MEETING
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
THURSDAY 6TH OCTOBER, 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
Anmar 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 Monday 3 October 2016. Requests must be submitted to anita.vukomanovic@barnet.gov.uk

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

Andrew Charlwood – Head of Governance

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Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

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Decisions of the Health Overview and Scrutiny Committee

4 July 2016

Members Present:-

AGENDA ITEM 1

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

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

Also in attendance
Councillor Helena Hart

1. MINUTES (Agenda Item 1):

The Chairman noted that the Committee had considered the urgent item on childhood immunisations in Barnet at the last meeting and resolved to refer the issue to the Secretary of State for Health. The Chairman commented that Committee Members were provided with the draft letter to comment on before it was sent. The Committee noted that the letter had been sent and, whilst a response had not yet been received, the Chairman would chase a response if necessary.

The Chairman welcomed Councillor Anmar Naqvi, who was attending his first meeting.

The Committee considered the minutes of the last meeting as set out in the report and noted that the word, “that” in paragraph 8 of Agenda Item 7 (Children’s Mental Health and Eating Disorders) was duplicated, and requested that one “that” be deleted.

Subject to the above change, the Committee:

RESOLVED that the minutes of the last meeting be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

None.

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

Councillor Stock declared a non-pecuniary interest in relation to Agenda Item 11 (Healthwatch Barnet Update Report) 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.

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

7. MEMBER'S ITEM - COUNCILLOR COHEN (Agenda Item 6a):

The Chairman introduced the Member's Item in the name of Councillor Philip Cohen. The Chairman informed the Committee that she had asked the Governance Officer in attendance to contact both relevant parties - NHS Property Services, and Central London Community Healthcare NHS Trust (CLCH) to provide a response on the issue. The Committee noted that CLCH had not responded to the request.

The Member's Item drew attention to the fact that certain additional services, namely District Nursing, Baby Clinics, COPD Clinics and Physiotherapy, provided by the East Barnet Health Centre prior to its closure, have not returned to the centre since its reopening. However, they are still being delivered in other locations.

Councillor Cohen informed the Committee that he had raised the issue with the East Barnet Residents' Association who had received confirmation from CLCH that this was because NHS Property Service are changing the charging arrangements.

The Chairman noted that the Governance Service had circulated a response to Committee Members from NHS Property Services prior to the meeting, which was as follows:

> *"For the new financial year 2016/17 there were some important changes to charging arrangements. This included a move to market-based rental charging on all freehold properties, which has been agreed with the Department of Health and NHS England.*
>
> *On 4 April 2016 Pat Mills, Commercial Director at the Department of Health issued a letter to the NHS to set out the background on the move to market rentals along with the reimbursement arrangements (please see attached).*
>
> *The move to market rents is consistent with initiatives being introduced more widely across central government to improve utilisation and value for money in property occupancy.*
>
> *As a result of the changes, many occupiers will see higher rental charges, however others will reduce. It is important to note that it is intended that any cost increases are reimbursed and commissioners will receive funding adjustments from NHS England to make this possible.*
>
> *The change has benefits for the NHS:*
> *•It helps the NHS understand the true cost of occupation and reflect these transparently.*
> *•It informs decisions about the best location for services and investment.*
> *•It drives better and more efficient use of space.*
> *•The rent is one of a set of actual costs applied transparently to each occupation, allowing invoices to be clearly itemised.*
> *•Itemised invoicing provides clarity about costs for the use of space and services, enabling any inconsistencies to be identified."*

The Chairman proposed that the Committee requests a response from CLCH and if the response is not satisfactory or not received, then a full report be requested for the Committee's October meeting. The Committee agreed to this.

RESOLVED that the Committee provides their instructions to the Governance Service in respect of this item as set out above.

8. MINUTES OF THE NORTH CENTRAL SECTOR LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Agenda Item 7):

The Chairman introduced the last two sets of minutes from the North Central London Joint Health Overview and Scrutiny Committee (JHOSC).

The Committee considered the minutes of the meeting dated 11 March 2016.

The Chairman noted that at the meeting, the Chairman had amended her declaration of interest to note that the Eleanor Palmer Trust, of which she is a trustee, only runs one care home, not more than one, as indicated in the minutes.

