MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 4TH JULY, 2016

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

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

Councillors

Val Duschinsky
Arjun Mittra
Gabriel Rozenberg
Caroline Stock
Philip Cohen
Ammar Naqvi
Laurie Williams

Substitute Members

Councillor Shimon Ryde BSc (Hons)
Councillor Daniel Thomas BA (Hons)
Councillor Anne Hutton
Councillor Maureen Braun
Councillor Kath McGuirk
Councillor Barry Rawlings

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore the deadline for public questions or comments is Wednesday 29 June 2016. Requests must be submitted to Anita Vukomanovic, as per the contact details below.

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

Andrew Charlwood – Head of Governance

Governance Services contact: Anita Vukomanovic 020 8359 7034
anita.vukomanovic@barnet.gov.uk
Media Relations contact: Sue Cocker 020 8359 7034

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	1 - 16
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)	
4.	Report of the Monitoring Officer	
5.	Public Question Time (If Any)	
6.	Members' Items (If Any)	
a)	Member's Item - Councillor Cohen	17 - 20
7.	Minutes of the North Central Sector London Joint Health Overview and Scrutiny Committee	21 - 42
8.	Adult Audiology, Wax Removal and Community ENT Service	43 - 50
9.	Colindale Health Project	51 - 60
10.	Finchley Memorial Hospital	61 - 66
11.	Healthwatch Barnet Update Report	67 - 114
12.	Health Overview and Scrutiny Forward Work Programme	115 - 120
13.	Any Other Items that the Chairman Decides are Urgent	

FACILITIES FOR PEOPLE WITH DISABILITIES
Hendon Town Hall has access for wheelchair users including lifts and toilets. If you wish to let us know in advance that you will be attending the meeting, please telephone Anita

Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk. People with hearing difficulties who have a text phone, may telephone our minicom number on 020 8203 8942. All of our Committee Rooms also have induction loops.

FIRE/EMERGENCY EVACUATION PROCEDURE

If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by Committee staff or by uniformed custodians. It is vital you follow their instructions.

You should proceed calmly; do not run and do not use the lifts.

Do not stop to collect personal belongings

Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions.

Do not re-enter the building until told to do so.

This page is intentionally left blank

Decisions of the Health Overview and Scrutiny Committee

16 May 2016

Members Present:-

AGENDA ITEM 1

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

Councillor Val Duschinsky
Councillor Arjun Mittra
Councillor Gabriel Rozenberg
Councillor Caroline Stock
Councillor Philip Cohen
Councillor Laurie Williams

Also in attendance

Councillor Helena Hart

1. MINUTES (Agenda Item 1):

The Chairman introduced the minutes of the last meeting and noted that at that meeting, the Committee had considered a report on health tourism. The Committee noted that they had subsequently requested to be provided with the final amount invoiced to non-British patients for the financial year of 2015 – 2016. She mentioned that the figures provided by the Royal Free London NHS Foundation Trust had been circulated to the Committee that afternoon and that the data had be broken down into:

1. What had been invoiced: £2,347,219

2. What had been paid: £508,447

3. If the payment had been received, was it i) on the spot or ii) afterwards: no figure received

The Chairman expressed shock at the huge amount of nearly £2 million relating to outstanding invoices. The Committee had requested a further report on health tourism from the Royal Free London NHS Foundation Trust to be bought to their meeting in either July or October 2016.

The Chairman commented that the Governance Service had arranged a site visit at the Barnet, Enfield and Haringey Mental Health Trust. The Chairman noted that one Member who had expressed an interest was unable to make the agreed date and requested that the Governance Service see if another date was available to accommodate all Members wishing to attend.

The Chairman noted that, following consideration of The Annual Report of the Director of Public Health, the Committee had requested to be provided with additional information regarding the provision of psychological therapies within Barnet. The Chairman advised that this information had been circulated to Committee Members via e-mail on 10 May 2016.

Referring to the issue of car parking at Barnet Hospital, the Chairman informed the Committee that she had attended a site visit with Councillor Stock and Councillor Zinken, who is on the Board of Governors at the Royal Free, and had made some suggestions to the Officer in attendance about urgently increasing the number of parking spaces.

RESOLVED that the minutes of the meeting dated 8 February 2016 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

None.

3. DECLARATION OF MEMBERS' INTERESTS (Agenda Item 3):

Councillor Caroline Stock declared a non-pecuniary interest in relation to Agenda Item 9 (NHS Trust Quality Accounts) by virtue of her husband being an Elected Public Governor of the Council of Governors at the Royal Free London NHS Foundation Trust.

4. REPORT OF THE MONITORING OFFICER (Agenda Item 4):

None.

5. PUBLIC QUESTION TIME (IF ANY) (Agenda Item 5):

None.

The Chairman paid tribute to Amy Trevethan, who had resigned as a Councillor and had previously been a Member of the Health Overview and Scrutiny Committee. The Chairman noted the work and contribution of former Councillor Amy Trevethan on the Committee. The Chairman noted that she had been in correspondence with Ms. Trevethan regarding the report scheduled on the agenda on Children's Mental Health and Eating Disorders, which had arisen as a result of a Member's Item in Councillor Trevethan's name.

THE CHAIRMAN ANNOUNCED A VARIATION IN THE ORDER OF THE AGENDA TO POSTPONE AGENDA ITEM 6 (MEMBER'S ITEMS) TO FOLLOW AFTER AGENDA ITEM 9 (NHS TRUST QUALITY ACCOUNTS) AND TO TAKE ITEM 11 (ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT) NEXT.

6. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 11):

The Chairman informed the Committee that she wished to bring an urgent item to the attention of the Committee following a referral from Barnet's Health and Wellbeing Board on the issue of poor childhood immunisation rates in Barnet.

The Chairman noted that Barnet Council's Director of Children's Services, the Clinical Commissioning Group Chairman and the Director of Public Health had sent a joint letter to NHS England on 1 April 2016 expressing their concern and frustration in relation to this issue but that they had not received a response.

The Chairman invited Councillor Helena Hart, Chairman of Barnet Health and Wellbeing Board (HWBB), Mr. Chris Munday, Director of Children's Services and Dr. Andrew Howe, Director of Public Health (Barnet and Harrow Councils), to the table.

The Committee noted that the issue of immunisation rates for Barnet had previously been referred from the HWBB to the Health Overview and Scrutiny Committee in December 2014, when, at the time, NHS England had given assurance that reported childhood immunisation rates in Barnet were not an accurate reflection of immunisation uptake in the Borough. The Committee were informed by NHS England that a Task and Finish Group had been established to ensure the transfer or immunisation data to the new data system, "System One"

The Chairman informed the Committee that when considering that item, the Committee had amended a recommendation as set out in the report considered by the Committee on the evening, as below:

Recommendation 3: That the Committee will continue to seek assurance ~~is satisfied~~ that appropriate governance arrangements are in place within NHS England in relation to immunisations to protect the health of people in Barnet and to this effect requests an update report in March 2015 to inform on the progress of the Task and Finish Group

The Committee noted that the above amendment was carried and became the substantive item, which was then subsequently approved by the Committee.

The Chairman noted that on March 2015, the Committee received the requested report from NHS England on the work of the Task and Finish Group and that NHS England advised that the recent data on immunisations was more positive, although there was more work to be done around immunisations, particularly in relation to five year olds for MMR.

Councillor Helena Hart addressed the Committee. Councillor Hart expressed her thanks to the Chairman for taking the referral as an urgent item and commented that the issue of childhood immunisations had warranted concerted action at the Health and Wellbeing Board. The Committee noted that there had been continual low reporting rates of child immunisations and that the issue had been going on for two years.

The Committee noted that the HWBB had a discussion on the issue at their meeting on 10 March 2016 and that they had requested a full report and action plan from NHS England. Councillor Hart noted that the Officers from NHSE in attendance at the Health and Wellbeing Board had commented that there was no need for concern because there had not been any outbreaks. The Committee noted that the HWBB had taken exception to this and felt that it was an inadequate and inappropriately complacent response.

Mr. Munday informed the Committee that the lack of information on immunisation uptake was a significant and worrying issue for Barnet. The Committee noted that NHS England had advised that they had audited 20 General Practices but that the details of those audits had not been made available. The Committee also noted that there are a total of 62 Practices across Barnet and so therefore two thirds had not been audited. Mr. Munday informed the Committee that as the Statutory Director of Children's Service, he was extremely concerned about the performance of NHS England in relation to childhood immunisations.

Dr. Howe noted that there had been no progress on the data, although NHS England had repeatedly insisted that it was a data problem rather than a lack of immunisation uptake. Dr. Howe also expressed concern at NHS England's performance in relation to tri-borough immunisation.

The Chairman, who had attended the HWBB meeting, expressed concern at NHS England's lack of professionalism when dealing with the issue. The Chairman advised the Committee that she wished to refer the issue to the Secretary of State for Health and sought the Committee's support in doing so.

A Member of the Committee put on record his agreement with this action and suggested that the letter should make the point that NHS England should be taking the issue much more seriously.

A Member questioned if NHS England were responsible for the whole range of childhood immunisations. Dr. Howe informed the Committee that they were and expressed concern about recent cases of Measles being reported which he said was very worrying.

The Chairman suggested to the Committee that she draft a letter to the Secretary of State on the issue which could then be circulated to Members of the Committee. The Committee agreed with this action.

RESOLVED that the Committee expresses their concern at the poor rates of childhood immunisation in Barnet by NHS England and that the Committee refers the matter to the Secretary of State for Health.

7. CHILDREN'S MENTAL HEALTH AND EATING DISORDERS (Agenda Item 7):

The Chairman invited the following Officers to the table:

- Chris Munday – Commissioning Director for Children and Young People and Statutory Director for Children's Services
- Eamann Devlin – Children and Adolescent Mental Health Services Joint Commissioning Manager (interim), Barnet CCG
- Dr Mark Berelowitz, Lead Clinician for the Eating Disorder Service at the Royal Free London NHS Foundation Trust
- Dr Andrew Howe, Director of Public Health (Harrow and Barnet Councils)
- Ruth Ouzia, Senior Consultation Manager

The Chairman noted that the report had arisen as a result of a Member's Item in the name of Councillor Amy Trevethan. The Chairman commented that as Councillor Trevethan was particularly interested in this matter, she had been in touch with her following her resignation as a Councillor in order to put forward any questions on her behalf.

Referring to the report, the Chairman noted that an allocation of £198,000 was made available to Barnet and that the decision was made to place £100,000 against development of the existing service, with the remainder being invested in Out of Hours and Crisis Care related works. The Chairman questioned if the £100,000 was just going to crisis care, or if it would include self harm care as well. Dr. Berelowitz informed the Committee that the £100,000 was being invested in order was to reduce waiting times. The remaining £98,000 would be used for out of hours and crisis care including suicide

4

and self-harm. Ms. Ruth Ouzia commented that extra recruitment was underway to appoint more specialist staff members to the existing team.

The Chairman noted that the report stated that: “As part of the Transformation Plan Barnet will roll out training for all eating disorder staff as part of the “Improving access to Psychological Therapies for children” (CYP-IAPT), provide outreach education training for eating disorders and provide telephone support for General Practitioners.” The Chairman questioned who was included in the outreach education and whether GPs could access the telephone support line during as well as after a consultation. Mr. Devlin informed the Committee that feedback had been obtained from many Headteachers to the effect that teachers often found it hard to have conversations with pupils or even identify the signs and symptoms of eating disorders. The Committee noted that a training session had recently been held so that staff would know what to do if they were worried about a child. The Committee also noted that GPs could access the telephone line either during a consultation of afterwards.

Mr. Devlin informed the Committee that there is less stigma than there used to be about eating disorders although stigma is a much bigger issue for boys than girls.

The Committee noted that The Royal Free London CAMHS eating disorder service covered the five North Central London Boroughs plus the London Borough of Brent. The Committee noted that Brent did not commission the Royal Free Hospital’s “intensive service” but they buy-in when they need to.

The Committee commented that the Psychiatry reviews that were being undertaken by service being very positive.

Referring to the report, the Chairman noted that a study by King’s College London and the UCL Institute of Child Health in 2011 had shown a 60 per cent increase in females with the types of eating disorders known as Eating Disorders Not Otherwise Specified (EDNOS), and a 24 per cent increase in males. The Chairman questioned if EDNOS would be taken as seriously from a treatment point of view and if it could be a stepping stone to anorexia, bulimia or binge eating. The Chairman further questioned if patients would only get treatment when fully diagnosed with one of the three disorders mentioned above. Dr. Berelowitz informed the Committee that that the term EDNOS would be applied to someone who doesn’t meet all the criteria of other eating disorders. The Committee noted that EDNOS could be a misleading term and it didn’t mean that the condition was less severe. Dr. Berelowitz informed the Committee that a patient would not be denied treatment because they did not have all of the symptoms of anorexia, bulimia and binge eating.

The Chairman noted that most patients wait over a year from first symptoms before seeking treatment and questioned how best to reach these people. Dr. Berelowitz informed the Committee of the importance of ensuring that schools, GPs, youth groups and other such organisations are as aware of the issue as they can be. Dr. Berelowitz commented on the importance of ensuring that primary care providers in particular are aware of the risks. Dr. Berelowitz also informed the Committee that eating disorders were often perceived as a more predominately female illness. The Committee noted that because boys do not menstruate, it could be harder to tell the difference between Orthorexia and Anorexia in males.

Referring to the report, a Member commented on the higher rate of referrals to the eating disorders service in Barnet compared with Camden. Dr. Berelowitz informed the

5

Committee that there were more than twice as many young people in Barnet as in Camden, which would account for the higher figure. Dr. Berelowitz also noted that the higher rate of referrals in Barnet could also reflect better education and detection.

A Member questioned if it would be possible to do further work to see if the high number of Barnet patients being referred to the eating disorder service was not only due to Barnet's greater population, but also good diagnosis and early detection. Dr. Berelowitz informed the Committee that a study could be done, but that it would not be worth doing unless it was to a very high standard and that such a study would be very expensive. The Committee noted that the Eating Disorders Service would not be able to fund it from their own treatment resources.

The Chairman noted that the report stated that a depressed mood is often a common feature of an eating disorder and questioned if a GP would consider this diagnosis if a young person presented with depression. Dr. Berelowitz commented that diagnosis in such circumstances was difficult because there would be so much else to rule out. He also commented on the need to ensure good education concerning dietary issues at primary care level.

A Member questioned if people are being sent out of the Borough for treatment if there is not a bed available locally. Dr. Berelowitz said that it was hard to say what the exact capacity for treatment was in Barnet, because NHS England requires that every bed for eating disorders is open to every person in the country, so a Barnet calculation cannot be done. He believed that there were 400 adolescent beds in England. Dr. Berelowitz commented that the number of patients being sent out of Borough per year had been no more than five patients from all the five NCL Boroughs combined. He stressed that it was most important to keep them in school as much as possible.

A Member commented that the fact that Barnet has a higher rate of referrals than other Boroughs could indicate that other Boroughs should have higher referral rates. The Member questioned if the service was content that Barnet schools have the right policies in place to spot the warning signs of an eating disorder and to make a referral. Mr. Munday referred to the CAMHS transformation plan and noted that work with schools was planned to help schools understand how good their policies are. Mr. Munday noted that many school are academies and so will have their own policies. Mr. Munday further commented that he would be very happy to work with Dr. Berelowitz and colleagues in Education and Skills in order to progress the issue.

Responding to a question from a Member, Dr. Berelowitz informed the Committee that some schools are better at calling the service when they have an issue of concern and stressed the importance of the service making a link with every school in the Borough.

The Chairman sought the Committee's support to receive a future report on the issue of eating disorders. The Committee supported this.

RESOLVED that:

1. **The Committee notes the report**
2. **The Committee requests to be provided with an additional report on eating disorders at a future meeting.**

6

8. NORTH WEST LONDON, BARNET & BRENT WHEELCHAIRS SERVICE REDESIGN (Agenda Item 8):

The Chairman introduced the report, which provided the Committee with an update on the North West London, Barnet and Brent Wheelchair Service redesign.

The Chairman invited Garrett Turbett, Senior Business Planning & Commissioning Manager (Interim) at Barnet CCG, to the table.

Mr. Turbett informed the Committee that following the award of the contract to ADM Healthcare, the contract was now moving into mobilisation. The Committee noted that the service re-design had involved service users, clinical advisors and the independent standards body for disability equipment and wheelchair services.

The Committee noted the focus on getting the service right going forwards and also, on getting the right equipment at the right time for the user. The Committee noted that the successful bidder, ADM Healthcare can provide a "Chair in a Day" which can be modified on the spot to make it suitable for the user.

The Committee noted that the contract would also include a breakdown service, so, if a user was out at any time with an issue, for example a puncture, the provider would provide a breakdown service for rescue at no extra charge.

Mr. Turbett informed the Committee that the contract would go live on 1 July 2016 and that the project was on track.

The Vice Chairman questioned the timescale for the delivery of the "Chair in a Day". Mr Turbett informed the Committee that it would vary because for example, motorised chairs will have a schedule of maintenance and that it wouldn't be necessary for all service users to be provided with a new chair.

A Member commented that there could be improvements in technology in future years and questioned if there would be money to pay for it, rather than bulk buying and having to use the same equipment for many years. Mr. Turbett informed the Committee that the contract was for three years with the option to extend for two years, which is not too long. Mr. Turbett also noted that it is in the provider's interests to make sure that they are up to speed with wheelchair technology and that they work their contacts to make the best deals.

Responding to a question from a Member, Mr. Turbett informed the Committee that whilst you might expect a contract to be awarded on the basis of 70% importance on quality and 30% on financial consideration, this contract had been awarded on a basis of 90% quality, and 10% finance.

RESOLVED that the Committee notes the contents of the report, the proposed direction of travel in relation to awarding the contract to the new provider and the required timescales.

9. NHS TRUST QUALITY ACCOUNTS (Agenda Item 9):

The Committee scrutinised the Central London Community Healthcare NHS Trust's Quality Account 2015-16 and wish to put on record the following comments:

- The Committee were pleased to note that CLCH had appointed Angela Greatley OBE as their new Board Chair and that they were currently recruiting a new Chief Executive.
- The Committee congratulated the Trust on being ranked 'Outstanding' in the first annual 'Learning from Mistakes' league which was published in March 2016 and noted that the Trust is one of only eighteen providers in the country that has achieved this ranking in one of the latest quality initiatives launched by NHS Improvement.
- The Committee noted that when scrutinising a previous Quality Account, they had requested a response to the patient stories. The Committee were pleased to note that this had been done in this year's Quality Account under the heading of "Learning from the Story".
- The Committee congratulated the Trust on their "good" rating from the CQC.
- The Committee welcomed Quality Priority 1 – Positive Patient Experience, Preventing Harm – Developing a Quality Alert Process for Stakeholders. The Committee were pleased to note that the Trust would develop a mechanism by which clinicians in other organisations will be able to quickly alert CLCH to issues within their service. The Committee noted that a secure e-mail system would be established to assist with this.

However:

- The Committee had expressed their concerns about pressure ulcers to the Trust during the consideration of last year's Quality Account. The Committee noted that CLCH was a large Trust, with patients being treated across many areas, both at home and on wards. The Committee welcomed the new initiative on pressure ulcers which would involve input from nurses and healthcare providers.
- The Committee also expressed concern that there were several areas in which CLCH was failing to hit its KPIs in relation to pressure ulcers and that that there was a lack of a specific section on pressure ulcers within the Quality Account. The Committee noted that the issue of pressure ulcers was an area of concern for the Trust and welcomed the re-launch of another pressure ulcer working group and making pressure ulcers part of staff appraisals.
- The Committee commented that Graph 17, which showed the proportion of patients who did not have pressure ulcers could be clearer and that it did not match the Key Performance Indicator.
- The Committee noted that there had been complaints about staff communication which the Trust felt could be down to waiting times at Walk in Centres.
- The Committee noted that in October and November 2015, the number of complaints the Trust received had spiked. The Committee noted that the Trust believed this was down to the onset of the winter season and requested to be provided with further information on this.

8

- The Committee expressed concern at the staff survey results showing the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. The Committee noted that the score for 2015 was 24%, down from 28% in 2014. Whilst the Committee appreciate that this is an improvement of 4% within one year, the Committee noted that this figure is above the national average for community Trusts which is 21%.
- The Committee noted that in relation to "End of Life Care", CLCH had received "requires improvement" markers in the respect of the care being: Safe, Effective, Well Led, and Overall. The Committee welcomed however, that the overall rating was "Good". The Committee were pleased to note the recent recruitment to an End of Life care post
- The Committee noted that a percentage for the number of complaints upheld was not included in the Quality Account and suggested that it would be a useful statistic.
- The Committee commented that not many members of the public would know what the term "cold chain incidents" meant and suggested that an explanation be included in the final version of the Account.
- The Committee expressed their concern that there were 58 incidents reported (5.0%) resulting in severe harm, which was higher than the cluster rate of 0.7%. The Committee were very concerned to note that there was one incident which resulted in the death of a patient whilst in the Trust's care.
- The Committee requested that the Trust define the acronyms "MUST" and "AGULP" within the Account because they would not be clear for members of the public who might be reading the document.
- The Committee noted the achievements of the Trust against the Commissioning for Quality and Innovation (**CQUIN**) payment framework goals for 2015/16, and expressed concern at the forecast drop in income for dementia, value based commissioning and children's safe transition into adult services. The Committee noted that the figures within the draft Quality Account were not the final figures.

The Committee scrutinised the Royal Free London NHS Foundation Trust Quality Account 2015-16 and wish to put on record the following comments:

- The Committee welcomed the new £2 million endoscopy unit which opened in December 2015 at Chase Farm Hospital.
- The Committee were pleased to note that in December 2015, the Dementia Implementation Group launched a new 12 month strategy for dementia care. The Committee noted that it comprised three work streams each focussed on one of the main stakeholders in world class dementia care: the patients and their carers, the staff and the organisation.
- The Committee welcomed the following continuing actions being taken in relation to making the Trust more dementia friendly: introducing Dementia boxes; introducing tiptree tables, involvement in "John's Campaign", providing parking

9

discounts, the “Forget-me-not” scheme being built into electronic records, and welcoming carers 24/7.

- The Committee were pleased to note that Dementia awareness is now part of the routine induction for all staff with over 850 staff having been trained.
- The Committee were pleased to note that the Trust would be looking into increasing the ability of Dementia advocates or “anchors” to care.
- The Committee were pleased to note that the Trust’s goal is to reduce severe sepsis-related serious incidents by 50% across all sites (A&E and Maternity) by 31 March 2018 and welcomed the delivery of the following milestones: Staff training in sepsis recognition in Maternity and Barnet ED; Testing of improvement tools: sepsis trolley, sepsis safety cross, sepsis grab bag, sepsis checklist sticker; Introduction of sepsis improvement tools: Severe sepsis 6 protocol; Monitoring of data and PDSA cycle improvements; Review of improvement to attain 95% compliance
- The Committee welcomed the work that the Trust was doing to recruit more A&E Consultants and staff.

