was very poor and the choice was very limited with some of the options quoted on the menu not being available regularly. One person had only eaten vegetarian as the kosher food was so poor.

Portion size: All felt the portion size was good – though some felt it was slightly too large at times! All also said that the food reached them hot and was appealing. Some mentioned that they particularly liked the puddings.

Availability of additional snacks: There did not appear to be much take-up of snacks in between meals on this ward. Only one of the 9 people we spoke to was aware that they could ask for something to eat in between meals and the others, although they were not aware, felt they would not need anything in between meals. Several were not aware of other places in the hospital where they could get food such as the café and restaurant.

Comparison with previous visits: 4 patients had been in Barnet Hospital before. 2 felt that the food was about the same as their last stay and 2 felt it was better.

Need for friends and family to bring in food: Of the 9 people that we spoke to only 1 person had visitors who brought food into the hospital for them, and that was due to the kosher food. 4 others had what they described as extras brought in but not food to replace meals.

Any Occasions when meals have been missed: The only occasions when patients had missed meals was when they had been needing medical procedures. On most occasions when this had happened the patient's meal was kept in the fridge and heated when they returned to the ward, so it was fresh for them when they were ready. Everyone we spoke to felt that this was very flexible and worked very well.

General comments

The general atmosphere in the ward was very calm and cheerful – more so at lunchtime than in the evening. The staff were without fail caring and appeared competent. All were concerned for the welfare of their patients.

Comments from patients and relatives:

- Very pleased with the food
- Help is available if you need it
- Kosher food is not good – only the chicken option is ever available.
- Feel Barnet is a very good hospital and when need to go to hospital, always ask to come to Barnet
- Quite happy with treatment here
- Feel if you ask for something it takes quite a long time for it to come – not enough staff (assistance relating to care)
- Not enough staff to care for very dependent patients. Students need to spend more time on wards as although they are very nice, they are in awe of the patients and not confident at all.
- Like to record strongly that the nursing is great

Recommendations

- To ensure that time is taken to read through the menu with patients who may have problems in reading it so that they are able to access the same range of choices.
- To explore the quality and availability of kosher food which was reported as being poor.
- To ensure that all patients are given the opportunity to clean their hands before eating.
- To maintain the focus of staff on supporting all patients with eating in the evening to avoid some having to wait for assistance and mealtime becoming so lengthy.
- To ensure that all patients (and staff) are aware that snacks are available in between meals if needed and these should be kept on the wards. Also ensure that patients are aware of where else in the hospital food is available.

Conclusions

We felt that this was a well organised and calm ward. The observation at lunchtime was more favorable than in the evening but both were positive generally. The staff were very positive and cheerful at lunchtime and there was a stronger sense of the senior staff having a clear overview of what was going on across the ward.

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Olive Ward – Medical / Care of the Elderly and Gastroenterology

22 Beds (2 x 6 Bays; 1 x 4 Bay & 6 single rooms)

Healthwatch Authorised Representatives:

Melvin Gamp and Jill Smith

Dates of Visits: 13 April 2014 and 8th May 2014 -

Patients spoken to: Number of patients observed: 12 patients in two bays for dinner; 16 patients in three bays for breakfast

Appendix Bi

Number of patients/visitors spoken to: On the first visit we spoke to 6 patients and one staff member helped respond for a patient. On the second (morning) visit we spoke to 4 patients and one relative. Due to lateness of breakfast service and drugs round, our interviews were limited.

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is obviously a key element in the recovery and wellbeing of patients and it was felt that this would be an interesting area to investigate and to establish if there were suggestions that could be made to help improve the whole experience for patients. Healthwatch was also aware of some feedback from patients and residents about concerns relating to the care and support to patients at mealtimes.

The project was developed by a small team of volunteers from Healthwatch and some staff members. To find out the background information some members of the team met with the Contract manager from Steamplicity, the Company who hold the catering contract at Barnet Hospital, and the contract services manager at the hospital, to fully understand the contract and responsibilities of the Steamplicity staff and the hospital staff. They also had the opportunity to see the kitchen area, and to sample some of the food served to patients.

We also met with Terina Riches the Director of Nursing at Barnet and Chase Farm Hopsital to discuss the visits and to agree the timescales and protocols to be followed during the visits.

The team of volunteers, who are all fully trained Enter and View Authorised Representatives, were then briefed on the protocols and background information.

Methodology

The Healthwatch team selected the wards they wished to visit at the hospital. This was to have a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the public, as well as avoiding children's wards and acute/ assessment wards. They then allocated a small team of two trained volunteers to each ward. Each of these teams aimed to visit the ward on more than one occasion and at different times of the day. eg lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week, thus hopefully making the observations consistent too.

The dates of the visits were notified to the Director of Nursing, but not the wards that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they were not expecting the teams. The visits took place over an 8 week period from mid March to mid May.

The aim of each visit is to observe a mealtime, and to talk to as many patients and their visitors as feasible. The observations were recorded along with the feedback from the patients and their visitors that we spoke to and these have then been put into a short report for each ward, and will be summarised for the whole hospital on conclusion of the investigations. A set of standard observation charts were developed to try and ensure the teams were all looking for the same initial information, and standard questions were developed to be asked of all of the patients and visitors.

The ward reports will be sent to the ward managers via the Director of Nursing, in draft for them to comment on and check for factual accuracy. The overall summary report and the final versions of the ward reports will be available to the public via the Healthwatch website. They will also be sent to the CQC, and the Council's Health Overview and Scrutiny Committee.

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 patients who met members of the Enter and View team on that date.

Findings

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

Cleanliness/hygiene: None of the observed immobile patients were given the opportunity to wash their hands before eating, and no wipes were provided. The more able ones could approach the sink themselves.

Support: All patients observed had managed, or were assisted, to get into a suitable eating position in time for their meal.They were also all able to reach both food and drinks. Staff also helped with any containers that required opening. Filled jugs of water were noticed at each bed site and some patients sat in a bedside chair to eat their meal.

Being a gastro ward, the staff obviously had greater difficulties in feeding some patients. In the evening 3 patients were served using red trays, and staff also assisted patients with special diets. It was noticed that although red trays were not used for breakfast, staff were assisting many of the patients and offering alternatives from the limited range of food. They were also seen to be coaxing those with no appetite. Some of the patients who were asleep were gently awakened and offered their breakfast.

Protected Meal Time: On neither of our visits was a bell rung to indicate the start of protected mealtime, neither was there a visible notice on the ward board.

On the first visit in the evening the patients were prepared for eating from 6pm and the first meals were served at 6.15pm, and the mealtime finished about 7pm. There were 4 nurses and 2 healthcare assistants on duty and one catering hostess served all of the meals. Staff members were observed trying to get patients to eat and supplied alternatives where possible, but they obviously didn't have time to chat.

On our second visit at Breakfast time, although the Healthwatch members arrived at 07.00, breakfast did not commence until 08.10 and ran late, until 09.15. Four nurses were on duty, plus 2 Healthcare assistants and the catering hostess. There were some signs of medical activity in Bay 2 during the protected period, and whilst we were at the ward, an ambulance crew arrived to take a patient to another hospital.

We felt there was a lot of work for one hostess. All of the food and drink was on her trolley which she had to push around the various bays, and included the assortment of cereal dispensers. It obviously took a lot of time to distribute to each patient.

We observed one patient was cutting-up an apple which he had saved from the previous day to supplement his breakfast.

Clearing Up after Meals: Breakfast was easier to clear up than the main meal, but both were adequately dealt with.

Phase 2: Feedback from Patients

Length of Stay:

7 of the patients spoken to had been in hospital between 2-7 days, and one more than 3 months. The other 3 were between 8 and 30 days.

Support with Eating: At breakfast, patient's comments mirrored the support observations already mentioned above. At dinner, only two patients received help for eating/drinking. Two patients reported to us that they felt they needed help but did not receive it.

Quality and Choice of food and drink: It should be emphasized that as the range of breakfast content was quite minimal, most comments regarding the quality of food and drink refer to lunch and dinner meals. 8 patients felt that there was enough choice of food (although at breakfast, some toast would have been appreciated), and two felt there was not. Only two stated that there was an insufficient choice of drink. Regarding the quality of the food at dinner, eight said the smell was O.K. whilst two disagreed. Most found the temperatures alright, but six liked the tastes.

The Healthwatch representatives felt that the breakfast on offer was a little sparse.

Complaints: On our first visit two patients told us they had complained about the food, and one felt it had improved since they complained, but the other person disagreed. At the morning visit no major complaints were reported as having been made about the food, although one patient confided some disatisfaction, and another compared it unfavorably with their experience in another hospital.

Ordering system: At the dinner time visit all but one of the patients felt the system was easy to use. Three patients had had situations where the food they received was not what they had ordered – one of these was around a different variety of soup, one a different fruit, and one a different juice. One person mentioned that the menu does not state what is sugar-free for diabetics. This may be a difficulty in understanding the coding on the menus for the different types of dishes.

As there was no breakfast menu, the patients had to select their choice from the trolley, or were assisted to do so by members of the staff. One patient found nothing met with her requirements and was only having a nutritional supplement drink.

Dietary/cultural requirements: Most of the patients agreed that the food met with their dietary/cultural needs.

Portion size: All agreed that the main meals were large enough or "too big".

Availability of additional snacks: Unfortunately, none of the patients we spoke to knew that snacks and hot drinks are available between meals. Similarly, only one knew that food was available elsewhere within the hospital (shop or café).

Comparison with previous visits: Four patients had previously stayed at this hospital, and all agreed that food and drink was "about the same" as when they were last here.

Need for Friends and family to bring in food: Four patients in the evening told us that family had brought them in additional food which they had not requested, but relatives had wished to do so.

Any Occasions when meals have been missed: At the first visit three patients told us they had missed meals due to feeling ill and being unable to eat. In the morning only one patient complained of missing a meal, when they were initially taken to A & E. They didn't know that they could then request something to eat.

General comments: There was a very "busy" feel about the ward and bays.

For the breakfast visit the day shift had just come on duty, and the staff were going around in clusters, sorting out the patients requirements. Accordingly, when asked, we were advised which side rooms NOT to visit. Staff appeared to be very competent and assisted their patients when they saw help was required, and obviously knew by their past experiences, which ones were in need. Unfortunately, because the breakfast took so long and was followed by the drugs round, we were unable to speak to as many patients as we would have liked.

Comments from patients and one relative:

- Toast would be nice – Poor selection at breakfast – Nothing hot
- Didn't know restaurant existed
- Better food at UCH!
- Meal was too big; all food comes at regular times.
- Didn't have anything, but they watch me. Have "Ensure" (nutrient drink)
- Can't be bothered to complain
- They are set meals on the plate, and it's a waste as they include some items that are not liked
- I've never been unhappy with a whole meal.
- Everything is OK
- From one patient, with poor opinions: Food is disgusting; warm, never hot; inedible; settled for tuna salad & sandwich; the sausage & mash had congealed gravy; can't drink the tea or coffee and the chocolate drink was all powder.
- There was a relative carrying out 24 hour care for their child with a learning disability. They had slept on the floor to be near. However they were not offered any sustenance throughout.
- We spoke to one relative who stated that they were happy with the care for her relative and the food that she was being offered. The nurse had explained to her how nutrition is recorded and referral made to the dietitian if necessary using a scoring system.

Comments from the Healthwatch Representatives:

- At dinner we observed a patient who had been transferred from the CDU where they had been given kosher puree meals. Accordingly, above their bed was the notice: Special Instructions, KOSHER PUREE. However, only solid meals were available so the relative, who was present, ordered some soup and tried to mash up some fish, but they couldn't eat it. No other suitable alternatives appeared to be available.
- We noticed that one patient had been given an early breakfast, and was well prepared to be transferred to the Royal Free.
- Although a light breakfast, it seemed too much for just one hostess to cope with, and this explained the lengthy procedure.
- We thought that the breakfast was very minimal, and the cereal bowls small and shallow, although nobody actually complained about this.

- The “All day Breakfast” from Steamplicity, can be ordered at any time of day EXCEPT breakfast!

Recommendations:

- We felt that while the observers were present the level of care offered at those specific meals was good. However, this was not entirely reflected in the feedback from the patients, who raised some concerns about the lack of help to eat their meals. This needs to be addressed.
- To consider a wider breakfast menu, with additional hot items added, including if possible toast.
- Because of the time factor, a different method of delivery should be considered for breakfast, or one additional hostess provided. There is a lot of work for one person and some mistakes were made with wrong food delivered, probably due to time pressures and trying to complete the job quickly.
- Ensure that all patients are given the opportunity to clean their hands prior to the meal.
- Ensure that all patients understand the meals recommended for their conditions on the menu eg dishes most suitable for diabetics
- Advise all patients that snacks and drinks are available between meals, and also that there is a shop, coffee bar and restaurant at Ground Level, if required by them and relatives/friends who visit.

Conclusions

As this ward provides care for patients with gastro problems and many are also elderly, it is a difficult ward in regards to feeding. Nevertheless, the *Protected Mealtimes Protocol* should be strictly adhered to, and this was not the case when we visited. However, we did notice that members of staff were gentle and dedicated, with the best interests of their patients as a paramount feature. This would indicate good leadership from senior staff. However when questioned, at dinner, two patients mentioned that they did not receive help (when needed) with their food and drink, which needs to be addressed. We felt that the staff were very aware of our presence and may have been more diligent as a result.

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Walnut Ward: Medical and Respiratory

22 Beds: - 2 bays of 5 beds (1 male, 1 female), 2 bays of 4 beds (1 male, 1 female), 4 single rooms

Healthwatch Authorised Representatives:

Tina Stanton, Alan Shackman

Dates of Visits: 22 April 2014, 14 May 2014

Patients spoken to: Number of patients observed: all bays and rooms were observed on both visits (virtually all beds occupied)

Number of patients/visitors spoken to: 6 patients and 2 visitors on behalf of the patient

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients and to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet has also been alerted to concerns raised by patients and residents about the care and support to patients at mealtimes.

The project was developed by a small team of volunteers and staff from Healthwatch Barnet. To fully understand the process, the Team undertook the following research.

- Meeting with the Contract Director from Medirest, the Company which holds the catering contract at Barnet Hospital, and the Facilities Manager at Barnet Hospital, to fully understand the contract and responsibilities of the Medirest/Steamplicity staff and the hospital staff. Also had the opportunity to see the kitchen area, and to sample some of the food served to patients.
- Meeting with Head of Patient Experience at Barnet and Chase Farm Hospital to discuss the project.
- Meeting with Terina Riches the Director of Nursing at Barnet and Chase Farm Hospital to discuss the visits and to agree the timescales and protocols to be followed during the visits.

The team of volunteers, who are all fully trained Enter and View Authorised Representatives, were then briefed on the protocols and background information.

Methodology

There are 18 wards at Barnet Hospital. The team agreed to visit 6 wards during the period mid-March to mid-May. The reasons for this are as follows:

- To visit a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the public.
- To avoid visiting critical hospital services, such as children's wards and acute/ assessment wards.

The Enter and View teams consisted of two trained volunteers for each ward. Each of these teams aimed to visit the ward on more than one occasion and at different times of the day. e.g. lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week. The dates of the visits were notified to the Director of Nursing, but not the wards that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they could not anticipate the actual date a visit was to take place.

The Teams did not approach any wards that had notification of infections.

Each visit comprised two distinct parts. Phase 1 was to observe activity from start to finish of mealtime. To minimise the risk of our presence affecting behaviour, our observers took care to be as unobtrusive as possible and not to interact with staff and patients. In Phase 2, when mealtime was over, as many as possible patients and their carers/visitors were approached with a standardised questionnaire. Some discussions with staff and volunteers also took place Thus observations could be compared for consistency with patient feedback.

This information was then summarised into a short report for each ward, and a full report will be produced for the whole hospital on conclusion of the visits. . The draft ward reports were sent to the ward managers via the Director of Nursing, for their comments and to check for factual accuracy. The overall summary report and the final versions of the ward reports are available to the public via the Healthwatch website. They are also sent to the Care Quality Commission, Barnet Clinical Commissioning Group and the Council's Health Overview and Scrutiny Committee.

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 patients who met members of the Enter and View team on that date.

Findings

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

Cleanliness/hygiene: Around half the patients who were immobile, were given the opportunity to clean their hands prior to eating, predominantly those who were to receive red trays

Support: A jug of water or other drink was always on the bedside trolley although, of course, many patients needed help in pouring and drinking. Even semi-mobile patients would have had no problem reaching a drink.

All those unable to get into a suitable position to eat were helped to do so, whether sitting up in bed or in a chair. All patients received appropriate help to eat and drink, although not always as immediately as we would have liked to see. By the time help arrived food must have been getting cold in some cases.

At lunchtime many ward staff helped deliver meals. In the evening all meals were delivered by the hostess alone.

Protected Meal Time: Whilst the protected mealtime protocol was largely followed, there was no formal announcement of the beginning of protected mealtime. One doctor continued with the patient after a tray had been delivered.

Clearing Up after Meals: The evening meal was cleared away (and delivered) exclusively by the hostess. Lunchtime was more of a joint effort. The visiting husband of one elderly lady commented on what he called 'a disconnect' between patients and ward staff, particularly at the evening meal. His wife had eaten very little of her meal, which had then been cleared by the hostess. Surely, he said, this means that ward staff will not be aware that my wife is not eating.

Phase 2: Feedback from Patients

Length of Stay

Two of the patients we spoke to had been in hospital for more than 2 weeks, two more than 1 week, and two less than 1 week.

Support with Eating: Everyone we spoke to was satisfied with the support they were getting. Meals we observed were always left in reach and uncovered ready to eat.

Quality and Choice of food and drink: Those we spoke to were satisfied with menu choice and the food itself. Occasionally the meal ordered was not received but not regularly.

Complaints: One patient complained to us about receiving the wrong meal, but acknowledged that the mistake was put right. No formal complaints had been made to the hospital staff.

Ordering system: All patients found the ordering system straightforward and easy to use.

Dietary/cultural requirements: All patients we spoke to felt the food met their needs.

Portion size: Some patients felt that, if anything, the portion sizes were too large.

Availability of additional snacks: A selection of snacks should always be held on the ward. Patients were not aware of this, and the staff did not seem to be aware of it either.

Need for Friends and family to bring in food: Some Patients had food brought in by friends and family but these were extra items and were not necessary.

Any Occasions when meals have been missed: No patients we spoke to had missed any meals. Sister emphasised that when patients were away from the ward for treatment over mealtime, she was always careful to offer the patient a snack on return to the ward

General comments

Positives

- All patients received whatever help was necessary to enable them to eat as much of the meal as they wanted/were able. Mostly this help was immediate, and whilst delays for a minority certainly need to be pointed out we take no serious issue (but see specifics below). Patients undoubtedly received good care.
- Alternatives are readily offered to those patients who, for whatever reason, do not want or are unable to eat what is on their trays. Staff make it clear that it is no trouble.
- Staff appeared totally competent and friendly.

- Patients and relatives alike were without exception complimentary.

Areas for possible improvement

On neither visit was the ward fully focused during the mealtime period on delivering food and assisting patients. Not all ward staff were involved. Whilst at lunchtime the ward sister was observed to take charge, in the evening she was preoccupied. This is not to say that the evening mealtime did not run smoothly. It was, however, largely unsupervised. To an observer there felt to be an element of the ad hoc in providing help to patients who did not have red trays but who nonetheless clearly need some assistance. We inevitably asked ourselves whether all individual members of staff were clear on their responsibilities at the evening meal.