The Chairman informed the Committee that when considering Agenda Item 6 (GPs in Care Homes) the Committee had been informed that Barnet CCG had undertaken a pilot of enhanced service to care homes from 2014-15, but that the pilot had not been renewed as it had not resulted in a decrease in the number of ambulance callouts to take patients to A&E.

The Chairman informed the Committee that the London Borough of Enfield has a Care Home Assessment Team (CHAT) which has been successful in reducing unnecessary A&E visits and has resulted in enhanced care for care home residents generally. The Chairman suggested that GPs in Care Homes should be put on the Committee's work programme.

A Member of the Committee commented on the role of key worker housing in relation to recruitment of healthcare industry staff. The Governance Officer in attendance informed the Committee that the matter of keyworker housing would not fall within the remit of this Committee. The Chairman suggested that the Member could discuss the possibility of the Housing Committee receiving a report on the matter.

A Member requested that the Committee receive a report on the Sustainability and Transformation Plan (STP). The Chairman suggested that the Committee receive a report on the STP once it has been considered by the JHOSC. The Chairman undertook to ask the JHOSC Chairman when the JHOSC would receive the STP, so that the Committee could then determine when to receive its own report.

The Committee considered the minutes of the JHOSC meeting dated 29 January 2016.

The Chairman referred to the Maternity Services Update item and noted that a resident who was in attendance at the meeting had commented that as North Middlesex University Hospital is situated in a very diverse community, there are particular pressures on its services. The resident referred to the issue of unbooked deliveries which is placing extra, unforeseen pressure on maternity services. The JHOSC had questioned

the circumstances surrounding the number of unbooked deliveries at the North Middlesex University Hospital. The JHOSC had been informed that such mothers might not have a GP because of their residency status.

A Member asked if the JHOSC might look at the effect of the European Union referendum on the health service. The Chairman suggested that the Member contact the JHOSC Chairman, Councillor Alison Kelly, to enquire.

The Chairman informed the Committee that the JHOSC was a public meeting and all Members were welcome to attend.

RESOLVED that the Committee notes the minutes of the JHOSC.

9. ADULT AUDIOLOGY, WAX REMOVAL AND COMMUNITY ENT SERVICE (Agenda Item 8):

The Chairman invited Dr. Ahmer Farooqi, GP Board Member of Barnet Clinical Commissioning Group and Theresa Callum, Head of Programmes - Demand Management, Barnet Clinical Commissioning Group (CCG), to the table.

Ms. Callum introduced the report and noted that when the Committee had last received a report in December 2015, the CCG were planning to decommission the existing service with the intention of bringing all services under one umbrella and going to procurement from one provider. The Committee noted that this procurement process had resulted in the appointment of a new provider, Concordia Health. Ms. Callum informed the Committee that mobilisation meetings have been set up with Concordia Health in order to ensure that the service is ready to begin operation on 1 October 2016.

A Member noted that the proposed new model would see services provided side by side at two or three locations and asked where the locations were. Ms. Callum informed the Committee that services would be provided at Finchley Memorial Hospital and Edgware Community Hospital. The Committee noted that the option of the third site had been left open as the CCG wanted to see where patients would be coming from.

Ms. Callum informed the Committee that to make the service viable, the CCG has, so far, felt that there needed to be a maximum of three sites. However, the option of having a fourth site is being maintained in case it proves necessary.

A Member questioned why Concordia Health had won the contract. Dr. Farooqi informed the Committee that all bidders had scored highly, but Concordia Health had achieved the highest score. Although Concordia health were new providers in Barnet, they have a track record of already providing ENT services in Haringey. Dr. Farooqi also noted that Concordia Health had demonstrated very good attention to detail in terms of the patient pathway, as well as demonstrating good IT processes. The Committee noted that bidding for a contract was an open process and that the bidder with the highest score would win the contract.

A Member questioned how the contract would be monitored to ensure that the service is provided to the expected standard. Dr. Farooqi informed the Committee that Barnet CCG had been in contact with the neighbouring CCG who already commission Concordia Health. Ms. Callum noted that the CCG has already started a series of fortnightly mobilisation meetings with the provider to ensure that the service is ready for October and informed the Committee that as with any other contract, it would be

monitored very closely at the start to ensure it is being delivered to the required standard. The Committee noted that the CCG would also obtain feedback from patients and referring GPs.