However:

- The Committee noted that the winter had seen unprecedented pressure on accident and emergency departments and urgent care pathways and acknowledged that the 4 hours A&E target was challenging.
- The Committee expressed concern that the Trust has reported 10 “Never Events” during 2015/16, 8 of which related to surgery. The Committee noted the Trust’s new goal to improve compliance with the “5 steps to safer surgery” to 95% and to reduce the number of surgical never events by 31 March 2018. The Committee were informed that when a “never” event has taken place, often, junior Members of staff have felt something was wrong but felt unable to speak up. The Committee requested the Trust to put measures in place to encourage staff to feel able to voice concerns.
- The Committee noted that regarding falls the Royal Free acknowledged that they were “worse than the average, so there is room for improvement”
- The Committee were concerned to note that the rate per 100,000 bed days of cases of C.diff infection that have occurred within the Trust amongst patients aged 2 or over had increased from 17.5 in 2014/15 to 20.4 in 2015/16.
- The Committee noted that the Trust would look to improve their performance in relation to Delayed Transfers of Care and welcomed closer working with colleagues in care homes and in the community.
- The Committee were concerned about the lack of data in relation to re-admissions to the Trust within 28 days of discharge.
- The Committee were alarmed that the issue of staff/colleagues reporting being bullied, harassed or abused was raised in the Quality Account again this year. The Committee wished to put on record their concern that 34% of colleagues had reported recent experience of harassment, bullying or abuse. The Committee noted the five suggestions to improve the staff experience: a strong campaign on

10

bullying and harassment; working closely with leadership teams in the units with worst outcomes from the staff survey; setting clear expectations of managers in relation to appraisal, staff engagement and team communication activity; rapid improvement of the intranet with clear and easy ways to find policy, procedures and forms; delivering leadership training to support managers.

- The Committee wished to put on record their concern regarding the insufficient amount of patient parking at Barnet Hospital and disappointment that a quarter of the visitor/patient parking had been changed to staff parking.
- The Committee wished to put on record their shock at statistics provided by the Trust which show that a deficit of approximately £2 million as a result of unpaid invoices from overseas visitors not entitled to free NHS services. The point was made that the Committee were referring to invoices that the Trust had issued and did not take into account people accessing the hospital who had not been invoiced therefore the £2 million deficit could be much greater.

The Committee scrutinised the Draft Quality Account from the North London Hospice for the year 2015-16 and wish to put on record the following comments:

- The Committee welcomed the fact that the North London Hospice would be trying to reduce the length of their Quality Account which would make the document more public friendly.
- The Committee welcomed the "easy read" literature produced by the Hospice and noted the pertinence of having "easy read" literature for people with learning disabilities. The Committee were pleased to note that a number of staff employed at the Hospice had previously worked with people with learning disabilities and were able to bring those skills into providing palliative care. The Committee were also pleased to note that people with learning disabilities are invited to visit the Hospice before they stay in order to make them more comfortable with the environment.
- The Committee welcomed the significant reduction in closed bed days from 116 in 2013-14 to 30 in 2015-16.
- The Committee welcomed the use of "Hello, my name is…" badges.
- The Committee welcomed the actions taken to improve the personal safety of patients, which included the access code number being changed more frequently, printing of paper being undertaken in secure areas, and confidential waste being stored in secure bins before collection for destruction.
- The Committee welcomed the "Come and Connect" scheme which was available for registered patients as well as those who had been discharged from Outpatients and Therapy, which provides a means of meeting socially which can be compromised by illness.
- The Committee were pleased to note that Key Performance Indicator 1, *"Did you feel / the patient was referred to the hospice at the right time"* would be changed to *"Do you feel staff treat you with compassion; understanding; courtesy; respect; dignity?"*

11

- The Committee noted that there had been an increase in “minor” category clinical incidents from 68 in 2014-15 to 153 in 2015-16. However the Committee acknowledged that the Hospice had introduced a new risk management database and that this increase could likely be down to an increase in reporting.
- The Committee were pleased to note that patients did not contract any of the following infections whilst in the care of the North London Hospice Inpatient Unit: C.Diff, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia; MRSA.
- The Committee welcomed the fact that “Oyster” training to volunteers to help develop emotional competence and resilience was taking place and would be continuing.
- The Committee welcomed the inclusion of user feedback and noted that the feedback was very moving.

However:

- Whilst the Committee applauded the efforts of staff working at the Hospice, the Committee expressed concern about staff working with patients being required to “tick boxes” and suggested that project outcomes were clearly defined.
- The Committee noted that the Hospice was continuing offer free “Sage and Thyme” training but thought it would be helpful to define the term more clearly so that members of the public reading the document would understand.
- The Committee expressed concern at the fact that the Handwashing Audit at the Winchmore Hill Site had seen a significant decrease in compliance since the first audit. The Committee expressed their disappointment in noting that 2015-16 compliance was 61% compared with 77% for the first audit. The Committee noted that the developments at Winchmore Hill had also seen an increase in the number of staff and volunteers within the service and that despite the completion of induction training, the theory of infection control and hand hygiene is not being put into practice as much as it should be. The Committee welcomed the fact that further training has been, and will continue to be provided for staff and volunteers. The Committee were pleased to note that the audit will be completed again in 6 months to continue to monitor compliance and requested to be provided with the results.
- The Committee noted that 14 of the 15 patients who developed Grade 3 or 4 pressure sores were admitted with pressure sores which progressed under North London Hospice care but acknowledged that the Hospice client group is prone to increased incidence and vulnerability to pressure ulcers.
- The Committee expressed surprise and concern that GPs and clinicians were unaware of the extent of the Hospice’s services and the support

12

available for those with a Long Term Condition and sought assurance that the Hospice was developing a marketing plan to get the message out.

RESOLVED that:

1. **The Committee requests that the above comments be included in the final version of the respective Trust's Quality Accounts.**
2. **The Committee requests to be provided with the results of the next handwashing audit at the Winchmore Hill site from the North London Hospice.**
3. **The Committee requests to be provided with the percentage of patients at the Hospice who had Alzheimer's or Dementia from the North London Hospice.**
4. **The Committee requests to be provided with information on the "Gold Standard" for Hospice care.**

10. MEMBERS' ITEMS (IF ANY) (Agenda Item 6):

At the invitation of the Chairman, Councillor Philip Cohen introduced his Member's Item on Community Pharmacies. Councillor Cohen outlined the rationale to his Member's Item, which included the following points:

- *"The Government wants to reduce total funding for pharmacies amounting to £170 million as part of what it calls 'efficiency savings' which is essentially the contribution to the austerity drive in the economy. At the same time it wants to streamline the prescribing system by increasing online ordering of prescriptions and 'click and collect' systems as well as home delivery. Other reforms proposed are to locate more pharmacists in GP practices and other settings like care homes.*
- It seems clear to me (Councillor Cohen) that will be the effect of the cuts ie many smaller pharmacies will face closure. At this point I want to refer to the views of an expert, ie a community pharmacist, Brian Isaacs, who is manager of the Brand Russell Pharmacy in East Barnet Village, in my ward. We have discussed this issue and he wishes to make the following comments:

  "The government wants to reduce the number of pharmacies by attrition by reducing their basic establishment payments and their reimbursement costs, thus the weakest go to the wall. That is not the way to reduce costs. The government are intent on reducing costs without appreciating the consequences. There are other ways to reduce spending for instance checking whether patients need all their repeat medication, thereby reducing waste. There are many others."
- Pharmacies are ideally placed to reduce the GP workload, due to easy access with no appointment, dealing with minor ailment treatments and influenza vaccinations."

13

Councillor Cohen requested that the Committee consider submitting a joint response to the consultation.

A Member commented that many people were shifting their activities online and that further efficiencies shouldn't be opposed.

A Member commented that they had noticed a large number of pharmacies opening up in certain areas in very close proximity to each other in certain areas and expressed concern that this was an over-supply of provision.

Councillor Cohen expressed his concern that if pharmacists were located in GP practices the public might experience the same problems of access and appointment as they currently face seeing a GP. The Chairman noted that patients often used a GP pharmacy for a one-off prescription following a consultation but would go to a high street chemist to purchase a whole range of non-medicinal and beauty products as well as repeat prescriptions.

The Vice Chairman noted that there had been an increase of 20% in the number of pharmacies since 2003 and that this had been much higher than the percentage increase in the population. He considered that it would be important to scrutinise the proposals after the consultation.

Councillor Cohen informed the Committee that the purpose of his Member's Item was to ask the Committee to:

"Express its concern that the reduction in the overall funding package for pharmacies in 2016-17 could lead to the closure of community pharmacies in Barnet and elsewhere. It agrees that while pharmacies perform a valuable public service and are well placed to reduce the workload of GPs and A&E departments, they can be more efficient in prescribing, customer access and in working more closely with GPs and care homes. The Committee would wish the Government to have further discussions with the Pharmacy profession to find other ways to make efficiency savings while protecting existing payments to pharmacies"

The Chairman sought clarification as to whether there was consensus on the issues raised by Councillor Cohen in his Member's Item. The Chairman noted that there was not and suggested that the Committee move to the vote on whether to contribute to the consultation as a Committee.

The Chairman moved to the vote and asked Members to vote FOR or AGAINST submitting a Committee response to the consultation. Votes were recorded as follows:

For	3
Against	5
Abstentions	0

The vote was lost.

The Chairman informed the Committee that individuals or political groups could contribute to the consultation outside the meeting, should they wish.

The Vice Chairman suggested that the Committee keep a watching brief on the issue.

14

RESOLVED that the Committee note the Member's Item.

11. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME (Agenda Item 10):

The Chairman invited Councillor Helena Hart, Chairman of the Barnet Health and Wellbeing Board, and Dr. Andrew Howe, Director of Public Health (Harrow and Barnet Councils) to the table.

Councillor Hart provided the Committee with an update on the work of the Health and Wellbeing Board. She drew the Committee's attention to a long term item on the Board's agenda, the Strategic Framework for Primary Care for Barnet.

The Committee noted that proposals would be going to Barnet CCG's Clinical Cabinet to have an Older Person's Assessment Unit and a specific GP Practice with an emphasis on the frail elderly based at Finchley Memorial Hospital. The Committee also noted that a permanent breast screening unit on site was now likely to go ahead.

Dr. Howe informed the Committee that both the Primary Care Strategy and the Sustainability and Transformation Plan would be significant strategies for the provision of healthcare in the Borough.

The Governance Officer in attendance noted that the Committee would receive reports on the following issues at the July 2016 meeting:

- An update report on the utilisation of space at Finchley Memorial Hospital.
- An update report on the work of Healthwatch Barnet
- An update report on the Colindale Health Project
- An update report on Ear, Nose and Throat (ENT) Adult Audiology and Wax Removal Service Redesign.

The Vice Chairman requested that it be put on record the Committee's thanks to the Chairman for her superb chairmanship of the Committee. The Vice Chairman noted that the Chairman always went the extra mile to keep Members of the Committee informed on health issues.

The Chairman thanked the Vice Chairman and the entire Committee for their valuable contributions to the meetings during the past year. She also thanked the Governance Officer.

RESOLVED that the Committee notes the Forward Work Programme.

The meeting finished at 10.00 pm

15

This page is intentionally left blank

AGENDA ITEM 6a

	Health Overview and Scrutiny Committee **4 July 2016**
Title	**Member's Item in the name of Councillor Philip Cohen**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	None
Officer Contact Details	Anita O'Malley, Governance Team Leader Email: anita.vukomanovic@barnet.gov.uk Tel: 020 8359 7034

Summary

The report informs the Health Overview and Scrutiny Committee of a Member's Item and requests instructions from the Committee.

Recommendations

1. **That the Health Overview and Scrutiny Committee's instructions in relation to this Member's item are requested.**

1. WHY THIS REPORT IS NEEDED

1.1 Councillor Philip Cohen has requested that a Member's Item be considered on the following matter:

HOSC: 4 July
Member's Item: Cllr Phil Cohen
Additional services at East Barnet Health Centre

"Additional services provided at the East Barnet Health Centre before the closure of the Centre – specifically District Nursing, Baby Clinics, COPD clinics and Physiotherapy - have not returned to the Centre since its re-opening and are instead being provided at other locations such as Finchley Memorial hospital, Holbrook House, or the New Barnet Subud Centre.

I raised this with the East Barnet Residents' Association and they have now received confirmation from the CLCH NHS Trust that these services have not yet returned to the EBHC because NHS Property Services are changing the charging arrangements which is likely to result in an increase in the cost of the space. CLCH are waiting for confirmation of the revised rental charges before they agree any future lease for the space.

I would like HOSC to receive confirmation that any increase in rent will not prevent any of these services from returning to the East Barnet Health Centre, and also confirmation of when the rent and lease will be finalised and the additional services relocated back to the Health Centre."

1. REASONS FOR RECOMMENDATIONS

1.1 No recommendations have been made. The Committee are therefore requested to give consideration and provide instruction.

2. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

2.1 Not applicable.

3. POST DECISION IMPLEMENTATION

3.1 Post decision implementation will depend on the decision taken by the Committee.

4. IMPLICATIONS OF DECISION

4.1 Corporate Priorities and Performance

4.1.1 As and when issues raised through a Member's Item are progressed, they will need to be evaluated against the Corporate Plan and other relevant policies.

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

4.2.1 None in the context of this report.

4.3 **Legal and Constitutional References**

4.3.1 The Council's Constitution (Meeting Procedure Rules, Section 6) states that a Member, including appointed substitute Members of a Committee may have one item only on an agenda that he/she serves. Members' items must be within the term of reference of the decision making body which will consider the item.

4.3.2 The Health Overview and Scrutiny Committee terms of reference includes:

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 Chairman, Vice- Chairman, Members and substitutes to be appointed by Council which may 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.*

a. Risk Management

i. None in the context of this report.

b. Equalities and Diversity

i. Members' Items allow Members of a Committee to bring a wide range of issues to the attention of a Committee in accordance with the Council's Constitution. All of these issues must be considered for their equalities and diversity implications.

c. Consultation and Engagement

i. None in the context of this report.

2. BACKGROUND PAPERS

a. None.

This page is intentionally left blank

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 11TH MARCH, 2016** at 10.00 am in the Committee Room 4, Town Hall, Judd Street, London WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (Chair) (LB Camden)
Councillor Pippa Connor (Vice-Chair) (LB Haringey)
Councillor Martin Klute (Vice-Chair) (LB Islington)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Richard Olszewski (Substitute) (LB Camden)

MEMBERS OF THE COMMITTEE ABSENT

Councillor Danny Beales (LB Camden)
Councillor Jean Roger Kaseki (LB Islington)

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

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Jean-Roger Kaseki (Islington) and Councillor Danny Beales (Camden).

2. DECLARATIONS OF INTEREST

Councillor Pippa Connor declared that her sister was a GP in Tottenham.

Councillor Richard Olszewski declared that he was on the governing body of the Royal Free Hospital and that he gave communications advice to the Pharmacists' Defence Association.

Councillor Alison Cornelius declared that she was a trustee of the Eleanor Palmer Trust, which ran care homes.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There were no notifications of any items of urgent business.

5. MINUTES

Consideration was given to the minutes of the meeting of 29th January 2016.

Members enquired whether a letter had been sent on behalf of the Chair regarding support for the Committee. Members were informed that a letter had been sent to the Camden Chief Executive and a Camden strategy officer was liaising with the Haringey officer who had previously supported the Committee on this.

Members noted that information on the spend on preparing for inspections had been provided by two trusts. They welcomed this.

It was noted that reference to Councillor Cornelius as chairing the meeting on Barnet, Enfield and Haringey Mental Health Trust Quality Accounts at the bottom of page 12 should refer to Councillor Connor instead.

RESOLVED –

THAT the minutes be approved, subject to the amendment of 'Councillor Cornelius' to read 'Councillor Connor' at the bottom of page 12.

6. GPS IN CARE HOMES

Consideration was given to a report on Primary Care-related Support for Residential and Nursing Care Residents.

Members received a presentation from representatives from Barnet, Enfield and Haringey Clinical Commissioning Groups (CCGs) (Paul Allen, Raksha Kukadia and Cassie Williams). The presentation highlighted the differences between the boroughs, as some had much larger care home sectors than others. Barnet had more than 100 care homes, whereas Haringey had only 436 beds spread between 12 homes (10 nursing and 2 residential).

Mr Allen explained that Enfield CCG had created a Care Homes Assessment Team (CHAT) as a joint service to help support residents in care homes. Virtually all GPs and care homes in the borough had signed up to this, having rolled out from an initial 7 homes, and it seemed to be working well.

Ms Williams said that Haringey did not have a service such as CHAT; however, they had a plan to institute 'ward rounds' in care homes to identify incidents of poor health

which required primary care for residents. This proposal would be submitted to the CCG's Investment Committee for approval. It was noted that funding arrangements for GPs treating care home residents needed to be carefully designed so that GPs were not being paid twice for attending to patients there.

Ms Kukadia reported that Barnet CCG had had a pilot of an enhanced service for care homes from 2014-15. The pilot had not been renewed for future years, as they did not see a decrease in A & E visits or ambulance call-outs as a result.

It was noted that there was not a full list of Camden care homes in the report. The Chair noted that some care homes which had caused members concern were not on the list. She expressed disappointment that no one from Camden CCG was in attendance.

There was a discussion about training for care home staff. It was noted that some care homes did not take advantage of opportunities to train their staff, and that turnover of staff was high – so it was a constant task to train new staff as they started.

Members welcomed the Enfield approach and queried why it had not worked in Barnet. They were informed that there were more care homes in Barnet and that the Enfield scheme was multi-disciplinary, whereas the Barnet scheme was GP-led.

Members asked what the metrics of success were, and were informed that they were statistics such as: reductions in A & E visits, reductions in the number of cases of ulcers and fewer falls. Members asked that the 5 CCGs work together on standardising KPIs and driving improvements together. Officers said that commissioning of a large proportion of care home beds was done by local authorities, so aspects of the way they operated were driven by local authority procurement policies.

Members queried how enhanced payments to GPs operated. They were informed that the details varied from CCG to CCG, but enhanced payments were paid to cover the time involved in visiting care homes and seeing the residents. Councillor Klute expressed concern that this could take GPs away from their normal work in their surgeries and so have an adverse impact on their other patients. CCG officers said the enhanced payments enabled practices to employ locums or part-time staff to visit care homes or who could cover for colleagues who were doing the visits.

Councillor Connor welcomed the more multi-disciplinary, nurse-led approach taken by CHAT. She commented that the approach taken by Haringey CCG seemed to her to be too doctor-led. Haringey CCG commented that it did not employ nurses and so was not in a position to create a nurse-led team. Additionally, there were certain tasks that only doctors were authorised to perform and so a nurse-led team would not be able to tackle these as effectively.

Councillor Cornelius informed the meeting that Barnet Health Scrutiny had received information on the number of hospital admissions and what they were for from the largest 10 care homes. This was suggested as something that other borough health scrutiny committees could obtain information on for the care homes in their boroughs.

RESOLVED –

THAT the report and the comments above be noted.

7. WHITTINGTON HOSPITAL - DEVELOPMENT OF ESTATES STRATEGY

Consideration was given to a summary report from the Whittington Hospital.

Simon Pleydell, the Chief Executive of Whittington Health, addressed the Committee and made a number of points, including:

- The need for the Trust to have a modern estate that met the needs of patients.
- There were 38 premises in the Trust's "estate" – a number of which were shared with primary care services.
- The Trust wished to consolidate its operations into fewer, fit-for-purpose, buildings.
- The implementation of the estate strategy could be a 20 year process but the Trust wanted to establish the general parameters soon.
- The Trust was aiming to use IT to change working practices and enable more efficient use of resources.

Members noted Mr Pleydell's report and presentation and asked if a copy of the full Estate Strategy document could be circulated.

ACTION: Vinothan Sangarapillai (Camden Committee Services)

Councillor Klute mentioned that the estate strategy had been discussed at Islington's most recent Health Scrutiny meeting. He noted that there had been concern by members that the Trust would be working with outside companies and that there was a danger of being entangled in unsuitable PFI contracts. He highlighted a disadvantageous LIFT (Local Improvement Finance Trust) contract which the hospital had been tied into for 25 years.

Mr Pleydell said that there was a need for the Trust to work with firms that had expertise which the Trust lacked. He also noted that NHS England had told NHS trusts that they should not expect capital funding from the Treasury. It was therefore necessary to explore other options. He said that the Trust would not necessarily be entering into PFI arrangements with the private companies it was working with.

The Chair said that Camden Council, in its Community Investment Programme (CIP), had been able to finance developments through revenue from the sale of council land and of flats in mixed developments. She urged the Whittington to look at Camden's example from the CIP and see what could be done to maximise the value of sites the Trust wanted to dispose of and to minimise borrowing.

There was a discussion about the need to consolidate the buildings health services were provided from. It was reported that health visitors worked from 14 different sites in one borough.

There was a discussion about the estimate of a £6m backlog of capital works that was required. Members queried the source of the figures. They were informed that the Whittington was required to rate its buildings as a form of stock survey and that there were figures known as 'ERIC (Estates Return Information Collection) returns' to calculate backlogs.

It was noted that there was a high staff vacancy rate. A major factor in this was that many health workers could not afford to live in London. Hence, they were moving out of the city and not wishing to work for London institutions. The Trust needed a residential accommodation strategy to house its staff in shortage occupations. Members commented that health bodies should work with local authorities on their key worker housing strategy, as this was an issue that local councils in London were very concerned about as well.

A question was asked about how the estate strategy tied into the health devolution pilot. Mr Pleydell said that the Whittington was involved in the group, but its effectiveness depended on other bodies such as foundation trusts being willing to pool their assets. It was early days for this North-Central London pilot.

Members asked that local authorities be kept informed of what the Trust were trying to do. They were of the view that poor communications had caused a number of problems before.

Members asked how local authorities were involved in the Trust's consultation process outside of JHOSC and borough's health scrutiny bodies. They were informed that the Trust had a well-being board that included local authority representatives and other stakeholders.

Mr Pleydell agreed to provide a programme of updates to the Committee as the estate strategy progressed and to answer questions members wished to email him individually.

ACTION: Simon Pleydell (Whittington Health)

RESOLVED –

THAT the report and the comments above be noted.

8. PROCUREMENT OF URGENT INTEGRATED CARE SERVICE (111/OUT OF HOURS)

Consideration was given to a report on the Procurement of an Integrated Urgent Care Service for North Central London.

Dr Sam Shah and Dr Jo Sauvage addressed the Committee. Dr Shah was accompanied by his students who were specialising in public health.

Dr Shah and Dr Sauvage thanked the Committee for its input into the process. They said that they had had positive interactions with patients and the public and this had helped them design the questions to ask bidders. They had screened bidders and issued invitations to tender. A decision would be made on which provider to select at the end of March. The provider's contract would start in October.

Members welcomed the fact the procurement exercise had taken on comments from councillors, patients and the public.