We did not explore in detail how information is recorded on the amount of food eaten or not by patients. This is obviously recorded for those with red trays but we did not observe that it was being monitored in other situations. We felt that this needed to be picked up in some situations where the hostess would clear away the tray and the nursing staff may not be aware of what was left. However we did not explore this any further so it may be picked up by the hostess reporting back.

Specific matters that need to be mentioned

- A patient with dementia and unable to feed himself, nonetheless did not have a red tray. On our visit this did not matter since his family were present and provided all necessary help, including adjusting the bed to an upright position i.e. ward staff did not take responsibility for getting the patient into a suitable position to eat.
- One staff member feeding an elderly patient did so on 'automatic pilot', just putting spoonfuls of food into her mouth without speaking at all or making any attempt to communicate. This was difficult for the patient, as she often closed her eyes so did not know when the food was coming.
- A patient able to walk with assistance was taken to the lavatory only as the meal was being delivered. On their return, 5 minutes later, it took some time for it to be noticed they were just sitting there not eating. A healthcare assistant finally came over to get them started. The patient then cleared their plate by themselves.
- It was noticeable that at lunchtime no patient had a hot dessert

Recommendations

- To explore mealtimes being more tightly managed and with greater supervision of staff.
- To ensure that all patients are given the opportunity to clean their hands before eating.
- To ensure guidance is given to staff on the need to communicate with patients whilst they are eating and to provide prompt support.
- To ensure that all patients (and staff) are aware that snacks and hot drinks are available in between meals if needed
- To ensure that all aspects of protected mealtime protocol are observed at each meal.

Conclusions

The two mealtimes – lunch and evening – which we observed went smoothly. Patients needing help received it. Staff, in the main, interacted well with patients. The few adverse incidents could, perhaps, have been avoided with a stronger leadership presence and input.

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Spruce Ward - Medical/Stroke

Ward consisted of 24 beds (2 x 4 bed bays, 2 x 5 bed bays and 6 single rooms.)

Healthwatch Authorised Representatives:

Derrick Edgerton and Linda Jackson

Dates of Visits: Monday 14th April and Tuesday 22nd April

Patients spoken to: Number of patients/relatives spoken to: 12 patients and 8 relatives

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients and to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet has also been alerted to concerns raised by patients and residents about the care and support to patients at mealtimes.

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- Meeting with the Contract Director from Medirest, the Company which holds the catering contract at Barnet Hospital, and the Facilities Manager at Barnet Hospital, to fully understand the contract and responsibilities of the Medirest/Steamplicity staff and the hospital staff. Also

had the opportunity to see the kitchen area, and to sample some of the food served to patients.

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Methodology

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- To visit a cross section of wards to get a good understanding of the situation, and also to take into account feedback from the public.
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The Enter and View teams consisted of two trained volunteers for each ward. Each of these teams aimed to visit the ward on more than one occasion and at different times of the day. eg lunch and evening meal, and also on different days of the week including weekends. This method was chosen so that the teams would be familiar with the ward and could observe the differences seen at different times of the day/week. The dates of the visits were notified to the Director of Nursing, but not the wards that were due to be visited. Therefore although the ward managers had been briefed to expect visits, they could not anticipate the actual date a visit was to take place.

The Teams did not approach any wards that had notification of infections.

Each visit comprised two distinct parts. Phase 1 was to observe activity from start to finish of mealtime. To minimise the risk of our presence affecting behaviour, our observers took care to be as unobtrusive as possible and not to interact with staff and patients. In Phase 2, when mealtime was over, as many as possible patients and their carers/visitors were approached with a standardised questionnaire. Some discussions with staff and volunteers also took place Thus, observations could be compared for consistency with patient feedback.

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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 patients who met members of the Enter and View team on that date.

Findings

Appendix Bi

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

Cleanliness/hygiene: At neither meal did the observers see any of the patients clean their hands prior to eating. When questioned patients responded that they were not given the opportunity to do so.

Support: Our observation was that meals were put within reach of patients, with individual tables being moved and space made as necessary. Patients in bed were moved to an upright position (if required). It was observed that some individuals who had only ordered a sandwich or desert were questioned by staff as to whether that was adequate. In 2 cases additional food was obtained. It was observed that some patients were given spoons to assist eating.

The "red tray" system was in use and staff did assist those individuals, although at times it appeared to be a long time (45mins) coming.

On both visits, relatives (and in one instance a paid carer) were observed assisting and at lunchtime a hospital volunteer came in to help. It was stated that advice had been given to relatives as to how to assist in eating (e.g. make sure person is sitting up etc).

All patients had a drink with their meal, jugs of water were provided for each patient. According to the hostess hot drinks were always available, although patients said they had to ask for hot drinks and they were not offered away from meal times.

Protected Meal Time: The start of lunchtime was indicated by a bell being rung at 12noon. This did not happen at the evening meal. No indication was given as to the end of protected meal time.
Staff not directly involved in serving food appeared to be observant.
(It was pointed out to the ward manager that the notice board gave different timings for mealtimes to what actually occurred.)

On our evening visit the hostess was off sick and no replacement was sent. This resulted in a staff nurse having to spend more than 10 minutes on the phone seeking assistance from the catering staff. The ward sister had not been made aware. The catering supervisor eventually came to serve the meals which then started later than normal.

It appeared that meals were served in no particular order so red and normal trays were sent out simultaneously. As the majority of staff were involved in taking food round, this meant that those who needed staff to assist them had to wait until all food had been served. A relative mentioned that she had observed patients that needed assistance having to wait a long time. Inevitably their meals became cold.

Clearing Up after Meals:

This was done more efficiently at lunchtime than in the evening. It was noted that the water jugs were replenished at this time.

Phase 2: Feedback from Patients

Length of Stay: The longest stay was noted as 7 weeks, majority greater than 2 weeks.

Support with Eating: Patients felt that staff did give assistance to those that needed it.

Quality and Choice of food and drink: Of the patients we spoke to some praised the food and none actually said they disliked it. The relatives interviewed seemed generally satisfied. There was the odd situation where an individual did not get what they ordered, but this appeared to be swiftly resolved.
There were comments by a patient and another patient's relative that the "soft" and "pureed" options were not particularly palatable.

Complaints: No patients we spoke to had made any complaints about the food.

Ordering system: This was the area where most unfavourable comments were made. Patients who cannot see well, cannot hear well, on special diets or do not speak English well, all appear to miss out here. Senior staff had previously told us that that large menus with pictorial representations of the dishes were available. The supervisor told us that meals could be pre-ordered for several days (by a relative etc) but this was not known. As most patients on the ward were there for several weeks, having variety in the diet is important.

Dietary/cultural requirements: We spoke to the relatives of an individual eating Halal meals. They appeared satisfied but were unaware that they could also order food on behalf of the patient (who spoke little English so had had a lot of pasta!).

Portion size: Some patients stated that portion size was too large! None felt they were insufficient.

Availability of additional snacks: There appeared to be some confusion between the hostess and ward staff as to what snacks (if any) were available to be given out between meals or at night. Hostess said snacks were available, staff appeared uncertain. Several patients mentioned the time period between lunchtime and the evening meal meant they got hungry.

Need for Friends and family to bring in food: 2 patients were having food regularly bought in, one because it was the patient's preference to, the other because the relative wanted to. The latter patient was going to start on ward food shortly.

Any Occasions when meals have been missed: If due to an ordering error this was resolved as speedily as possible (getting meal from storage to ward). On a few occasions meals had been missed due to medical reasons was recorded and monitored by staff.

General comments:

The volunteer said "I like to assist with feeding patients. We chat, they relax and eat more. Many are quite anxious but feel they cannot approach busy staff. I can reassure them. It's good for me as well"

A patient said "The food is adequate but bland. Nothing to look forward to."

A patient said "I sometimes wish I could have a cup of tea".

A relative said "I come in most days to see my mother. The amount of assistance given seems to depend on the team at the time."

A relative commented that the same type of food served at UCLH was better. However she also said that she would be writing to the hospital to thank them for the standard of care given to her relative.

Recommendations

1. To check the availability of large pictorial menus and to review the ordering system to ensure that all patients and relatives are clear that they can pre-order meals when it suits them (eg in advance when a relative is visiting)

2. To ensure that communication between the catering staff and ward staff is improved to enable staff absences can be covered where necessary without delaying the delivery of meals to patients.

3. To enable all patients the opportunity to clean their hands prior to eating, to help maintain good hygiene and to also enhance their feeling of dignity.

4. To identify patients that need assistance to eat, and serve their meals when there is a member of staff available to help them so that meals stay hot.

5. To explore the quality of pureed/soft food options.

6. To clarify the availability of snacks and drinks between meals and at night.

Conclusions

- The observers felt that the staff worked together well as a team to get the food served and to give assistance where required (although on occasions patients had to wait to be assisted)

- Overall it was apparent that there were no major issues with the quality and taste of the food, both from the patients and relatives point of view.

- Patients and relatives were nearly all complimentary about the standard of care.

Healthwatch Barnet Enter and View Meal-Time Review

Details of Ward:

Barnet Hospital, Willow Ward - Female Surgical Ward

Ward consisted of 17 beds (3 x 5 bed bays, and 2 single rooms.)

Healthwatch Authorised Representatives:

Lisa Robbins and Nahida Syed

Dates of Visits: Meals observed: Monday 14th April and Tuesday 13th May

Patients spoken to: Number of patients/relatives spoken to: 11 different patients (and 1 relative)

Introduction

Healthwatch Barnet decided to investigate the care, support and food offered to patients at mealtimes in Barnet Hospital. Food and hydration is a key element in the recovery and wellbeing of patients and a key area in which Healthwatch should review the care and support to patients and to comment on good practice and to make suggestions and recommendations on ways to improve the whole experience for patients. Healthwatch Barnet has also been alerted to concerns raised by patients and residents about the care and support to patients at mealtimes.

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Findings

Phase 1: Our Observations

Preparation and Assistance with eating and drinking

Cleanliness/hygiene: At neither meal did the observers see any of the non- mobile patients clean their hands prior to eating, and no wipes were provided. Those patients who were mobile were able to go to wash their hands.

Support: All meals were placed close to patients where they could easily reach them. Most patients were eating in bed and had tables brought across their beds for them to eat off. Some were sitting in chairs beside their beds.
All patients had water jugs which were replenished at meal times and were within reach.
Many patients were helped into a good position for eating, though most were able to get themselves comfortable.
The red tray system was in use and we observed one red tray being delivered to a patient who needed assistance with eating and to be encouraged. The patient
had dementia and was not interested in eating, but the staff were very skillful in persuading her to eat and several different staff tried many approaches to encourage her.
Patients were encouraged to eat and given plenty of time. Alternatives were offered where the patients were reluctant in some cases.
Due to the nature of the ward several patients were not eating (nil-by-mouth) whilst waiting for surgery.

Protected Meal Time: Protected meal time is not observed on this ward. The ward sister explained that as they are very dependent on the operating list for each day, it is not practical to follow the protected meal time protocol. Therefore there was no indication centrally of when meals were being served.

During the evening meal we observed a very helpful and caring staff member supporting her patients and ensuring their food was all accessible for them. However she then interrupted the meals of two of them to administer injections and medication.

We observed a surgeon having a detailed discussion with a patient about her operation during lunchtime, but the patient was not able to eat so was presumably not disturbed by the timing of the discussion.

The meals were distributed over a long period of time. At lunchtime only 7 of the patients were able to eat, so this was done quite quickly, but in the evening 14 were eating. The first meals were served at 6.10pm and the meal finished at 7.30pm. The ward is equipped with 2 microwaves which can take a long time for when many patients are eating hot meals.

Staff involved in serving food appeared to be observant, and especially in the evening were very supportive and chatty with the patients which seemed to help cheer up particularly the older patients.

Clearing Up after Meals: This was done quite efficiently and pleasantly when the hostess was sure all had finished eating.

Phase 2: Feedback from Patients

Length of Stay:

We talked to two patients who had been on the ward for more than 30 days. 8 of the patients we spoke to had been in hospital for between 2 and 7 days, and one for 15 days.

Support with Eating: All of the patients we spoke to felt that staff did give assistance to those that needed it. We observed several situations where staff supported those who needed help with eating.

Quality and Choice of food and drink: The feedback on the quality of food was very mixed. 6 people felt the food was very good and had no issues with it at all.
We spoke to two patients who ate Halal food and both found it poor.
One patient felt the food was very poor quality and tasted very bland.
One patient (who was present for both visits) required kosher food and is diabetic and had experienced significant issues with the food. They felt that the main course kosher food was very poor and some items were regularly not available. The patient felt that their diabetes had suffered as a result of not having appropriate food available and was very dependent on friends and family bringing in food.

Complaints: The patient above had raised their issues with the ward staff and the catering staff who had been working to try and resolve these but the patient felt the food was still unsatisfactory. The patients' relative had investigated if Passover food was available and had been assured that it was, but it had not been made available to the patient.

Ordering system: All patients found the ordering system easy to follow and use. Two patients had medical issues which meant they needed to be careful what they ate – it appeared that they may not have had much dietitian support to choose appropriate meals, and had ended up having further problems as a result of their food choice.

Dietary/cultural requirements: We spoke to two patients who were eating Halal food and both found them unpalatable and lacking in taste. The above comments on kosher food were also received.

Portion size: Some patients stated that portion size was too large. None felt they were insufficient.

Availability of additional snacks: No patients and none of the staff were aware that snacks were available between meals. The ward staff felt it would be useful to have some snacks available during the day.

Need for Friends and family to bring in food: As already mentioned, 1 patient was having food brought in to accommodate her dietary requirements. All other patients we spoke to only had food brought in as an extra/treat and because family members wished to bring it in, but not to supplement their diet.

Any Occasions when meals have been missed: Due to the nature of the ward several patients had missed meals whilst waiting for surgery. In one case surgery had been postponed on two occasions so meals had been missed. Two patients also told us they had missed meals when they were first admitted to A&E and were not aware of how to obtain food whilst going through this process.

General comments:

- 'The staff are very, very good'
- Generally happy with care
- Would like to have more fresh fruit.
- Not aware that can get a cup of tea or coffee from the machine at any time.
- Would like to have more cups of tea during the day – don't really drink water so feel don't get enough hydration.
- Food excellent.
- Feel the ward is not clean at all times.

One patient raised an incident of concern about their care and we passed the details on to the Nursing Matron.

Recommendations

7. To consider if the protected mealtime protocol, or part of it, such as avoiding administering of medication during mealtimes, should apply to this ward.
8. To enable all patients the opportunity to clean their hands prior to eating, to help maintain good hygiene and to also enhance their feeling of dignity.
9. To explore the quality of Halal and kosher food served.
10. To ensure that diabetic patients requiring kosher food can be adequately accommodated.
11. To ensure that, where needed, dietary advice is available to patients.
12. To ensure that all patients are aware of the tea and coffee facilities that they can use, and that all are aware of where else in the hospital food and drinks can be purchased.
13. To clarify the availability of snacks and drinks between meals and at night.
14. Ensure that where patients have been admitted through A&E they are made aware of how to obtain food and drink at all times.

Appendix Bi

Conclusions

- The observers felt that the staff worked together well as a team to support the patients with eating and to give assistance where required and there was a cheerful atmosphere on the ward. However mealtimes were long and drawn out and were quite disjointed.

- The ward manager had a strong presence on the ward and was very visible and known to the patients, who expressed their confidence in her.

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AGENDA ITEM 11

	Health Overveiw and Scrutiny Committee **08 December 2014**
Title	**Immunisation Rates in Barnet**
Report of	Andrew Howe, Director of Public Health Kenny Gibson, Head of Early Years, Immunisation and Military Health, NHS England (London Region) Amanda Goulden - Population Health Practitioner Manager, NHS England
Wards	All
Status	Public
Enclosures	Appendix 1 NHS England Barnet Immunisation Report
Officer Contact Details	Sarah Crouch Consultant in Public Health T: 020 8736 6834 Sarah.Crouch@harrow.gov.uk

Summary

In November 2013, a report was presented to the Health and Wellbeing Board (HWWB) by NHS England to explain a significant drop in reported childhood immunisation (COVER) rates in Barnet since April 2013.

At this time, NHS England gave assurance that the decline in rates was not representative of the proportion of children in Barnet receiving the recommended vaccinations but rather due to a data management problem.

In September 2014 the Health and WellBeing Board reviewed the progress in childhood immunisations and noted that there were still concerns about local immunisations reporting mechanisms. As a result the HWWB decided to raise the matter with Health Overview and Scrutiny Committee to enable a referral for remedy to the Department of Health if performance does not improve.

A variety of solutions have been proposed by NHS England to address the problem in Barnet working with community providers to improve their data management systems and

working with primary care to improve the retrieval of records through IT systems.

Recommendations

1. That the Committee notes the assurance given from NHS England that reported childhood immunisation rates in Barnet are not an accurate reflection of immunisation uptake in the borough.

2. That the Committee seeks assurance from NHS England that sufficient action is being taken to address this issue and that alternative surveillance measures are in place whilst childhood immunisation (COVER) data is inaccurate.

3. That the Committee is satisfied that appropriate governance arrangements are in place within NHS England in relation to immunisations to protect the health of people in Barnet.

1. WHY THIS REPORT IS NEEDED

1.1 In November 2013, a report was presented to the Health and Wellbeing Board by NHS England to explain a significant drop in reported childhood immunisation (COVER) rates in Barnet since April 2013.

1.2 At this time, NHS England gave assurance that the decline in rates was not representative of the proportion of children in Barnet receiving the recommended vaccinations but rather due to a data linkage problem. Specifically, the problem was reportedly due to a lack of transfer of information from GP systems to the Child Health Information System (information system housing child health/care records from which immunisation rates are monitored). Since April 2013, Central London Community Healthcare NHS Trust (CLCH) has been responsible for ensuring the Child Health Information System is updated locally.

1.3 In September 2014 NHS England provided an update to the situation and a range of actions were outlined to address the problem. A six month action plan was devised to improve data and reported coverage in Barnet which formed a part of deep dive action plan. Plans were produced by NHSE via the technical sub group to advise trajectories based on interventions. These trajectories, once finalised will be monitored and evaluated at NHSE Quality and Performance Improvement Board. A protocol had been put into place across London for earlier scrutiny of immunisation rates prior to submission to COVER by the patch and central immunisation commissioning teams in NHSE. This is helped by the new minimum child health dataset (implemented 1st September 2013) which enables monthly reports on immunisations to the NHSE immunisation teams.

1.4 All practices in Barnet are now signed up to Quality Medical Solutions (QMS) enabling GP's to send their immunisation data safely and easily to the Child Health Department.

1.5 A Task and Finish Group within NHS England has been set up to ensure the smooth transfer to the new Immunisation Upload Tool called System One. This system will be fully implemented by July 2015. The Task and Finish Group reports to the Children's Directorate IT User Group. The purpose of the group is to provide a forum to ensure that development work is clinically led and approved at every step and that an IT solution and new processes enable the accurate reporting of immunisation uptake.

1.6 Regular meetings are held with Central London Community Healthcare (CLCH) to address data issues. A 'deep dive' examination of all CLCH processes (not just immunisation) has recently taken place.