The Chairman asked how many ENT sites in Haringey were run by Concordia Health. Dr. Farooqi undertook to provide this information to the Committee.

Responding to a question from the Chairman, Dr. Farooqi informed the Committee that the length of the Barnet contract was three years plus with an option to extend to five, although either side could give six months' notice.

The Vice Chairman asked if there would be any savings as a result of the new service. Ms. Callum informed the Committee that it was hard to predict any savings because demand for the service increases each year.

A Member questioned if it would be possible to reduce the number of appointments a patient would need to attend to one single visit. Ms. Callum informed the Committee that the contract has the requirement to see 95% of patients within one visit and that if this is not achieved, the provider must provide clinical evidence to explain why not.

Responding to a question from a Member, Dr. Farooqi informed the Committee that nose and throat treatment tends to be dealt with in one go in a community setting, but if this is not possible, then the patient would be referred into a hospital setting.

Responding to a question from a Member, Ms. Callum informed the Committee that the CCG would provide a briefing on progress six months into the live contract (April 2017) The Chairman suggested that when the Committee have received the briefing, they can decide if they require a further report.

RESOLVED that:

1. **The Committee requests to be provided with the number of ENT sites run by Concordia Health in Haringey.**
2. **The Committee requests to be provided with an update on service delivery six months from the go live date, ie in April 2016.**
3. **That the Committees notes the report.**

10. COLINDALE HEALTH PROJECT (Agenda Item 9):

The Chairman invited Vanessa Piper, Assistant Head of Primary Care, NHS (London Region) and Adam Driscoll, Commissioning Lead – Planning, London Borough of Barnet, to the table.

Mr. Driscoll informed the Committee that public consultation had been undertaken and that work on an Outline Business Case for the replacement of the Graham Park Health Centre, together with the Full Business Case for a new start-up Practice in Beaufort Park had begun. The Committee noted that the documents would be going through the internal governance processes for NHS England and Barnet CCG in autumn 2016.

The Vice Chairman expressed concern about health care capacity in the Beaufort Park area due to the increase in population in the past four years. The Vice Chairman advised that he was not aware of any increase of GP provision in the

area. Mr. Driscoll informed the Committee that Graham Park would have both children's centres and GP services.

The Vice Chairman asked for confirmation on the timing of providing additional GP capacity and for recruiting GPs before a property for a GP practice had been found. Ms. Piper informed the Committee that in addition to the contract providing for additional GP capacity, there were additional NHS England initiatives to increase provision. Mr. Driscoll informed the Committee that the project would be taken straight to Full Business Case in order to speed up the process.

The Vice Chairman sought assurance that the new service would be in operation within a year, or that it would be imminent and in conjunction with increased GP capacity in the area too. Ms. Piper informed the Committee that the London Borough of Barnet and NHSE could set out the discussions that they have had regarding increasing GP capacity in the area.

The Chairman invited Sean Barnett, Interim Programme Manager for Barnet CCG, to the table. Mr. Barnett informed the Committee that the CCG was undertaking a number of schemes to increase physical capacity, workforce and diversity of the workforce.

A Member reiterated the point made by the Vice Chairman on the growth of population in the area and stressed the need for ensure adequate GP capacity.

Referring to the report, the Chairman noted that Burnt Oak Councillors had been contacted as part of the consultation. The Burnt Oak Councillor present on the Committee advised that he was not aware of any outreach consultation to Ward Councillors. Mr. Driscoll undertook to look into the reasons why.

A Member questioned when the Committee could receive an update report following the business cases being reviewed by NHSE. The Committee noted that the business cases would be seen by NHSE in the Autumn and instructed that they receive a report at either their October or December meeting.

RESOLVED that the Committee notes the report and requests a further update at a future meeting.

11. FINCHLEY MEMORIAL HOSPITAL (Agenda Item 10):

Mr. Barnett remained at the table and introduced the report, which provided the Committee with an update on the plans to develop new services at Finchley Memorial Hospital and improve the utilisation of the building.

The Committee noted that the CCG's preferred options for the utilisation of the site were as follows:

1.) An Older Person's Assessment Service: Which would provide good value for money and would be suitable for the types of patients that were anticipated at the hospital.
2.) Using the empty in-patient ward to expedite transfer of patients from acute care.