Questions were asked about a number of KPIs (key performance indicators). With regard to KPI L5, Dr Shah said this was about ensuring that the out-of-hours provider had access to those GP records which they needed. With regard to KPI N9, he clarified that this was about identifying how long it took a patient to go through the clinical journey for a particular incident. KPI L13 was about reducing the number of cases where the OOH service referred someone for an ambulance but on re-triage an ambulance visit was felt to be not necessary.

Members asked about whether pharmacists and other related medical professionals would be being included in the service. They were informed that providers would not be being mandated as to how many and what type of staff they should employ, but that bidders had submitted a detailed workforce model which did show what specialists they would be employing.

A question was asked about how often the CCGs would meet with the provider. They were informed that, initially, there would be frequent meetings – more than one per week – but that they would become less frequent as the service stabilised and bedded in.

A member asked how they could measure whether people had equal access to the service. Dr Shah said that the CCGs would receive statistics on the population of the area and on service usage and could see if there were discrepancies.

It was suggested that a report could come back in a year's time on how the service had launched, what the issues that had arisen were and how they had been resolved.

ACTION: Dr Sam Shah & Jo Sauvage

RESOLVED –

THAT the report and the comments above be noted.

9. WORK PROGRAMME

Consideration was given to the work programme report.

Members were of the view that they wanted to see reports on health estates devolution, an update on the primary care 'case for change', the five-year NCL CCGs strategic plan and the London Ambulance Service for the next meeting. They also wanted an update on the LUTS clinic when the review had concluded.

There was discussion about items members wished to consider at meetings later in the year. Some members wished to have a report on sexual health services, but the majority view was that this was something that could be considered by borough health scrutiny committees.

Members wanted to have information about dementia and stoke pathways. They noted that GPs had been given targets to improve their diagnosis of dementia this year.

Members wished to see information about the plans for 7-day NHS services. The CCGs could be asked to provide information about the framework that would be implemented, and members could question them on it.

There was a discussion on CAMHS (Child and Adolescent Mental Health Services). A view was expressed by a member that it was not person-centred enough. Councillors Connor and Kelly agreed to liaise on this outside of the meeting to identify the best way of tackling the issue.

RESOLVED –

(i) THAT it be agreed that items on health estates devolution, the primary care 'case for change', the five-year CCG strategic plan and the London Ambulance Service be put on the agenda for the next meeting;

(ii) THAT the work programme report be updated to reflect the comments made above.

10. DATES OF FUTURE MEETINGS

Members agreed to move the June meeting to 10th June 2016 and the March 2017 meeting to 24th March 2017.

RESOLVED –

THAT the meeting dates, times and locations for meetings in 2016-17 be:

- Friday, 10th June 2016 @ 10am (Islington)
- Friday, 30th September 2016 @ 10am (Haringey)
- Friday, 25th November 2016 @ 10am (Barnet)
- Friday, 27th January 2017 @ 10am (Enfield)
- Friday, 24th March 2017 @ 10am (Camden)

11. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

The meeting ended at 1.05pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
Telephone No: **020 7974 4071**
E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 29TH JANUARY, 2016** at 10.00 am in the Council Chamber, Enfield Civic Centre, Silver Street, Enfield EN1 3XA

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice Chair)

Councillor Graham Old (LB Barnet)
Councillor Alison Cornelius (LB Barnet)
Councillor Charles Wright (LB Haringey)
Councillor Jean Kaseki (LB Islington)
Councillor Ann-Marie Pearce (LB Enfield)
Councillor Abdul Abdullahi (LB Enfield)

OTHERS IN ATTENDANCE

Andy Ellis, Scrutiny Officer, LB Enfield
Jane Juby, Scrutiny Officer, LB Enfield
Rob Mack, Principal Scrutiny Support Officer, LB Haringey
Vinothan Sangarapillai, Committee Services LB Camden
Jonathan Hampston, Public Affairs and Consultation Manager, North and East London Commissioning Support Unit
Julie Juliff, Maternity Commissioning Lead, North Central London CCGs
Laura Andrews, Patient and Public Engagement Manager, Enfield CCG
Claire Wright, Enfield CCG
Catherine Swaile, Haringey CCG and LB Haringey
Nicola Wise, Head of Hospital Inspection, CQC

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

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Danny Beales, Councillor Martin Klute and from Cllr Alison Cornelius for lateness.

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

The Declarations of Interest made at previous meetings were **NOTED.** There were no further Declarations of Interest.

3. ANNOUNCEMENTS

The Chair reported that the Chief Executive of the Whittington Hospital had been due to attend the meeting to update on the Lower Urinary Tract Review but, as the review was still in progress, it was felt to be better that he attend at a later date.

Cllrs Beales and Kelly had been due to visit the University College Hospital Stroke Unit but this had been postponed. Thanks were expressed to Cllr Pearce for the recent meeting regarding stroke services which had provided useful information to take back to individual boroughs.

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There were no notifications of items of urgent business.

5. MINUTES

The Minutes of the Meeting held on Friday 27 November 2015 were **AGREED** as a correct record.

6. MATERNITY SERVICES UPDATE

Julie Juliff gave the following update, the key points of which were as follows:

- The purpose of the report was to ensure Value for Money and safe services were the key priorities.
- The birth rate seemed to have levelled off at present; however the Royal Free, Barnet and University College Hospitals were reporting increased activity this year. It was not yet clear why this was the case, whether growth is from our boroughs or that people from outside the NCL boroughs accessing the service may be contributing to the situation.
- JJ's role is to assist the North Central London CCGs (Clinical Commissioning Groups) to commission and monitor outcomes , as well as participate quarterly reviews into maternity for each Trust.
- A maternity dashboard had been implemented this year which indicated Trusts' performance. All outcomes put onto the dashboard were now being reported on.
- Data for the third quarter would shortly be available.
- There would also shortly be enough comparative data to analyse.

- Referring to the recent CQC (Care Quality Commission) Maternity Survey, it was noted that London generally had lower levels of patient satisfaction. A presentation was available which gave further details and could be circulated **ACTION: Rob Mack**
- All Action Plans were being collated at the moment.
- At the time of the CQC Survey, the North Middlesex University Hospital's new Head of Midwifery had not yet been in post and this may have impacted upon results.

The following questions and comments were then taken:

Cllr Kelly, based on a meeting with the Trust, noted that throughput at the Whittington Hospital was a concern as there were a lower number of births at this hospital than at others and so there was concern that not enough experience was being built up there. Councillors questioned whether there was a view that there were too many providers in the North Central London area. Julie did not feel this was a concern currently.

CQC Maternity Survey 2015

Q: Why did the CQC Survey take so long to complete?
A: The CQC would have been responsible for these timescales.

Cllr Old commented that the results of the Survey were disappointing and worrying in respect of the North Middlesex University Hospital, given that he had recently visited the Hospital with Cllr Bull and morale appeared to be high after the recent move of maternity services from Chase Farm.

Julie Juliff replied that the Survey had been undertaken in February of last year and that she expected that the situation had improved since then. However, the intention was to look into this further. It was also important to note that comparisons had been made against national, rather than London, data.

It was also noted that the fabric of a building surveyed may well have affected results on cleanliness; and it was difficult to deep clean an older building.

Maternity Dashboard

Cllr Kelly referred to the maternity dashboard, and asked if any additional indicators should be added.

Julie Juliff replied that the purpose of the dashboard was primarily to monitor clinical outcomes to help clinicians understand their performance.

Antenatal Screening and Caesarean Sections

It was noted that current focus was on ensuring antenatal screens were carried out by 12 weeks of pregnancy; however, it was now recognised that screening should be carried out at 10 weeks for Sickle Cell anaemia and Thalassaemia and 13 weeks for Downs Syndrome.

Monitoring of the Caesarean Section rate needed breaking down further to understand what proportion of them were for first time mothers and how many were planned or emergency procedures. There was potentially too high a proportion of elective C-Sections and these were being checked to ensure all NICE (National Institute of Health and Care Excellence) guidance was being followed in this respect.

A resident commented that it should be recognised that North Middlesex University Hospital was situated in a very diverse community and there were particular pressures on its services that should be taken into account. He also raised the issue of un-booked deliveries which would place extra, unforeseen pressure on maternity services and thought these could be better managed.

It was then asked how the North Central London area compared to other areas in respect of antenatal screening.

Julie Juliff responded that the area compared favourably with the rest of London, especially given the greater mobility of the population. It was not known, however, how it compared with other large cities, such as Manchester as this data is no longer collected nationally. Work was ongoing with GPs to improve referral rates and a research project was also being conducted with East London University to determine what may prevent women from booking screens – cultural issues may be a factor.

Un-booked Deliveries

Cllr Kelly asked whether there was any data on un-booked deliveries, particularly for the North Middlesex University Hospital, to understand better the circumstances around these.

Julie Juliff replied that one factor could be that such mothers did not have a registered GP and this may be because of their residency status. It was important to note however, that maternity care could not be withheld if someone was unable to pay for that care.

Cllr Kelly suggested that there should be further work undertaken with local community groups to reassure and work with such mothers.

Perinatal Mental Health

Julie Juliff reported that important work was ongoing in this area for mothers during and after pregnancy.

It had been recognised that there had not been a fully formed service up until now, and workshops had recently been held with commissioners to develop a strategy.

Implementation of the strategy was now under consideration. It had been agreed that the service at the Whittington Hospital would be the starting point for development going forward and that the aim was to create a single North Central London service with one central referral point and clearer pathways.

Development work would continue through 2016/17; an update was proposed for a future meeting.

Cllr Cornelius commented that she felt there was a particular issue with providing effective perinatal mental health services at the North Middlesex University Hospital. The new service should provide clinical specialities at all hospitals across all Boroughs and should be consistent.

Julie Juliff commented that, in addition, all maternity staff were currently receiving training in order to better identify potential patients in need of the service.

It was asked if anyone identified as needing the service transferred to the Whittington Hospital. Julie Juliff responded that those with severe issues could be referred to the Mother and Baby Unit at the Homerton.

Cllr Cornelius expressed concern at how support would be provided until the full, new service was up and running and asked what 'safety net' was in place during the transition period?

Julie Juliff replied that Haringey CCG had recently released funds to the Barnet, Enfield and Haringey (BEH) Mental Health Trust to increase the level of service it could provide in this regard in the meantime.

The Committee **AGREED** that an update on 'Stop Gap' services be provided to them in 6 months' time **ACTION: Vinothan Sangarapillai**

It was further **NOTED** that as yet, comprehensive figures for perinatal mental health cases were not available; but these would be collected in the near future. It was also acknowledged how significant an impact mental health issues in the mother could be upon a child's psychological health. It was also **NOTED** that 50% of those women who had an existing mental health condition were likely to relapse during pregnancy but this was often difficult to predict.

The issue of specialist units to deal with patients developing psychosis was raised. It was **NOTED** that the Mother and Baby Unit at the Homerton Hospital was the primary service point for this, and this was operated by NHS England (not the CCG). It was **AGREED** that mothers should be referred to this Unit wherever possible, rather than standard adult psychiatric care.

Cllr Kelly then asked how maternity services were co-designed with users. Julie Juliff responded that it had been difficult up to now to find service users willing to participate but that the Maternity Services Liaison Committee did involve them. It was **AGREED** that there was room for improvement in this regard.

Cllr Abdullahi raised the issue of substance misuse among pregnant women and asked how big a problem this was. The figures for this would be obtained **ACTION: Julie Juliff.** More information on how local authorities currently worked with DAATs (Drug and Alcohol Teams) was also requested **ACTION: Julie Juliff.**

Referring to the final pages of the report, the Committee acknowledged that much positive work had been done across both local and London wide networks in reducing the numbers of stillbirth.

Members of the Committee then expressed concern that there may be, in fact, too much provision and that consequently, this may impact on overall safety.

Julie Juliff responded that there was no evidence this was the case and that all services were NICE compliant, with staffing levels as they should be.

Cllr Kelly asked if safety was less of a concern in larger units. Julie Juliff responded that this was debateable and that a unit needed to be of significant size in order to ensure 24 hour cover. In addition, larger units may not be what patients wanted; proximity may be more of a concern. Development of services going forward was essentially about creating the right models, rather than the right buildings.
Cllr Wright asked if Ms Juliff undertook commissioning across the whole sector. Julie Juliff responded that she worked for the Lead CO for maternity, on behalf of all CCGs, and did commission across the whole sector. At present, each CCG commissioned their own services but were looking to increase joint commissioning.

Referring to mortality rates in childbirth, the Committee requested further data in this regard (data was published annually both nationally and by Borough) **ACTION: Julie Juliff.**

Referring to the Appendix provided by Imperial College, London, the Committee expressed concern at the data provided for Great Ormond Street Hospital. Cllr Kelly commented that Imperial College had been invited to the meeting, but were not available.

In conclusion, the three key strategic risks for maternity services across the North Central London area were identified as being:

a) Perinatal mental health;
b) Ensuring value for money whilst maintaining patient safety;
c) Patient experience.

The Committee made the following **RECOMMENDATION:**

1. That further work be undertaken to improve the involvement of local people in co-designing services.

7. CQC INSPECTION PROCESSES

The Chair introduced Nicola Wise, Head of Hospital Inspection and reiterated the wish of the Committee to receive **written** reports in future rather than presentations.

Nicola Wise outlined the CQC inspection process as follows:

- The CQC carried out both inspection programmes and enforcement;
- There had been a significant shift from short, one day inspection visits to comprehensive reviews carried out by a team of inspectors over a number of days.
- Certain experts were sometimes also engaged to support inspections.
- The inspection programme covered three main areas:
    - Hospitals;
    - Mental Health services; and
    - Adult Social Care.
- Primary medical services were also inspected.
- Inspection concentrated on determining if services were:
    - Safe;
    - Effective;
    - Caring;
    - Responsive; and
    - Well led.
- Inspections looked at, for example, fundamental staffing standards, staff interaction with patients, management awareness of issues and how organisations approached learning.
- Inspections did not try to 'catch people out' but helped to identify areas of good practice and aimed to work with organisations.
- There were two further Comprehensive Inspection Reviews planned for University College Hospital, London and the Royal Free Hospital. Camden and Islington Mental Health Trust also had an upcoming inspection.
- In addition to planned inspections, the CQC could also undertake an inspection in response to specific concerns. Follow-up inspections after these ensured appropriate action had been taken.
- Inspections resulted in the following ratings:
    - 1 – Outstanding;
    - 2 – Good
    - 3 – Required Improvement;
    - 4 – Inadequate.

- If an organisation received a 3 or 4 rating, a 'Quality Summit' meeting would be held with that organisation to ensure plans were in place and a warning notice would be issued. A follow-up inspection would also be undertaken after 6 months.
- Nicola Wise expressed the wish of the CQC to work more closely with bodies such as the JHOSC to share information and create a working dialogue.

The following comments and questions were then taken:

Cllr Kelly asked if the CQC had approached the relevant Lead Members for Health regarding the upcoming University College Hospital and Royal Free Hospital inspections. It was felt that there was a lack of clarity as to who was involved with and aware of such inspections.

Cllr Connor commented that the North Middlesex University Hospital, after its inspection, had seemed uncertain as to the time frame for follow-up action. Cllr Connor endorsed Cllr Kelly's view that there should be improved consideration of who should be involved both before and after inspections and there needed to be improved feedback to stakeholders such as the JHOSC.

Cllrs Kelly and Cornelius also commented that there was also a lack of appropriate notification around Quality Summit meetings.

Cllr Pearce enquired as to how many days and how big a team was required to undertake an inspection. Nicola Wise responded that a Comprehensive Inspection usually took 3-4 days with a team of 30-50 people. An analyst was sometimes also engaged to work on the team who may put forward data requests prior to the visit. After the inspection visit was completed, a report would then be drafted and this would usually take up to 2 weeks. If very serious issues of concern were found during the inspection, a follow-up visit would take place at a much sooner date than the usual 6 months.

Cllr Kelly acknowledged that it was a difficult task to remain consistent in approach with all hospitals across the country and recognised the CQC's work in this regard.

A resident attendee asked if hospitals were aware that an inspection was due to take place.

Nicola Wise responded that for a Comprehensive Inspection, hospitals would be notified.

The resident responded that false impressions could be created if a hospital was aware of an inspection and suggested that unannounced inspections, during the day and evening, should be undertaken.

The Committee **RECOMMENDED** that:

1. A letter be sent to the London Scrutiny Network to ascertain if there was a national framework for engagement and public local accountability, especially with regard to Quality Summits;
2. That information be provided on the level of spend per hospital (to include Great Ormond Street and the Camden and Islington Mental Health Trust) in preparing for an inspection.

Nicola Wise would also circulate the presentation for this item **ACTION: Nicola Wise.**

8. NEW MODEL FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Claire Wright, Enfield CCG and Catherine Swaile, Haringey CCG and Haringey Council, introduced the new model for CAMHS as follows:

- The Government's Autumn Statement had provided new money for CAMHS services, initially to fund a number of pilot projects. Two pilot projects had been successful in obtaining funding in the North Central London area; these aimed to create closer links between schools and statutory services.
- The remaining funding would be disaggregated to Boroughs via CCGs.
- A standard 'blanket' formula for disaggregating funding had been applied which had not recognised Borough profiles.
- Across the North Central London area there were currently a variety of providers of CAMHS which had resulted in a complex overall picture.
- Individual Boroughs were therefore working on Transformation Plans to improve and develop more coherent services.
- Some services operated as shared services across Boroughs, for example, those for Eating Disorders. Boroughs in these cases were therefore working together to ensure the right level and parity of investment.

The following questions and comments were then taken:

Q: Why are CCGs providing services for eating disorders; was this not originally provided by NHS England?
A: Community services are provided by CCGs.

Q: There is a minimum standard for all services but there appears to be different offers in different Boroughs. Does this not lead, in effect, to a 'postcode lottery'?
A: There is an acknowledged lack of parity, where this is the case funding is being targeted locally to ensure improved standards. These are outlined in each borough's Transformation Plan.

Q: How are the funding allocations determined?
A: These are determined by NHS England, devolved to CCGs.

Q: Is it the case that the North Central London area has one of the highest numbers of mental health cases and, consequently, why investment by the corresponding CCGs is quite high?
A: There is a concern that, in some areas, levels of spend are actually lower than they should be; for example, in Haringey.

Members of the Committee expressed a wish to see in further detail how spend was allocated across boroughs and whether there were any historical reasons for this. Cllr Old, however, felt that this may be of limited value and that it may be better to focus more on outcomes.

It was **NOTED** that national minimum data sets would be available from February and outcomes could be determined more clearly from these.

The issue of mental health services within schools was then discussed. It was **NOTED** that spend within schools was not included in current captured data. Ofsted regulations had imposed some duties on schools to offer emotional support; but there was a lack of clarity as to what this should be.

It was suggested that it might be useful to undertake an audit of schools to determine what services they provided and their expenditure. Such information could be obtained from the local authority; or directly from the school if it was not local authority maintained.

Cllr Wright commented that there appeared to be a significant stream of funding and commissioning of CAMHS within schools that were as yet not fully known and that these were likely to be early intervention services that were critical to children's ongoing development.

Cllr Abdullahi asked how the transition from CAMHS to adult mental health services was currently managed and how it would be further developed. Were CCGs confident that transition was happening successfully?

Claire Wright responded that development plans in this respect had been detailed in Enfield's Transformation Plan for next year but that it was in fact the overriding intention to avoid the need for transition completely i.e. that mental health issues were resolved before adulthood. There was no current evidence that where transition was necessary, this was not being managed successfully in Enfield; however, Cllr Abdullahi was invited to report any concerns to them.

Cllr Cornelius commented that she felt Haringey's Transformation Plan appeared to be redeveloping services 'from the beginning' and thought that some of this work should have already taken place.

Catherine Swaile replied that there were overall good services being provided in Haringey but that the Transformation Plan identified gaps. There would be greater focus on using evidence bases nationally to help improve outcomes. This was not to say, however, that outcomes were not already good.

Cllr Kaseki asked what provision was or would be, in place for the most vulnerable patients.

Claire Wright and Catherine Swaile responded that the Future in Mind initiative would cover 5 areas which included care for the most vulnerable (for example, those on the Autistic Spectrum). The 5 year plan had just commenced to establish current provision and performance, and develop on these.

It was then asked whether services were being co-designed with the community.

Claire Wright and Catherine Swaile replied that this was a key tenet of the Transformation Plans and that the Plans had undergone an assurance process to check that community had been appropriately engaged. It was also confirmed that GPs had been engaged in the process.

The Committee made the following **RECOMMENDATIONS:**

1. To keep CAMHS a priority and a partnership;
2. That prevention be looked at as a key element of the service;
3. That each Borough's appropriate Scrutiny Panel see and review their Transformation Plans in more detail.
4. That CAMHS be brought back to the Committee for review of initial outcomes of the Transformation Plans and any learning within the next year.
5. That data on schools be collated to identify the types of services and spend thereon.
6. That the Risk Registers for each Borough be circulated.

9. TERMS OF REFERENCE AND PROCEDURAL ARRANGEMENTS FOR NORTH-CENTRAL LONDON JHOSC

It was proposed that a list of services commissioned by NHS England should be included as a rolling programme for agenda items entitled 'Specialised Commissioning' **ACTION: Rob Mack**

It was **NOTED** that, as the borough which currently provided the Chair, LB Camden was required to provide officer support to the Committee but that it did not have allocated support in additional to general administrative support from Committee Services.

It was **RESOLVED** that LB Camden work with the other participating authorities to ensure an appropriate level of support for the Committee, and that a letter would be drafted for the Chair in this regard **ACTION: Vinothan Sangarapillai**

10. WORK PROGRAMME

11 March 2016

Primary Care Update on the 'Case for Change' – it was **AGREED** that the Islington CCG lead and NHS England representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

NHS/111 Out of Hours GP Services – Commissioning – it was **AGREED** that the Islington CCG lead and NHS England representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

North Central London CCG Strategic Planning Group – It was **AGREED** that an Enfield CCG representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

Potential Future Items

It was **AGREED** that the following be added:

- GP Care for Older People in Care Homes;
- Whittington Hospital – Estate Strategy
- Sexual Health Update

It was **AGREED** that the GP Care for Older People in Care Homes item be brought to a future meeting, that Cllr Abdullahi draft proposed questions for the Committee on this item and that an Enfield CCG representative be invited in this regard **ACTION: Rob Mack/ Vinothan Sangarapillai**

11. DATE OF NEXT MEETING

It was noted that the next meeting would be on 11th March 2016 at Camden Town Hall.

12. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

It was **AGREED** that a meeting on the BEH MHT Quality Accounts should be held. It was **AGREED** that Cllr Cornelius chair this meeting.

The meeting ended at 1pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
Telephone No: **020 7974 4071**
E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

This page is intentionally left blank

AGENDA ITEM 8

Barnet Health Overview and Scrutiny Committee

4 July 2016

Title	Ear, Nose and Throat (ENT) Adult Audiology and Wax Removal Service Redesign
Report of	Barnet Clinical Commissioning Group
Wards	All
Status	Public
Urgent	No
Key	*None*
Enclosures	Appendix A – Submission from Barnet CCG.
Officer Contact Details	Theresa Callum, Barnet Clinical Commissioning Group Teresa.Callum@barnetccg.nhs.uk

Summary

At their meeting in December 2015, the Committee considered a report on the CCG's planned service redesign and procurement of the Ear, Nose and Throat (ENT) Adult Audiology and Wax Removal Service.