1.7 Previously it was highlighted that there was no established relationship between GPs and Central London Community Healthcare and Child Health Information System (CLCH-CHIS) in Barnet; this has been addressed as part of the working group.

2. REASONS FOR RECOMMENDATIONS

2.1 Barnet council has a responsibility to scrutinise immunisation rates in Barnet to assure that there is sufficient uptake of vaccinations across all age groups. If enough people in a community are vaccinated, it is harder for a disease to pass between people who have not been vaccinated. The London target is for 95% immunisation rates for children. Immunisation rates for children in Barnet appear to have fallen far below this target.

2.2 NHS England has stated that childhood immunisation data is inaccurate and significantly underestimates uptake rates in Barnet. However, this problem has remained unresolved for a year and therefore represents a significant risk in itself. Without accurate data, Barnet council cannot effectively monitor immunisation rates and cannot provide assurance that residents are protected from vaccine-preventable diseases.

2.3 The issue has been referred to the Health Overview and Scrutiny Committee to highlight these significant concerns, facilitate discussion with partners at a senior level and to ensure that sufficient and timely action will be taken to address the problems identified.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None

4. POST DECISION IMPLEMENTATION

4.1 It is currently not possible to accurately monitor immunisation rates in Barnet and ensure that the population of Barnet is protected from threats to their health. It is anticipated that the Health and Wellbeing Board will set expectations for resolution of the problems and support partners to deliver against this expectation.

4.2 The Public Health team has, and will continue, monitoring immunisation rates in Barnet as best as it is able. The team has been working with NHS

England to understand the underlying issues and has sought assurance that the problems will be resolved in a timely fashion.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This work supports Barnet council corporate priorities to create better life chances for children and young people across the borough and to sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health.

5.1.2 Barnet council has committed, in the Children and Young People plan 2013-16, to an increase in the numbers of resident children immunised by their second birthday (MMR) as a measure of success of action in the Early Years.

5.1.3 This work also supports the Health and Wellbeing Strategy aim to give every child in Barnet the best possible start to live a healthy life. Specifically, the Health and Wellbeing Board have committed to a performance measure to maintain immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 Commissioning for immunisation screening and take up is the responsibility of NHS England. There are no financial implications of the findings of this report for Barnet and Harrow's public health team.

5.3 Legal and Constitutional References

5.3.1 Under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006, local authorities have a duty to provide information and advice to relevant organisations to protect the population's health; this can be reasonably assumed to include screening and immunisation. Local authorities also provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers to ensure all parties discharge their roles effectively for the protection of the local population.

5.3.2 It is NHS England's responsibility to commission immunisation programmes as specified in the Section 7A of The NHS Act 2006 agreement: public health functions to be exercised by NHS England[1]. In this capacity, NHS England will be accountable for ensuring local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels, as specified in the Public Health Outcome Indicators and KPIs. NHS England will be responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

5.3.3 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

5.3.4 "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."

5.4 Risk Management

5.4.1 Absence of accurate data about immunisation rates in Barnet presents a significant risk to the health of the population. The implication is that real changes in vaccination uptake may remain undetected, early warning signs of potential outbreaks of disease could be missed and opportunities for mitigating action delayed. Further, it is not possible at present to accurately monitor the impact of media stories or vaccination campaigns or analyse and improve pockets of poor coverage in vulnerable populations.

5.5 **Equalities and Diversity**

5.5.1 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 fulfil its equality duty 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.

5.5.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. 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.

5.5.3 Screening uptake is lower amongst socially deprived and ethnic minorities. Performance in relation to these groups is not presently available, but the

public health team will look for assurance that the programme is reaching diverse communities.

5.6 Consultation and Engagement

5.6.1 N/A

6 BACKGROUND PAPERS

6.1 Health and Wellbeing Strategy (2012-15) – first annual performance report (November 2013): http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7559&Ver=4

APPENDIX 1

Update on Immunisations in Barnet

Summary

This paper has been requested to inform Barnet HOSC about the 7a immunisation programmes currently commissioned by NHS England (London Region). It gives an update on the local picture of childhood Immunisations in Barnet, NHS England's plans to improve reported rates of childhood immunisation across London and local actions being undertaken to address these.

1.0 Background to 7a immunisation programmes

Immunisation is the most effective method of preventing disease and maintaining the public health of the population. Immunisation protects children against disease that can cause long-term ill health and in some cases even death.

Vaccine preventable diseases have markedly declined in the UK, largely due to the efforts of the national immunisation programme. A negative output has been that many members of the public and health professionals have forgotten about the severity of these diseases and can become complacent about vaccinations. In addition, the complexity of the immunisation schedule and the increasing volume of vaccine-related information – some of which may be misleading or inaccurate – can make it challenging to achieve the 95% herd immunity level.

Throughout England, the National Routine Childhood Immunisation Programme is delivered in a variety of settings by a large number of professionals from different disciplines. Before the age of 5 years, children should receive vaccinations against measles, mumps and rubella (via MMR vaccine); polio, diphtheria, tetanus, pertussis and Hib (via '5-in-1' vaccine, also called the primaries), pneumococcal infection (PCV), meningitis C (Men C), rotavirus and child 'flu. Teenage girls aged 12-13 years receive HPV and both boys and girls receive the teenage booster and Men C booster in school Year 10 since 2013/14. In London, immunisation uptake rates remain below the 95% levels required to achieve herd immunity. Reasons for the low coverage include:

- the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices
- London's high population mobility
- difficulties in data collection particularly as there is no real incentive for GPs to send data for Cohort of Vaccination Evaluated Rapidly (COVER) statistics
- large numbers of deprived or vulnerable groups.

2.0 Updated position

2.1 Reported immunisation rates for the Routine Childhood Immunisation Programme have dropped in Barnet since April 2013. Such a sharp drop is indicative of data management issues. In Barnet's case, the decline has been due to data linkage problems – i.e. transfer of information from GP systems to update the information on the Child Health Information System (CHIS), which since April 2013, has been the responsibility of Central London Community Healthcare NHS Trust (CLCH). If there had been a similar reduction in children being vaccinated we would see a much greater increase in reported cases of disease. Surveillance reporting shows that Barnet has no greater incidence of disease than other areas in London.

2.2 All practices in Barnet are now signed up to QMS enabling GP's to send their immunisation data safely and easily to the Child Health Department. It has taken a great deal of time and resources to achieve a COVER report from the new system. CLCH have experienced challenges converting data received from practices into a format that can be produced for COVER.

3.0 Actions

3.1 A Task and Finish Group has been set up to ensure the smooth transfer to the System One Immunisation Upload Tool. This will be fully implemented and go live by July 2015.The Task and Finish Group reports to the Children's Directorate IT User Group. The purpose of the group is to provide a forum to ensure that development work is clinically led and approved at every step and that an IMT solution and new processes enable the accurate reporting of immunisation uptake.
The group will review the extraction process, suggest improvements and approve the proposal from TPP –suppliers of System One for the upload tool.

3.2 Regular meetings are held with CLCH to address data issues. Given that the problem for the drop in rates is a data management issue, the focus has been on working to improve this situation. A 'deep dive' examination of all CLCH processes (not just immunisation) has recently currently taken place.

3.3 A specification is being developed that will enable data to be extracted by QMS in a suitable format to be suitably converted for the COVER report. This should also be able to provide alternative surveillance measures from the QMS system.

3.4 Previously it was highlighted that there was no established relationship between GPs and CLCH-CHIS in Barnet; this has been addressed as part of the working group.

3.5 An Information Governance Framework is now in place.

AGENDA ITEM 12

Health Overveiw and Scrutiny Committee

08 December 2014

Title	Screening Coverage and uptake in Barnet
Report of	Dr Andrew Howe, Director of Public Health
Wards	All
Status	Public
Enclosures	Appendix 1 Barnet Screening Report - NHS England
Officer Contact Details	Dr Jeff Lake, Consultant in Public Health 020 8359 3974 jeff.lake@harrow.gov.uk

Summary

Robust reporting of screening performance for local authority assurance has not yet been established by NHS England which now has the lead responsibility. Urgent resolution of this has been requested at the London Screening Board and progress is reported to Local Authority Directors of Public Health through the London Association of Directors of Public Health.

Available data suggests that screening performance in Barnet is being maintained but remains below national targets. In response to relatively low screening uptake in London as whole, NHS England has established a London Coverage Technical Group which will oversee and ensure robust commissioning and the implementation of best practice.

Recommendations

1. That the Committee notes that Local Authority Public Health assurance reporting is not yet in place, that the London Screening board has requested urgent resolution and the need to improve communication with London Directors of Public Health and to agree reporting arrangements with London HWBBs.

2. That the Committee notes the August 2014 NHS England screening coverage and uptake report to the Health Overview and Scrutiny Committee, showing that in Barnet, Cancer screening programme coverage remains short of national targets.

3. That the Committee request further updates on this agenda to ensure that the issues raised in this report are adequately addressed.

1. WHY THIS REPORT IS NEEDED

1.1 Cancer screening aims to identify early signs of a disease in otherwise healthy people before symptoms become apparent. Screening helps to detect physiological changes that may lead to cancer if not treated and to identify existing cancer as early as possible when the options for effective treatment are greatest. Cancer screening both prevents cancer and extends survival.

1.2 There are three cancer screening programmes; Breast, Cervical and Bowel. All three programmes are commissioned by the NHS England.

1.3 The local authority, through its Director of Public Health, has responsibility for assurance of these programmes.

2. REASONS FOR RECOMMENDATIONS

2.1 Reporting of screening performance for local authority assurance is not yet in place. Urgent resolution of this has been requested at the London Screening Board and progress is reported to Local Authority Directors of Public Health through the London Association of Directors of Public Health.

2.2 Cervical Screening coverage in women aged 25 – 64 in Q1 2014/15, was 72.66%, slightly lower than the London average of 73.8% and lower than the national target (80%).

2.3 Cervical Screening coverage in women age 25 – 49 (invited every three years) in Q1 (2014/15) was 61.04%, while in women aged 50 – 64 coverage was 74.24%

2.4 In order to improve cervical screening coverage a Cancer Research UK (CRUK) facilitator is supporting practices to improve GP systems, ensuring accuracy of practice lists and call/recall databases, there are also plans of commissioning of telephone contact service.

2.5 Breast screening coverage (Q3 2013/14) has remained constant at 69%; this is slightly higher than the London average of 68.37% but less than the national target (70%).

2.6 There is significant variation in breast screening coverage by practice, ranging from 48.31% to 88.73%; Forty one of the Barnet practices are achieving over the national target while 27 do not achieve the target.

2.7 To improve breast screening coverage a number of steps are being taken such as Cancer Research UK facilitator is supporting practices to boost

screening coverage, by maintaining accurate information about breast screening databases.

2.8 For bowel screening uptake in Q1 2014/15, Barnet achieved uptake of 49.48% in 60 – 69 year olds. This is higher than the London average of 48.1% but lower than the national target of 60%. Uptake in 70 – 74 year olds was 49.5%; this is higher than the NCL average of 46.82% (No London data for age extended populations).

2.8 In response to the failure to achieve national targets for cancer screening coverage/uptake, a longstanding issue for London, a London Coverage Technical Group has been established by NHS England which aims to ensure commissioning and implementation of best practice services across London.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None. The public health team will continue to monitor screening uptake in Barnet and work with NHSE London to bring about improvements in screening coverage, establish a system of good governance and robust reporting for LA assurance.

4. POST DECISION IMPLEMENTATION

4.1 It is currently not possible to offer robust assurance of Cancer Screening Programmes in Barnet. The Health and Well-Being Board will need to be satisfied that the issues are being addressed by the representative of the Association of Directors of Public Health at the London Screening Board.

4.2 The establishment of appropriate reporting mechanisms is currently being pursued through the Association of Directors of Public Health and its representation on the London Screening Committee.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This work supports the Barnet Health and Wellbeing Strategy which identifies the need to improve cancer screening uptake and survival rates.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 Screening for cancer is conducted for prevention and earlier diagnosis of cancers. Where more advanced disease is present, effective treatment options tend to be more limited and more invasive.

5.2.2 Funding for cancer screening programmes has transferred to NHS England although some elements continue to sit with CCGs. This presents some particular challenges for cervical screening where pathology and gynaecology services that support the service are included in block contracts. A NHSEL/CCG/Provider Task Finish Group has been formed to develop a model of co-commissioning cervical screening that supports performance and quality improvement across the entire pathway and also facilitates implementation of service developments.

5.3 **Legal and Constitutional References**

5.3.1 Under regulation 8 of the Local Authorities Regulations 2013, made under section 6C of the National Health Service Act 2006, local authorities have a duty to provide information and advice to relevant organisations to protect the population's health; this can be reasonably assumed to include screening and immunisation. Local authorities also provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers to ensure all parties discharge their roles effectively for the protection of the local population.

5.3.2 It is NHS England's responsibility to commission screening programmes as specified in the Section 7A agreement: public health functions to be exercised by NHS England[1]. In this capacity, NHS England will be accountable for ensuring local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels, as specified in the Public Health Outcome Indicators and KPIs. NHS England will be responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

5.3.3 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

5.3.4 "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."

5.4 Risk Management

5.4.1 London Screening Board chaired by Head of Public Health at NHS England (London Region) which includes membership from Local Authorities in place and looks into service developments, programmes assurance and programme governance.

5.5 Equalities and Diversity

5.5.1 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 fulfil its equality duty 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.

5.5.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. 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.

5.5.3 Screening uptake is lower amongst socially deprived and ethnic minorities. Performance in relation to these groups is not presently available, but the public health team will look for assurance that the programme is reaching diverse communities.

5.6 Consultation and Engagement

5.6.1 None.

6 BACKGROUND PAPERS

6.1 None

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APPENDIX 1

Update on Immunisations in Barnet

Summary

This paper has been requested to inform Barnet HOSC about the 7a immunisation programmes currently commissioned by NHS England (London Region). It gives an update on the local picture of childhood Immunisations in Barnet, NHS England's plans to improve reported rates of childhood immunisation across London and local actions being undertaken to address these.

1.0 Background to 7a immunisation programmes

Immunisation is the most effective method of preventing disease and maintaining the public health of the population. Immunisation protects children against disease that can cause long-term ill health and in some cases even death.

Vaccine preventable diseases have markedly declined in the UK, largely due to the efforts of the national immunisation programme. A negative output has been that many members of the public and health professionals have forgotten about the severity of these diseases and can become complacent about vaccinations. In addition, the complexity of the immunisation schedule and the increasing volume of vaccine-related information – some of which may be misleading or inaccurate – can make it challenging to achieve the 95% herd immunity level.

Throughout England, the National Routine Childhood Immunisation Programme is delivered in a variety of settings by a large number of professionals from different disciplines. Before the age of 5 years, children should receive vaccinations against measles, mumps and rubella (via MMR vaccine); polio, diphtheria, tetanus, pertussis and Hib (via '5-in-1' vaccine, also called the primaries), pneumococcal infection (PCV), meningitis C (Men C), rotavirus and child 'flu. Teenage girls aged 12-13 years receive HPV and both boys and girls receive the teenage booster and Men C booster in school Year 10 since 2013/14. In London, immunisation uptake rates remain below the 95% levels required to achieve herd immunity. Reasons for the low coverage include:

- the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices
- London's high population mobility
- difficulties in data collection particularly as there is no real incentive for GPs to send data for Cohort of Vaccination Evaluated Rapidly (COVER) statistics
- large numbers of deprived or vulnerable groups.

2.0 Updated position

2.1 Reported immunisation rates for the Routine Childhood Immunisation Programme have dropped in Barnet since April 2013. Such a sharp drop is indicative of data management issues. In Barnet's case, the decline has been due to data linkage problems – i.e. transfer of information from GP systems to update the information on the Child Health Information System (CHIS), which since April 2013, has been the responsibility of Central London Community Healthcare NHS Trust (CLCH). If there had been a similar reduction in children being vaccinated we would see a much greater increase in reported cases of disease. Surveillance reporting shows that Barnet has no greater incidence of disease than other areas in London.

2.2 All practices in Barnet are now signed up to QMS enabling GP's to send their immunisation data safely and easily to the Child Health Department. It has taken a great deal of time and resources to achieve a COVER report from the new system. CLCH have experienced challenges converting data received from practices into a format that can be produced for COVER.

3.0 Actions

3.1 A Task and Finish Group has been set up to ensure the smooth transfer to the System One Immunisation Upload Tool. This will be fully implemented and go live by July 2015.The Task and Finish Group reports to the Children's Directorate IT User Group. The purpose of the group is to provide a forum to ensure that development work is clinically led and approved at every step and that an IMT solution and new processes enable the accurate reporting of immunisation uptake.
The group will review the extraction process, suggest improvements and approve the proposal from TPP –suppliers of System One for the upload tool.

3.2 Regular meetings are held with CLCH to address data issues. Given that the problem for the drop in rates is a data management issue, the focus has been on working to improve this situation. A 'deep dive' examination of all CLCH processes (not just immunisation) has recently currently taken place.

3.3 A specification is being developed that will enable data to be extracted by QMS in a suitable format to be suitably converted for the COVER report. This should also be able to provide alternative surveillance measures from the QMS system.

3.4 Previously it was highlighted that there was no established relationship between GPs and CLCH-CHIS in Barnet; this has been addressed as part of the working group.

3.5 An Information Governance Framework is now in place.

AGENDA ITEM 13

Health Overview and Scrutiny Committee

8 December 2014

Title	**NHS Health Checks**
Report of	Dr. Andrew Howe, Director of Public Health
Wards	All
Status	Public
Enclosures	Appendix 1 - NHS Health Checks Scrutiny Report for Barnet and Harrow (January 2014).
Officer Contact Details	Audrey Salmon, Head of Public Health Commissioning Audrey.salmon@harrow.gov.uk

Summary

This report provides an update on progress resulting from the recommendations set out in the NHS Health Checks Scrutiny Report for Barnet and Harrow (January 2014)

Recommendations

The Barnet Health Overview and Scrutiny Committee note the progress in relation to the recommendations set out in the NHS Health Checks Scrutiny Report for Barnet and Harrow (January 2014).

1. WHY THIS REPORT IS NEEDED

1.1 Background

1.1.2 In January 2014, a scrutiny review of the local NHS Health Checks programme was undertaken to assess the delivery model and performance in Barnet and Harrow. It considered the views of key stakeholders and residents regarding the programme, analysed options and made recommendations to inform the commissioning strategy in both boroughs.

1.1.3 This paper sets out the actions undertaken or planned to address the recommendations from the scrutiny review.

1.1.4 The recommendations arising from the scrutiny review cover the following themes:

1. Health Checks promotion
2. Provider /Flexible delivery
3. Treatment Package
4. Referral pathways
5. Restructure financial incentives
6. Resources
7. Targeting
8. Screening Programme Anxiety
9. Barriers to Take-up
10. Learning Disability

1.2 Current Situation

1.2.1 The NHS Health Checks programme is a mandatory service provided by Barnet and Harrow Joint Public Health Service. It is a national risk assessment and lifestyle management programme which assesses an individual's risk of heart disease, stroke, kidney disease, and dementia and alcohol misuse with the objective of reducing death rates and the burden of disease from these conditions.

1.2.2 In 2014/15, the local eligible population (those between the ages of 40-74 without a pre-existing cardiovascular condition) is 93,000. A local target was set to invite 15% of the eligible population to Health Checks. There was also a target to deliver these assessments to 10% of the cohort.