3.) Breast Screening Unit: There is currently a mobile facility on site every four months but the CCG want this service to be permanently located within the hospital and available all year.
4.) New Primary Care Services, closely aligned to the existing Walk-in Centre.

The Committee noted that talks about the utilisation of the site had led to suggestions that the space could also incorporate a community hub and the CCG were in early talks with one community group about taking up some space in the building.

A Member expressed her frustration and noted that the Committee were told in October 2015 that the empty space was going to be put to use but that this had not yet come to fruition. The Member commented that there were a huge number of patients needing treatment and that this space needed to be used. The Member noted that the ideas of the utilisation of the site were excellent, but that a decision needed to be taken on the matter so that progress could be made. Mr. Barnett informed the Committee that the CCG had been through a huge amount of change in terms of senior staffing and that making a decision to move this forward was now progressing. Mr. Barnet advised the Committee that, where possible, the CCG was working with existing providers such as The Royal Free London NHS Foundation Trust and Central London Community Healthcare NHS Trust (CLCH) to make sure that the space can be utilised safely whilst providing value for money. It was acknowledged by Mr. Barnett that the empty space was incurring a significant cost.

The Member commented that the space was empty and questioned why patients could not just be moved in. Mr. Barnett informed the Committee that the CCG was required to commission certain services and had to follow the correct procedures. Mr. Barnett also noted that the CCG was taking the issue very seriously due to both the cost and pressure on the wider system. The Member noted that the Committee had expressed concern on the same matter a year ago.

A Member noted the issue of the cost of renting space on the site and commented that it could be difficult to persuade GP Practices to be based on site. Responding to a question from a Member, Mr. Barnett informed the Committee that the Walk in Centre is not a GP Practice but, by having it closely aligned with one, if a patient attending the Walk in Centre was not already registered with a Practice, they could register there.

The Member questioned how Delayed Transfer of Care could be reduced. Mr. Barnett informed the Committee that closer integration of primary care with secondary providers would assist with improving figures for Delayed Transfer of Care through the Discharge to Assess (DTA) service once commissioned.

The Chairman noted that the Older Person's Assessment Service would be opened by the end of the year but sought clarification as to whether this meant the financial year or the calendar year. Mr. Barnett undertook to provide this information to the Committee outside of the meeting.

A Member commented that the way that CCGs commission services can result in problems such as getting services into a complex building like Finchley Memorial Hospital and questioned when the problems started and if there would be a change in the way the NHS commissions. Mr. Barnett informed the Committee that it is difficult to commission good quality services into a building already being used by other services and that may require building works to facilitate service delivery. The Committee noted that former Primary Care Trusts used to have powers to provide services but the CCG is

not a provider and instead commissions services. The Committee noted that NHS England and the CCG have powers to jointly commission services as part of North Central London. However, this can cause some delay as there are five CCGs involved. The Committee noted that the CCG is hoping to move to Level 3 commissioning which would reduce NHS England's involvement and is consulting with GP practices before making a final decision along with the other CCGs in the NCL cluster.

The Chairman sought clarification as to whether the empty inpatient ward would be operational in time for winter 2016. Mr. Barnet undertook to provide this information outside the meeting.

Responding to a question from the Chairman on the mobile Breast Screening Unit, Mr. Barnett informed the Committee that the unit visited the site three times a year and would ordinarily expect the next visit to the site again in November 2016 but that he expected the permanent Breast Screening Unit to be housed before November 2016.

The Chairman suggested that the Committee receive an update report on the Finchley Memorial Hospital site at their meeting in December 2016. The Chairman also requested that the issue of primary care services be covered in that report.

A Member questioned if it would be possible to integrate the Falls clinic at Finchley Memorial Hospital with the Older Person's Assessment Service. Mr. Barnett informed the Committee that the service would take a holistic approach in undertaking assessments on Older People. Such a service would be designed to encompass a range of services provided by other organisations such as the Falls clinic either in partnership or as part of the service itself. This could also include psychological therapies and psychiatry work.