The Committee noted the report and requested to be provided with an update report at their July 2016 meeting.

This report set out at Appendix A provides the Committee with an update on the procurement process undertaken by the CCG, the outcome, and next steps. The Committee will be able to comment/ask questions about the process and provide their views to Barnet CCG who will be in attendance on the evening.

The Paper attached at Appendix A sets out:

- Clinical case for change (recap)
- Procurement Process
- Next Steps

Recommendations

1. **That the Committee note the report.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Clinical Commissioning Group has requested that the Barnet Health Overview and Scrutiny Committee receive an item updating them on the outcome of the Ear, Nose and Throat Adult Audiology and Wax Removal Service Procurement.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the issues relating to the provision of ENT services which will affect the residents of Barnet.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1 Once the Committee has scrutinised the report, they are able to consider if they would like to make any recommendations to Barnet CCG.

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 principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

- There are no financial implications for the Council.

5.3 Social Value

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 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.

5.4.2 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."

5.5 Risk Management

5.5.1 Not receiving this report would present a risk to the Committee in that they would not have the opportunity to scrutinise the provision of ENT services within the Borough.

5.6 Equalities and Diversity

5.6.1 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.

5.6.2 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.

5.6.3 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.

5.6.4 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.

5.7 Consultation and Engagement

5.7.4 Barnet CCG are taking the opportunity to engage with the Barnet Health Overview and Scrutiny Committee by submitting this report and attending the Committee meeting.

5.8 Insight

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

6 BACKGROUND PAPERS

6.6 None.

Title:	**Community ENT, Wax Removal and Adult Audiology Service redesign and Procurement – Update**
Date:	4th July 2015
Submitted to:	Health Overview and Scrutiny Committee
Author:	Ahmer Farooqi – GP Clinical Lead Teresa Callum – Head of Demand Management

1. Purpose

The purpose of this paper is to provide the Overview and Scrutiny Committee with an update following the recent procurement of the Community ENT, Wax Removal and Adult Audiology Service.

2. Clinical Case for Change

The CCG has had lots of feedback from GPs regarding the confusion they and patients experience when accessing this group of services. Many patients in this group will need to access one or more of these services currently, and have to navigate a range of service providers and locations, each one providing one or more "steps" of the patient pathway. This can be confusing for patients, confusing for GPs, and creates unnecessary multiple appointments for patients. This results in in a poor patient experience as well as poor value for money.

One of the reasons why problems are experienced is that it is not always obvious when the patient starts their journey which services they need to access. Typical examples which are not uncommon include:

- A patient needing a hearing test attends their appointment, only to be sent away again to have their ears cleaned, before re attending for their hearing test.

- Patients attending the Community ENT service could end up with a diagnosis requiring a hearing test and the fitting of a hearing aid. They then are discharged from one service, back to their GP for referral through the AQP route. The same patient may also need their ears cleaned, involving a third separate visit.

Patients and GPs alike would benefit from a more streamlined service, with all services being co-located, across several sites, enabling patients to move seamlessly between the various service elements that they need in a single visit. This would vastly improve the patient experience, improve continuity of care and be a better, more effective use of resources. It would also mean that for GPs there would be a single point of entry into the system.

The proposed new service model is that all three services are provided side by side in two/three locations across Barnet on a one stop shop basis. This means that irrespective of

the reason for the patients referral, they will be able to access any combination of these services as part of the same appointment should they need to.

The service model and specification has been developed taking into account feedback from Local GPs, acute specialists, and the views of patients following a wide range of patient and GP engagement events. It is on the basis of this newly developed service model and accompanying service specification that the CCG agreed to go through a procurement process to commission a provider to deliver against this.

3. Procurement Process

The procurement process started in October 2015 with a bidder's market event. The purpose of the event was to give the CCG and potential bidders the opportunity to meet in an informal and dynamic atmosphere, to discuss and explore how such a service could best benefit Barnet patients. There was a high level of interest in the event with 30 attendees representing **13** organisations.

An evaluation panel was then established with roles and responsibilities documented. All members received evaluation training, guidance and support throughout the process from the Procurement leads. All thirteen organisations were invited to submit bids once the advert was released on the procurement portal. 6 organisation s submitted bids.

Once these were submitted they were then scored by the panel members individually within a two week timeframe, and scored against each of the criteria set out in the original documentation. This covered things like:

- Business continuity
- Technical and Professional ability
- Quality Assurance
- Information , Management and Technology

Following this stage, scores were moderated, and the three highest scored bids went through to the final stage, which comprised a presentation from each bidder, followed by a series of set questions covering a range of areas. The purpose of the interview stage was to test provider credibility and challenge against the written submission that they had made.

At the end of this process, the bid from Concordia Health had the highest score and therefore the recommendation of the panel was to award the contract to Concordia Health

4. Next Steps

A series of fortnightly mobilisation meetings have been set up with Concordia Health to ensure that the service is ready to begin operation on the 1st October. These meetings will are attended by a core group of people, Clinical lead, Project Lead, Informatics Lead, Contracts lead, Informatics and Quality representatives.

A communications Plan is being implemented which will ensure that GPs are fully conversant with what the new service offers their patients and the patient pathways are clear.

The contract will be monitored against the specification on a monthly basis going forward.

This page is intentionally left blank

AGENDA ITEM 9

Barnet Health Overview and Scrutiny Committee

4 July 2016

Title	**Colindale Health Project Update**
Report of	LB Barnet, NHS England and Barnet CCG
Wards	Colindale, West Hendon
Status	Public
Urgent	No
Key	*No*
Enclosures	None
Officer Contact Details	Adam Driscoll – Commissioning Lead for Planning Adam.driscoll@barnet.gov.uk

Summary

At their meeting in December 2015, the Health Overview and Scrutiny Committee received a presentation from NHS England and the London Borough of Barnet on the estates proposals for future GP services in Colindale. At the meeting, the Committee requested to be provided with a further update report at their July 2016 meeting.

This report provides details of the public consultation feedback on the proposals as described within the Options Appraisal document. Work to prepare an Outline Business Case for the replacement of Grahame Park Health Centre, together with the Full Business Case for a new start up practice in Beaufort Park as part of longer term Central Colindale proposals has been commissioned and work is underway on both documents. In parallel the Council has begun detailed negotiations with the developers of each of the key sites.

The next step in terms of the work of this committee will be the review of the two business case documents once they have been considered and approved by NHS England and Barnet CCG; this is anticipated in late Autumn 2016.

Recommendations

1. **That the Committee note the report.**

1. WHY THIS REPORT IS NEEDED

1.1 As part of their engagement plan, NHS England (NHSE) requested that the Barnet Health Overview and Scrutiny Committee receive a presentation on the provision of health services in the Colindale area. Upon consideration of the report, the Committee requested to be updated on the consultation feedback and progress with the business case in July 2016.

1.2 Updates in relation to matters previously raised by the Committee

1.2.1 Officers contacted Burnt Oak Ward Members as part of the Public Consultation and invited them to respond. However engagement from the Labour Group of Members continued to be mainly led by the Colindale Ward Members.

1.2.2 The difficulties associated with getting GPs to occupy newly delivered space within the new facilities will be de-risked for both Grahame Park and Central Colindale through the following matters that have been resolved:

a. Parkview Surgery have confirmed their preference to consolidate the branch surgery into their main practice, as a result they will not be required to take on a lease at the replacement Grahame Park health facility. This change to services will be integrated into and signed off as part of the Outline Business Case. The Practice will now consult on their plans to close the branch surgery and seek agreement from the North Central London Joint Committee for this service change.

b. Everglade Medical Practice has agreed to 'sponsor' the Outline Business Case for the replacement health facility at Grahame Park, and therefore has demonstrated full commitment to the relocation and the relevant implications associated with the business case.

c. NHS England (with CCG agreement) shall begin the procurement processes to identify and appoint a new GP provider for the Central Colindale facility during 2016-17. The procurement will specify that the practice will operate from the new temporary facility in Beaufort Park, alongside leading on developing the OBC for the longer term relocation to a permanent facility opposite Colindale Tube Station.

1.2.3 The Council will take the head lease for the new Community Hub at Grahame Park and is considering also taking the head lease for the temporary Central Colindale facility to ensure timely delivery of new services. The void cost risk for the spaces will be underwritten by Barnet CCG and this commitment will be made viable through careful financial planning as part of each business case.

1.2.4 Through Council held leases the process of creating new facilities and meeting local community health needs will be de-risked for all current providers and commissioners. The preparation of the Full Business Case for Central Colindale can therefore be prepared ahead of the completion of the NHS England procurement process for the new GP provider. Overall this will ensure faster delivery of the new services.

1.3 Outcomes of the Public Consultation

1.3.1 A report on the findings of the public consultation was published by Barnet Council in March 2016 on its Consultation Hub website. Please see section 1.4 of this report for a summary of the headline findings, and the background papers for the full details.

1.3.2 The consultation consisted of an online survey published on engage.barnet.gov.uk. Paper copies were available in Grahame Park Library and Grahame Park Health Centre. A letter and leaflet with details of the consultation were sent to residents of Grahame Park, the Colindale area (as defined in the Colindale Area Action Plan) and West Hendon, and patients of the Everglade Medical Practice and Parkview Surgery.

1.3.3 In total 103 surveys were completed, including 86 online responses and a further 17 paper responses. Of the 93 respondents who specified in what capacity they were completing the survey, 95 per cent of responses were from Barnet residents, with a further single response from a Barnet resident and business, one from a local GP provider, one from a representative of Central London Community Health and two others, including a member of a GP patients' panel. This was viewed by a local Ward Member as a successful level of response to a public consultation in the locality.

1.3.4 Four drop-in sessions also took place, though attendance at these events was low. Residents and stakeholder organisations were invited to send any specific queries about the public consultation to NHS England via post, email or telephone. It is possible that people were unaware of the consultation, but due to the nature of questions and queries raised, it is considered that the low levels of controversy with the proposals meant less people felt the need to articulate concerns or seek clarity in person at consultation events.

1.3.5 The public consultation has delivered improved local awareness, particularly amongst stakeholders, and has therefore informed the direction of travel and specific requirements needing to be fed into the commissioning of the Outline Business Case for Grahame Park and / Full Business Case for Central Colindale.

1.4 Feedback from the Public Consultation

1.4.1 The following information is the main findings of the report.

1.4.2 91% of survey respondents were registered at a GP practice, of which 39% were registered at Grahame Park Health Centre (Everglade and Parkview practices). 68% of the respondents agreed their GP practice building is safe and well maintained; whilst 59% agreed and 20% disagreed the facilities meet their needs.

1.4.3 There is lower satisfaction with the availability of GP appointments, 52% said they are unable to get an appointment when they need one compared to 37% that said they could get one.

1.4.4 There is a mixed level of satisfaction with GP opening hours (40% satisfied and 41% dissatisfied); yet 86% of respondents were in favour of extending GP opening hours. Opinions about how to extend hours of operation were split. Overall there was similar preference for both evening and weekend appointments, and lower preference for early mornings or lunchtimes.

1.4.5 Satisfaction with existing primary care services was generally positive with 66% satisfied with customer services, 51% with the range of services provided and 64% with the service provided by medical staff.

1.4.6 However booking appointments is clearly an issue, with 98% of respondents favouring effective telephone appointment booking systems (resolve in a single call) and 88% also wanting the introduction of online appointment booking services. Reducing the time and hassle of booking appointments is an important step for patients locally.

1.4.7 74% would like to be able to see a GP of their choice and 65% would like the option of telephone consultations. There was lesser interest expressed in being able to choose the gender of the GP (52% in favour) and low interest in access to 'online' consultations (35% in favour).

1.4.8 72% of respondents support a replacement health facility at Grahame Park, and 86% support the introduction of a temporary health facility (with a new start-up practice) operating from Beaufort Park, as soon as possible.

1.4.9 There was support, but to a slightly lesser extent (68%) for the long term Central Colindale provision being from the Peel Centre (opposite Colindale Tube Station); it is expected the 18% differential level of support for the permanent relocation is probably linked to those survey responses from residents of Beaufort Park.

1.4.10 There was more ambivalence around the proposal for no changes to GP services in West Hendon over the coming decade, with 65% of respondents answering 'don't know' or 'neither agreeing nor disagreeing'. However it should be noted that of the 20% of respondents who disagreed with this proposal, these tended to be those registered at GP practices in the West Hendon area.

1.4.11 Of the respondents who disagreed or strongly disagreed with the proposal for no change to services in West Hendon, most were registered at Hendon Way surgery (4 of 5 respondents registered), a GP practice in another borough (3 of 4 respondents), and the one patient registered at the Jai Medical Centre (Branch). Therefore it is recommended that NHS partners should have a watching brief in the local area to regularly review the impact of population change and capacity of primary care services.

1.5 Commissioning of the Business Case documentation

1.5.1 In December 2015 the NHS England Finance, Investment, Procurement and Audit (FIPA) Board received Project Initiation Documentation (PIDs) that followed their recommendation that the project split development of new facilities and services in Colindale into two separate business cases. Each business case must

stack up independently, but be developed in parallel to ensure interrelationships between the sites and services are fully taken into account:

- The replacement of Grahame Park Health Centre, with the business case to be sponsored by the current GP practices.

- The procurement of a new GP service for Central Colindale by NHS England provided there is support from Barnet CCG via co-commissioning arrangements, to be sponsored by NHS England London Region.

1.5.2 During January – March 2016 the Parkview Surgery proposal to consolidate into their main site was agreed to be requested via the Grahame Park Outline Business Case (OBC). A briefing paper on requirements, including those of facility owner Central London Community Health (CLCH), was prepared by NHS England for the practice.

1.5.3 In September 2015 the Colindale Health Project Board agreed to fund the development of the OBC for the replacement Grahame Park Health Centre using developer contributions. The board recognised that securing timely completion of the business case would commissioning the OBC on behalf of the practice.

1.5.4 In March 2016 NHS England wrote to LB Barnet to confirm that it has agreed with Barnet CCG to fund the preparation of the business case for Central Colindale through the Primary Care Transformation Fund.

1.5.5 In March 2016 the Council issued the tender specification for the two OBCs to North London Estate Partnership (NLEP). They are a pre-procured provider of consultancy services via an NHS framework agreement.

1.5.6 On 23 May 2016 Barnet Council confirmed the acceptance of the fee proposal from NLEP and formal development of the business case via delegated authority. It was agreed that project timescales would need to slip to recognise it will only be possible to achieve FIPA sign off of the business cases in September 2016 as opposed to June 2016 as indicated to the committee in December 2015.

1.5.7 Subsequently discussions with the NHS England Project Advisory Unit have helped to shape the direction of the recommendations sought through the business cases. The Grahame Park OBC will be unchanged. However the Central Colindale documents will now be a Full Business Case based on the temporary facility and creation of the new start-up practice.

1.5.8 Paired with a feasibility study (including a high level financial case) it will set a firm direction of travel for the long term relocation to the permanent facility, and the long term capital and revenue requirements associated with this new start up practice (feeding into Council and CCG business planning, enabling this information to feed into the NHS England procurement process).

1.6 Negotiation of detailed requirements and leases with developers.

1.6.1 In December 2015 the Council signed the S106 Agreement with Redrow for the Peel Centre site, this agreed to the provision of a health facility in Phase 2 of the development, to be made available to the NHS in two stages according to NHS space requirements for expansion and based on a market rent.

1.6.2 In February 2016 the Council commissioned Regional Enterprise (Re), drawing on health expertise from Capita Consulting, to undertake a review of space utilisation and service requirements for a replacement Grahame Park Health Centre. This process was designed to finalise the 'Schedule of Accommodation' requirements including consideration of opportunities for efficiencies associated with the co-location of health, children's and community facilities.

1.6.3 In April 2016 the Grahame Park report on accommodation requirements was completed and negotiations began with Genesis Housing Association around the best means of delivering the proposed community hub within their development.

1.6.4 In May 2016 NHS England commissioned the District Valuer to appraise the likely market rents associated with the various facilities in Colindale to inform lease negotiations and financial planning associated with the business cases.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the issues surrounding primary care provision in the Colindale regeneration area.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

1.1 None in the context of this report.

4. POST DECISION IMPLEMENTATION

1.2 Once the Committee has scrutinised the report, they are able to consider if they would like to make any recommendations to NHS England.

5. IMPLICATIONS OF DECISION

1.3 Corporate Priorities and Performance

1.3.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

1.3.2 The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- *Of opportunity, where people can further their quality of life*
- *Where people are helped to help themselves*
- *Where responsibility is shared, fairly*
- *Where services are delivered efficiently to get value for money for the taxpayer*

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

1.4.1 There are no financial implications for the Council associated with this report. However the Committee should note that it makes reference to the decision approved under delegated powers to commission business case documentation from North London Estates Partnership, the combined value of which was £73,496.50, as a call-off from the OJEU procured LIFTCo Strategic Partnering Agreement.

1.4.2 As reported in Paragraph 5.2.4 of the approved Delegated Powers Report (see paragraph 6.1 for reference and weblink), a budget of £137,500 has been allocated for delivery of the Outline Business Cases / Full Business Cases, comprising £62,500 of S106 monies and £75,000 from the Primary Care Transformation Fund. This budget funds both the costs of services from NLEP, as well as the council's own costs in relation to project management and oversight of the project.

1.5 Social Value

1.5.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

1.5.2 The Business Cases being developed will consider the social value opportunities that could be secured through the projects:

- At Grahame Park the principle opportunity is through the new 'Community Hub' to draw more closely together the planning and commissioning of children's and health services, alongside the opportunity to consider the role of community partners in supporting service delivery outcomes.

- In terms of the Central Colindale proposal, the procurement process for a new practice led by NHS England provides the opportunity to shape the requirements of services and capture these within the service specification for the new GP provider due to operate from these facilities.

1.5.3 Through the Colindale Health Project Board there is the opportunity for LBB, Public Health and Barnet CCG priorities to be considered in relation to the commission, and the opportunity for this will be considered as part of the preparation of the Full Business Case.

1.6 Legal and Constitutional References

1.6.1 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.

1.6.2 The Council's Constitution Article 15- Annex A (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as including 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."

1.7 Risk Management

1.7.1 Not receiving this report would present a risk to the Committee in that they would not have the opportunity to scrutinise the provision of primary care facilities within the area.

1.8 Equalities and Diversity

1.8.1 Equality and Diversity issues have been recognised as mandatory considerations in relation to this project, pursuant to the Equality Act 2010. Matters of equality and good relations have been integrated into day to day business, the design of policies and the intended approaches to the delivery of services.

1.8.2 The following duties set out in s149 of the Equality Act are supported through the work of the Colindale Health Project by effective collaboration and internal challenge between the project partners:

- *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.*

1.8.3 The Council has joined up its thinking with partners on Health and Wellbeing to produce a Joint Strategic Needs Assessment (JSNA). The JSNA aims to promote better outcomes for the rich diversity of all Barnet citizens by informing the approach to identify need, promoting inclusion and addressing social isolation. It will also ensure that every penny of public money is used as efficiently as possible and with maximum positive impact by having a shared understanding of the size and nature of Barnet's residents in each place.

1.8.4 Colindale is the 17th largest Ward by area in the borough, yet in 2012 it was the 3rd most populous ward with 18,727 residents and now it is the most populous Ward in the borough. Therefore the way people are living in Colindale represents a radical shift towards a more urban form of living experienced more commonly in Inner London. In that context the health and community infrastructure developed in Colindale will have an important role on future health outcomes in the locality.

1.8.5 Currently in Colindale Ward, the average life expectancy for men is slightly below the borough and London averages, and therefore partners involved in this project are aware of the need to ensure effective and timely availability of services. The Business Cases discussed in this report are focused on the needs of the local

population and securing enhancement of local health services whilst recognising the need for improvements sits within the context of limited public resources.

1.8.6 The public consultation report recognised it had delivered a consultation process that was broadly consistent with the demographic profile for the Colindale Ward in terms of gender, disability and age. However there were a number of underrepresented groups in the survey sample that should be targeted in relation to any subsequent consultation and engagement activities. Specifically this included 18-24 year olds and Asian and Black residents.

1.8.7 This in part may be due to the Ward having a disproportionately higher level of young people than the borough average, meaning a greater level of engagement with this harder to reach group would have been required to ensure proportional parity with the Ward average. In terms of the Asian and Black residents, again this group is much more significant in Colindale than the borough average, for example 12.8% of residents describe themselves as from Black African origin compared with a borough average of 4.3%. Together with the recognition that 63% of school children in the area do not have English as their first language in the home, compared to a borough average of 44%, means the BAME group of residents were again much harder to reach, in part due to language barriers.

1.8.8 Therefore it is a partial success that the survey did receive responses from both of these harder to reach communities, even though a greater proportion of responses would have been better. Therefore attention in relation to this consultation should be balanced by the feedback from stakeholders, such as Local Ward Councillors and Patient representation groups who have a role in speaking on behalf of all local interested parties and communities.

1.8.9 The Patient Participation Groups at Everglade Medical Practice and Parkview Surgery Branch Practice were offered additional engagement events about the public consultation. However, the Parkview Surgery advised that there were no major queries and NHS England did not receive any requests for specific engagement events from any other patient participation groups across the area.

1.9 Consultation and Engagement

1.9.1 The Project Team are taking the opportunity to engage with the Barnet Health Overview and Scrutiny Committee by submitting this report and summarising the feedback from the public consultation that was managed by LB Barnet.

1.9.2 The full report on the findings of the public consultation is available online, details of how to access the report are set out in the background section of this report.

1.9.3 By attending the Committee meeting it should offer the members the opportunity for any follow-up questions about the public consultation and how this has shaped the direction of travel for the Business Cases.

1.10 **Insight**

1.10.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

1.10.2 As part of the business case process, the background demographic analysis is being updated to ensure continued accuracy in relation to the projected timetable for population growth in the Colindale regeneration area.

6. BACKGROUND PAPERS

6.1 **Delegated Powers Report (dated 23 May 2016)** ***"Procurement of service to develop the business cases for future health facilities in Colindale"***

http://barnet.moderngov.co.uk/ieDecisionDetails.aspx?ID=6253

6.2 Colindale Health Facilities Project consultation documentation:

6.2.1 Public Consultation documentation on the Option's Appraisal report is available online at:

https://engage.barnet.gov.uk/commissioning-group/colindale-health/consult_view

6.2.2 The specific Consultation Findings report is available from that same website, the direct link is:

https://engage.barnet.gov.uk/commissioning-group/colindale-health/supporting_documents/Colindale%20health%20consultation%20report%20FINAL.pdf

AGENDA ITEM 10

Health Overview and Scrutiny Committee

4 July 2016

Title	**Finchley Memorial Hospital**
Report of	Governance Service
Wards	All
Status	Public
Urgent	No .
Key	*No*
Enclosures	Appendix A – Update Report from Barnet Clinical Commissioning Group and NHS England
Officer Contact Details	Anita O'Malley – Governance Team Leader anita.vukomanovic@barnet.gov.uk 0208 359 7034

Summary

At their meeting on 13 October 2015, the Committee considered a report which provided an update from NHS England and Barnet CCG on the provision of GP Services or a primary care facility at the Finchley Memorial Hospital site.