1.2.3 There has been an improvement in performance for the first quarter 1. When benchmarked against other London Boroughs, Barnet is now ranked 16th for health checks offered compared to 27th position in 2013/14. Barnet's performance for health checks received has also improved; the borough is now ranked 10th compared to being positioned 30th in 2013/14.

1.2.4 **Performance Issues**

Table 1 below shows the performance figures for each quarter of 2013/14. By the end of the year, the programme had underperformed (by 3.9%) against its annual target for 'offered' Health Checks. In relation to the target for 'received' Health Check, the programme had underperformed by 4%.

As a result of the actions, described above, performance has begun to improve. Figures for quarter 1 (2014/15), set out in Table 1, show that we have exceeded our target for that period. When compared to other London Boroughs, Barnet is ranked 19th and 25th for Health Checks 'offered' and 'received', respectively.

The programme will continue to develop and implement plans, as set out above, to maintain or improve uptake for the remainder of this year and beyond.

Table 1: Performance for 2013/14

BARNET	**Quarter 1** (PHE official figures reported)	**Quarter 2** (PHE official figures reported)	**Quarter 3** (PHE official figure reported)	**Quarter 4** (PHE official figure reported)	**Annual Total**
No. offered health check (Target)	4887 (5.36%)	4887 (5.36%)	4887 (5.36%)	3,554 (3.92%)	18,215 (20%)
No. offered health check (Actual)	4,921 (5.4%)	3,750 (4.1%)	2,794 (3.1%)	3,192 (4.9%)	14,657 (16.1%)
Population	91,139	91,139	91,139	91,139	
No. received health check (Target)	2,278 (2.5%)	2,278 (2.5%)	2,278 (2.5%)	2,278 (2.5%)	9,112 (10%)
No. received health check (Actual)	1,525 (1.7%)	1020 (1.1%)	1494 (1.6%)	1,430 (1.6%)	5,469 (6%)

Table 2: Q1 2014/15

BARNET	**Quarter 1**
No. offered health check Target – (% of eligible)	1,861 (2.0%)
Actual	5,018 (5.3%)
Population	93,092
No. received health check Target - (% of eligible)	1150 (1.2%)
Actual	2633 (2.8%)

1.2.5 The table below sets out the recommendations from the NHS Scrutiny Review (2014), the actions undertaken and planned activities.

Theme	Recommendation and Rationale	Progress (September 2014)
1. Health Checks Promotion	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).	In September 2014, Public Health England invited local Health Check programmes to express an interest in piloting a marketing campaign. We have expressed an interest in being a pilot site and are currently awaiting a response. Participation in this project would be an excellent way to raise the profile of the programme.
2. Providers / Flexible Delivery	Health Checks should be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups) to make Health Checks more accessible.	A GP led outreach programme is currently being piloted in Barnet. We will be delivering community pharmacists can support the delivery of Health Checks. There are plans to target the outreach programme at specific communities through faith centres. There are also plans to work with the voluntary and community sector to target vulnerable groups in the community. We will be delivering Health Checks in local workplaces, including the Council – with a particular focus on men. An outreach session took place in August 2014 in Beaufort Park after a week of promotional activity to raise awareness in the community.
3. Treatment Package	1) All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more	1) The need to streamline the process is recognised and as a result point of care testing will be introduced, where possible.

	attractive. 2) Commissioners should investigate feasibility of tailoring treatment options to specific communities.	This involves carrying out bloods testing as part of the Health Check. A GP practice profiling exercise is currently underway to understand how Health Checks are being delivered and what improvements can be made. Health Check training was recently delivered to practice staff and ways to streamline the service were promoted as part of this training. 2) 'Treatments' for any diagnosed illness would follow standard clinical protocol as led by the GP or nurse practitioner. Advice on lifestyle interventions are tailored to individual preferences as per discussions with the Health Check provider.
4. Referral Pathways	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment	The patient pathway is an essential element of the programme. Those who have been assessed with 'high risk' of heart disease are referred to their GP for additional investigative tests. Smokers are referred to stop smoking services. Hypertensive patients will commence appropriate medical treatment. Those with high blood glucose levels will be sent for a diabetic assessment. Those assessed with a 'low' or 'medium' risk factor may qualify for any of the above. In addition to this they will be given advice and/or an onward referral to local leisure facilities.
5. Restructure Financial Incentives	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with	Tiered payment structures which incentivise GPs to deliver Health Check to those most at risk are being developed for

	a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.	2015/16. The contract for 2014/15 cannot be altered at this point and we would seek to initiate this new payment structure for 2015/16.
6. Resources	1) Public Health England and local authorities must consider the cost of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. 2) Nationally, Public Health England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended. 3)Health Checks are currently not a mandatory requirement for GPs (delivered by Local Enhanced Service contracts) meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical space) to deliver	1) and 2): The local authority has a statutory obligation to deliver Health Checks (the risk assessment element) but is not responsible for the whole pathway. The local authority encourages GPs to provide lifestyle advice to patients who are assessed to have a low risk score. 3) Whilst GPs are not legally obliged to deliver this service, many of them see the value of this preventative screening programme, as demonstrated by a high level of sign up to the programme. 63 out of 69 local GPs in Barnet have signed up to deliver this programme. Public Health England benchmark local authorities' performance against agreed national targets and other authorities. Local authorities see GPs as key delivery partners that enable them to meet their statutory obligation. As a result, GPs are incentivised to improve the uptake of Health Checks.
7.Targeting	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- 1)Men (who statistically have a lower up-take than women); 2)Faith communities (who statistically have a high prevalence of certain	A GP led outreach programme is currently being piloted in Barnet. This will increase accessibility of the programme to the wider population. Please see number 1 for update on outreach activities. The outcome of these will be evaluated to assess if the targeted people have received

	diseases); and 3)Deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)	the service. The outreach programme will be evaluated to assess its effectiveness at meeting the target group.
8. Screening Programme Anxiety	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.	Public anxiety about screening is being managed in a number of ways: • Community engagement during outreach events helps develop a positive profile of the service. Each outreach event will be preceded by one week of local canvassing to raise awareness and to book people for Health Checks. • Training sessions for Health Check staff includes a specific section on addressing patient concerns. .
9. Barriers to Take-Up	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.	GP practice profiling is currently being undertaken to establish the reasons for poor uptake. The findings of the practice profiling exercise will be available in November and will be used to shape the future delivery model and improve service uptake. Initial findings from this profiling exercise have indicated that the barriers come from two key areas, one is General Practice and the other is the general public. The barriers include: **General Practice:** Lack of capacity, disinterest and non-attendance from patients, unsuitable times for Health Checks and conflicting priorities at the practice. **General Public**: Lack of interest from individuals, lack of awareness of the programme. People unwilling to

		go to GP if they don't feel ill. The Health Check programme is a screening programme and people who attend may not necessarily feel ill.
10.Learning Difficulties Disability (LDD)	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with LDD into the Health Checks programme before age 40 due to their overrepresentation in the health system	There are currently 4,071 LDD adults in Barnet between the ages of 30-74. Nearly 50% (2,014) of those LDD people are between the ages of 30-44. The programme will engage community groups who support adults with LDD in order to improve the take up, health outcomes and potential life expectancy.

2 **REASONS FOR RECOMMENDATIONS**

Not applicable, as this report is for information only.

3 **ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED**

Not applicable as this report is for information only.

4 POST DECISION IMPLEMENTATION

The Health Overview and Scrutiny Committee require 3 x 6 monthly updates from Barnet and Harrow Joint Public Health Service report on Health Check progress and performance. A decision has been taken to implement these recommendations and activity will be now monitored by the Health and Wellbeing committee and Health Overview and Scrutiny committee

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.2 Although a decision is not required, the NHS Health Checks Programme will contribute to the achievement of the following corporate priorities:

1. **To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health**.
   The Health Check programme demonstrates a strong partnership with the NHS, as General Practitioners (GPs) are commissioned to deliver the programme. The success of the programme is reliant on good communication between the commissioner and GPs and clear patient pathways, which are delivered by the local authority and the NHS.

   Performance measure: Participating GPs support the council in achieving its annual target. GPs are incentivised to offer Health Checks to 15% of their eligible population and provide assessment to 10% of the same cohort.

2. **To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.**
   The Health Check programme is targeted at those between the age of 40 – 74; therefore the over 55s will be encouraged to live a healthy and active life as part of this programme. This early intervention programme will reduce the burden, of late diagnosis of cardiovascular disease, on health and social care services and encourage healthier lifestyles for those between the ages of 40-74.

   Performance Measure:
   The lifestyle management element of the programme is currently being developed. Once this is established performance measures will be in place.

5.1.3 The Health Checks Programme also contributes to the following themes of the Health and Well-Being Strategy:

1. Wellbeing in the community – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
2. How we live – that is enabling and encouraging healthier lifestyles; and
3. Care when needed – that is providing appropriate care and support to facilitate good outcomes and improve the patient experience.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

This report is for information only. Therefore, there are no financial implications to this report as the activities outlined above are delivered within the allocated budget.

5.3 Legal and Constitutional References

The Health and Social Care Act 2012 transferred responsibility, from the PCT to Local Authorities, for commissioning the NHS Health Check programme from 1st April 2013. Local authorities have a statutory obligation to deliver the NHS Health Check programme.

The council's constitution (responsibility for functions annex A) sets out the responsibility of Barnet Overview and scrutiny committee. The committee has the following responsibilities:

1. 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.

2. To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

3. To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, Health Watch and/or other health bodies.

5.4 Risk Management

The risk of elected members not seeing this report means they will not be able to scrutinise it.

5.5 Equalities and Diversity

This report is for information only; an equalities impact assessment is not required. However, therefore this report states how the needs of sections of the local community will be met.

5.6 Consultation and Engagement

None required.

6 BACKGROUND PAPERS

NHS Health Checks Scrutiny Report for Barnet and Harrow (January 2014).

NHS Health Checks Scrutiny Review

Final Report

January 2014

Index

1. Executive Summary

1.1 Aim of Review

1.1.1 The aim of this Scrutiny Review was to review the current delivery model and performance of the NHS Health Checks Programme in Barnet and Harrow, consider the views of key stakeholder and residents on the programme, analyse options and make recommendations to inform the commissioning strategy in both boroughs.

1.2 Background to NHS Health Checks

1.2.1 The NHS Health Checks programme is a national risk assessment and management programme which assesses an individual's risk of heart disease, stroke, kidney disease, dementia and alcohol misuse with the objective of reducing death rates and the burden of disease from these conditions. It is a mandatory service provided by local authority public health teams.

1.2.2 The eligible cohort are aged 40 to 74 – approximately 91,000 people in Barnet and 64,000 people in Harrow. Public Health England expect 20% of the eligible population to be invited each year over a five year rolling programme with an update of approximately 75%. In Barnet this equates to 18,200 per year and 13,650 Health Checks completed. In Harrow this equates to 12,800 per year and 9,600 Health Checks completed.

1.3 Summary of Services / Existing Contracts

1.3.1 Currently in Barnet, 44 of 70 GP practices are signed up to deliver NHS Health Checks. However, 14 out of the 44 have not delivered any checks. At the time of the review, it was not possible to obtain the number of GP practices in Harrow signed up to deliver NHS Health Checks due to data transfer issues. Contracts in Barnet and Harrow have been transferred from primary care trusts and so continue to be delivered on that basis, although the Public Health team are reviewing performance and developing options for the checks to be delivered in the future.

1.4 Activity Levels and Current Performance

1.4.1 In 2012/13, Barnet and Harrow performed below the Department of Health target for performance – offering a Health Check to 20% of the eligible population. However, it should be noted that in 2012/13 Health Checks were still commissioned by primary care trusts and there remains scope to improve performance during the final years to the five year programme.

1.4.2 During the review, undertaking an analysis of performance for both boroughs was problematic as a result of the transfer of data from the primary care trusts to local authorities.

1.5 Strategic Direction and Policy Drivers

1.5.1 Public Health England and the Department for Health have placed an emphasis on the NHS Health Checks programme as a platform to provide a significant opportunity to tackle avoidable deaths, disability and reduce health inequalities in England. Barnet and Harrow are one of five NHS Health Checks Scrutiny Development areas and findings from this review will link into this national programme.

1.5.2 Locally, NHS Health Checks are priorities identified in the Corporate Plans and Health & Well Being Strategies of both Barnet and Harrow councils.

1.6 Best Practice

1.6.1 Barnet and Harrow currently deliver NHS Health Checks primarily though GP practices. The review considered a number of different areas nationally that were high performing or provided Health Checks through alternative or targeted delivery models. Consideration of best practice examples assisted the Scrutiny Review to make recommendations regarding delivery models to inform the future commissioning strategy.

1.7 Evidence

1.7.1 In addition to considering best practice and current performance, the review considered the views of key stakeholders including residents who were eligible for checks, specific sections of the community, commissioners, providers and other interested groups.

1.8 Return on Investment

1.8.1 The review has been conducted using the Centre for Public Scrutiny Return on Investment Model which seeks to quantify what the return on investment would be for a specific course of action being taken as a result of the scrutiny review.

1.8.2 The economic argument behind the NHS Health Checks screening programme is that the early detection of certain conditions or risk factors enables early intervention which can take the form of medical treatment or lifestyle changes. Treating conditions in their early stages or managing risk factors will:

i. be much more cost effective than treating chronic conditions; and

ii. result in an overall improvement in the health and wellbeing of the general population.

1.9 Recommendations

1.9.1 Findings and recommendations are intended to inform the future commissioning and management of the NHS Health Check Programme in Barnet and Harrow.

	Theme	Recommendation and Rationale
1	**Health Checks Promotion**	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).
2	**Providers / Flexible Delivery**	Health Checks should be commissioned to be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups)) to make Health Checks more accessible.
3	**Treatment Package**	All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more attractive. Commissioners should investigate feasibility of tailoring treatment options to specific communities.
4	**Referral Pathways**	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment
5	**Restructure Financial Incentives**	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.
6	**Resources**	Public Health England and local authorities must consider the cost of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. Health Checks are currently not a mandatory requirement for GPs (delivered by Local Enhanced Service contracts) meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical space) to deliver. Nationally, Public Health England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended.

7	**Targeting**	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- • men (who statistically have a lower up-take than women); • faith communities (who statistically have a high prevalence of certain diseases); and • deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)
8	**Screening Programme Anxiety**	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.
9	**Barriers to Take-Up**	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.
10	**Learning Disabilities**	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with learning difficulties into the Health Checks programme before age 40 due to their overrepresentation in the health system

2. Scope

2.1 Public Health England (PHE), the Local Government Association (LGA) and NHS England launched the NHS Health Check Implementation Review and Action Plan in July 2013. The purpose of the review was to consider progress made with the NHS Health Checks programme since its launch in 2009 and consider how to use the programme as a platform to provide a significant opportunity to tackle avoidable deaths, disability and reduce health inequalities in England.

2.2 PHE, the LGA and NHS England recognise that the involvement of local commissioners and providers is key to successful implementation of the NHS Health Checks programme.

2.3 In Spring 2013, the Secretary of State for Health launched a call to action to reduce avoidable premature mortality and the NHS Health Check programme has been identified as one of the 10 main actions which will assist in reducing premature mortality and focus on improving prevention and early diagnosis.

2.4 The *Global Burden of Disease* report (2013) highlighted the need to reverse the growing trend in the number of people dying prematurely from non-communicable diseases. Public Health England estimate that each year NHS Health Checks can prevent 1,600 heart attacks and save 650 lives, prevent 4,000 people from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier. As such, there is a national recognition that PHE should support local authorities to commission successful NHS Health Check programmes.

2.5 Further information on the economic case and health benefits of the NHS Health Checks Programme are set out in detail in the DoH and PHE Health Checks Implementation Review and Action Plan.[1]

2.6 Within the Health Checks Implementation Review and Action Plan, Issue 3 (Providing the NHS Health Check) states that 'PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning of the programme.'

2.7 In accordance with the national programme, the Centre for Public Scrutiny (CfPS) launched a programme in April 2013 to support local authority scrutiny functions to review their local approach to NHS Health Checks using its Return on Investment model. A joint 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. Members from both Barnet and Harrow supported the review of NHS Health Checks as it provided an opportunity to consider the local approaches to the check following the recent transfer of public health functions from the NHS to local authorities (from 1 April 2013).

[1] DoH and PHE Health Checks Implementation Review and Action Plan https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224805/NHS_Health_Check_implementation_review_and_action_plan.pdf

2.6 The scope of the Barnet and Harrow joint review was agreed as follows:

- 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;
- Explore whether GPs could be organised on a cluster basis to deliver NHS Health Checks in each borough; and
- Utilise the CfPS Return on Investment model to undertake an analysis of the cost/benefit of developing the NHS Health Checks Programme. The outcomes from this will influence the recommendations

2.7 The review took place between September and December 2013. This report includes the context, background, policy context, best practice examples, performance, methodology and key findings and recommendations.

3. Background

3.1 NHS Health Checks

3.1.1 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. Once the risk assessment is complete, those receiving the check should be given feedback on their results and advice on achieving and maintaining a healthy lifestyle. If necessary individuals should then be directed to either council-commissioned public health services such as weight management services, or be referred to their GP for clinical follow up to the NHS Health Check including additional testing, diagnosis, or referral to secondary care.

3.1.2 There is a statutory duty for councils to commission the risk assessment element of the NHS Health Check programme and this will be monitored by the Public Health Outcomes Framework[2]. Health Checks were previously commissioned by the primary care trusts which were abolished with the implementation of the Health and Social Care Act 2012.

3.1.3 The Public Health Outcomes Framework focuses on two high-level outcomes:

1. Increased life expectancy
2. Reduced differences in life expectancy and healthy life expectancy between communities

3.1.4 The Health Checks 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[3].

3.1.5 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. In Harrow and Barnet Health Checks are currently delivered exclusively at GP surgeries.

3.1.6 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 or high. Patients are offered personalised advice based on the outcome of their check.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
[3] www.healthcheck.nhs.uk

3.2 Funding

3.2.1 The public health funding allocation is ring-fenced, to be spent only 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 borough.

3.2.2 LB Barnet and LB Harrow Health Check Budget:

Barnet

- November 2012 – 31 March 2013 – £150,000
- 1 April 2013 – 31 March 2014 – £500,000

Harrow

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

3.2.3 Figures are based on national calculator costs of implementation and an enhanced programme offering. In Barnet, this represents a large increase in investment compared to 2012/13. The final cost will depend on negotiations with providers on the unit cost of the health check element of the budget.

3.3 Commissioning

3.3.1 Year 1 – the joint Public Health team have been limited during year 1 (2013/14) due to the transfer of existing contracts from primary care trusts to the local authorities. Whilst this has constrained the service delivery options, this has enabled the Public Health team to carry out a data base-lining exercise which will be used to support de-commissioning or re-commissioning decisions.

3.3.2 Year 2 – the joint Public Health team have an opportunity from year 2 (2014/15) onwards to develop a commissioning strategy for NHS Health Checks in Barnet and Harrow based on findings of this scrutiny review.

3.3.3 At present, Barnet and Harrow have different payment mechanisms. Barnet GPs are paid for both offers and completions, whilst Harrow GPs are paid on completion only. At present, Barnet GPs may be incentivised to make offers only as they will receive payment for this element of the check. The Scrutiny Review are recommending that the financial incentives be restructured to maximise the impact of the programme locally (see recommendation 5).