RESOLVED that:

1. **The Committee notes the report.**
2. **The Committee requests to be informed whether the empty inpatient ward would be operational in time for winter 2016.**
3. **The Committee requests that the Director of Strategic Development at Barnet CCG be invited to provide a further update report to the Committee at their meeting in December 2016.**

12. HEALTHWATCH BARNET UPDATE REPORT (Agenda Item 11):

The Chairman invited Mike Rich, Head of Healthwatch Barnet, Amani Fairak, Policy and Research Officer, Healthwatch Barnet, Brent and Newham and Janet Tawsig, a Healthwatch Barnet Volunteer, to the table.

Mr. Rich introduced the item and noted that the reports looked at healthcare provision across the borough. Mr. Rich informed the Committee that the Hospice report had aimed to do a "shallow dive" into hospice services available in the Borough. The Committee noted that Healthwatch Barnet had carried out the report as a result of soft intelligence, such as people telling Healthwatch Barnet about their experiences.

Referring to the maternity report, Mr. Rich noted that the majority of people had seemed generally happy with their experience in Barnet. Mr. Rich noted that one of the themes

that had come across clearly from the people interviewed was they saw midwives were very under pressure.

The Committee noted that resourcing the community midwifery service could be a challenge and that patients sometimes found it difficult to get an appointment, the result of which often meant that women could be pushed back into hospital services, which reduced their choice.

Referring to the report, a Member noted that 38% of mothers had reported that they did not have a named midwife and questioned if there was a shortage of midwives in Barnet. Mr. Rich informed the Committee that the feedback had indicated that appointments with midwives are often brief and therefore it had been assumed that there was shortage of community midwifes. Mr. Rich commented that it appeared that with pressure of the numerous things that midwives had to do during an appointment, such as taking blood and urine samples, it left little time for patients and community midwives to get to know each other.

A Member noted that despite the maternity report analysis highlighting that 38% of mothers do not have a named midwife, this was not supported in any of the recommendations resulting from the report. Mr. Rich informed the Committee that the Royal Free, who are the maternity provider in Barnet, have advised that they plan for every woman to have a named midwife. The Chairman requested whether Healthwatch Barnet had received a formal response from the Royal Free, and if so, if could it be provided to the Committee. Mr. Rich undertook to contact the Royal Free and provide evidence that they have a plan which would then be circulated to the Committee. The Chairman also requested that the Royal Free be asked to provide any further comment on the research set out in Healthwatch Barnet's maternity report.

The Chairman further noted that 6% of the maternity survey respondents had reported that their baby had a tongue-tie condition which they felt had not been taken seriously or recognised and she commented that the figure seemed abnormally high. The Chairman asked that Healthwatch request that the Royal Free also provide comment on this statistic.

Referring to the hospice report, Mr. Rich informed the Committee that their local research had shown that people facing end of life care wanted choice and one of the challenges people had found was a lack of available information, making it hard for them to make choices. The Committee noted that Healthwatch Barnet felt that there was a need to join together with the community and voluntary sectors to make sure that this information was available. Mr. Rich informed the Committee that the report had also shown the following:

- That hospices are facing considerable financial restraints
- That very few places are available at the North London Hospice and that the triage process is such that it is very hard to access a place

The Vice Chairman noted that the Committee received the Quality Account from the North London Hospice on an annual basis. The Vice Chairman questioned the rationale for the hospices chosen for the report and commented that he would understand if a comparison was going to be made between the services received at each. Mr. Rich noted the point and commented that each hospice was one that Healthwatch Barnet thought would have patients from the borough. Mr. Rich informed the Committee that there was a need to do some comparison work and reiterated that the report before the Committee was a "shallow dive"

Ms. Tawsig informed the Committee that the Marie Curie and St. John's Hospices referred to in the report deal with some extremely specialist cases due to their location next to the Royal Free London Hospital. Ms. Tawsig also informed the Committee that the Peace Hospice in Watford has a good reputation and that that sometimes, managerial staff from the North London Hospice will visit the Peace Hospice to consider best practice.

The Vice Chairman commented that the report contained interesting points but noted that the report was not clear as to whether hospice care in the area was good or not. Mr. Rich noted that this was an important point but that the report should be seen first and foremost as a mapping exercise.

The Chairman referred to the hospice report and noted the comparisons between training for volunteers at different hospices. Ms. Tawsig informed the Committee that research had been undertaken to compare the continual training for volunteers, including how people work on inpatient units, health and safety training, and if health and safety e-learning is a useful tool. Ms. Tawsig advised the Committee that volunteers at the Watford hospice would give a choice of training to volunteers, some of which was face to face.