The report provided the Committee with an update on plans to improve utilisation of the Finchley Memorial Hospital site.

The Committee resolved the request a further update at their meeting in July 2016. The report set out at Appendix A provides this update.

Recommendations

1. **That the Committee note the update from Barnet Clinical Commissioning Group, and ask appropriate questions.**

1. WHY THIS REPORT IS NEEDED

1.1 At the meeting of the Health Overview and Scrutiny Committee on 12 December 2013, the Committee received a Members Item in the name of Cllr. Geof Cooke GP in relation to NHS England seeking to relocate local GP practices onto the Finchley Memorial Hospital site.

1.2 The Committee requested a further update from NHS England at their meeting on 20 October 2014. After receiving an update at their October meeting, the Committee resolved to request a further update in March 2015. The report attached Appendix A sets out a joint submission from NHS England and the Barnet Clinical Commissioning Group.

1.3 The Committee received a further report at their meeting in March 2015 and noted the project was scheduled to develop a series of initial options for review in April 2015, which would then need appraisal and planning in order to work through the commissioning and costing consequences. The Committee were informed at this meeting of the intention to identify agreed options by the summer of 2015, with a view to commencing work on implementing the new models of service. The Committee resolved a subsequent update at their meeting in October 2015, and as a result of their interest in the project, have requested another status update.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the site issues which have previously affected GPs moving into the premises, and be kept abreast of the future plans for healthcare at Finchley Memorial Hospital.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Following consideration of this item, the Committee will be able to determine any further actions that they wish to pursue.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 There are no financial implications for the council.

5.3 **Social Value**

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

5.4 **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."

5.5 **Risk Management**

5.5.1 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 Finchley Memorial Hospital.

5.6 **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 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.

5.9.2 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.

5.9.3 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.

5.9.4 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.

5.7 **Consultation and Engagement**

5.7.1 None in the context of this report.

5.8 **Insight**

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

6. BACKGROUND PAPERS

6.1 None.

Report to Barnet Health Overview and Scrutiny Committee – 4th July 2016

Update on Barnet CCG plans for Finchley Memorial Hospital

1. Introduction

The Health Overview & Scrutiny Committee has previously received reports from Barnet CCG on its plans to develop new services at Finchley Memorial Hospital (FMH) and to improve utilisation of the building. This paper provides a further update for the Health Overview & Scrutiny Committee on the CCG's progress with this project.

2. Background & Process to Date

The CCG's short list of preferred options is:

A) An Older People's Assessment Service (OPAS)

B) Putting the empty inpatient ward to use for the good of patients

C) Breast Screening

D) New Primary Care services, closely aligned to the Walk-in Centre

3. Older People's Assessment Service

The CCG's Governing Body has approved the business case and clinical specification for the new OPAS. The aim is to commence procurement of the new service which will be formally integrated and co-located with the existing Falls Service. The new service should be operational towards the end of the year.

4. Inpatient Ward

The CCG is working with colleagues in LBB and the main provider organisations to develop a specification for the use of the empty beds at FMH. The aim is to establish a "Discharge to Assess" model to improve utilisation of beds on the acute hospital sites and to better manage the flow of patients back to the community. Our plan is to have these beds operational in good time for the winter.

5. Breast Screening

Plans are at an advanced stage for a permanent Breast Screening service at Finchley to replace the mobile service. Once confirmed, this will include converting two rooms on the ground floor to create a new Breast Screening facility as part of the diagnostics suite (alongside X-Ray and Ultrasound). Due to the timings of the Breast Screening Programme it is likely that the mobile unit will return for its tri-annual visit in July but, once the new facilities are ready, the service will then move indoors as soon as possible. This change will also allow us to host a mobile MRI scanner on a more regular basis.

6. Primary Care and the Walk-in Centre

As previously reported, the Primary Care issue is contractually more challenging and the CCG is working with NHS England to develop a strategy for how a new service can be put in place. The aim is to link the new GP service more closely with the Walk in Centre, for reasons of service integration, clinical leadership and also more efficient use of resources. Our aim is to agree the way forward with NHS England in the next 2 – 3 months and we will be able to provide a further report to the HOSC in due course.

7. Improved Utilisation and other matters

The above workstreams will all lead to a more intensively utilised building. For example the Breast Screening service will treat 50 – 60 patients per day or an increase in footfall of circa 15,000 patients per annum – more if carers, friends and relatives are included. The new OPAS service will treat almost 3,000 patients per annum when operating at full capacity. We are keeping a log of these projected increases in footfall.

The close focus on how Finchley is being used has led to other improvements in addition to the top priority issues identified above. For example we are seeking to increase the Phlebotomy service which will lead to another circa 25,000 patient visits per annum and we also have a proposal for a mobile MRI scanner to come to the site – circa 2,500 patients per annum.

The CCG is taking a stronger lead on how providers are using space in the building and identifying where individual rooms are under-utilised. This is allowing us to plan for more services to come into the building.

8. Centre Management

The above approach will be greatly enhanced by the introduction of a stronger and more proactive Centre Management role. The Department of Health's property company, Community Health Partnerships (CHP) is responsible for Centre Management and will be introducing a new service that is more closely aligned with the CCG's objectives to improve use of this building. This will also start to address the question of greater involvement of community groups – something always envisaged for this building but not fully delivered to date. We have recently been working with some Mental Health 3rd sector groups about increasing their use of the building's community facilities and available space out of hours (when the building is relatively empty). This is a limited exercise at this moment in time but will expand as the new Centre Management service is implemented.

9. Summary

The Finchley Memorial Hospital Transformation Programme has developed into an exciting, complicated, multi-faceted programme but potentially significant improvements to patient care are starting to materialise as commissioning solutions are put in place. Over the next year we are confident that Finchley will start to operate in a way that fulfils its true potential as a dynamic hub for healthcare and other community services at the heart of Barnet's out of hospital health system.

Barnet CCG
July 2016

AGENDA ITEM 11

Barnet Health Overview and Scrutiny Committee

4 July 2016

Title	**Healthwatch Barnet**
Report of	Healthwatch Barnet
Wards	All
Status	Public
Urgent	No
Key	*No*
Enclosures	Appendix A - End of Life Care in Hospices Appendix B - Maternity Report - Executive Summary Appendix C - Maternity Report
Officer Contact Details	Anita O'Malley anita.vukomanovic@barnet.gov.uk 0208 359 7034

Summary

Healthwatch Barnet is the consumer champion for health matters in Barnet.

Healthwatch Barnet has been invited to the meeting in order to provide an update on their work. In particular, they will be providing the Committee with an update on their work in relation to End of Life care in hospices, and in relation to maternity care.

The reports set out at appendices A, B and C have been submitted by Healthwatch Barnet for the Committee to consider in advance of the meeting. Members are asked to consider the reports and ask appropriate questions at the meeting.

Recommendations

1. **That the Committee note the report.**

1. WHY THIS REPORT IS NEEDED

1.1 This report provides the Committee with the opportunity to be updated on the work of Healthwatch Barnet.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the issues surrounding health care in Barnet, as picked up by Healthwatch Barnet.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1 Once the Committee has scrutinised the report, they are able to consider if they would like to make any recommendations to Healthwatch Barnet.

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 principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

- There are no financial implications for the Council.

5.3 **Social Value**

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 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.

5.4.2 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."

5.5 Risk Management

5.5.1 Not receiving this report would present a risk to the Committee in that they would not have the opportunity to scrutinise the provision of primary care facilities within the area.

5.6 Equalities and Diversity

5.6.1 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.

5.6.2 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.

5.6.3 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.

5.6.4 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.

5.7 Consultation and Engagement

5.7.4 NHS England are taking the opportunity to engage with the Barnet Health Overview and Scrutiny Committee by submitting this report and attending the Committee meeting.

5.8 Insight

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

6 BACKGROUND PAPERS

6.6 None.

This page is intentionally left blank

Appendix A

healthwatch Barnet

Hospice Care in Barnet

A Healthwatch Barnet Report 2016

Executive Summary

Purpose: why we visited hospices

The recent report '*A Review of Specialist Palliative Care Provision and Access*' shows that there is a huge variation in the overall quality and provision of end of life care across London (London Cancer Alliance, PallE8 and Marie Curie, September, 2015). With this in mind, the Healthwatch Barnet Group for End of Life Care (EoLC) carried out a mapping exercise of current provision and existing EoLC practices in local hospices, in order to identify and to share good practice relating to palliative care and EoLC.

Methodology: how we collected information

During January and February 2016, members of the Healthwatch Barnet End of Life Care Group visited six hospices in North and East London, and Hertfordshire, to carry out face-to-face interviews. Hospices were asked questions relating to their current practices in EoLC and palliative care, relationships between them and care homes, the challenges they face, their training and development needs, and future change anticipated in service provision; detailed anecdotal information was also gathered.

Main observations:

- Hospice care and care at home are increasingly the preferred place of care, compared to hospitals
- Although a few patients may receive hospice care at an early stage of their illness; overall there is a need for it to be offered at a much earlier stage of illness than is currently the case
- Hospices are experiencing budget constraints
- There is a variation in the quality of training and development for staff and volunteers within hospice care

Key themes and recommendations:

The following five key themes and associated recommendations have been identified. They have led to a range of strategic implications for commissioners and operational implications for providers.

1. **Enabling choice for palliative and end of life care**
   - Review journey through care system from initial diagnosis to inform commissioning and improve practice
   - Improve and promote information on EoLC for patients and their families

2. **The quality of care provision**
   - Review best practice relating to staff-patient ratio
   - Ensure bed occupancy has defined staff-patient ratio for quality of care

3. **Resource management and how it is affected by budget constraints**
   - Include EoLC as a review priority in Health and Wellbeing Strategy refresh
   - Include requirement to provide end of life care in care homes when purchasing beds
   - Consider and promote ways to encourage resource sharing

- Create an opportunity for the voluntary and community sector to develop partnership work together in EoLC

4. **Staff and volunteer development**
   - Research and develop ways to attract and keep staff
   - Identify training needs
   - Ensure accredited training for staff and volunteers is available and accessible locally
   - Ensure take up of training amongst staff and volunteers

5. **The engagement of healthcare professionals in providing end-of-life and palliative care**
   - Develop and implement engagement plan for GPs, primary care and care home professionals

Next steps

Further research is needed to see how patients and their families experience current hospice care provision, and with local care homes to get their views about local EoLC provision. This report will be shared with hospices, care homes, HOSC, HWBB, and the wider network of EoLC providers and commissioners.

1. INTRODUCTION

Death and dying are an inevitable part of life, and although people are living longer, they are experiencing longer periods of ill-health before the end of their lives. While some people experience good quality end of life care, many people do not. Although the UK ranked top out of 40 countries in its hospice care network and statutory involvement in End of Life Care (Quality of Death, 2010), the variation in end of life care practice has been highlighted in recent reports, including the Parliamentary and Health Ombudsman's 2015 report Dying without Dignity, and CQC's 2016 report A Different Ending: Addressing Inequalities in End of Life Care.

What is Important to Me Review (2015) emphasises that there is a **national need** to improve End of Life and Palliative Care across the country. Among these needs are to enable individuals make their choice of where to die and to be cared for, to enable access to the right services at the right time and place, and to create the space for individuals to be attended by trained and qualified professionals. The review also highlights these person-centred services can be highly expensive, but there is an opportunity for cost-saving and development.

Barnet's ageing population indicates that there is more likely to be an increasing need for specialist end of life and palliative care. The over-65 population is expected to grow three times faster than the overall population between 2015 and 2030; the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6% (Barnet JSNA 2016-20). Coronary Heart Disease is the number one cause of death amongst both men and women, where men are expected to develop some long term conditions earlier than women. These indicators may suggest that there is a need for high quality EoLC in Barnet. (Barnet JSNA 2016-20). Death in hospital and in hospice care in Barnet is significantly higher than the England average (EoLC Intelligence profile, 2012).

Definitions

This project uses the following definitions of palliative and end of life care.

End of Life Care is described as a term commonly used when patients are identified as being likely to die within the next 12 months; this includes those people whose death is imminent and expected within the next few hours or days (GMC Guidance, 2013). Whereas, ***Palliative care,*** as defined by The World Health Organisation, is "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems,

physical, psychosocial and spiritual." NICE uses a similar definition, referring to "the active holistic care of patients with advanced progressive illness" (End of Life Care JSNA for West London, 2016).

2. AIMS AND OBJECTIVES

Aims

This report is to shed light on end of life and palliative care practices in hospices, in order to inform commissioning and service development in hospices, care homes and all other end-of-life services. Healthwatch acknowledges that, looking into end-of-life care service provision across all other services, requires more resources. Therefore, the report acts as a first step to lay ground for further research for good practice and high quality care.

Objectives

- To undertake a 'shallow dive' insight-gathering exercise to uncover good practice of EoLC in hospices.
- To find out about current links between care homes and hospices with reference to partnership work or shared resources to support the delivery of EoLC.
- To inform hospices, care homes, CCGs, HWBB, and HOSCs of current service provision
- To make recommendations for future service improvement

3. METHODOLOGY

Between January and February 2016, Healthwatch Barnet End of Life Care Group visited six hospices in North and East London and Hertfordshire areas, and conducted semi-structured interviews with their management representatives. The hospices were Peace Hospice Care, St Luke's, St John's, St Joseph's, Marie Curie Care, and North London Hospice. The questions aimed to tease out information on:

- Staff and volunteer development and retention in hospices
- Links between care homes and hospices
- Current challenges hospices face, and demand for end of life and palliative care
- General and specialist services provided by hospices

4. FINDINGS

4.1 Current hospice and EoLC provision

There are hospices that receive patients who are Barnet residents. Hospice care offers high-quality holistic care that includes a range of services including a high staff-patient ratio, 24-hour specialised care, and a range of non-clinical services including alternative therapies, emotional support, and spiritual services besides many others. The current provision in hospices is as follows:

Community care

All hospices offer day care services either at the hospices premises, or in residential settings and at people's homes. The services range from complementary therapies, such as massage therapy, physiotherapy, discussion groups, chaplaincy and spiritual services, bereavement counselling, information on finance and benefits, and signposting to specialist services related to the family's individual needs. GP support is variable and there is often an issue

with getting GPs into a patient's home a maximum of a fortnight before death so that a death certificate can be signed.

In-patient care
All the hospices have an in-patient unit, where an individual is referred by a GP, hospital or other health professionals, and can be admitted for a short period of time, normally for two weeks, pending the complexity of their health condition, and whether or not the hospice is their preferred place of death.

Educational support
Some hospices work closely with a range of other professionals including GPs, care homes, and other hospices. Some hospices share educational resources with other hospices, offering both staff and volunteer development. One hospice assigns a care home coordinator to offer training, to care home staff, in care planning for End of Life Care. Some hospices utilise Gold Standards Framework (GSF) training with GPs and other services, although the uptake from GPs is low.

4.2 Local capacity

The hospices' workforce consists of paid staff to deliver medical care and management roles, and of volunteers to carry out emotional and social support, and frontline administration. Volunteers usually account for the majority of the hospice workforce. Some hospices may prefer to recruit newly qualified nurses who may need an extra support structure in EoLC.

Staff turnover tends to be variable, specifically Health Care Assistants. Some staff move to a nursing or other post. There seems to be a lack of opportunity for personal and professional development particularly in nursing. Staff are more likely to feel deskilled, and therefore, often seek opportunities for career progression outside the organisation.

Qualifications and training requirements for staff and volunteers vary based on roles. Clinical roles have a set of qualifications and training requirements, with some roles requiring work experience. Consultants, GPs, medical directors, neurologists, nurses and other clinicians carry valid registration as per their area of profession. However, recruiting to specific roles, such as nursing, is a constant challenge, due to national shortage. Hospices, therefore, tend to hire registered nurses but they do not need to have had previous work experience in hospices or end of life care, as training in this area will be provided.

Non-clinical volunteering roles, such as befriending, administration, or facilitating community activities, may require some work experience, or relevant training will be provided. A role description and person specifications are usually advertised when recruiting for volunteers to deliver these roles.

4.3 How residents access local services

Referrals are accepted from GPs, hospitals, and other health professionals. Self-referrals are accepted if the patient gives consent to the hospice to seek their GP's consultation for

further assessment and suitability for the hospice services. Usually, patients attending community day services are known to the hospice through their in-patient units.

4.4 Hospice learning and development

All staff and volunteers are required to complete their hospice's training programme. Staff training is mandatory, which includes health and safety procedures, manual handling of equipment, equality and diversity, safeguarding of adults at risk, and infection control. The staff programme, in some hospices, is complemented by having access to annual appraisals, supervision sessions and peer mentoring. Volunteers are usually required to attend an orientation programme about the hospice's policies and procedures, and role-specific training. Volunteers may have access to mandatory training based on their role.

Training is available online and in face-to-face class. Volunteers' uptake of training can be challenging. A number of hospices has increased their volunteers' uptake by changing how the training is delivered.

4.5 How care homes and hospices work together

There is no clear picture of how hospices and care homes are working together as this varies from one hospice to another. However, the links, we observed, between hospices and care homes can be summed up as follows:

- **Education**: Hospices have the skill and expertise to provide training in palliative and end of life care to care home staff. However, care homes have no mandatory contractual obligations for staff development with hospices, and therefore, staff may not necessarily be encouraged to seek professional or personal development
- **Care provision**: hospices provide clinical support and advice when requested to some individuals in care homes

5. KEY THEMES

Key theme 1: Enabling choice for palliative and end of life care

- Hospices and being cared for at home are more increasingly the preferred place of care, compared to hospitals
- Patients may not be aware of the choices available to them and the way to access those choices.

Key theme 2: The quality of care provision

- Hospital discharge into hospices can be a long process. The triage system at different hospices may vary.
- Referrals to hospices usually come at a late stage of a patient's symptoms development
- The preferred priorities of care are dealt with too late, making the creation of difficult conversations more stressful and challenging
- There is a need for hospice care at a much earlier stage than is currently happening, although a few patients may arrive at hospice at an early stage of their illness
- Some beds are left empty in order to accommodate patients with more complex needs and staffing capacity

- Concerns about the shortage of nurses in order to provide high quality care both in the hospice and in the community

Key theme 3: Resource management and how it is affected by budget constraints

- Hospices are considering re-allocating more of their budget from in-patient to community care
- Budget constraints increase competition and call for resource-sharing between hospices
- There seems to be a need for sharing good practice and learning lessons about patient care between hospices, in a manner that facilitates further partnership work and efficiency
- Some hospices have more access to research which may have an impact on creating more development opportunities

Key theme 4: Staff and volunteer development

- The content and mode of staff training varies across hospices
- There is a huge variation in the quality of volunteer training, while the proportion of volunteers is a large part of hospice workforce
- High staff turnover has an impact on building good knowledge, retaining experience, and providing a sound training base
- Although larger organisations attract more highly qualified staff, there is a difficulty recruiting nurses to permanent posts
- Lack of staff retention is evident, especially among, nurses, doctors, and HCAs as they feel they are being de-skilled working in EoLC only

Key theme 5: The engagement of healthcare professionals in providing end-of-life and palliative care

- Lack of engagement from care homes due to staff unavailability and non-contractual requirements for staff development with hospices
- Variation in engagement with GPs

6. RECOMMENDATIONS

A number of reviews and reports (West London JSNA EoLC, Wiltshire CCG Review of EoLC 2015) on End of Life Care emphasise the need for the early identification of people with EoLC needs, providing guidance and training to professionals and families as to how access and make use of existing EoLC services, and also ensuring a consistent approach to quality management in EoLC.

There are strategic and operational implications for commissioners and providers respectively, as follows:

For commissioners	• Include EoLC as a review priority in the Health and Wellbeing Strategy refresh • Ensure accredited training for staff and volunteers is available locally • Create an opportunity for the voluntary and community sector to develop partnership work together in EoLC
For providers	• Ensure take up of training amongst staff and volunteers and set up a personal development plan • Promote community involvement: volunteering in hospices and visitors to care homes/ homes • Review best practice relating to staff-patient ratio
For commissioners and providers	• Consider and promote ways to encourage resource sharing • Identify training needs • Research and develop ways to attract and keep staff • Develop a strategy for training, recruiting and retaining nurses • Review patient journey through care system from initial diagnosis to inform commissioning and improve practice, e.g., shared records • Improve and promote information on EoLC for patients and their families • Develop and implement engagement plan for GPs and primary care professionals, and to enable them keep their EoLC register up to date • Ensure bed occupancy has a defined staff-patient ratio for quality of care

7. NEXT STEPS

These findings are the first step to capture the overall view of current EoLC practices, and of opportunities for development and improvement. The long-term aim is to identify opportunities for capacity-building EoLC in hospices, care homes and other end-of-life services. Further research is needed to see how patients and their families experience the current hospice care provision, and local care homes to get their views about local EoLC provision.

8. REFERENCES

- End of Life Care Guidance, General Medical Council, 2013
- The Quality of Death: Ranking end-of-life care across the world, the Economist Intelligence Unit, 2010
- Exploring the Experience of End of Life Care, Project Report for NHS Wiltshire CCG, 2015
- Place of Dying and End of Life: Summary of Shallow Dive Study Final Report, Healthwatch Cornwall, 2015.
- National End of Life Care Profiles for Local Authorities: Barnet, 2012
- Joint Strategic Needs Assessment, Barnet, 2015-2020
- Policy Briefing: What's Important to Me: A Review of Choice in End of Life Care, Executive Summary, Healthwatch Merton, 2015
- End of Life Care: Key Themes and Recommendations, Joint Strategic Needs Assessment Report for Hammersmith and Fulham, Kensington and Chelsea, and Westminster, 2016
- http://www.ombudsman.org.uk/reports-and-consultations/reports/health/dying-without-dignity
- http://www.wiltshireccg.nhs.uk/wp-content/uploads/2015/05/Final-Patients-Association-End-of-Life-Care-Report-for-Wiltshire-CCG-2015.pdf
- http://www.healthwatchcornwall.co.uk/wp-content/uploads/2015/01/FINAL-PLACE-OF-DYING-EOL-INSIGHTS-AND-EXPERIENCES.pdf
- https://www.barnet.gov.uk/dam/jcr:4b3e6328-6d3e-404b-a7a0-8ffb939b992d/Barnet's%20JSNA%202015-2020,%20Executive%20Summary.pdf
- http://www.healthwatchmerton.co.uk/sites/default/files/policy_briefing_-whats_important_to_me_2.pdf
- http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/la_2012_pdfs
- http://www.jsna.info/sites/default/files/EOLC%20Key%20Themes%20Report.pdf
- http://www.healthwatchlewisham.co.uk/news/review-choices-end-life-care,
- http://www.healthwatchkent.co.uk/news/have-you-experienced-end-life-care-recently

9. ACKNOWLEDGEMENT

Marie Curie Hospice
North London Hospice
Peace Hospice
St Luke's Hospice
St John's Hospice
St Joseph's Hospice
Healthwatch Barnet staff and volunteers

Appendix B

healthwatch Barnet

Pregnancy in Barnet

A review of women's experiences in Barnet

June 2016

Executive Summary

Purpose: Why we are looking into maternity services

The State of Maternity Services reports that the number of births in England was 660,000 in 2014 (Royal College of Midwives, 2015). In Barnet, there were 5,244 births in 2014 (ONS, 2015). The report highlights a number of areas in maternity care, in particular, the demand for more experienced midwives, who are 50 years of age or less, and the fact that the age of expectant mothers is sharply rising to be 40 or older. In the UK, although the number of live births has decreased by approximately 36,600 live births since 2012 (ONS, 2012-2014), it is estimated that 2,600 more midwives are still needed to cover current demand nationally. Moreover, 31% of midwives in England are aged 50 or older, which may imply that newly qualified midwives may not be able to gain the experience they need from their more experienced peers before their retirement. Also the age of expectant mothers of who are 40 or older has increased by 78%. This means that more women require specialist care that responds to their age needs.