3.4 Link to Corporate Priorities and Health & Well Being Strategies

3.4.1 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.

3.4.2 The Barnet Health and Well-Being Strategy (Keeping Well, Keeping Independent) 2012 – 2015 identifies that, in relation to lifestyle factors, that statutory agencies need to "Increase both the offer and take-up of health and lifestyle checks in primary care to all people aged between 40 and 74 years to help reduce risk factors associated with long term conditions." A target of delivering a "Year on year increase based on the 2009/10 baseline of people aged between 40 and 74 who have received an NHS Health Check. In five years our coverage should be 80%."

3.4.3 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."

3.4.4 The Harrow Health and Well-Being Action Plan 2013 – 2016 has under the objective of "Early identification of cardiovascular disease and diabetes though the health checks programme" the following targets:

1. Promote uptake of health checks including use of social marketing (June 2013)
2. Evaluate outcomes and referrals onto other services as a result of health checks programme (March 2014)
3. Implement a programme of activity to provide health checks to Harrow residents who are not yet registered with GPs (September 2013)

3.5 Marmot Review

3.5.1 Sir Michael Marmot was commissioned by the Government to review what would best reduce health inequalities in England[4]. The review proposed that health interventions should be offered to everyone (and not just the most deprived) but that it must be 'proportionate to the level of disadvantage' – the principle of 'proportionate universalism.'

[4] http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

4. Context

National Context

4.1 Purpose and Rationale

4.1.1 The purpose of the NHS Health Check has been outlined in sections 1 and 3 above.

4.1.2 The rationale for the NHS Health Check programme is to identify those who are at a higher risk of developing certain illnesses at a stage where the illness may still be prevented and/or future complications of an illness could still be avoided. The NHS Health Checks screening programme is expected to have beneficial effects on people's health, as well as saving money in the health and social care economy in the future as costly interventions will be prevented. Public Health England recommends that 20% of the eligible population should be invited each year and that councils should aim for 75% of those offers to be taken-up.

4.1.3 Local authorities took over responsibility for the NHS Health Check from 1 April 2013. Nationally, the check is most likely to be offered in GP surgeries and local pharmacies. However, a number of areas have offered and/or delivered health checks via different providers and in other suitable and accessible locations in the community. Examples of alternative delivery models are explored in section 5 of this report.

4.2 Responsibilities

4.2.1 Local authorities are responsible for commissioning the Health Checks programme and have a statutory obligation to provide the patients GP with the outcomes and data of an individual's Health Check. Local authorities are responsible for commissioning the checks and for monitoring the amount of invitations and take-up. Clinical Commissioning Groups (CCGs) are responsible for ensuring that there is appropriate clinical follow-up such as additional testing, referral to secondary care and on-going treatment. The connection between these two aspects of the programme is essential in making it successful.

4.3 Budget, Potential Savings and Take-Up

4.3.1 The Department of Health (DoH) has estimated that the NHS Health Check programme is likely to be cost effective in the long-term. The programme is underpinned by cost-benefit modelling which considers cost in relation to quality adjusted life years (QALY – the number of years added by the intervention) which shows that it is extremely cost effective. The programme is also likely to generate significant social care savings as a result of a reduction of people accessing care through ill health. The cost calculations include two components:

- The cost of the check itself plus any follow-on tests or monitoring; and
- The cost impact of the interventions that are provided as a result of the NHS Health Checks.

Modelling conducted by the Department for Health when the programme began in 2008/09 proposed that a basic NHS Health Check would cost in the region of £23.70. This does not include the cost of lifestyle and other follow-up services provided by local authorities and health to reduce the health risks identified by the check.

4.3.2 The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health and well-being benefits[5].

4.3.3 A substantial number of people will need to receive the NHS Health Check and subsequent support for the programme is necessary in order to achieve its estimated savings. Current data shows that this expected to be a significant challenge. A study analysing data from the NHS Health Checks programme in 2011/12, published in the Journal of Public Health[6] in August 2013, concluded that coverage was too low currently to make the programme pay for itself. An article in PulseToday found that national figures for 2012/13 showed that overall uptake (the proportion of people invited who received the check) was 49%, having fallen back from 51% the previous year[7]. This data indicates that significant steps will need to be taken at a local and national level to improve take-up. Local authorities have a legal duty to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check as part of their statutory duties. The higher the take up rates for the programme, the greater the reach and impact of the programme and the more likely the programme is to tackle health inequalities.

4.3.4 The NHS Health Checks website offers a 'Ready Reckoner' tool which can be used to identify the potential service implications, health benefits and cost savings of NHS Health Checks per local authority. The tool uses 2010 population data from Office for National Statistics to base its estimates on and presumes that 20% of the eligible population is invited to a health check each year, and that the 75% of these people will take up the offer of a health check[8]. The extent to which Barnet and Harrow are achieving this performance will be explored in detail in section 6

[5] DoH and PHE Health Checks Implementation Review and Action Plan https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224805/NHS_Health_Check_implementation_review_and_action_plan.pdf

[6] http://jpubhealth.oxfordjournals.org/content/early/2013/07/22/pubmed.fdt069.abstract?sid=0cf9fa5e-eb55-4946-8f48-0d696fbd20e2

[7] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/less-than-half-of-patients-attend-nhs-health-checks-show-official-figures/20003835.article#.UI_vX9K-qK4

[8] http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/ready_reckoner_tools

Indicative Costs and Savings for Barnet

4.3.5 Applying the Ready Reckoner Tool[9] for Barnet, it is estimated that the total cost of providing NHS Health Check for one year based on national estimates would be £673,408 (against an approved budget of £500,000 for 2013/14). The workforce requirements to undertake NHS Health Check in this year would be 4,243 hours of time to invite people to Health Check and arrange appointments, 5,039 hours of contact time for the Health Check tests and 3,536 hours of contact time for feedback on the results.

4.3.6 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 673,408	£ 107,397	£ (566,011)
5th year after checks	£ 1,373,409	£ 705,042	£ (668,367)
10th year after checks	£ 1,679,593	£ 1,475,877	£ (203,716)
15th year after checks	£ 2,056,281	£ 2,014,528	£ (41,753)
20th year after checks	£ 2,367,931	£ 2,419,419	£ 51,487

Indicative Costs and Savings for Harrow

4.3.7 Applying the Ready Reckoner Tool estimation for Harrow is that the total cost of providing NHS Health Check for one year based on national estimates would be £458,726 (against an approved budget of £456,000). The workforce requirements to undertake NHS Health Checks in this year would be 2,874 hours of time to invite people to Health Check and arrange appointments, 3,424 hours of contact time for the Health Check tests and 2,395 hours of contact time for feedback on the results.

4.3.8 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 458,726	£ 73,347	£ (385,380)
5th year after checks	£ 936,550	£ 481,750	£ (454,800)
10th year after checks	£ 1,141,916	£ 1,005,487	£ (136,429)
15th year after checks	£ 1,396,064	£ 1,369,713	£ (26,352)
20th year after checks	£ 1,604,439	£ 1,642,587	£ 38,147

4.3.9 The Ready Reckoner tool provides some indicative data on the potential costs and savings in each borough. Whilst the tool highlights that the NHS Health Checks programme will take 20 years to provide net savings, these savings will be across the whole health economy and will result in improved health and well-being for people more generally.

[9] Total costs and savings will vary across Local Authorities, depending on demographic factors. More detailed information about the health benefits can be found when using the Ready Reckoner Excel tool.

4.4 Approaches to Implementation

4.4.1 The NHS Health Check Programme is most beneficial when it reaches people that would not otherwise be identified as being at risk, for example people who are unlikely to visit their GP's regularly now. Reaching these groups is difficult, but will be an essential aspect of successfully implementing the NHS Health Checks programme in Barnet and Harrow.

4.4.2 The health and financial benefits associated with the programme will not accrue until people's risk of diseases has been reduced. This reduction can be achieved by medication, but also by changes in lifestyle such as increasing exercise, following a healthy diet and giving-up smoking. These changes in lifestyle are often difficult to achieve for people, even when they are provided with support services. There is, therefore, a balance to be achieved between medical interventions and encouraging people to take ownership of their own health and well-being. In line with other public health programmes (such as the Smoke Free initiative), the NHS Health Checks programme commissioned in Barnet and Harrow should seek to achieve a balance between intervention and individual responsibility for healthy lifestyle choices. Measuring the impact of the programme should have a medium to long-term perspective to ensure that lifestyle changes are maintained by individuals on an on-going basis.

4.4.3 The NHS Health Check Implementation Review and Action Plan describes commissioners' and providers' experiences with implementing the NHS Health Checks Programme. The review identifies that several commissioners considered that successful implementation had been driven by a 'mixed model' for delivery. GP's were central to the successful delivery of the Programme as they hold patients records and are a trusted source of care for most patients. However, GP services can be supplemented by a variety of other providers as follows:

- Community Teams – commissioned to make contact with those who are typically resistant to presenting in a doctor's surgery by visiting community centres, shopping centres, leisure centres, church groups, markets, football clubs and work spaces.

- Health Buses – used in supermarket car parks and other public spaces, both for walk-ups and by people notified by their GP's that the service would be available at that time and place.

- Private Providers – commissioned to provide Health Checks in collaboration with GP's who are sometimes able to provide a room in their surgeries.

- Pharmacies – used with mixed success, as they sometimes lack private space to perform the checks and can have difficulties in targeting the right audiences.

4.4.4 Public Health England is currently working on providing a repository of local case studies to support local implementation which will be published on the NHS Health Checks website.

4.5 Experts Views on NHS Health Checks Screening Programme

4.5.1 Whilst it is anticipated that there will be significant potential health and financial benefits as a result of the NHS Health Checks programme, there is a limited amount of peer reviewed evidence to support the success of mass screening programmes. Whilst PHE and DoH advocate the programme and are promoting and investing in it, a number of health care professionals have expressed concern regarding the effectiveness of the programme.

4.5.2 Dr Richard Vautrey, Deputy Chairman of the British Medical Association's GPs Committee, has said that "Last year they were talking about taking money from disease prevention, now they want to do this. We are very suspicious. Previous screening programmes have been introduced after much consideration and analysis of evidence. It doesn't seem like this is." [10]

4.5.3 Professor Nick Wareham, Director of the Medical Research Council Epidemiology Unit, has said that the current programme may not represent the best use of resources. Instead, the advisor to Public Health England urged public health leaders to target high-risk individuals as the evidence suggested this was likely be cost-effective.[11]

4.5.4 A study by NHS Heart of Birmingham, published in BMJ Open in March 2013[12] suggested that the NHS Health Checks Scheme programme overlooks a third of patients at high risk of having or developing diabetes, as patients with high HbA1c levels, but with normal or low body weight were not identified for further tests.[13]

4.5.6 The Chair of the Royal College of General Practitioners, Professor Clare Gerada, has backed a call from Danish researchers for the NHS Health Checks programme to be scrapped.[14] [15] The Danish research evaluated screening programmes run in a number of countries and concluded that general health checks failed to benefit patients and could instead cause them unnecessary worry and treatment.

4.5.7 Barbara Young, Chief Exec of Diabetes UK, expresses support for the programme by stating that "…while the £300 million it costs to run might sound like a lot of money, diabetes and other chronic conditions are expensive to treat. This means that once you factor in the savings in

[10] http://news.bbc.co.uk/1/hi/health/7174763.stm
[11] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/reconsider-age-based-approach-to-health-checks-urges-public-health-england-adviser/20004268.article#.UlPsGtK-qK4
[12] http://bmjopen.bmj.com/content/3/3/e002219.long
[13] http://www.pulsetoday.co.uk/clinical/therapy-areas/diabetes/health-checks-scheme-fails-to-identify-a-third-of-patients-at-risk-of-diabetes/20002241.article#.UmAebdK-qK4
[14] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/gerada-scrap-health-checks-programme/20004025.article#.UlPjQNK-qK4
[15] http://www.bbc.co.uk/news/health-23765083

healthcare costs, the NHS Health Check is actually expected to save the NHS about £132 million per year." [16]

4.5.8 Despite the concerns outlined above, the NHS Health Checks programme has been identified by the Secretary of State as an important vehicle for improving prevention and early diagnosis and the initiative is supported nationally by, PHE, DoH and the LGA. In addition, Health Checks are corporate priorities for both Barnet and Harrow councils and there is a significant opportunity for both authorities to utilise the data from this review to inform their commissioning strategies to deliver best value for money.

[16] http://www.bbc.co.uk/news/health-23765083

5. Performance

5.1 Targets

5.1.1 There are no nationally prescribed targets in relation to NHS Health Checks. However, PHE suggest that health and well-being boards should aim to offer checks to 20% of their eligible population every year and for 75% of those offered checks to take them up. NHS Health Checks is a rolling five-year programme meaning that 100% of the eligible population should have been offered a check at the end of the period. In relation to quarterly performance, a local authority that has offered the Check to 5% of the population in quarter 1 and sustain that over the following three quarters will have offered a check to 20% of the eligible population at the end of the year.

5.1.2 High performing areas are those that both **offer** to a high proportion of the eligible population cohort and then achieve a high **transfer rate** (i.e. converting the Health Checks offered into Health Checks received).

5.2 Performance Data

Outcomes – 2012/13

5.2.1 NHS England data[17] identifies that Health Checks in Barnet and Harrow in 2012/13 scored slightly lower than the London average, but close to the national average. Data for all London boroughs has been included in Table 1 for comparison purposes:

[17] http://www.england.nhs.uk/statistics/statistical-work-areas/integrated-performance-measures-monitoring/nhs-health-checks-data/

Table 1 – Number of eligible people that have been offered and received NHS Health Checks (April 2012 – March 2013) (England and London)

Name	Number of people eligible for a NHS Health Check	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that were offered a NHS Health Check
England	**15,609,981**	**2,572,471**	**1,262,618**	**16.5%**
London	**2,082,748**	**429,027**	**194,035**	**20.6%**
Havering PCT	69,304	6,529	4,771	9.4%
Kingston PCT	53,678	7,661	5,668	14.3%
Bromley PCT	100,037	23,117	9,042	23.1%
Greenwich Teaching PCT	63,098	15,137	6,511	24.0%
Barnet PCT	**114,883**	**18,357**	**4,758**	**16.0%**
Hillingdon PCT	72,886	6,742	3,783	9.3%
Enfield PCT	79,400	12,746	5,503	16.1%
Barking and Dagenham PCT	41,328	12,821	4,152	31.0%
City and Hackney Teaching PCT	55,561	11,483	6,775	20.7%
Tower Hamlets PCT	48,778	9,365	7,242	19.2%
Newham PCT	40,000	9,500	5,369	23.8%
Haringey Teaching PCT	55,476	12,523	6,461	22.6%
Hammersmith and Fulham PCT	40,050	6,568	4,276	16.4%
Ealing PCT	70,881	15,789	9,931	22.3%
Hounslow PCT	55,297	6,997	4,501	12.7%
Brent Teaching PCT	76,444	15,410	9,505	20.2%
Harrow PCT	**76,840**	**12,477**	**5,827**	**16.2%**
Camden PCT	49,685	14,761	4,378	29.7%
Islington PCT	42,650	10,167	7,142	23.8%
Croydon PCT	100,197	20,047	2,512	20.0%
Kensington and Chelsea PCT	50,475	7,651	590	15.2%
Westminster PCT	61,800	13,307	7,119	21.5%
Lambeth PCT	92,171	26,592	6,382	28.9%
Southwark PCT	79,294	21,145	6,524	26.7%
Lewisham PCT	72,646	19,279	6,622	26.5%
Wandsworth PCT	57,000	15,984	12,766	28.0%
Richmond and Twickenham PCT	49,856	14,305	4,857	28.7%
Sutton and Merton PCT	113,300	24,184	13,364	21.3%
Redbridge PCT	72,000	12,015	6,286	16.7%
Waltham Forest PCT	62,932	8,301	3,388	13.2%
Bexley Care Trust	64,801	18,067	8,030	27.9%

5.2.2 However, the statistics in Table 1 above should be treated with caution. There is a significant variation in the national statistics relating to the number of people eligible for an NHS Health Check (114,883 in 2012/13) and locally derived statistics provided by Public Health (91,139 in 2013/14 (see 5.2.3 below)).

Outcomes – Quarter 1 2013/14

5.2.3 The table below summarises the performance information regarding the NHS Health Check Programme for Quarter 1 of 2013/14:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that were offered a NHS Health Check of those offered
Barnet	91,139	4,911 (5.4%)	1,520 (1.7%)	31%
Harrow	63,879	1,093 (1.7%)	582 (0.9%)	53.2%
London	1,967,213	94,245 (4.8%)	41,517 (2.1%)	44.1%
England	15,323,148	598,867 (3.9%)	286,717 (1.9%)	47.9%

5.3 Comparative Performance

5.3.1 London Boroughs where a higher percentage of people are offered the health check tend to have a lower percentage of health checks received. At the same time, boroughs where a high percentage of the people received a health check tend to have offered health checks to a relatively low percentage of the population. Boroughs with the highest overall performance are those that both offer checks to a high percentage of their population as well as have a high percentage of checks delivered.

5.3.2 The London Borough of Wandsworth has been identified as an example of a local authority where both the percentage of offers made and the percentage of checks received have been on target.