The Chairman noted that general requests for more face to face learning for volunteers had not been taken on board by all hospices. Mr. Rich advised that Healthwatch Barnet had some concerns about the work on training needs that was done with e-learning.

The Chairman informed the Committee that in the last financial year, 2,323 patients had been treated by the North London Hospice at the Barnet and Enfield sites and that they reach a huge number of people. The Chairman noted that the requirements of washing down and cleaning rooms between patients resulted in a certain amount of lost bed days.

RESOLVED that:

1. **The Committee notes the reports from Healthwatch Barnet.**
2. **The Committee requests that Healthwatch Barnet contact the Royal Free London NHS Foundation Trust and provide the information as set out above.**

13. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME (Agenda Item 12):

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 referred to the item that the Committee had considered on the utilisation of Finchley Memorial Hospital and noted that it had originally been intended that two GP Practices move onto site but that the costs involved were too high. Councillor Hart noted that the Practices that had been interested in occupying the Finchley Memorial Hospital site had required a better and wider range of services for patients in order to make it worthwhile for them to spend the money and that, in the end, they had chosen not to move in. Councillor Hart echoed the concerns raised by the Health Overview and Scrutiny Committee in relation to the issues raised during the consideration of the Finchley Memorial Hospital item. She also welcomed the decision to provide a permanent breast screening unit that she had been advised it would be in place by the end of the summer. Councillor Hart informed the Committee that she had been following

up on the issue of breast screening which had been raised by the Member of Parliament for Finchley and Golders Green and noted that breast screening coverage was currently at 64%. The Committee noted the need for being proactive and issuing follow up letters to those who do not take up a screening appointment.

The Committee noted that, at their last meeting, they had received an urgent item on the issue of childhood immunisation rates in Barnet. Councillor Hart informed the Committee that she was aware of new information that the Committee would be interested in which was as follows:

- Since the beginning of 2016, the North London Health Protection Team have been notified of 58 positive cases of Measles, 6 of which are from Barnet.

The reason why 6 cases have been contracted in Barnet included:

- 1 child receiving one MMR jab, but not the second.

The Committee noted that it is possible given the age of those contracting measles who had not been immunised, that it was a result of the MMR and Autism scare some years ago.

Councillor Hart advised that it was important to read these reasons in public session and to stress that one dose of MMR vaccination is not sufficient and that there is no proven link between the vaccine and Austim. Dr. Howe informed the Committee that NHS England, who are responsible for childhood immunisations, were insistent that the issue of the uptake of immunisations was a problem with the dataset. However that could not yet be confirmed.

The Committee noted that a Member briefing on Public Health had taken place earlier that evening and that Dr. Fabunmi had provided an update on Children's Centres. Councillor Hart informed the Committee that all Children's Centres in Barnet had now achieved "healthy status".

The Committee noted that Barnet had been placed joint first in London for a Gold Award as part of the Healthy Schools Programme and commented that is was positive that schools were recognising mental ill health as a problem among young people and doing something about it.

Councillor Hart informed the Committee that the campaign on Shisha was progressing well and that campaign materials, including posters for buses and the underground, were being produced. The Committee noted that the campaign material was hard hitting and was being tested on focus groups of young people. The Committee noted the importance of young people understanding the dangers of shisha and noted that a programme with young people would see children making videos on shisha. The Committee noted that Environmental Officers would be making visits to establishments licensed to sell shisha to check for compliance. A Member of the Committee noted that shisha was a licensing issue and suggested that representatives from Licensing should attend the Health and Wellbeing Board whilst the issue is being discussed. Councillor Hart informed the Committee that Licensing were involved and that they were also participating in a Task and Finish Group, which included senior representatives from Planning, Licensing, Environmental Health and Public Health. The Committee noted that Councillor Hart would report back on the progress of the Task and Finish Group in due course.

A Member commented on the need for the public to be more aware of the complications that can arise from contracting Measles, Mumps or Rubella, which can include going blind.

The Chairman suggested writing to specific age cohorts about the dangers of MMR. Dr. Howe informed the Committee that Public Health England are considering doing that and that they already have an age related campaign underway. Dr. Howe undertook to speak to Public Health England about this suggestion.