The 2015 report describes the ageing workforce of midwives as a 'time bomb', which is hoped to guide commissioners to invest in the development of more qualified and experienced midwives. In Barnet, there are currently 176 WTE[1] midwives practising with an average age of 40[2]. As part of the Royal Free London Trust development programme, the main provider of maternity care in Barnet, a number of midwives got promoted; and an ongoing rolling recruitment programme is in place which states that they will be at full establishment for midwives by December 2016[3].

Healthwatch Barnet carried out a piece of research about the experiences of women who live in Barnet, and used different maternity services across the borough in the last two years. Feedback from mothers in Barnet showed that they had mixed experiences with care; some highlighted the dedication of the long-standing midwives; some had medical complications which required intensive care; whereas others did not have breastfeeding support whilst in hospital. Overall, mothers value the contact and relationships they develop during the period of their pregnancy and after birth, which demonstrates the vital role that professionals, specifically midwives, play in the lives of mothers and their babies.

Methodology: How we made our findings

- A questionnaire was developed by Healthwatch Barnet staff and a volunteer partner, based on the maternity national survey, and was widely circulated through various channels including voluntary-sector organisations, social media and online platforms, including Barnet-based groups on Mums Net, Survey Monkey, Facebook, and Twitter.
- The questionnaire focussed on antenatal, post-natal care, breastfeeding support and community services. Respondents were asked for comments on an optional basis.
- Two hospital visits held; one to Barnet Hospital, and another one to Royal Free London Hospital, as part of Barnet CCG's visit for contract monitoring of service providers.

[1] Employed by the Royal Free London Trust

[2] Information provided by the Director of Midwifery, the Royal Free London Foundation Trust, 17 June 2016

[3] See Note 2

- One engagement event at a parenting workshop.
- One visit to the Royal Free Maternity Service Users' Forum.
- Leaflets distributed in various public events.
- An interview with a midwife, who is also a Healthwatch volunteer.
- We received responses from 74 participants, as follows:
    - Survey: 64 respondents (56 had given birth; 8 were pregnant)
    - Hospital visits: 5 respondents (1 antenatal; 3 postnatal; 1 partner)
    - Maternity Service Users' Forum: 5 participants

Note: All respondents used Barnet-based services, of which 7 respondents used Hampstead-based services at the Royal Free London Hospital. Therefore, the findings of mothers' feedback apply to both service sites (Barnet and Hampstead), except where it clearly highlights a specific service site.

Findings

Feedback was recorded, from new and expectant mothers, during the research period from October 2015 to January 2016. Key themes emerged.

General care

- Mothers generally were happy with the care they received, and there was an acknowledgement that 'midwives were rushed off their feet'.
- More than 50% of mothers had the option of giving birth either at hospital or at a birth centre, compared to 34% had the option of home birth
- 50% of mothers chose their preferred choice for giving birth, for the location, followed by 30% for the type of experience offered to them.
- 38% of mothers did not have a named midwife. Seeing various professionals over a short period of time, had led, sometimes, to receive conflicting advice, more specifically from both hospital and community midwives, and health visitors.
- The communication approach and availability of midwives may impact the mother's experience of care.
- At the Barnet site, there seems to be insufficient recognition of identifying babies who were tongue tied; on one occasion, a mother had sought private services to get this resolved at her own expense. In Hampstead site, one mother claimed to have waited for 20 weeks for a tongue-tie appointment.

Community care

- Making an appointment with community midwives is difficult, due to capacity issues.
- Antenatal appointments are held, sometimes, in non-community settings (eg Chase Farm Hospital), where some mothers may 'find it difficult to access'.
- Appointments with midwives are very short and brief.
- Limited support provided on breastfeeding, and post-natal care.
- Many mothers are not aware of what community support is available including maternity classes.

Hospital care

- An opportunity for raising awareness among expectant and new mothers of maternity care services is available both at the hospital and in the community.

- Barnet Hospital phone advice, for women in labour, has mixed experiences between receiving good advice, and unhelpful information.
- At the Barnet site, food, after labour, may vary and be provided within hours following a woman's labour. Sometimes, it includes tea and biscuits only.
- At the Barnet site, Victoria ward has been described as 'under-staffed'.

Recommendations

A. For commissioners

- To commission accessible antenatal appointments in the local community.
- To commission antenatal services which incorporate increased support for breastfeeding post-natal care.
- To ensure that community support is an integral part of the post-natal support and defined within the service specification.

B. For providers

- To ensure expectant mothers are aware of their named team of midwives, and to provide them with specific contact detail.
- To consider reviewing how to enable mothers make an informed choice, about evidence-based birth options, including home birth as an option for normal pregnancy or to lower risk mothers.
- To ensure that food, in Barnet Hospital after labour, is provided to mothers when needed.
- To explore options for providing breastfeeding support through voluntary groups and other avenues.
- To provide more frequent and longer midwife home visits for postnatal community care.
- To widely promote existing NHS antenatal and postnatal classes through various channels.
- To publicise community post-natal support and proactively signpost new mothers to these services.
- To widely promote the Maternity Service Users' Forum among mothers and their families, and in a user-friendly language.
- To identify training needs of midwives and all maternity-related staff, specifically related to communication.

C. For providers and commissioners

- To ensure babies with a possible tongue-tie condition[4] are being identified and referred for advice in a timely manner.
- To consider reviewing how to ensure that new and expectant mothers are clear about the advice and information provided to them.

D. For midwives

[4] NHS Choices defines tongue-tie as "a problem affecting some babies with a tight piece of skin between the underside of their tongue and the floor of their mouth … [which may] prevents the baby feeding properly and also causes problems for the mother". Website accessed on 31 May 2016

- To ensure that new and expectant mothers are clear about the advice and information provided to them.

E. For expectant and new mothers

- To consider attending and providing feedback at Maternity Users' groups and forums organised by maternity care providers, at a local GP practice, or at hospital
- To ask, your GP, midwife, or health visitor, for help and information when you are in need of advice with regards to antenatal care, breastfeeding support, and all other maternity care

This page is intentionally left blank

Appendix C

healthwatch Barnet

Pregnancy in Barnet

A review of women's experiences in Barnet

June 2016

Contents

Introduction

Healthwatch Barnet is an independent local organisation, and part of the national network led by Healthwatch England. Healthwatch aims to help local people get the best out of their health and social care services, to enable residents to contribute to the development of quality health and social care services, and to provide information on local services in Barnet. It was formed in April 2013.

We listen to people's views about Barnet health and social care services. We listen to individuals of all ages and from all of Barnet communities. We visit community groups, public events, hospitals and health and social care venues to tell local people about Healthwatch. We listen to what they say about health and social care – the good and the bad. If there are concerns about the quality or safety of services, or there are unmet needs, we feedback patient's experience, to local commissioners and decision makers, in order to improve the service.

The Community Outreach Team of Healthwatch Barnet was swift to build upon existing positive contacts and a range of outreach sessions in a variety of venues were arranged. In September 2015, Healthwatch Barnet was present at a meeting with Barnet CCG. There was an urge to learn about the patient experience with maternity services in Barnet. In September 2015, in response to the concerns raised, Healthwatch Barnet designated maternity services as a priority area for research.

Note: All responses of women, who took part in our research, are anonymous except for those who have explicitly expressed their interest to stay in touch with Healthwatch Barnet, and provided their contact detail.

Word cloud: based on 49 quotes from survey respondents

What has worked well?

Support Visits Midwives Breastfeeding Midwife Birth Labour Ward Care Starlight Ward Staff Regular Team

What has not worked?

Tongue Tie Diabetes Staff Natal Care Ward Health Visitors Midwife Support Waiting

Birth Barnet Midwives

Executive Summary

Purpose: Why we are looking into maternity services

The State of Maternity Services reports that the number of births in England was 660,000 in 2014 (Royal College of Midwives, 2015). In Barnet, there were 5,244 births in 2014 (ONS, 2015). The report highlights a number of areas in maternity care, in particular, the demand for more experienced midwives, who are 50 years of age or less, and the fact that the age of expectant mothers is sharply rising to be 40 or older. In the UK, although the number of live births has decreased by approximately 36,600 live births since 2012 (ONS, 2012-2014), it is estimated that 2,600 more midwives are still needed to cover current demand nationally. Moreover, 31% of midwives in England are aged 50 or older, which may imply that newly qualified midwives may not be able to gain the experience they need from their more experienced peers before their retirement. Also the age of expectant mothers of who are 40 or older has increased by 78%. This means that more women require specialist care that responds to their age needs.

The 2015 report describes the ageing workforce of midwives as a 'time bomb', which is hoped to guide commissioners to invest in the development of more qualified and experienced midwives. In Barnet, there are currently 176 WTE[1] midwives practising with an average age of 40[2]. As part of the Royal Free London Trust development programme, the main provider of maternity care in Barnet, a number of midwives got promoted; and an ongoing rolling recruitment programme is in place which states that they will be at full establishment for midwives by December 2016[3].

Healthwatch Barnet carried out a piece of research about the experiences of women who live in Barnet, and used different maternity services across the borough in the last two years. Feedback from mothers in Barnet showed that they had mixed experiences with care; some highlighted the dedication of the long-standing midwives; some had medical complications which required intensive care; whereas others did not have breastfeeding support whilst in hospital. Overall, mothers value the contact and relationships they develop during the period of their pregnancy and after birth, which demonstrates the vital role that professionals, specifically midwives, play in the lives of mothers and their babies.

Methodology: How we made our findings

- A questionnaire was developed by Healthwatch Barnet staff and a volunteer partner, based on the maternity national survey, and was widely circulated through various channels including voluntary-sector organisations, social media and online platforms, including Barnet-based groups on Mums Net, Survey Monkey, Facebook, and Twitter.
- The questionnaire focussed on antenatal, post-natal care, breastfeeding support and community services. Respondents were asked for comments on an optional basis.
- Two hospital visits held; one to Barnet Hospital, and another one to Royal Free London Hospital, as part of Barnet CCG's visit for contract monitoring of service providers.

[1] Employed by the Royal Free London Trust
[2] Information provided by the Director of Midwifery, the Royal Free London Foundation Trust, 17 June 2016
[3] See Note 2

- One engagement event at a parenting workshop.
- One visit to the Royal Free Maternity Service Users' Forum.
- Leaflets distributed in various public events.
- An interview with a midwife, who is also a Healthwatch volunteer.
- We received responses from 74 participants, as follows:
    - Survey: 64 respondents (56 had given birth; 8 were pregnant)
    - Hospital visits: 5 respondents (1 antenatal; 3 postnatal; 1 partner)
    - Maternity Service Users' Forum: 5 participants

Note: All respondents used Barnet-based services, of which 7 respondents used Hampstead-based services at the Royal Free London Hospital. Therefore, the findings of mothers' feedback apply to both service sites (Barnet and Hampstead), except where it clearly highlights a specific service site.

Findings

Feedback was recorded, from new and expectant mothers, during the research period from October 2015 to January 2016. Key themes emerged.

General care

- Mothers generally were happy with the care they received, and there was an acknowledgement that 'midwives were rushed off their feet'.
- More than 50% of mothers had the option of giving birth either at hospital or at a birth centre, compared to 34% had the option of home birth
- 50% of mothers chose their preferred choice for giving birth, for the location, followed by 30% for the type of experience offered to them.
- 38% of mothers did not have a named midwife. Seeing various professionals over a short period of time, had led, sometimes, to receive conflicting advice, more specifically from both hospital and community midwives, and health visitors.
- The communication approach and availability of midwives may impact the mother's experience of care.
- At the Barnet site, there seems to be insufficient recognition of identifying babies who were tongue tied; on one occasion, a mother had sought private services to get this resolved at her own expense. In Hampstead site, one mother claimed to have waited for 20 weeks for a tongue-tie appointment.

Community care

- Making an appointment with community midwives is difficult, due to capacity issues.
- Antenatal appointments are held, sometimes, in non-community settings (eg Chase Farm Hospital), where some mothers may 'find it difficult to access'.
- Appointments with midwives are very short and brief.
- Limited support provided on breastfeeding, and post-natal care.
- Many mothers are not aware of what community support is available including maternity classes.

Hospital care

- An opportunity for raising awareness among expectant and new mothers of maternity care services is available both at the hospital and in the community.

- Barnet Hospital phone advice, for women in labour, has mixed experiences between receiving good advice, and unhelpful information.
- At the Barnet site, food, after labour, may vary and be provided within hours following a woman's labour. Sometimes, it includes tea and biscuits only.
- At the Barnet site, Victoria ward has been described as 'under-staffed'.

Recommendations

A. For commissioners

- To commission accessible antenatal appointments in the local community.
- To commission antenatal services which incorporate increased support for breastfeeding post-natal care.
- To ensure that community support is an integral part of the post-natal support and defined within the service specification.

B. For providers

- To ensure expectant mothers are aware of their named team of midwives, and to provide them with specific contact detail.
- To consider reviewing how to enable mothers make an informed choice, about evidence-based birth options, including home birth as an option for normal pregnancy or to lower risk mothers.
- To ensure that food, in Barnet Hospital after labour, is provided to mothers when needed.
- To explore options for providing breastfeeding support through voluntary groups and other avenues.
- To provide more frequent and longer midwife home visits for postnatal community care.
- To widely promote existing NHS antenatal and postnatal classes through various channels.
- To publicise community post-natal support and proactively signpost new mothers to these services.
- To widely promote the Maternity Service Users' Forum among mothers and their families, and in a user-friendly language.
- To identify training needs of midwives and all maternity-related staff, specifically related to communication.

C. For providers and commissioners

- To ensure babies with a possible tongue-tie condition[4] are being identified and referred for advice in a timely manner.
- To consider reviewing how to ensure that new and expectant mothers are clear about the advice and information provided to them.

D. For midwives

[4] NHS Choices defines tongue-tie as "a problem affecting some babies with a tight piece of skin between the underside of their tongue and the floor of their mouth … [which may] prevents the baby feeding properly and also causes problems for the mother". Website accessed on 31 May 2016

- To ensure that new and expectant mothers are clear about the advice and information provided to them.

E. For expectant and new mothers

- To consider attending and providing feedback at Maternity Users' groups and forums organised by maternity care providers, at a local GP practice, or at hospital
- To ask, your GP, midwife, or health visitor, for help and information when you are in need of advice with regards to antenatal care, breastfeeding support, and all other maternity care

Background

A. Current practice and service provision

Maternity care in Barnet is commissioned by Barnet Clinical Commissioning Group (CCG). Since July 2014, the service has been acquired by the Royal Free London NHS Trust. The Trust offers maternity care at Barnet Hospital, the Royal Free Hospital in Hampstead, Finchley Memorial, and Chase Farm, in addition to community care at general practice, delivering 8,000 babies (5,000 at Barnet Hospital, and 3,000 at the Royal Free Hampstead) per year.

Barnet Hospital

- Maternity day assessment unit: This is a specialist maternity walk-in centre for women who are 20 weeks or more pregnancy, and who have obstetric problems, and require additional care. It is also available for mothers with postnatal problems up to six weeks.
- Parent education classes: A number of workshops for parents are offered including breastfeeding, labour ward tour, water birth besides others. They are offered at Barnet Hospital and local children centres.
- Barnet birth centre: This is an alongside midwife-led unit, and is a newly refurbished birth centre that consists of five birthing suites with private en-suite facilities; three postnatal care rooms with shower and toilet; three birthing pools; and birth stools and amenities. This service provides all forms of pain relief except for epidural.
- Hospital consultant-led unit: This comprises 13 birthing rooms with either private or shared en-suite facilities; 2 obstetric theatres; 4-bedded theatre recovery ward; 2-bedded close observation unit; 2 birthing rooms as bereavement suites; and Victoria ward which is a 48-bedded ward for antenatal and postnatal care. This service provides access to pain relief including epidural.
- Edgware birth centre: This is a freestanding midwife-led unit, and it offers antenatal care; antenatal workshops including infant feeding and active birth and water birth; five en-suite birth rooms and postnatal bedrooms; three birthing pools; and birth stools.
- Amenity rooms: They are rooms available for women who are clinically well, and wish to have extra privacy, on Victoria ward. They can be booked through a midwife once admitted in labour, and it is available on a ‘first come first served’ basis. Women who choose an amenity room are expected to pay for their stay per night, and will be treated as NHS patients. However, if another woman requires the room for a clinical need, this woman will take priority. In this case, any advance payment will be refunded.

Royal Free Hospital, Hampstead

- Maternity day assessment unit: This is a specialist maternity walk-in centre for woman who are 20 or more weeks pregnant and who have medical problems and require additional care. It is also available for mothers with postnatal problems up to six weeks.

- Foetal medicine unit: This is a specialist unit that is made of up of foetal medical consultant and specialist midwives to provide care for women when there is a concern about their unborn baby.
- Heath birth centre: This is an option for women who have been told by their maternity team that they are able to have their baby at home but would feel more comfortable in a hospital setting. It is located at the Royal Free Hospital.
- Parent education classes: A number of workshops for parents are offered including breastfeeding, labour ward tour, water birth besides others. They are offered at the Royal Free Hospital.
- Labour ward: there are five birthing rooms, three bedded close observation maternity assessment unit (high dependency area) and two obstetric theatres.
- Postnatal care: This is a ward that has four 4-bedded areas, one 3-bedded area, four en-suite single rooms, and a feeding lounge. Women can stay here after birth for up to 3 days pending their medical condition. Birthing partners are welcome to visit or stay overnight. The ward is attended by a multi-disciplinary team including midwives, healthcare assistants, paediatricians and obstetricians.
- Tongue-tie service: This is located at the Royal Free Hospital, for newborn babies who require surgery with tongue-tie conditions, where referrals are accepted from North Central London Community.

Community care

- Antenatal care: This includes booking the first antenatal appointment date within two weeks of seeing a GP about a woman's pregnancy, and before reaching 13 weeks of pregnancy. The appointment is arranged with a community midwife to plan antenatal care. A midwife may refer the woman to other professionals including an obstetrician, a physiotherapist, or a dietician as per a woman's needs.
- Postnatal care: After the hospital discharge, a midwife makes a home visit to run a regular check-up on the mother and the new baby. The visit is usually carried out within one day after the mother is discharged from the hospital.

Royal Free Maternity Service Users' Forum

As part of the patient engagement strategy, the Royal Free Trust, organises a series of maternity users' meetings. The meeting serves as (see Appendix for detail):

- An opportunity for mothers to provide feedback about the maternity care they receive
- A platform to seek advice and to find information about what services are available and how to access them.

B. Barnet CCG commissioning intentions for maternity care in 2016-17[5]

- There is a monitoring system in place to review the progress of the service performance and to highlight if there is any action required to rectify any issue. This is delivered through the Maternity Action Plan, with timescales agreed between the provider and Barnet CCG.

[5]For detail, please refer to Barnet CCG's Commissioning Intentions 2016-2017, http://www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Commissioning-intentions-plan-2016-17.pdf

- A London-wide service specification has been developed by the Maternity Strategic Clinical Network during 2015-16. This has been consulted on by commissioners and providers from across London and is implemented within the 2016-17 contract. The Trusts (including RFL) work with CCGs in the sector through the maternity network to ensure that the clinical pathways for these women are appropriate, meet best practice guidelines (e.g. NICE, RCOG) and offer value for money.
- There is a service specification in place for the National Diabetic Eye Screening (DES), for mothers who may require special eye care as a direct result of diabetes.
- In 2016, commissioners plan to work with maternity care providers to identify obstetric and midwifery leads for perinatal mental health.
- Funding has been secured to recruit additional midwives to maintain a midwife to birth ratio of 1:28 as recommended by the RCM and RCOG (Royal Free London, 2016).

C. Comparison with similar services outside Barnet

The 2013 CQC patient survey results for maternity care at the Royal Free London Trust shows similar results compared to other trusts, in terms of women's experience and their families (Quality Assurance, Barnet CCG, 2015). However, the Trust has significantly better scores compared to most other NHS trusts in England for two areas[6]:

- Women were given a choice about where antenatal check-ups would take place
- Decisions about how women wanted to feed their babies respected by midwives

D. Current guidance[7]

Staffing

Although NICE guidance does not recommend a specific staff-to-mother ratio in clinical or community settings, it recommends providing one-to-one midwifery support to mothers during labour. For safe midwifery staffing in maternity settings, however, it offers a systematic approach to establish a staffing ratio, and that is to consider, not exclusively, the following (Safe Midwifery Staffing in Maternity Settings, NICE, 2015):

- The number of midwives and the range of other professionals at any given time
- The skill mix of staff
- Risk factors including medical complications
- Historical trends of maternity care needs, and prediction of maternity demands
- The individual preferences and the need for holistic care

Personalised care

The recent Maternity Review (2016) chaired by Baroness Julie Cumberledge outlines that women should have their own personal maternity budget, which includes one-to-one midwifery care. With the assistance of professionals to make informed decisions, the personal budget will enable women to choose their care package that suits their needs. A pilot scheme could initially be rolled out later in 2016.

Antenatal care

[6] Information provided by the Director of Midwifery, Royal Free London Foundation Trust, 17 June 2016

[7] Please refer to NICE and UNICEF UK guidance for each section, for detail.

NICE guidance (Antenatal Care, 2016) advises that every pregnant should:

- Have a named midwife during her pregnancy
- Have access to antenatal care by week 10 (by week 12 according to an older guidance)
- Receive information on where she will be seen and by who
- Be informed of the likely number, timing and content of antenatal appointments
- Have access to antenatal classes and breastfeeding workshops
- Have the right to accept or decline this opportunity

Birth options

For mothers who have normal pregnancy, they should be encouraged to give birth at home or at a midwife-led unit, provided they are also given information on the range of services and support available should they choose either birth option (Intrapartum Care, NICE, 2014).