5.3.3 In quarter 1 2013/14, the top five London Boroughs for **offering** the highest percentage of their eligible population a NHS Health Checks are:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of those offered
Camden	50,399	4,925 (9.8%)	924 (1.8%)	18.8%
Greenwich	60,012	5,605 (9.3%)	1,981 (3.3%)	35.3%
Lambeth	65,181	5,870 (9%)	2,013 (3.1%)	34.3%
Islington	44,687	3,429 (7.7%)	1,840 (4.1%)	53.7%
Westminster	52,589	3,971 (7.6%)	1,479 (2.8%)	37.2%

5.3.4 In quarter 1 2013/14, the top five London Boroughs for highest percentage of people that have **received** the health check after being offered it are:

Q1 2013-14	Total eligible population 2013-2014	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of those offered
Hounslow	61,153	664 (1.1%)	664 (1.1%)	100.0%
City of London	2,266	72 (3.2%)	72 (3.2%)	100.0%
Havering	70,211	1,507 (2.1%)	1417 (2%)	94.0%
Newham	59,455	1,720 (2.9%)	1376 (2.3%)	80.0%
Wandsworth	64,128	3,203 (5%)	2419 (3.8%)	75.5%

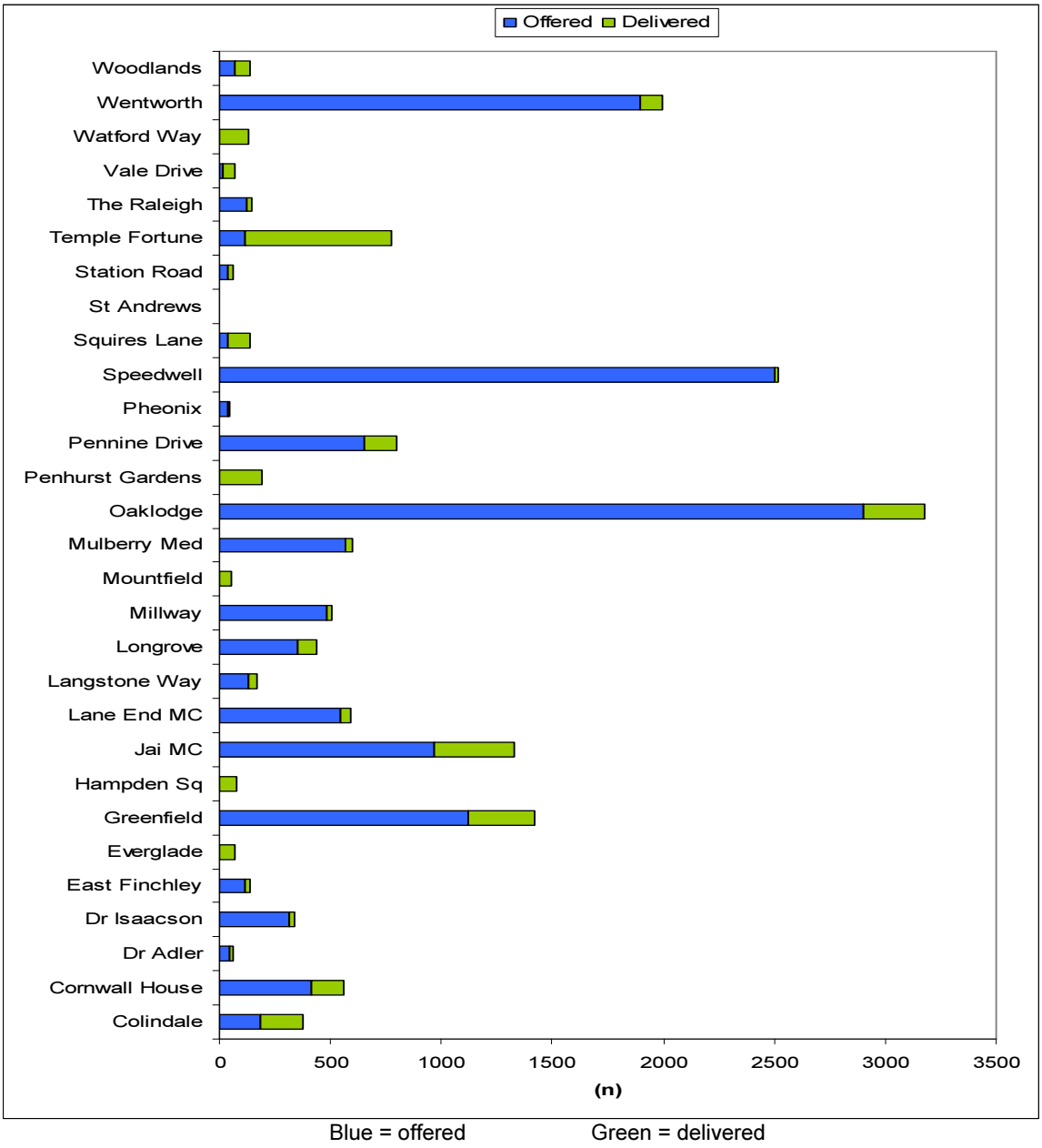
5.3.5 For the NHS Health Checks programme to be successful, commissioners should be seeking to meeting or exceeding both targets to ensure that the reach of the programme is as wide as possible.

5.4 Local GP Practice Performance

5.4.1 As part of the review, the Public Health team provided a breakdown of the performance of individual GP practices in Barnet and Harrow during 2012/13.

5.4.2 Table 1 provides relevant statistics for Barnet. Due to issues with the data transferred to the council, performance information for Barnet was only available for the period November 2012 to March 2013. Barnet achieved a 19% conversion rate from 'offered' status to 'delivered'. The table shows that larger GP surgeries tended to be the worst performing.

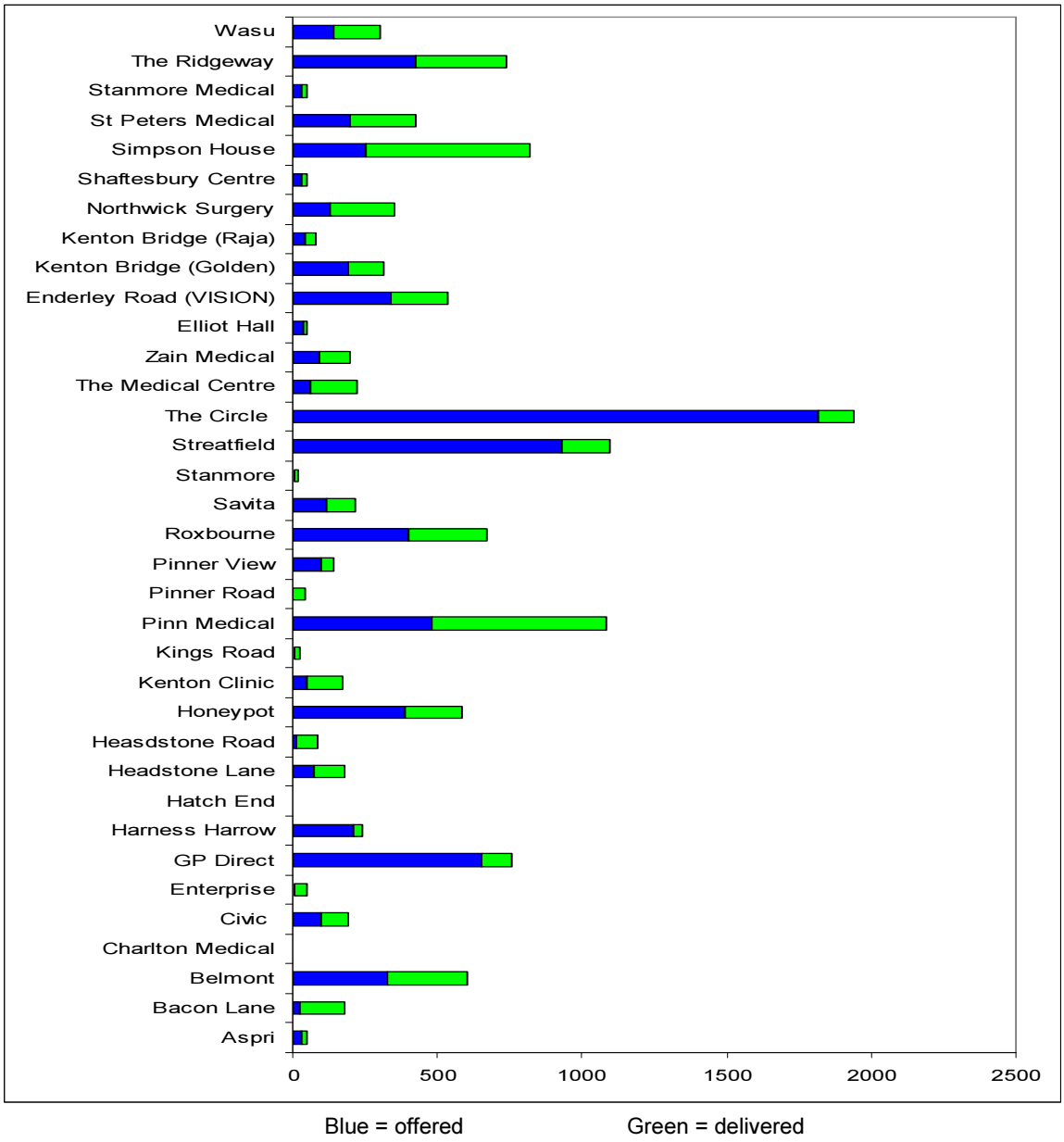
Table 1 – GP surgeries in Barnet performance, Nov 2012 – March 2013



Blue = offered Green = delivered

5.4.3 Table 2 shows the statistics for Harrow. Members were advised that Harrow has a 38% conversion rate. As with Barnet, the larger surgeries had the lowest performing rates.

Table 2 – GP surgeries in Harrow performance between April 2012 – March 2013



6. Best Practice

6.1 In conducting the review, Members have explored best practice examples to identify the principal differences between the approach taken in Barnet and Harrow and the approach in high performing areas.

6.2 Haringey

6.2.1 In 2012/13 the activity for NHS Health Check offers in Haringey was 12,523 and 6,461 checks were delivered. This translates to a 52% uptake rate, which is better than the uptake rate for 2011/12 (which stood at 35%).

6.2.2 Haringey's programme is targeted at areas of highest deprivation and CVD mortality: East, Central and part of West Haringey (Stroud Green and Hornsey wards). Over 70% of the Health Checks Programme is delivered by GPs in Haringey. The programme is being supported by behavioural support programmes (e.g. Health Trainers) and these arrangements have been strengthened during 2013/14. Community programmes that ran in 2012/13 included a focus on mental health users and a focus on men.

6.2.3 Haringey identified that to improve uptake they had to:

- increase coverage across eligible practices;
- reduce variation in activity;
- target high risk groups;
- target men;
- improve data quality; and
- improve onward referral mechanisms.

6.2.4 Haringey consider that one of the main reasons for success is that alcohol misuse screening delivered as part of NHS Health Checks programme has encouraged people to take part. They are also planning to deliver some Health Checks at community events in order to expand the reach of the programme.

6.3 Teesside

6.3.1 Teesside have used several techniques to achieve success with delivering NHS Health Checks. Firstly they have invested in a rolling training budget that can be allocated to external providers to help extend the availability of the service. Secondly they have used social marketing techniques to help inform the development of a communications and marketing strategy. By doing this they have made the service more visible. They have delivered Health Checks under the local identity of 'Healthy Heart Check' which has further helped to make the service more accessible and embedded in local culture.

6.3.2 Teesside have targeted certain groups and have created a prioritisation list of certain groups to help tailor the service and to increase take up. They have also invested directly in dedicated primary care informatics (or information management systems), a nurse facilitation team and project management as a way of extending the reach of the service. It is worth noting that death rates from heart disease have reduced at a faster rate in Teesside than England as a whole since the implementation of the Health Checks programme. Health Checks in Teesside have also been provided at particular work places in an effort to make the take-up more substantial.

6.4 County Durham

6.4.1 In comparison to national performance, County Durham has been very successful in delivering NHS Health Checks. They promoted Health Checks via a 'Check4Life', campaign which is based on the 'Change4Life' national health and well-being programme. They have utilised the same branding as the Change4Life campaign which has improved recognition locally.

6.4.2 County Durham have carried out the service with 'opportunistic screening' (when someone requests that their doctor or health professional undertakes a check, or a check or test is offered by a doctor or health professional) with a focus on predicting and preventing vascular disease risk. Health Checks have been conducted on a 'one-stop-shop' approach in order to make the delivery of these checks more accessible, attractive and patient focussed. They have also promoted the service at road shows, such as 'Health@Work', where Health Checks have been offered in certain work places.

6.4.3 In addition to this, County Durham has focussed on the notion of 'Mini Health MOTs', which are targeted at certain groups. This has helped to broaden the scope of the service and has helped to promote the service across the area. In analysing the success of the campaign, County Durham found that 91.3% were very satisfied with the Mini Health MOT, whilst 99.1% would recommend it to others. Intertwined with the NHS Health Checks, it was also reported that 82.2% were very satisfied with the NHS Health Check and that 99.6% would recommend an NHS Health Check to other people. During 2011/12 73.5% of those offered a Health Check in County Durham took the offer. To date 2013/14, 8,509 people have been offered a Health Check and 3,936 people have received one from an eligible population cohort of 164,760.

6.5 Richmond upon Thames

6.5.1 The London Borough of Richmond upon Thames has been successful in delivering NHS Health Checks. They have adopted an approach that relies on a strong advertising premise supported by a strong database to record the number of checks offered and delivered. As a result, Richmond is one of the leading boroughs in London in delivering NHS Health Checks.

6.5.2 Richmond works with more than 40 different partners including GPs, pharmacies, outreach and external providers to deliver Health Checks. Lifestyle programmes such as weight management, diabetes prevention and a health trainer service have been specifically commissioned for patients to be referred to.

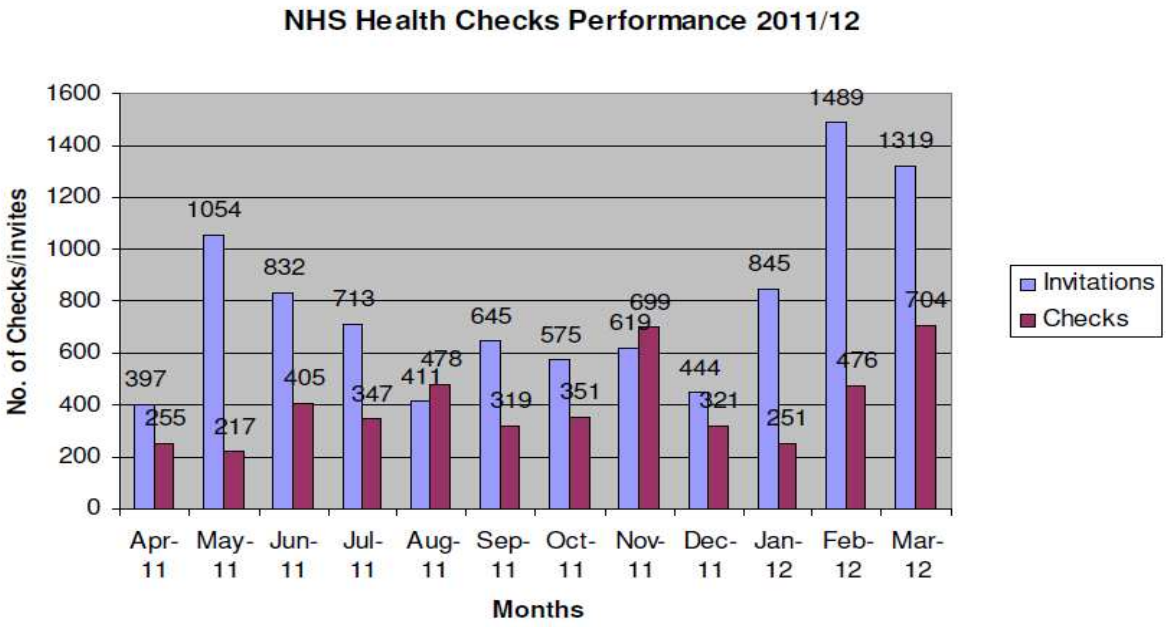
6.5.3 Richmond launched a pilot programme in 2009 in line with the national launch of the NHS Health Checks programme which focussed on delivering Health Checks in the most deprived wards in a pharmacy setting. This helped to make the service accessible both in terms of timing and capacity. The Public Health team also carried out a Health Needs Assessment and selected the top three deprived wards and the six pharmacies which were best suited to run the pilot. Health Checks have been delivered by the *Live Well Richmond* service which also provides an exercise referral scheme in addition to other lifestyle services. This has helped the Health Checks delivery model to become locally known. GPs have been commissioned to deliver targeted invitations based on factors such as age, gender, body mass index, ethnicity, blood pressure/cholesterol levels, physical activity and smoking status.

6.5.4 More than 50% of the eligible population have been invited and more than 20% have received a check. More than 200 people have been newly diagnosed with various cardiovascular diseases such as hypertension, diabetes, chronic kidney disease and coronary heart diseases as a result of a health check. In 2011/12, 5,700 health checks were completed in general practice, pharmacy and at community outreach events which exceeded DoH targets.

6.5.6 Richmond have delivered a marketing programme which comprises newspaper adverts, a dedicated webpage[18], letters, posters, leaflets and press releases to attract people for a health check. They also emphasised selling through personal sales (pharmacists, GPs and outreach), incentivising GPs, through focus groups and direct invitations.

6.5.7 Richmond use iCap, an IT system, to keep track of their Health Check performance. This system has enabled them to target checks where necessary and assists in provide statistical analysis as follows:

[18] https://www.live-well.org.uk/richmond/



6.6 Enfield – Innovision Health and Well-being Limited

6.6.1 In November 2012, Enfield Council awarded a contract for Community Health Checks to Innovision Health and Well-being Limited. This was done in an effort to allow targeting of health checks to communities that do not traditionally access primary care or who do not respond to invitations from primary care, which should improve the number of health checks being completed.

6.6.2 Innovision deliver health checks in both primary care and community settings. They perform health checks on behalf of GPs in communities and make a focussed effort to understand communities. By doing so, they are able to deliver health checks regularly. In Enfield, for instance, Innovision have noted that there is a large Turkish and Kurdish population and they have targeted Health Checks in those communities' first languages.

6.6.3 In Enfield, Innovision has established relationships with organisations such as ASDA, Tesco, various health centres and sports centres to enable delivery in these settings to encourage those who would not otherwise go to their GP. In an ASDA in Enfield, there is a weekly footfall of around 55,000; Innovision deliver checks in this ASDA on a daily basis. They determined that this was a good site after surveying the local area both in terms of weekly footfall and the regular attendance from specific communities. Innovision are also aiming to deliver Health Checks in all Boots stores in every London Borough that they are operating within (currently Brent, Haringey, Enfield and Islington). In addition, they deliver checks at community events, particularly in deprived areas in order to achieve their commitment of working with deprived communities.

6.6.4 Innovision have an on-line system where Health Check data is inputted to. This enables Public Health to be provided with non-identifiable data and has subsequently helped with reporting. This system has been used with Enfield and previously Haringey. The Innovision Health Check comprises the follows:

- BMI, weight and blood pressure checks are undertaken immediately
- The check takes 15-20 minutes
- Results of the above are given straight away
- If the patient falls out of the appropriate health range then they are signposted to their GP. GPs receive this information which they can then use as data in the future; the onus is on the GP to contact any patient who has risk factors or is in need of treatment.
- Innovision stress that primary care settings are the only places where advice can be given; those performing checks for Innovision are directly instructed not to give advice
- Checks are tailored to communities and are performed in appropriate settings (such as mosques, restaurants and wherever is possible)

7. Evidence

7.1 The Scrutiny Review recognised the importance of considering quantitative and qualitative evidence from a variety of sources. On that basis, the Group undertook three separate and distinct elements of engagement with key stakeholders as detailed below.

7.2 Community Engagement

7.2.1 The review commissioned a Community Engagement work stream to identify barriers to take-up across both boroughs. The full findings from the Community Engagement element of this project are attached at **Appendix A**. However, a summary of the key recommendations emerging are detailed below:-

i. Marketing and promotion – people are not familiar with the Health Checks brand and individuals would like to know more about the objectives of the programme. GPs need to be convinced of the value of the programme at a national level.

ii. Value for money – the economic case for Health Checks needs to be developed in greater detail by Public Health England. In addition, residents were concerned about the overlap with other screening programmes and wanted to see a more joined up approach to supporting wellness. The value of investing in Health Checks over other initiatives was questioned. Residents felt that support to make lifestyle changes should be free and have a long-term focus.

iii. Innovative approaches to delivery – residents considered that commissioners should take a more flexible approach to delivery (e.g. community teams, a health bus, clinics at flexible times)

iv. Effective IT – effective and joined up IT systems (across health and social care) would be essential for identifying the target population, collating data and information about individual risks, ensuring that follow-ups timely and evaluating the Health Checks programme. Residents wanted IT systems to provide a joined up and holistic view of their health.

v. Competency of providers – residents considered that the Health Check should be provided by a registered professional to ensure that advice and support started seamlessly in the context of the discussions relating to risk factors.