A Member suggested that when the Committee receive the scheduled report on Health Tourism, the issue of Brexit be considered. The Chairman advised that, at the moment, Britain was a Member of the European Union and that the report that had been requested was to do with non-EU citizens receiving treatment.

The Vice Chairman suggested that the Committee received a report from the London Ambulance Service NHS Trust concentrating on North London and analysing whether patients from Hospices were able to gain access to A&E.

A Member commented that Capita had been awarded an England-wide contract of administrative support services for Primary Care and suggested that both the Committee and the North London Joint Health Overview and Scrutiny Committee (JHOSC) receive a report on the matter. The Vice Chairman suggested that the Member liaise with the Chairman of the JHOSC to see if it was a report that could be considered. The Chairman asked the Member if he had received any complaints from residents in the Borough regarding this. She stated that she had not received any complaints and Councillor Hart agreed that she had not received any either. The Member informed the Committee that the issue had been reported in the health press. The Member undertook to provide the Governance Officer with the relevant health press articles.

A Member noted that the Committee was due to receive a report on eating disorders and requested that this report also address the issue of Body Dysmorphia. The Committee agreed to this request and asked that the scope of the eating disorders report be amended to include this.

RESOLVED that:

1. **The Committee notes the Forward Work Programme.**
2. **The Committee requests that the issue of Body Dysmorphia be included within the future Eating Disorders report.**

14. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 13):

None.

The meeting finished at 9:50 pm

AGENDA ITEM 6

	Health Overview and Scrutiny Committee **6 October 2016**
Title	**Member's Item in the name of Councillor Philip Cohen – Sustainability and Transformation Plan**
Report of	Head of Governance
Wards	All
Key	No
Urgent	No
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:

Sustainability and Transformation Plan

"I request that the HOSC receives an update on progress to produce the North Central London Sustainability and Transformation Plan, including details of what changes or cuts to health services are likely to be included in the plan, the impact on local health services, and full details of the public consultation."

2 REASONS FOR RECOMMENDATIONS

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

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

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

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 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.

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

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 The 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.

5.3.2 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.*

5.4 Risk Management

5.4.1 None in the context of this report.

5.5 Equalities and Diversity

5.5.1 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.

5.6 Consultation and Engagement

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 10TH JUNE, 2016** at 10.00 am in the Committee Room 1, Islington Town Hall, Upper Street, London N1 2UD

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Richard Olszewski (LB Camden)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
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. ELECTION OF CHAIR FOR MUNICIPAL YEAR 2016-17

RESOLVED –

THAT Councillor Alison Kelly be elected as Chair of the Committee for the 2016-17 municipal year.

2. ELECTION OF VICE-CHAIR FOR MUNICIPAL YEAR 2016-17

RESOLVED –

THAT Councillors Pippa Connor and Martin Klute be elected as Vice-Chairs of the Committee for the 2016-17 municipal year.

3. DECLARATIONS OF PECUNIARY, NON-PECUNIARY AND OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

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.

4. ANNOUNCEMENTS

There were no announcements.

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

There were no notifications of any items of urgent business.

6. TERMS OF REFERENCE

RESOLVED –

THAT the terms of reference of the Committee be noted.

7. MINUTES

RESOLVED -

(a) THAT the minutes of the meeting held on 11 March 2016 be confirmed and the Chair be authorised to sign them, subject to the following amendments –

Minute 2 – Page 7 - Declaration of Interests – amend the words 'care homes' in paragraph 3 to 'one care home in the Borough of Barnet'
Minute 6 – Page 10 – GPs in Care Homes – in the first paragraph, delete the word 'the' and insert the word 'their' before 'largest 10 care homes'

ACTION – PETER MOORE (ISLINGTON COMMITTEE SERVICES)

(b) THAT the Chair, Councillor Kelly, update the Committee at the next meeting on identifying the best way of tackling the issue of the CAMHS service not being person-centred enough

ACTION – COUNCILLOR ALISON KELLY (CHAIR)

8. MINUTES OF BARNET, ENFIELD AND HARINGEY MENTAL HEALTH SUB-GROUP

RESOLVED –

THAT the minutes of the Barnet, Enfield and Haringey Mental Health Sub-Group meeting held on 13 May 2016 be noted.