Postnatal care

Postnatal care is advised to be holistic and provided up to 8 weeks, pending the condition of the mother and baby (Postnatal Care, NICE, 2016); this would take into account the woman's physical, mental and social wellbeing and her baby, where formal debriefing is not recommended.

Breastfeeding

UNICEF UK calls on the government to promote and to encourage breastfeeding among mothers and professionals by adopting a national strategy for breastfeeding and reducing the advertising of breast milk substitutes in all clinical settings (UNICEF UK, 2016). NICE guidance (2014) on breastfeeding recommends the following, but not exclusively:

- To offer breastfeeding support sessions in the final trimester showing breastfeeding position and how to attach the baby correctly
- To promote breastfeeding benefits and support among mothers, specifically the ones who have access to less education and resources
- To ensure that midwives are appropriately trained and skilled to provide breastfeeding support confidently and competently
- To provide locally accessible peer support on breastfeeding

Findings

"I was able to trust every single one of them. They took their time to explain everything to me".
– An expectant mother at Barnet Hospital.

A. Hospital visits

Healthwatch Barnet made two visits; one to Barnet Hospital; and another one to the Royal Free Hospital in Hampstead. Five participants were met; 2 expectant mothers; 2 mothers at postnatal ward; and 1 partner.

Communication

Staff and clinicians: Generally, all mothers describe hospital staff and clinicians as professional and helpful; they provide detailed explanations about their conditions. This feedback was consistent across both hospital sites.

Agency staff: In Barnet Hospital, one mother reports, during her stay at hospital, that there was a number of agency staff, to whom she felt that she needed to constantly

remind them of her monitoring her blood pressure and other medical needs. She describes regular staff are more attentive, and knows when to follow up with her about her needs.

Changeable team of professionals: In Barnet Hospital, one expectant mother, who was admitted into hospital due to diabetes, says that over a period of 6-8 weeks, she had seen 12-15 professionals from different disciplines.

Environment

In Barnet Hospital, one mother reports, after giving birth, she waited for nearly nine hours, in order for the bed sheets to be replaced. She commented, "It was unhygienic".

B. Survey

There were 64 respondents to our online survey that took part between October 2015 and January 2016; 53 of which had given birth recently; 11 are expectant mothers.

Note:

Around 80% of respondents are Barnet residents, and 20% are not. All respondents used Barnet-based services, either hospital or community services, or both.

Approximately 79% had given birth or plan to give birth in Barnet-based services, 10% used Hampstead-based maternity services, 5% had a home birth and 6% used non-Barnet-based hospital services. See Appendix for a breakdown graph.

Feedback received is as follows:

During pregnancy

Access

- Having difficulties in making an antenatal appointment with a midwife is a reoccurring theme, where mothers report they find it difficult to find a midwife available.
- Appointments with midwives are reported to be very brief, and mothers wish that they are longer.

Choice of birth

- Mothers report that they have been given different options as to where they can have their babies. The majority report that they have been given the choice of giving birth at hospital (56%), followed by giving birth at a birth centre or a midwife-led unit (51%). Home birth was the least option provided (34%). Around 28% of mothers say that they were not given any option due to their medical conditions. See detailed breakdown of responses in Appendix.
- 78% of mothers have chosen Barnet Hospital/Barnet Birth Centre as their first choice for giving birth.

When asked about why they made this choice, location comes as the primary reason, followed by the type of experience offered.

Contact with professionals and midwives

1. 38% of mothers report that they did not have a named midwife or a team of midwives.

"Didn't really receive good advice on how to care for the wound and ended up with an infection. Was told not to use water as stitches were dissolvable. Odd!"

2. Most mothers report that they have either regular contact or often with their midwife during pregnancy, while 19% report that they rarely had any contact
3. Mothers report to have seen different health professionals during their pregnancy; 58% have been seeing a hospital midwife; 52% seeing a community midwife; 47% seeing a hospital doctor or a consultant; 30% seeing a GP. There is also an indication that mothers have seen both a hospital doctor and a hospital midwife only. See Appendix
4. Most mothers report that they had good experiences with midwives, but that their contact with them was either very brief, or not seeing the same midwife. Poor experience, which is only 14% of responses, is mainly highlighted by the unavailability of midwives, brief and short appointments, and doubting the clinical experience of some of the midwives.

Antenatal classes

- The quality of antenatal classes varies based on the capability and the midwifery expertise of the facilitator. Some mothers report that they have attended NHS and private classes. NHS classes are described as informative, and sometimes not comprehensive. Private classes are reported to be informative, but expensive.
- Access to information about antenatal classes and breastfeeding support varies. Some report that they learnt about the classes by word of mouth.

"The health professionals involved in the surgery were brilliant. They really took the time to explain what was happening and reassure us and we're very human. The anaesthetist in particular was great"

At labour

Contact with midwife, hospital ward, or birth unit

Around 58% of mothers say that at the start of their labour had contacted their midwife, labour ward or birth unit. Mothers' experience with phone advice is rather mixed, with some respondents report that they have good and helpful advice, while others report that staff over the phone were unfriendly and unhelpful.

Place of birth

Hospital or labour ward seems to be the place where mothers gave birth; 76% of mothers report that they have given birth in hospital or a labour ward; followed by a birth centre or a midwife-led unit; and only 2 mothers had a home birth.

Medical complications

51% of mothers report that they had medical complications. Some mothers had to change their first choice of place of birth, moving from a birth centre or a home birth to a labour ward in hospital. This is either for medical reasons; or because the midwife did not attend on time for the planned home birth.

Partner's involvement

Overall, mothers report that they had a positive experience having their partners involved in the birth process, with some highlighting that their partners were encouraged and made feel welcome to stay longer. Two mothers comment that their partner felt either "…useless" or "the midwife in charge…was not partner-friendly".

Contact with baby after birth

82% of respondents say that they had skin-to-skin contact with their baby shortly after birth. Those who did not have contact was for medical reasons; one mother claims that the contact option was not offered.

Interventions during the birth

Mothers report to have had the following interventions during the birth, in order of response numbers, indicated between (), as follows:

- Stitches (27)
- Internal/external tears (18)
- Assisted vaginal delivery (18)
- Episiotomy (12)
- Un-planned Caesarean section (8)

Support and advice

Mothers rate receiving pain relief and receiving general information after birth as good or excellent support. And they rate the food and drinks service, and breastfeeding support to be of a poorer service. Emotional support received is rated mostly as adequate. Generally, Victoria ward, at Barnet Hospital, has been described as 'under-staffed', with 'no adequate care'.

Food and drinks are generally described as basic to include sandwiches, crisps, and with some mothers report to have received tea and toast only, while some report that they had been offered food after a few hours up to one day after birth.

Breastfeeding advice has mixed experience. When it is provided is either informative or helpful, or conflicting as it is provided by different professionals. Some mothers report to not have any breastfeeding advice at all despite being in hospital for a few days. See Appendix for demonstrations.

Ward and facilities

- The new facilities at Barnet Birth Centre are described as improved and 'like being at home'
- Some mothers report to have been cared for well, while others acknowledge that the postnatal ward was understaffed.
- A high number of visitors in postnatal ward per mother can be uncomfortable and noisy.
- Postnatal care is described as inadequate with important advice and information is not provided after birth.
- Mothers may receive conflicting advice as a result of being looked after by various midwives.
- After birth, sometimes a private room is available. Some mothers report to have moved, after birth, due to the unavailability of rooms.

Hospital discharge

The discharge process has been generally described as a delayed process, where some mothers 'had to push' for discharge, which is due to delays in obtaining blood test results or paperwork outstanding. Nearly 8% of mothers were discharged late at night.

After birth and postnatal community support

Midwife's visits

- Appointments booked for midwife's home visits are given with no specific time slot during the day.

Postnatal community support

- Conflicting advice provided by professionals is due to having different midwives and health visitors for different visits.

C. Royal Free Maternity Service Users' Forum

The meeting focussed on seeking the mothers' feedback on the service they are receiving at the hospital; seeking their views working more closely with a community midwife as a new model of care in the community; and providing them with advice and information on various maternity care and services. The meeting was led by midwives, and held at the Royal Free London Hospital, at the Labour Ward. For detail on the women's feedback and midwives' advice provided, please see the Appendix

D. Overall survey feedback from mothers

What is working well?

- Having a designated and consistent team of professionals or midwives
- Midwives attended their appointments regularly
- Antenatal care on the high dependency ward was appreciated
- Clean and friendly environment at the birth centre
- Health professionals including ACACIA team, anaesthetists, hospital and community midwives are helpful and caring

What is not working?

- Attending antenatal appointments, at Edgware or Chase Farm Hospital may be inconveniently located for women who may find it difficult to travel to, and not locally accessible in the community
- "The stitching process and recovery. The stitches didn't hold well and gaped. I was also upset that I couldn't donate cord blood as it was a weekend. This is an essential resource which should be available 24/7"
- Conflicting advice from different professionals
- Midwives are 'rushed off their feet'
- Tongue-tie complications are not recognised by paediatricians
    - More postnatal care is needed
    - More breastfeeding support is needed
    - Mistakes made by doctors and midwives
    - Lack of clarity or information about health conditions

- Lack of access or time with doctors for advice and information
- Short appointments with midwives
- More night staff are needed

Analysis

A. Service operations

- *Birth options*: The majority of mothers, from the survey, choose to give birth at Barnet Birth Centre or Barnet Hospital, as opposed to other options including home birth. They have indicated that their choice is mainly made based on the location, and the information they receive about the type of birth experience they are going to have should they use the birth centre. This may reflect the strong relationship mothers develop with their midwife or health professional, and the trust they place in their advice and expertise. From the survey, it seems that mothers prefer to give birth at a birth centre, despite that approximately 50% of survey respondents did *not* report to have had any clinical complications or medical needs, and therefore, are considered to likely have a normal or low-risk pregnancy. Evidence suggests that home birth is very likely to be a safe option for second time and low-risk mothers. It would be useful to carry out further research as to why mothers choose the type of experience offered in a birth centre, compared to other birth options; what resources a mother is looking for to support her baby's birth; how mothers feel about giving birth at home as opposed to a birth centre; and what resources a midwife needs in place to support a home birth?
- *Tongue-tie condition*: 6% of survey respondents report that they their baby had a tongue-tie condition which they felt it was not taken seriously or recognised by paediatricians or midwives. This may imply that this condition may culturally not be recognised, among maternity professionals, to have a perilous impact on breastfeeding or baby's development.
- *Skin-to-skin baby contact:* it is commended to notice that most mothers report to have had skin-to-skin baby contact, in accordance with NICE guidelines, which is often encouraged by midwives, except in the case that the baby or mother may have clinical needs, where contact may be delayed until it is safe.
- *Breastfeeding support:* it appears that breastfeeding support may be inconsistently provided both at hospital and at home. The variation in support reportedly highlighted by mothers is to be due to the variation in identifying issues that affect breastfeeding (e.g tongue-tie condition), the lack of support staff to offer breastfeeding advice, or to the provision of conflicting advice from various professionals on breastfeeding. Further research, onto the role of lactation consultant in the NHS, may be needed, and through linking with the NCT (National Childbirth Trust).
- *Postnatal care:* Mothers seems to have a mixed experience with care provided after birth at hospital and at home. Repeatedly, there is a request for having support on breastfeeding, quality food after birth, and longer and time-specific home visits. This may indicate that women's experience is calling for a holistic approach to provide postnatal care from delivery to home visits. This is consistent with UNICEF and NICE guidelines, for children and women's mental and physical wellbeing.

B. Resources

- *Capacity*: Mothers highlight that community midwives' home visits are often very short and brief; midwives arrive late to appointments; or provide unspecified time slots during the day for their home visit leaving the mother waiting for them at home all day. Further research is needed to explore as to why mothers have this experience with community midwives, and as to why there is a slightly higher rate of respondents who used hospital midwives more than community midwives.
- *Midwifery competence*: Mothers recognise that newly qualified midwives need support from more experienced midwife peers in order to build up their confidence and clinical expertise in supporting mothers and identifying any underlying medical issues at an early stage.
- *Staff-patient ratio*: there is a variation of mothers' satisfaction with postnatal support (including food, breastfeeding), after giving birth immediately, which highlights the importance of having a consistent staff-patient ratio. There seems to be no clear guidance from NICE regarding a staff-mother ratio for antenatal, and postnatal community support. NICE recommends that one-to-one support should be offered during labour only. This may have led to variations in providing care in the antenatal and postnatal period, where midwives are more likely to be available during labour but not before or after birth.

C. Women's experience

- *Recognition of good midwifery practice*: mothers emphasise the value of having a good relationship with their midwife and other health professionals. Regardless of their experience with care, they repeatedly appreciate the importance of having a supportive and competent midwife who makes a valuable difference to their baby and quality of life during and after pregnancy.
- *Relationship with a named midwife*: nearly 40% of mothers report to not have a named midwife, either due to having a normal pregnancy or being followed up by a GP, due to a shortage of midwives. Most respondents appreciate to have a designated team or a named midwife with whom they are able to build a relationship. Evidence shows that having a good relationship with a midwife supports the mother and baby for better physical, mental and emotional development, where a midwife is able to detect early signs of medical issues, and provide the necessary advice and support, to reduce the risk of any further complications.
- *Individual's experience vs. clinical conditions*: from the survey, it appears that women have mixed care experiences. In some cases, having an easier birth and a normal pregnancy may lead to having a positive experience with maternity care, while having clinical complications may lead to having a negative experience with care. What makes the difference is to have a consistent and continuous approach to care, provided by a supportive, competent and accessible midwife.

"One of my appointments was over Christmas when my [GP practice] was closed so they told me to go to the hospital. The midwife spent the first 5 minutes of the appointment telling me that the doctors shouldn't have sent me and they are over worked as it is… rushed the appointment"
An expectant mother.

Recommendations

A. For commissioners

- To commission accessible antenatal appointments in the local community.
- To commission antenatal services which incorporate increased support for breastfeeding post-natal care.
- To ensure that community support is an integral part of the post-natal support and defined within the service specification.

B. For providers

- To ensure expectant mothers are aware of their named team of midwives, and to provide them with specific contact detail.
- To consider reviewing how to enable mothers make an informed choice, about evidence-based birth options, including home birth as an option for normal pregnancy or to lower risk mothers.
- To ensure that food, in Barnet Hospital after labour, is provided to mothers when needed.
- To explore options for providing breastfeeding support through voluntary groups and other avenues.
- To provide more frequent and longer midwife home visits for postnatal community care.
- To widely promote existing NHS antenatal and postnatal classes through various channels.
- To publicise community post-natal support and proactively signpost new mothers to these services.
- To widely promote the Maternity Service Users' Forum among mothers and their families, and in a user-friendly language.
- To identify training needs of midwives and all maternity-related staff, specifically related to communication.

C. For providers and commissioners

- To ensure babies with a possible tongue-tie condition are being identified and referred for advice in a timely manner.
- To consider reviewing how to ensure that new and expectant mothers are clear about the advice and information provided to them.

D. For midwives

- To ensure that new and expectant mothers are clear about the advice and information provided to them.

E. For expectant and new mothers

- To consider attending and providing feedback at Maternity Users' groups and forums organised by maternity care providers, at a local GP practice, or at hospital
- To ask, your GP, midwife, or health visitor, for help and information when you are in need of advice with regards to antenatal care, breastfeeding support, and all other maternity care

Conclusion

Women consistently appreciate the value of building a long lasting relationship with their midwife who is able to recognise them by their first name, and to make them feel valued and cared for. Most of the issues and concerns, raised by the mothers in the survey, emphasise the value of long-term investment in staff development and recruitment of experienced and competent midwives who are caring and supportive of women's needs. It is commended to note that maternity care is at the top priority list for commissioners and providers in Barnet. It would be useful to work in partnership with mothers and patients, keeping in mind, that investing in relationship-building between mothers and midwives is what would provide good care and healthy families on the long-term. Further research is needed to explore a sustainable approach to antenatal and postnatal community support including breastfeeding, lactation, and the recruitment and development of more community midwives.

"People do not buy goods and services. They buy relations, stories and magic" - ***Seth Godin***

References

- Antenatal Care, NICE Guidance, April 2016
- Barnet CCG commissioning intentions for maternity care in 2016-17
- Births by area of usual residence of mother, UK, ONS, 2012-2014
- Intrapartum Care for Health Mothers and Babies, NICE, 2014
- Maternity care at Barnet Hospital, Royal Free London. Retrieved on 6 May 2016
- Maternity care at the Royal Free Hospital, Royal Free London. Retrieved on 6 May 2016
- Maternity Services at Royal Free London Foundation NHS Trust, Quality Assurance Report, Barnet CCG, 2015
- Royal Free London Maternity Risk Register, November – December 2015. March 2016
- Safe Midwifery Staffing in Maternity Settings, NICE Guidance, February 2015
- State of Maternity Report Royal College of Midwives, 2016

Acknowledgement

- Barnet CCG
- Healthwatch Barnet staff and volunteers
- Participants and members of the public
- Royal Free London NHS Foundation Trust
- Sarah Brown, a Healthwatch volunteer and a midwife

Glossary of Terms

CCG	Clinical Commissioning Group
GP	General Practitioner
NICE	National Institute for Health and Care and Excellence
NCL	North Central London
NCT	National Childbirth Trust
RCOG	Royal College of Obstetricians and Gynaecologists
RCM	Royal College of Midwives
RFL	Royal Free London
WTE	Whole Time Equivalent

Appendix

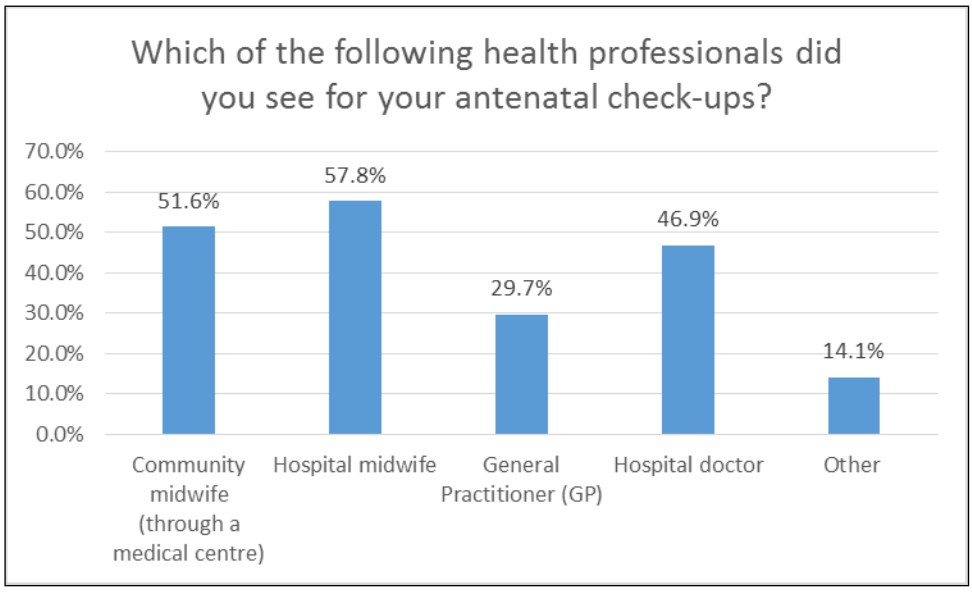
Mothers' feedback and midwives' advice at the Royal Free Maternity Service Users' Forum

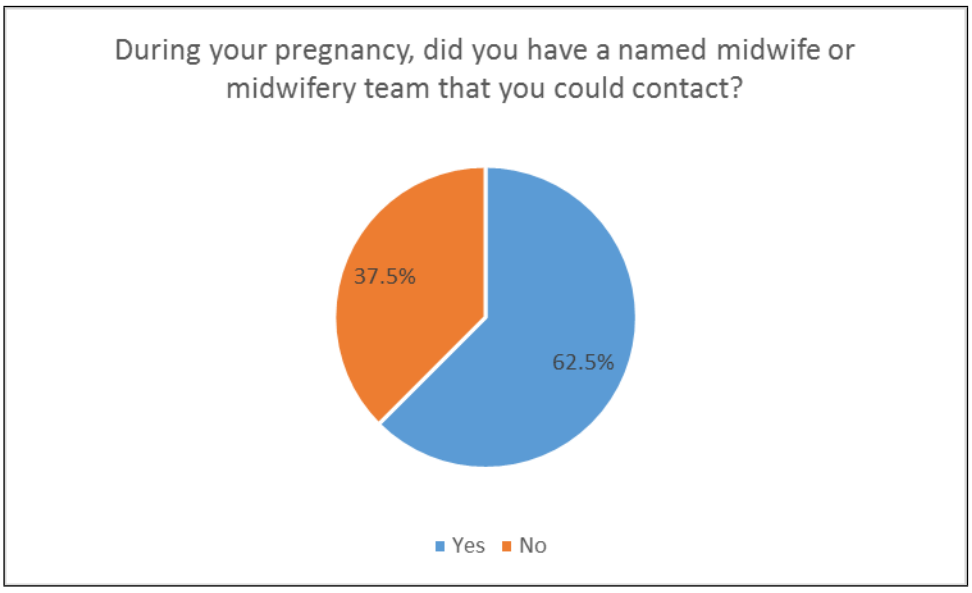
- "I prefer to work with a hospital midwife if I am coming [to the hospital]"
- "I would like to see continuity working with the same midwife"
- "I like the labour service here. It is my third baby, and it is great"
- "I don't have a community midwife as yet"
- "I had a bad experience coming from another hospital to the Royal Free, but it is such a good experience being here [at the Royal Free]"
- "It would be good if medical records are accessible across both sites in Barnet and the Royal Free Hospitals"
- "It would be good to have some clarity on why we are being called for" – a comment provided on receiving calls from midwives.
- "The medical care here is excellent, and the forward care planning is reassuring"
- "I was waiting in A&E for 11 hours, and I felt dehydrated, but then the doctor told me that I did not need to wait at A&E and I should go straight to see him".