7.3 Questionnaire

7.3.1 To support the review, Scrutiny Officers conducted a snap survey of Barnet and Harrow residents to gauge awareness and take-up of NHS Health Checks. The survey was promoted locally by both councils communications

teams and via local networks, such as Healthwatch. The survey received 47 responses and the detailed findings are detailed in the sections below. Responses to the questions relating to the residents' experience of the checks should be treated with caution due to the relatively small sample size. They do, however, provide some insight into the views of people who have experienced an NHS Health Check:

7.3.2 85.7% of respondents were from Barnet and 14.3% of respondents were from Harrow.

7.3.3 In response to the question 'Have you ever been offered a Health Check from your GP?' 80.9% stated 'no' and 19.1% stated 'yes'. This highlights that the vast majority of respondents had not been offered a check, despite the Health Check programme having been in place in both boroughs since 2009.

7.3.4 Respondents were asked to provide the name of their registered GP surgery. 17 different practices in Barnet and three different practices in Harrow were identified as not offering Health Checks to participants.

7.3.5 Of those respondents that had been offered a Health Check, 100% had taken up the offer. Respondents were asked to identify the reasons why they had accepted the offer and their responses are summarised below:

- General health and well-being check
- Aware of the Health Check programme and wanted to see how it worked in practice.
- Multiple health issues
- Precautionary measure
- Family history of high cholesterol, cardiovascular disease or diabetes

7.3.6 When questioned how important they considered regular health checks to be, 71.4% considered that it was very important and 28.6% considered that it was neither important or unimportant.

7.3.7 When questioned how beneficial they considered the Health Check that they had received to be, 66.7% considered it was beneficial or very beneficial and 33.3% considered it was not very beneficial or not beneficial at all. Respondents were asked to give reasons for their answer. One respondent stated that they were dissatisfied as they were still waiting for their blood test results following a check completed over a week ago.

7.3.8 Respondents were asked whether they considered that there were any areas of the Health Checks process that could be improved. 57.1% answered yes and 42.9% answered no. Respondents were asked to identify specific areas for improvements and the responses are summarised below:

- Consider the option of Integrated Medicine (homeopathy or other natural medicine choices)
- Scans for aneurysm
- Prompt results and more screening around breast cancer, etc.

- Health Checks should consider an individual's mental health too

7.3.9 When respondents were questioned whether they would recommend the Health Check to other people, 85.7% said yes and 14.3% said no. Respondents were asked to give reasons for their answers which are summarised below:

- Early detection of diseases
- Encourage people to make healthy lifestyle choices for them and their families
- Concern for the health and wellbeing of others
- Useful especially for men as they tend not to visit their GPs
- Early detection of health issues and an opportunity to discuss these with health professionals

7.4 Stakeholder Workshop

7.4.1 It was agreed at the outset of the project that engagement with stakeholders was key to understanding the overarching issues. In November 2013, Barnet and Harrow held a Stakeholder Workshop, facilitated by the CfPS Expert Advisor and supported by Scrutiny Officers from Barnet and Harrow. The aim of the workshop was to provide Members of the Scrutiny Working Group and key external stakeholders with the opportunity to:

- Understand the external factors that currently influence the commissioning and delivery of the Health Check in the Barnet and Harrow
- Identify the barriers to delivering the Health Check
- Identify opportunities for effective delivery in the future
- Discuss the improvements in services that could be achieved by change
- Identify and prioritise issues to be considered in the commissioning of the Health Check

7.4.2 The workshop was a deliberative forum which enabled participants to consider relevant information, discuss the issues and options and develop their thinking together before coming to a consensus view. The facilitators used the CfPS Stakeholder Wheel (as shown in Table 3 below) to structure the discussion throughout the workshop and to address the return on investment question of:

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

7.4.3 Based on the discussions that took place, the following recommendations emerged from the Stakeholder Workshop:

	Theme	Recommendation and Rationale
1	**Health Checks Promotion**	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).
2	**Providers / Flexible Delivery**	Health Checks should be commissioned to be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups)) to make Health Checks more accessible.
3	**Treatment Package**	All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more attractive. Commissioners should investigate feasibility of tailoring treatment options to specific communities.
4	**Referral Pathways**	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment
5	**Restructure Financial Incentives**	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.
6	**Resources**	Public Health England and local authorities must consider the cost of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. Health Checks are currently not a mandatory requirement for GPs (delivered by Local Enhanced Service contracts) meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical space) to deliver. Nationally, Public Health England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended.

7	**Targeting**	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- • men (who statistically have a lower up-take than women); • faith communities (who statistically have a high prevalence of certain diseases); and • deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)
8	**Screening Programme Anxiety**	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.
9	**Barriers to Take-Up**	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.
10	**Learning Disabilities**	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with learning difficulties into the Health Checks programme before age 40 due to their overrepresentation in the health system

7.4.4 Although listed as separate elements above, the Public Health team are recommended to undertake a **whole system review** (offer, appointment, results, advice etc.) to inform the future Health Checks commissioning strategy.

7.4.5 The recommendations at 7.4.3 have been endorsed and adopted by the Scrutiny Review Group.

7.4.5 In addition to the recommendations outlined above, the following have been identified as priority areas for Public Health to consider when commissioning Health Checks in the future:

1. Improve take-up across the board

2. Engage with local Healthwatch to promote

3. Communication – liaise with community leaders

4. Communication – develop and embed a local message articulating the offer

5. Providers and incentives need to be realigned

6. Target Health Checks locally to specific communities

7. Understanding barriers to take up in areas offered

8. Examine the whole system from offer to follow on

9. Communicate the advantages

10. Extent that service providers can encourage take-up (e.g. weekend availability)

11. Follow up with personalised letters and phone calls; state the advantages

12. Improve access based on research

13. Initiate follow-up programmes

8. Return on Investment

8.1 When applying to become a CfPS NHS Health Check Scrutiny Development Area, Barnet and Harrow committed to using the CfPS Return on Investment Model (RoI) to conduct the review.

8.2 The RoI model seeks to quantify what the return on investment would be for a specific course of action being taken as a consequence of the scrutiny review. As identified in the Stakeholder Workshop section, the RoI question that this review has been seeking to address is

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

8.3 The economic argument behind the NHS Health Checks screening programme is that the early detection of certain conditions or risk factors enables early intervention which can take the form of medical treatment or lifestyle changes. Treating conditions in their early stages or managing risk factors will:

i. be much more cost effective than treating chronic conditions; and

ii. result in an overall improvement in the health and wellbeing of the general population.

8.4 Public Health England has estimated that over the next four years around £57 million will be saved through Health Checks and that over a 15 year period £176 million will be saved. After 20 years the NHS Health Checks programme is expected to have paid for itself and deliver improvements to the general health and well-being of the population.

8.5 The RoI modelling below will seek to analyse cost of this review against the potential financial benefits of implementing the recommendations arising. It is acknowledged that the RoI modelling could be open to challenge as it is based in a number of assumptions. Notwithstanding this, the model does provide a platform to demonstrate the potential financial and social benefits that implementing scrutiny recommendations could deliver if implemented; the model should therefore be considered on that basis.

Return on Investment – Cost of Scrutiny Review vs. Potential Savings

Table 2 (Input Costs)

Input	Scrutiny Officer Review	Public Health	External Engagement	**Total**
	2 x Scrutiny Officers for 1 day per week for 24 weeks (mid-July to mid-December) = 168 hours Plus 5 days of graduate trainee support = 37 hours Total hours 373 hours x £25 per hour = **£9,325**	Public Health Officers (including involvement in planning meetings, providing data and attending) Total hours = 10 days or 74 hours x £25 per hour = **£1,850**	22 days = **£13,370**	**£24,545**

Table 3 (NHS Health Checks – Newly Diagnosed Conditions)

	Number of people eligible for a Health Check	Number of Health Checks offered to the eligible population	Number of Health Checks performed	Transfer rate (take up of those offered)	Number of cases of Hypertension diagnosed as a result of a Health Check	Number of cases of Diabetes diagnosed as a result of a Health Check	Number of cases of High Cholesterol diagnosed as a result of a Health Check
Harrow (2012/13)	62,892	12,680 (20.16%)	3,729 (5.93%)	34%	65	32	815
Barnet (2012/13)	69,904	16,820 (24.06%)	3,263 (4.67%)	19%	146	65	750
Richmond (2011/12)	Approximately 19,000	9343 (c. 50+%)	4823 (c. 25%)	51%	152	19	Data not available

8.6 In considering the financial implications of not treating risk factors or diagnosed conditions early, a review of information available on the cost of treating chronic conditions was undertaken. The result of the modelling below should be treated with caution as the financial assumptions have not been fully tested. The findings do however provide an estimation of the potential savings across health and social care following the roll out of a successful NHS Health Checks programme in Barnet and Harrow.

8.7 The British Heart Foundation reports that 103,000 heart attacks occur every year, costing around £2 billion per year to treat or £19,417 per case. Diagnosing conditions such as Hypertension can be argued to prevent heart attacks from occurring later on therefore meaning that for every case diagnosed £19,417 is potentially saved. On this premise, the following amount of money will be saved as a result of Health Checks:

8.7.1 LB Harrow

In 2012-13, 3,729 had health checks (5.93% of the eligible population). This led to 65 cases of hypertension being diagnosed, saving a potential of £1,262,105.

If the uptake was improved to 11.86%, then it is possible that around 130 cases of hypertension could be diagnosed, saving a potential £2,524,210.

8.7.2 LB Barnet

In 2012-13, 3,263 had health checks (4.67% of the eligible population). This led to 146 cases of hypertension being diagnosed, saving a potential of £2,384,882.

If the uptake was improved to 9.34%, then it is possible that around 292 cases of hypertension could be diagnosed, saving a potential £5,669,764.

8.8 If the recommendations arising from this review (as set out in the following section) are agreed and implemented, it is anticipated that there will be a significant increase in the uptake of NHS Health Checks in both boroughs, particularly if roll-out of the checks is prioritised based on demographic risk factors.

8.9 **Social Return on Investment**

8.9.1 The Scrutiny Review Group wish to emphasise that the implementation of the recommendations made will deliver social as well and financial benefits. Encouraging people to adopt healthy lifestyles and managing pre-existing conditions before they become chronic will deliver health and well-being benefits in addition to the potential financial savings.

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9. Summary Findings and Recommendations

Summary Findings

9.1 Following consideration of all the evidence received during the review, Members questioned whether GPs were the correct vehicle for delivering NHS Health Checks. Whilst performance in Barnet and Harrow had been around the national average, there was a lack of awareness of the checks in both boroughs. Best practice examples demonstrated that alternative delivery models could improve up-take by targeting to specific groups and making the checks more accessible.

9.2 Data supplied by the Public Health team had indicated that the cohort of patients presenting for health checks were not reflective of the demographics in each borough (e.g. there were a disproportionate number of women from more affluent areas). As such, presentations were not linking with communities identified as being at risk. There should therefore be a focus on hard to reach groups including specific ethnic communities with high risk factors, mental health patients, the homeless and men.

9.3 The Group recognised that there should be a balance between interventions and individuals managing their own risk factors. A communications campaign should therefore seek to strike a balance between promoting the checks locally and encouraging people to adopt healthier lifestyles.

9.4 Members recognised the importance of ensuring that there was a clearly defined pathway for those identified as being most at risk. Medical interventions should be supported later in the pathway by risk management and reduction elements and a joined up approach would be required to achieve this.

9.5 Contracts transferred from primary care trusts were inconsistent and in Barnet did not incentivise completion of the check. The Group considered that when the commissioning strategy was defined, there should be consistent payment by results contracts across both boroughs. Members were supportive of the work being undertaken within the West London Alliance to regularise NHS Health Checks contracts on a sub-regional level.

9.5 The Group recognised that greater work was required to understand the whole costs of the NHS Health Check process. Local authorities are responsible for commissioning the check and CCGs are responsible for ensuring an appropriate clinical follow-up. Further evaluation of the post-check care costs is required to provide an accurate cost benefit analysis.

9.6 The Group were supportive of the recommendation in the PHE / LGA paper titled *NHS Health Check: Frequently asked questions* (September 2013) that "Health and Wellbeing Boards (HWBs) should ensure that NHS Health Check is reflected in the commissioning plans stemming from locally agreed Joint Health and Wellbeing Strategies (JHWSs) and that it is resourced to operate

effectively. Coordinating the programme with wider strategic decision making by the whole council will avoid duplication, and can help maximise the programme's impact and value for money. It is important to ensure that the risk management and reduction elements of the NHS Health Check (lifestyle interventions such as stop smoking services, weight management courses and drug and alcohol advice) are properly linked to other council services like education, housing and family support."

Recommendations

9.7 The Group agreed that the recommendations arising from the Stakeholder Workshop, as detailed in **section 7.4.3** should form the basis of the recommendations to each council's Cabinet and Health & Well-being Board as recommendations were supported by all of the quantitative and qualitative research undertaken as part of this review.

10. Project Activity

A summary of the meetings in carrying out this scrutiny review is provided below:

Date	Activity
25 July 2013	Approved the Project Briefing to enable the review work to commence in advance of formal committee approvals Approved the composition of the Task and Finish Group (3 Harrow Members and 3 Barnet Members Approved the consultation / engagement approach Agreed an outline plan for the utilisation of the CfPS Expert Advisor support available
18 September 2013	Received a summary of activity to date Reviewed and agree the Project Plan Received the results of a data mapping exercise undertaken by the public health team (including trend analysis) Agreed the approach to engaging with key stakeholders and residents / patients
2 October 2013	Received a presentation from the CfPS Expert Adviser on the ROI approach Agreed the format of the Stakeholder Workshop
1 November 2013	Stakeholder Workshop attended by Public Health England (London), GPs, Practice Managers, Healthwatch, Diabetes UK, Cabinet Members, Barnet / Harrow Public Health and Barnet CCG
4 December 2013	Results of an online questionnaire on Health Checks (promoted via Engage Space, Twitter / Facebook, Older Adults Partnership Boards and Members) Results of community engagement exercise which includes focus groups (generic, men and deprived areas) and 1:1 interviews Outline report, co-authored by LB Barnet and Harrow Scrutiny Officers

11. Acknowledgements

The Scrutiny Review Group wishes to thank those attendees and witnesses outlined below in addition the officers in the joint public health team who supported them during their work.

Councillors	
Councillor Vina Mithani	Harrow Council
Councillor Alison Cornelius	Barnet Council
Councillor Graham Old	Barnet Council
Councillor Helena Hart	Barnet Council
Councillor Barry Rawlings	Barnet Council
Councillor Ben Wealthy	Harrow Council
Councillor Simon Williams	Harrow Council
Council Officers	
Dr Andrew Howe	Joint Director of Public Health, Barnet and Harrow
Mary Cleary	Interim Senior Public Health Commissioning Manager
Rosanna Cowan	Public Health Commissioner
Dr Matteo Bernardotto	GP VTS Trainee at North West London NHS Trust, Public Health
Andrew Charlwood	Overview and Scrutiny Manager, Barnet Council
Felicity Page	Senior Professional Scrutiny, Harrow Council
Edward Gilbert	Graduate Trainee / Assurance Officer, Barnet Council
Hannah Gordon	Graduate Trainee, Barnet Council
Witnesses	
Brenda Cook	Expert Advisor, Centre for Public Scrutiny
Stephanie Fade	Managing Director, What Matters Cubed
Paul Plant	Deputy Regional Director – London, Public Health England
Christine Gale	Pinner Road Surgery, Harrow
Smita Mody	Pinner View Medical Centre, Harrow
Dr Sue Sumners	Barnet Clinical Commissioning Group Chairman
Councillor Helena Hart	Cabinet Member for Public Health, Barnet Council
Cllr Simon Williams	Health and Wellbeing Portfolio Holder, Harrow Council
Dr Pandya	Savita Medical Centre, Harrow
Roz Rosenblatt	London Regional Manager, Diabetes UK
Rhona Denness	Healthwatch Harrow
Selina Rodrigues	Healthwatch Barnet

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AGENDA ITEM 14

Health Overview and Scrutiny Committee

08 December 2014

Title	Health and Well-Being Strategy Performance Report – Year 2
Report of	Dr Andrew Howe, Director of Public Health
Wards	All
Status	Public
Enclosures	Appendix 1 - Health and Well-Being Strategy Year 2 Performance Report
Officer Contact Details	Jeff Lake, jeff.lake@harrow.gov.uk Neel Bhaduri, neelanjan.bhaduri@harrow.gov.uk Claire Mundle, Claire.mundle@barnet.gov.uk

Summary

This report for the Health Overview and Scrutiny Committee summarises the progress that has been made by local partners to improve the health and well-being of Barnet's population in the past 12 months, in line with the objectives and targets set out in the Health and Well-Being Strategy (2012-15).

Recommendations

1. That the Health Overview and Scrutiny Committee notes the second annual Health and Well- being Strategy performance report, the progress that has been made so far to meet the Strategy's objectives and the priorities agreed by Health and Wellbeing Partners for the year ahead.
2. That the Health Overview and Scrutiny Committee identify areas covered in the report that it wishes to discuss further with a view to developing an action plan in respect of those matters as it considers appropriate.

1. WHY THIS REPORT IS NEEDED

1.1 Barnet's Health and Well-Being Strategy was launched in October 2012. The Strategy sets out how Barnet's services will work together to address the most

pressing health and well-being needs within the Borough. It was published following thorough consultation with local stakeholders about the health and well-being issues that need to be addressed in order to support Barnet's residents to keep well and keep independent.

1.2 The four chapters of the Strategy- Preparing for a Healthy Life, Well-Being in the Community, How we Live, and Care when Needed- set out the provision that needs to be in place to make sure people can keep well and independent, and explains what difference this should make to people's health. Each chapter contains a series of commitments and targets that will help the Health and Well-Being Board know how these plans are progressing, and how much impact these changes are having on people's lives. The performance targets set a clear direction of travel for all agencies in the Borough focused on delivering health and well-being objectives.

1.3 Progress that has been made by local partners to improve the health and well-being of Barnet's population over the past 12 months was reported to the Health and Wellbeing Board on 13th November 2014 along with proposed priorities for the year ahead..

1.4 The priority areas for Year 3 are:

Preparing for a Healthy Life

1. That the Health and Well-Being Board will continue to work with NHS England to address the pre-school immunisations data issues they have identified so that the local area can be assured that immunisation rates are being increased.

2. The Health and Well-Being Board will continue to provide on-going strategic multiagency leadership and ensures a robust safeguarding arrangements to the two forthcoming transformation programmes in response to legislative changes that affect children and young people- namely the development of a new model for health visiting and school nursing services for 2015-16; and the development of a single, simpler 0-25 assessment process and Education, Health and Care Plans for children with special educational needs and disabilities from 2014.

Well Being in the Community

3. The Health and Well-Being Board will continue to work collectively and promote early intervention and prevention of mental health problems for children, working aged adults and older people and ensure robust local service provision.

4. The Health and Well-Being Board will continues to promote models that limit social isolation, in partnership with Older Adult's Partnership Board and Barnet Older Adults Assembly.

5. The Health and Well-Being Board will provide a specific focus to the solutions that will most effectively reduce level of excess cold hazards in elderly peoples' homes.

How we live

6. The Health and Well-Being Board will ensure for an everyday prevention approach, which is essential in all services, making use of Making Every Contact Count. This is an approach that considers lifestyles and wider determinants of health e.g. education, housing, the environment. All partner organisations should ensure that their contracts require providers to use every opportunity to deliver brief advice to improve health and wellbeing whether in health, social care or wider services. Priorities for brief advice are smoking, alcohol, diet and physical activity although advice should be tailored to the needs of the individual.

7. The Health and Well-Being Board will ensure coordination of activities across partners to tackle increasing and higher risk drinking in the Borough, considering the various local levers it has at its disposal to affect change.

8. The Health and Well-Being Board will continue to work with NHS England to address screening uptake in the Borough, to ensure that national targets are not only met.

Care when needed

9. The Health and Well-Being Board will ensure implementation of the integrated care proposals, that will support Barnet's frail elderly residents and those with long-term conditions to maintain independence in their own homes for as long as possible.

10. The Health and Well-Being Board will ensure oversight and endorsement of the work taking place locally to develop self-care initiatives that will help residents maintain their independence (including telecare) and to support the Borough's many carers to maintain their own health and well-being as well as that of the people they care for.

2. REASONS FOR RECOMMENDATIONS

2.1 To ensure that the Health Overview and Scrutiny Committee are sighted on performance in addressing the priorities identified (section 1.4) in the Health and Wellbeing Strategy, those selected for particular attention in the year ahead and have the opportunity to provide scrutiny of these plans.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable

4. POST DECISION IMPLEMENTATION

4.1 The recommendations in the report were approved by the Health and Well-Being Board on the 13th November 2014 and partners will proceed with their implementation plans.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Barnet's Health and Well-Being Strategy was launched in October 2012 reflecting the corporate priorities of the Local Authority and its partners and following consultation with local stakeholders.

5.1.2 Performance in addressing these priorities is summarised in the report.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 Partners commissioning intentions and work plans are aligned to the objectives of the Health and Well-Being Strategy and so are financed within their available resources. The priorities reflect those areas where evidence demonstrates good return on investment.

5.3 Legal and Constitutional References

5.3.1 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.

5.3.2 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.

5.3.3 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

5.3.4 "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." "To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents." "To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships in the public, private and voluntary sectors."

5.3.5 Responsibility for Health and Well Being Strategy rests with the Health and Wellbeing Board.

5.4 Risk Management

5.4.1 Implementation plans, including identification and mitigation of risks, are taken forward by the respective partners and managed through their own systems.

5.5 Equalities and Diversity

5.5.1 Council needs to comply with the Equality Act 2010 in the provision of all services. The specific duty set out in s149 of the Equality Act is to have due regard to need to: Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.2 The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.5.3 The targets within the Health and Well-Being Strategy have been set based on the results of the Joint Strategic Needs Assessment which considers health and social care outcomes across all of Barnet's population groups and pays particular attention to the different health inequalities that exist in the Borough.

5.6 Consultation and Engagement

5.6.1 Healthwatch Barnet play an important role in ensuring that the Health and Well-Being Strategy is making a difference and in advising lead agencies on how the voices of users and carers can feed in to the performance management of the Strategy.

5.6.2 Partnership Board co-chairs, and Healthwatch Barnet, have been asked to contribute to the production of the in-depth progress reports contained within the performance report. The write up of the Partnership Board Summit (June 2014) is also attached at Appendix 3, which includes a section on the work that the Partnership Boards have been doing to support delivery of the Health and Well-Being Strategy.

5.6.3 The performance report has been presented at the Partnership Boards Catch-Up, on the 20th November 2014, where Partnership Boards has been asked to work with Health and Well-Being Board members to identify how they can support delivery of the Year 2 priorities that are contained in the performance report.

5.6.4 Partnership Boards, alongside a wider set of stakeholders, will be invited to participate in the refresh of the JSNA and Health and Well-Being Strategy in early 2015.

6. BACKGROUND PAPERS

Health and Well-Being Board 17 November 2011 – item 5- Developing the Health and Wellbeing Strategy. The Health and Well-Being Board endorsed the broad approach of the Performance Management Framework.
http://barnet.moderngov.co.uk/Data/Health%20&%20Well-Being%20Board/201111171000/Agenda/Document%204.pdf

Health and Well-Being Board 27th June 2013- item 10- Performance Management Framework for the Health and Well-Being Strategy. The Board agreed to the updated proposals for managing performance of the Health and Well-Being Strategy and agreed for a full Annual Report against year one of the Health and Well-being Strategy to be bought to the November Board meeting. http://barnet.moderngov.co.uk/documents/s9320/HWBB%20JUNE%202013%20Performance%20Management%20Paper%20FINAL.pdf

Health and Well-Being Board 19th September 2013- item 10- Proposed revisions to the targets in the Health and Well-Being Strategy. The Board approved the proposed revisions to the existing targets in the Health and Well-Being Strategy. http://barnet.moderngov.co.uk/documents/s10733/Proposed%20revisions%20to%20the%20targets%20in%20the%20Health%20and%20Well-Being%20Strategy.pdf

Health and Well-Being Board 21st November 2013- item 4- Health and Wellbeing Strategy (2012-15)- First Annual Performance Report. The Board agreed the priority areas for Year 2 set out in the report, with additional identification of a Mental Health priority to take forward in the second year of the Strategy. http://barnet.moderngov.co.uk/documents/s11739/Health%20and%20Well-Being%20Strategy%202012-15%20First%20Annual%20Performance%20Report.pdf

	Health and Well-Being Board **13th November**
Title	**Health and Well-Being Strategy Performance Report – Year 2**
Report of	Director of Public Health
Wards	All
Date added to Forward Plan	November 2013
Status	Public
Enclosures	Appendix 1 - Health and Well-Being Strategy Performance report Appendix 2 – Progress report, NHS Health Checks Appendix 3 – report of the Partnership Board Summit, June 2014
Officer Contact Details	Jeff Lake, jeff.lake@harrow.gov.uk Neel Bhaduri, neelanjan.bhaduri@harrow.gov.uk Claire Mundle, Claire.mundle@barnet.gov.uk

Summary

This report for the Health and Well-Being Board evidences the progress that has been made by all local partners to improve the health and well-being of Barnet's population in the past 12 months, in line with the objectives and targets set out in the Health and Well-Being Strategy (2012-15).The report also sets out recommendations about the areas in the Strategy that the Board should focus its attention on in 2015/16.

Recommendations

1. **That the Health and Well-Being Board considers the second annual Health and Well-Being Strategy performance report and assesses the progress that has been made so far to meet the Strategy's objectives.**
2. **That the Health and Well-Being Board endorses the recommendations outlined in the final section of the performance report, and agrees to take these recommendations forward in Year 3.**

1. WHY THIS REPORT IS NEEDED

1.1 Barnet's Health and Well-Being Strategy was launched in October 2012. The Strategy sets out how Barnet's services will work together to address the most pressing health and well-being needs within the Borough. It was published following thorough consultation with local stakeholders about the health and well-being issues that need to be addressed in order to support Barnet's residents to keep well and keep independent.

1.2 The four chapters of the Strategy- Preparing for a Healthy Life, Well-Being in the Community, How we Live, and Care when Needed- set out the provision that needs to be in place to make sure people can keep well and independent, and explains what difference this should make to people's health. Each chapter contains a series of commitments and targets that will help the Health and Well-Being Board know how these plans are progressing, and how much impact these changes are having on people's lives. The performance targets set a clear direction of travel for all agencies in the Borough focused on delivering health and well-being objectives.

1.3 This report for the Health and Well-Being Board documents the progress that has been made by local partners to improve the health and well-being of Barnet's population over the past 12 months. It provides the Board with the information it needs to assess current performance, and also to identify areas of the Strategy that should focus its attention on over the coming months.

1.4 This is the second annual performance report of the Health and Well-Being Strategy. Responses have been collated from responsible service delivery leads that captures:

- The key achievements of the past 12 months
- The most recent performance data against the Strategy's targets, compared to the data reported in the Year 1 performance report
- Commentary to assess the progress

1.5 Using this information, the public health team have proposed a set of priority areas within the strategy that the Board could helpfully focus on over the next 12 months, to ensure that the best possible health and wellbeing outcomes are achieved for Barnet's populations.

2. REASONS FOR RECOMMENDATIONS

2.1 In order to focus the Health and Well-Being Board's approach to future performance management, a series of recommendations have been developed in light of the information provided for this report, and the additional data analysed during the horizon scanning process. The areas focused on below were selected for one or more of the following reasons:

- That performance is off-track
- That performance cannot be currently be judged and significant effort is required to resolve this

- That the policy context has changed and a co-ordinated local response is required
- That they are a new or growing health and well-being challenge, as identified by the Barnet Health Profile.

2.2 The recommended 10 priority areas for Year 3 are:

Preparing for a healthy life

1. **That the Health and Well-Being Board continues to work with NHS England to address the pre-school immunisations data issues they have identified so that the local area can be assured that immunisation rates are being increased (as the Strategy requires them to be and in line with the referral made to the Health Overview and Scrutiny Committee)**

2. **That the Health and Well-Being Board provides on-going strategic multi-agency leadership and ensures robust safeguarding arrangements to the two forthcoming transformation programmes in response to legislative changes that affect children and young people- namely the development of a new model for health visiting and school nursing services for 2015-16; and the development of a single, simpler 0-25 assessment process and Education, Health and Care Plans for children with special educational needs and disabilities from 2014.**

Well-Being in the community

3. **That the Health and Well-Being Board partners work collectively to promote early intervention and prevention of mental health problems for children, working aged adults and older people and ensure robust local service provision.**

4. **That the Health and Well-Being Board continues to consider what partners collectively should be doing to promote models that limit social isolation, in partnership with Older Adult's Partnership Board and Barnet Older Adults Assembly.**

5. **That the Health and Well-Being Board gives specific focus to the solutions that will most effectively reduce level of excess cold hazards in elderly people's homes.**

How we live

6. **That the Health and Well-Being Board considers an everyday prevention approach to be essential in all services, making use of Making Every Contact Count. This is an approach that considers lifestyles and wider determinants of health e.g. education, housing, the environment. All partner organisations should ensure that their contracts require providers to use every opportunity to deliver brief advice to improve health and wellbeing whether in health, social care or wider services. Priorities for brief advice are smoking, alcohol, diet and physical activity although advice should be tailored to the needs of the individual.**

7. **That the Health and Well-Being Board considers in-depth how it can coordinate activities across partners to tackle increasing and higher risk drinking in the Borough, considering the various local levers it has at its disposal to affect change.**

8. **That the Health and Well-Being Board continues to work with NHS England to address screening uptake in the Borough, to ensure that national targets are not only met (as the Strategy requires them to be and in line with the referral made to Health Overview and Scrutiny Committee).**

Care when needed

9. **That the Health and Well-Being Board oversees the implementation of the integrated care proposals, that will support Barnet's frail elderly residents and those with long-term conditions to maintain independence in their own homes for as long as possible.**

10. **That the Health and Well-Being Board provides on-going oversight and endorsement of the work taking place locally to develop self-care initiatives that will help residents maintain their independence (including telecare) and to support the Borough's many carers to maintain their own health and well-being as well as that of the people they care for.**

2.3 The Health and Well-Being Board is asked to consider focusing time on these recommendations over the coming year, to have a significant impact on health and well-being in the Borough.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided the recommendations in the report are approved, the Year 3 priorities will come into effect immediately, and Board Members will be expected to review the forward plan in light of this decision to ensure there is enough time given to these priority areas at future Board meetings.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 Barnet's Health and Well-Being Strategy was launched in October 2012. The strategy sets out how Barnet's services will work together to address the most pressing health and well-being needs within the Borough. It was published following thorough consultation with local stakeholders about the health and well-being issues that need to be addressed in order to support Barnet's residents to keep well and keep independent.

5.1.2 The CCG and Public Health work plans has been deliberately aligned to the

objectives of the Health and Well-Being Strategy.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 Where relevant, financial performance or implications have been noted in the performance report.

5.3 **Legal and Constitutional References**

5.3.1 This performance report supports the Board to meet the requirements of its Terms of Reference, which are set out in the Council's Constitution (responsibilities for functions, Annex A): 'To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the Joint Strategic Needs Assessment and performance manage its implementation to ensure that improved outcomes are being delivered'.

5.3.2 The Terms of Reference of the Health and Wellbeing Board are set out in the Council's Constitution (Responsibility for Functions, Annex A), The Health and Wellbeing Board is required to: 'Jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies'.

5.3.3 The Council needs to comply with the Equality Act 2010 in the provision of all public health services. The specific duty set out in s149 of the Equality Act is to have due regard to need to:

> *Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
> *Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
> *Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

5.3.4 The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.4 **Risk Management**

5.4.1 An effective system of performance management mitigates the risk that the Health and Well-Being is not actively managing performance against key objectives, or is being inefficient in devoting resources to the measurement of non-priorities.

5.5 **Equalities and Diversity**

5.5.1 The targets within the Health and Well-Being Strategy have been set based on the results of the Joint Strategic Needs Assessment, which considers health and social care outcomes across all of Barnet's population groups and pay particular attention to the different health inequalities that exist in the Borough.

5.6 **Consultation and Engagement**

5.6.1 Healthwatch Barnet play an important role in ensuring that the Health and

Well-Being Strategy is making a difference, and in advising lead agencies on how the voices of users and carers can feed in to the performance management of the Strategy.

5.6.2 Partnership Board co-chairs, and Healthwatch Barnet, have been asked to contribute to the production of the in-depth progress reports contained within the performance report. The write up of the Partnership Board Summit (June 2014) is also attached at Appendix 3, which includes a section on the work that the Partnership Boards have been doing to support delivery of the Health and Well-Being Strategy.

5.6.3 The performance report will be presented the next Partnership Boards Catch-Up, on the 20th November 2014, where Partnership Boards will be asked to work with Health and Well-Being Board members to identify how they can support delivery of the Year 2 priorities that are contained in the performance report.

5.6.4 Partnership Boards, alongside a wider set of stakeholders, will be invited to participate in the refresh of the JSNA and Health and Well-Being Strategy in early 2015 (see paper on *Forward Planning*).

6. BACKGROUND PAPERS

Health and Well-Being Board 17 November 2011 – item 5- Developing the Health and Wellbeing Strategy. The Health and Well-Being Board endorsed the broad approach of the Performance Management Framework. http://barnet.moderngov.co.uk/Data/Health%20&%20Well-Being%20Board/201111171000/Agenda/Document%204.pdf

Health and Well-Being Board 27th June 2013- item 10- Performance Management Framework for the Health and Well-Being Strategy. The Board agreed to the updated proposals for managing performance of the Health and Well-Being Strategy and agreed for a full Annual Report against year one of the Health and Well-being Strategy to be bought to the November Board meeting.
http://barnet.moderngov.co.uk/documents/s9320/HWBB%20JUNE%202013%20Performance%20Management%20Paper%20FINAL.pdf

Health and Well-Being Board 19th September 2013- item 10- Proposed revisions to the targets in the Health and Well-Being Strategy. The Board approved the proposed revisions to the existing targets in the Health and Well-Being Strategy.
http://barnet.moderngov.co.uk/documents/s10733/Proposed%20revisions%20to%20the%20targets%20in%20the%20Health%20and%20Well-Being%20Strategy.pdf

Health and Well-Being Board 21st November 2013- item 4- Health and Wellbeing Strategy (2012-15)- First Annual Performance Report. The Board agreed the priority areas for Year 2 set out in the report, with additional identification of a Mental Health priority to take forward in the second year of the Strategy.

http://barnet.moderngov.co.uk/documents/s11739/Health%20and%20Well-Being%20Strategy%202012-15%20First%20Annual%20Performance%20Report.pdf

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AGENDA ITEM 15

Health Overview and Scrutiny Committee

8 December 2014

Title	**Health Overview and Scrutiny Committee Work Programme**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Committee Work Programme June 2014 - May 2015
Officer Contact Details	Anita Vukomanovic, Governance Service Email: anita.vukomanovic@barnet.gov.uk Tel: 020 8359 7034

Summary

The Committee is requested to consider and comment on the items included in the 2014/15 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2014/15 work programme**

1. WHY THIS REPORT IS NEEDED

1.1 The Health Overview and Scrutiny Committee Work Programme 2014/15 indicates forthcoming items of business.

1.2 The work programme of this Committee is intended to be a responsive tool, which will be updated on a rolling basis following each meeting, for the inclusion of areas which may arise through the course of the year.

1.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

2. REASONS FOR RECOMMENDATIONS

2.1 There are no specific recommendations in the report. The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be incorporated to the work programme and will be reflected in forthcoming agendas.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Committee Work Programme is in accordance with the Council's strategic objectives and priorities as stated in the Corporate Plan 2013-16.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 The Terms of Reference of the Health Overview and Scrutiny Committee are contained within the Constitution, Responsibility for Functions, Annex A.

5.4 **Risk Management**

5.4.1 None in the context of this report.

5.5 **Equalities and Diversity**

5.5.1 None in the context of this report.

5.6 **Consultation and Engagement**

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

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London Borough of Barnet Health Overview and Scrutiny Committee Work Programme November 2014 - May 2015

Contact: Anita Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
8 December 2014			
Liverpool Care Pathway: Update from the North London Hospice	Update report from the North London Hospice on the national government guidance on the Liverpool Care Pathway since its discontinuation.		
Healthwatch Barnet Enter an View Reports and Update Reports	Committee to receive an update on Enter and View Visits, including visits undertaken to Barnet Hospital.		
Surgery Branch Closure - Business Case from Dr Isaacson & Partners			
NHS Health Checks Scrutiny Review: Recommendation Tracking	To receive a six monthly update on the implementation of the recommendations from the NHS Health Checks Scrutiny Review.	Director of Public Health (Barnet and Harrow)	
Immunisation Rates in Barnet	Referral from Barnet Health and Wellbeing Board: Committee to receive an update report on Immunisation Rates in Barnet.	Director of Public Health (Barnet and Harrow)	
Screening Coverage and uptake in Barnet	Committee to receive an update on Screening Coverage and uptake in Barnet.	Director of Public Health (Barnet and Harrow)	

Subject	Decision requested	Report Of	Contributing Officer(s)
Performance Against Health and Wellbeing Strategy	Committee to receive and Update.	Director of Public Health (Barnet and Harrow)	
Royal Free London NHS Foundation Trust Acquisition: Update Report			
9 February 2015			
Annual Report of the Director of Public Health	To consider the 2014 Annual Report of the Director of Public Health; and to consider an update on the 2013 Annual Report (to include update on Call to Action on Physical Activity)	Director of Public Health (Barnet and Harrow)	
30 March 2015			
Heatlhwatch Barnet Enter and View Visits - Update Report	Committee to receive an update on the visits to Barnet Hospital as reported to Committee at their meeting in December 2014.		
Royal Free London NHS Foundation Trust Acquisition - Update Report (to include Ambulances)	Committee to receive an update report from the Royal Free London NHS Foundation Trust provide an update report on the topic of Ambulances.		

Subject	Decision requested	Report Of	Contributing Officer(s)
GP / Primary Care Services at Finchley Memorial Hospital - Update Report	Committee to receive an update from NHS England and Barnet Clinical Commissioning Group on GP / Primary Care Services at the Finchley Memorial Hospital site.		
11 May 2015			
NHS Trust Quality Accounts			
Unallocated Items			
Public Health Commissioning Intentions		Director of Public Health (Barnet and Harrow)	