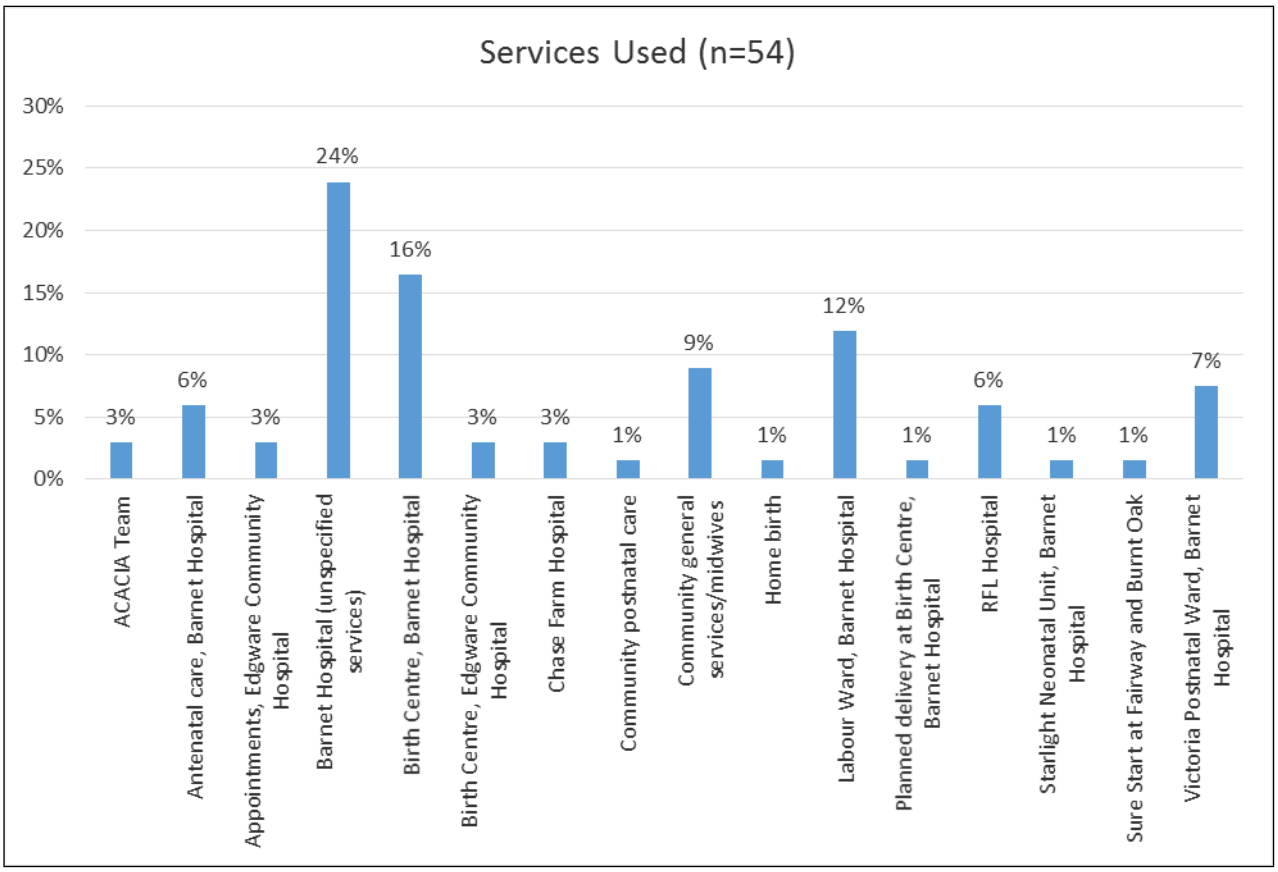
The following information was provided in the group meeting:

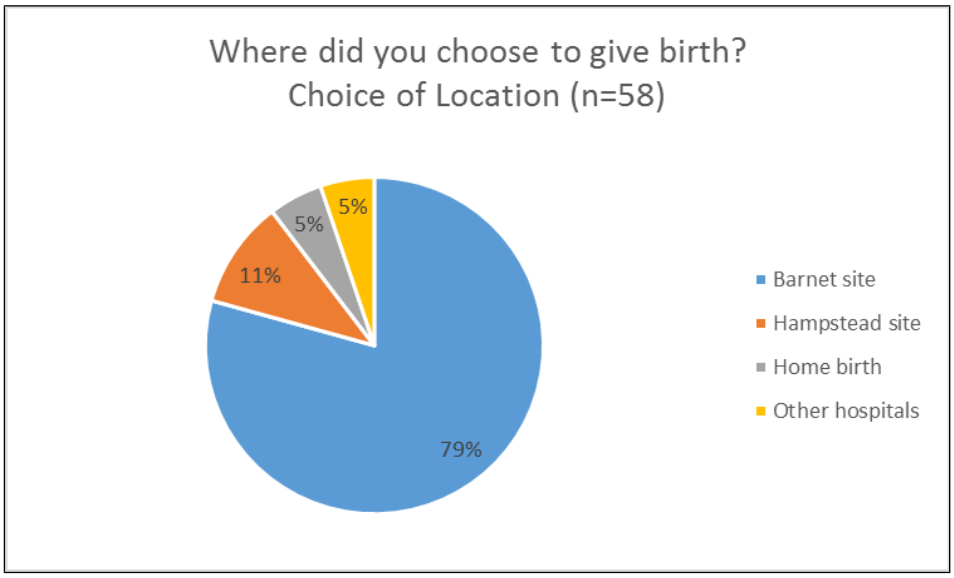
- If you are pregnant and coming to A&E, ask to see an obstetrics professional, and you will be seen shortly.
- Ask for help and information from your midwife or the professional team.
- Visit the Royal Free Trust's website as a valuable resource to find general information and advice.
- If you have any concerns before you go into theatre for your planned C-section, talk to your midwife about your wishes for skin-to-skin contact with your baby, or when you see appropriate.
- Check the Royal Free Trust's twitter account for general information on maternity care.
- Register with their local Children Centre for further community support and information on breastfeeding.
- Complete Family and Friends Test to send your feedback to improve services.
- The Royal Free Trust aims to get national accreditation for the Breastfeeding Enhancement Service, with the aim to increase confidence among mothers on breastfeeding.

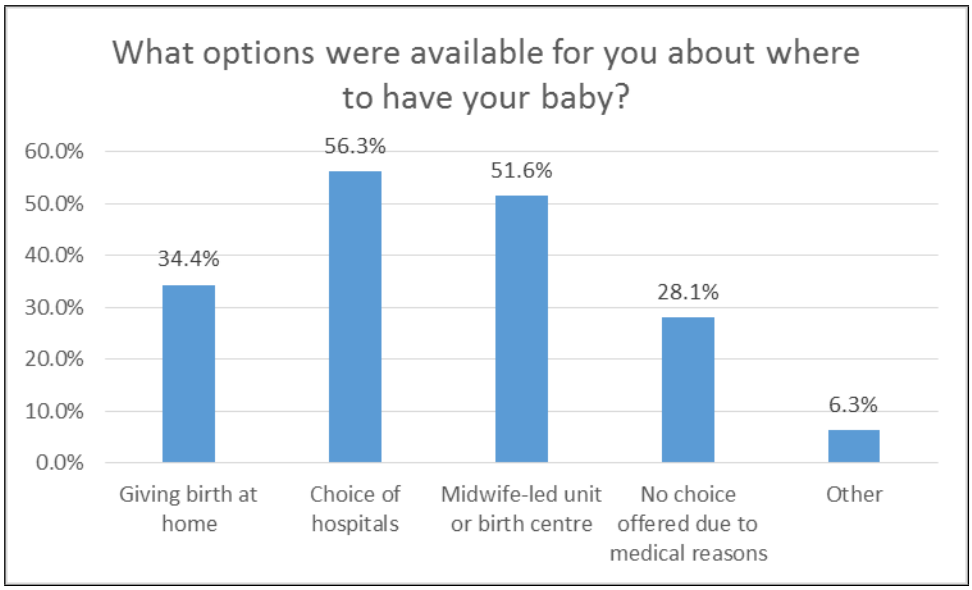
Graphs

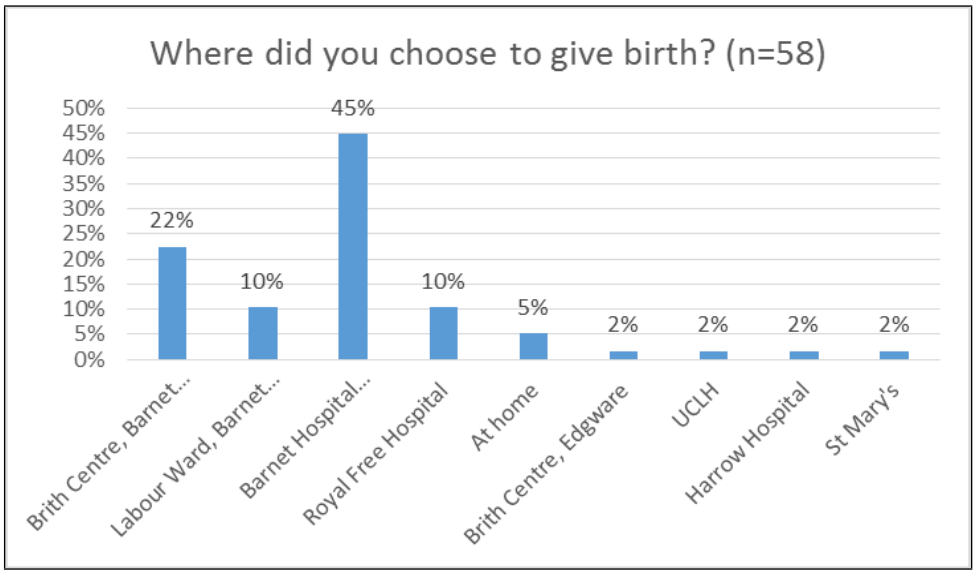

Which of the following health professionals did you see for your antenatal check-ups?
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
51.6%
57.8%
29.7%
46.9%
14.1%
Community midwife (through a medical centre)
Hospital midwife
General Practitioner (GP)
Hospital doctor
Other

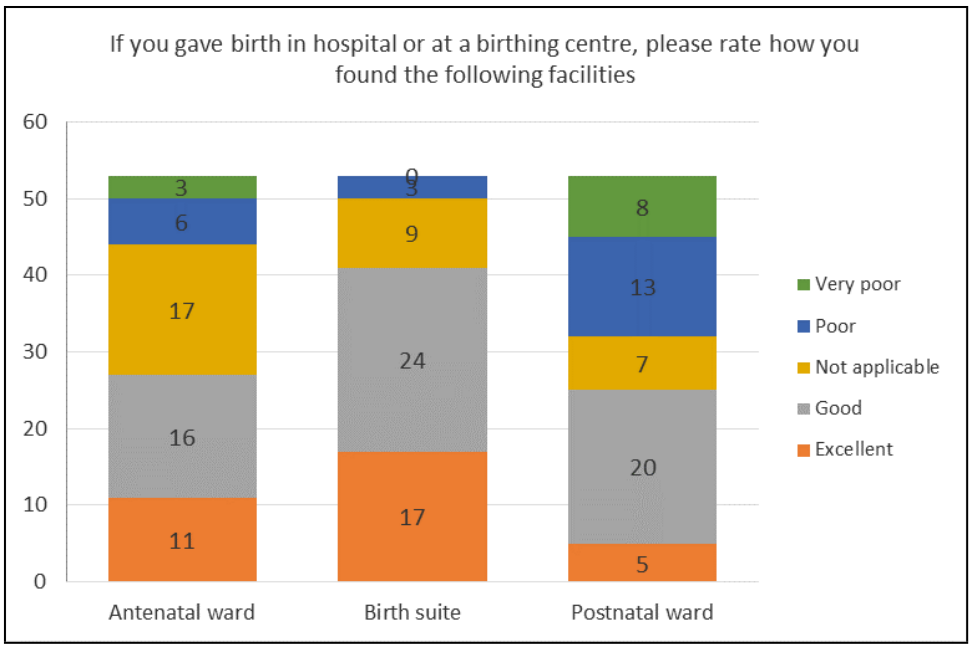

During your pregnancy, did you have a named midwife or midwifery team that you could contact?
37.5%
62.5%
Yes
No

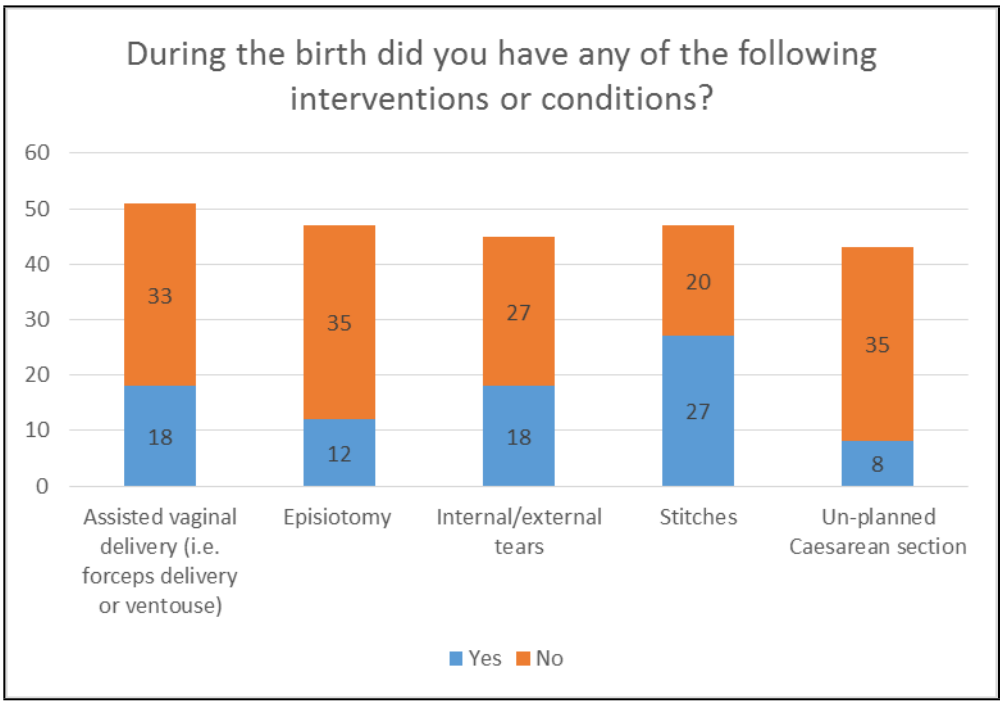

Services Used (n=54)
30%
25%
20%
15%
10%
5%
0%
3%
6%
3%
24%
16%
3%
3%
1%
9%
1%
12%
1%
6%
1%
1%
7%
ACACIA Team
Antenatal care, Barnet Hospital
Appointments, Edgware Community Hospital
Barnet Hospital (unspecified services)
Birth Centre, Barnet Hospital
Birth Centre, Edgware Community Hospital
Chase Farm Hospital
Community postnatal care
Community general services/midwives
Home birth
Labour Ward, Barnet Hospital
Planned delivery at Birth Centre, Barnet Hospital
RFL Hospital
Starlight Neonatal Unit, Barnet Hospital
Sure Start at Fairway and Burnt Oak
Victoria Postnatal Ward, Barnet Hospital

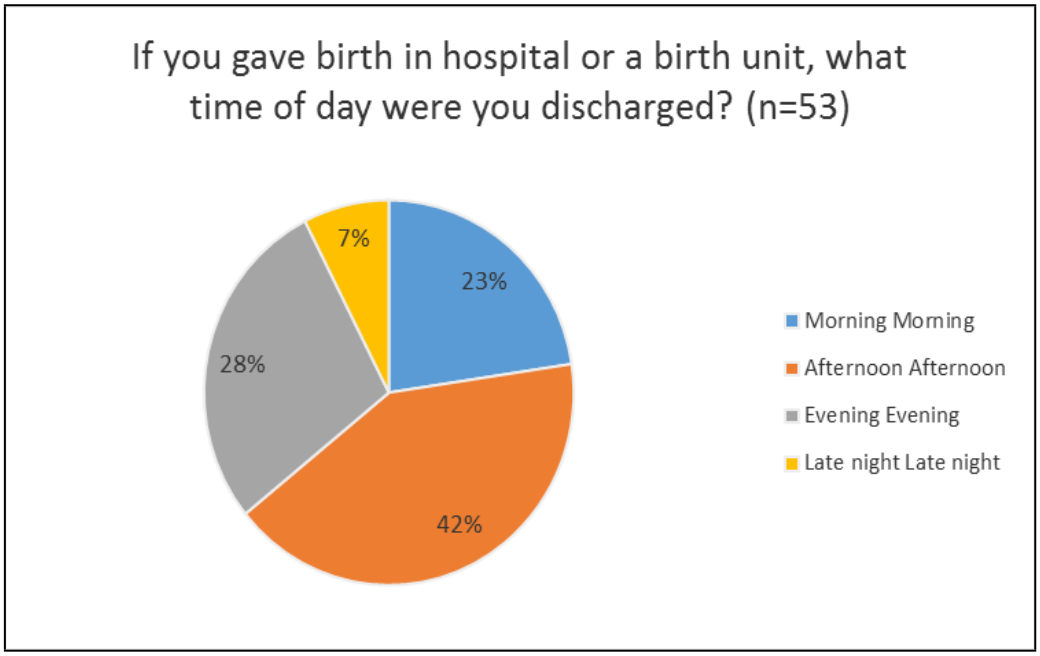

Where did you choose to give birth?
Choice of Location (n=58)
5%
5%
11%
79%
Barnet site
Hampstead site
Home birth
Other hospitals

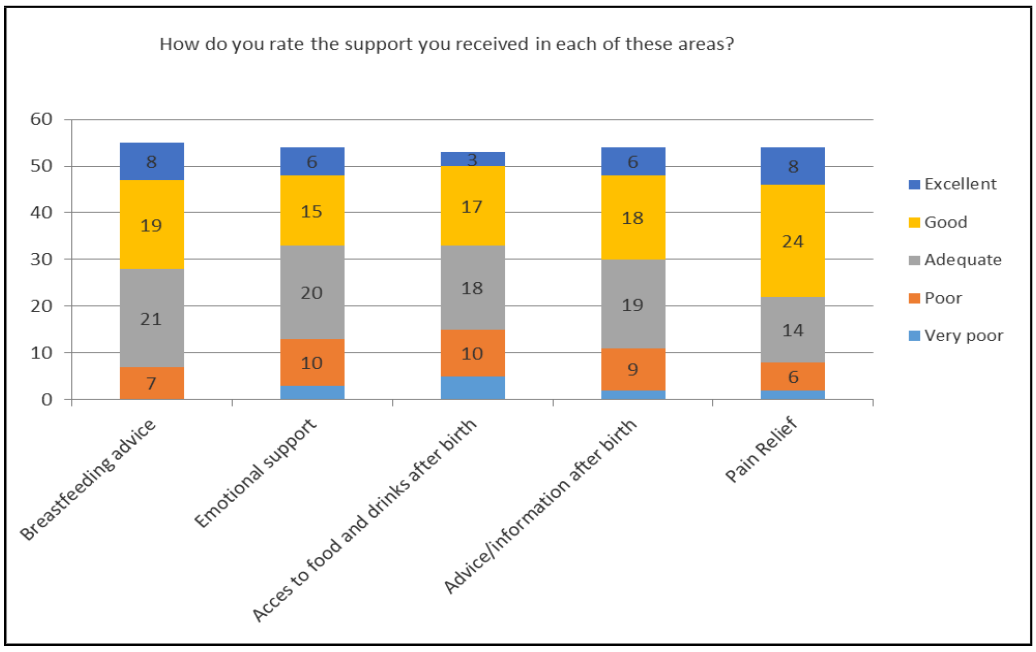

What options were available for you about where to have your baby?
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
34.4%
56.3%
51.6%
28.1%
6.3%
Giving birth at home
Choice of hospitals
Midwife-led unit or birth centre
No choice offered due to medical reasons
Other


Where did you choose to give birth? (n=58)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
22%
10%
45%
10%
5%
2%
2%
2%
2%
Brith Centre, Barnet...
Labour Ward, Barnet...
Barnet Hospital...
Royal Free Hospital
At home
Brith Centre, Edgware
UCLH
Harrow Hospital
St Mary's


If you gave birth in hospital or at a birthing centre, please rate how you found the following facilities
60
50
40
30
20
10
0
3
6
17
16
11
9
3
9
24
17
8
13
7
20
5
Antenatal ward
Birth suite
Postnatal ward
Very poor
Poor
Not applicable
Good
Excellent


During the birth did you have any of the following interventions or conditions?
60
50
40
30
20
10
0
33
18
35
12
27
18
20
27
35
8
Assisted vaginal delivery (i.e. forceps delivery or ventouse)
Episiotomy
Internal/external tears
Stitches
Un-planned Caesarean section
Yes
No


If you gave birth in hospital or a birth unit, what time of day were you discharged? (n=53)
23%
42%
28%
7%
Morning Morning
Afternoon Afternoon
Evening Evening
Late night Late night


How do you rate the support you received in each of these areas?
60
50
40
30
20
10
0
8
19
21
7
6
15
20
10
3
17
18
10
6
18
19
9
8
24
14
6
Excellent
Good
Adequate
Poor
Very poor
Breastfeeding advice
Emotional support
Acces to food and drinks after birth
Advice/information after birth
Pain Relief

This page is intentionally left blank

AGENDA ITEM 12

Health Overview and Scrutiny Committee

4 July 2016

Title	**Health Overview and Scrutiny Committee Work Programme**
Report of	Governance Service
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Committee Forward Work Programme
Officer Contact Details	Anita O'Malley, Governance Team Leader 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 2016/17 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2016/17 work programme**

1. WHY THIS REPORT IS NEEDED

1.1 The Health Overview and Scrutiny Committee Work Programme 2016/17 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 This approach allows the Committee to respond to Health related matters of interest in the Borough.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 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.

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be published on the Council's website.

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 2015-20.

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

5.2.1 None in the context of this report.

5.3 **Social Value**

5.3.1 N/A

5.4 **Legal and Constitutional References**

5.4.1 The Terms of Reference of the Health Overview and Scrutiny Committee is included in the Constitution, Responsibility for Functions, Annex A.

5.5 **Risk Management**

5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**

5.6.1 None in the context of this report.

5.7 **Consultation and Engagement**

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

London Borough of Barnet Health Overview and Scrutiny Committee Forward Work Programme July 2016 - May 2017

Contact: Anita Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk

Title of Report	Overview of decision	Report Of *(officer)*	Issue Type (Non key/Key/Urgent)
4 July 2016			
Adult Audiology, Wax Removal and Community ENT Service	Committee to receive an update report from Barnet CCG on the redesign on the Adult Audiology, Wax Removal and Community ENT Service.	Barnet CCG	**Non-key**
Healthwatch Enter and View Reports and Update Report	Committee to receive a report from Healthwatch Barnet on their recent work. The report will provide an update in their activities in relation to a) maternity and b) hospices	Healthwatch Barnet	**Non-key**
Finchley Memorial Hospital	Committee to receive a report on the utilisation of facilities at Finchley Memorial Hospital	Barnet CCG	**Non-key**
Colindale Health Project	Committee to receive a report from NHS England and LBB on the Colidale Health Project.	NHS England and Barnet CCG	**Non-key**
6 October 2016			
Health Tourism	Committee to receive a report from Barnet CCG and The Royal Free London NHS Foundation Trust on health tourism.		**Non-key**

Title of Report	Overview of decision	Report Of *(officer)*	Issue Type (Non key/Key/Urgent)
5 December 2015			
Cricklewood GP Health Centre	Following the report on 6 July 2015, the Committee have requested to receive an update report on services at the Cricklewood GP Health Centre.		**Non-key**
Items to be Allocated			
Eating disorders	Following a Member's Item in the name of Councillor Trevethan, the Committee received a report on Eating Disorders at their meeting in May 2016. The Committee have resolved to request a further report on the matter from Barnet CCG.		**Non-key**

This page is intentionally left blank