9. NCL SUSTAINABILITY & TRANSFORMATION PLAN AND ESTATES DEVOLUTION PILOT

Mike Cooke, Chief Executive of L.B.Camden, and Dr. Jo Sauvage, Chair of Islington CCG, representative of the NCL Transition Group and co-Chair of the NCL Clinical Cabinet, were present for discussion of this item. Ray James, Director of Health, Housing and Adult Social Services at L.B.Enfield was also present.

The tabled presentation was outlined for Members.

During discussion of the report the following main points were made –

- It is important to recognise that financial and performance challenges cannot be met by adopting the same approach as in the past, and that there is a need to develop a more sustainable system, with more of a focus on early intervention and prevention and to recognise that primary care is an important element in this
- NCL is a complex health area and whilst progress is being made, there are important short and long term issues that need to be addressed
- A Clinical Cabinet has been set up and there is good social care input and Finance Directors are also meeting on a regular basis, in order to look at financial challenges and ways of closing the financial gaps
- NHS England was expecting a submission on proposals by the end of June, however it had since been recognised that this would now just be a 'staging' post for interim proposals, but there is a need to continue to develop the planning process with wider engagement from August/October, which would include residents, voluntary and community sector organisations and the community, together with Trusts and Local Authorities
- The NCL organisations were working together, whilst recognising that each borough had different needs. However, there is a collective commitment to deliver a strategic commissioning framework and to have a standardised process for delivery and access to primary care and to look at the areas of inequality
- There is an opportunity to deliver services more effectively and institute better prevention measures, however there is also the need to work more closely with other organisations, such as pharmacies and the voluntary and community sector in delivering services
- In response to a question, it was stated that there were a range of people involved in the Clinical Cabinet, which include Public Health, Directors of Social Services, Directors of Children's Services, etc.
- There will be some areas where all 5 boroughs will need to be involved, other areas where only 1 to 3 boroughs would need to be involved, and some activity at a sub-borough level. NCL are looking to put patients at the centre of their work and the Clinical Cabinet commissioners are looking to have a collective approach
- It was noted that NCL was a large area and complex in comparison to other STP footprints. Effective relationships, mutual trust and strong leadership would be required in order to make the grouping successful. The Committee

considered the challenge that North Central London did not have a strong sense of 'place'

- Concern was expressed at the shortage of GP's and that many older GP's would be retiring over the next few years. It was noted that the shortage of GP's is particularly severe in L.B.Enfield and that this is an issue that NCL would be looking at across the footprint, particularly in terms of projected population growth
- Reference was also made to the lack of GP provision for care homes and that many care homes were rated as requiring improvement or inadequate. If there was better GP provision this could result in fewer admissions to hospital or visits to A&E. There are significant challenges with an increasing elderly population, and that best practice needed to be taken on board in future proposals
- In response to a question as to the process of how issues would be considered at the JOHSC and at individual Borough Scrutiny Committees, the Chair stated that she had asked the L.B.Camden Chief Executive to consider this and report back to a future meeting
- It was stated that there are opportunities to improve system design, in order to establish new processes that will deliver more effectively and make financial savings
- The issue of the frail elderly is a particularly challenging one, and it may well be that hospital services need to provide additional community access, given that more complex needs will need more specialist treatment
- A Member referred to the need to provide more podiatry services in the community for the elderly
- It was stated that there is a need to develop more effective primary care provision and to involve the voluntary and community sector and pharmacies in delivering a more effective health prevention message to the community
- It was noted that the financial resources available for prevention work had decreased in recent years and that a different approach needed to be taken in future. There is a need to look at what is provided and how it is targeted. In addition, whilst prevention tended to provide long terms savings, these were not always taken account of when making shorter term financial planning decisions
- In response to a question, it was stated that there is a need to develop opportunities to do things differently, and whilst a lot of work has been done to identify transactional efficiencies, there is a need to look at transformation of services to deliver financial savings and to work with NHS Trusts on this. One example is delivering a more focused HR workforce that can work across organisations rather than in 'silos' and to look at activity modelling
- It was commented that NCL governance arrangements were complex as it covered several administrative areas. It was suggested that arrangements could be overseen by a joint Health and Wellbeing Board; however detailed proposals on decision-making would need to be developed. The Committee emphasised the importance of transparency, accountability, and embedding cross-borough scrutiny into NCL work

- Concern was expressed that many Trusts had significant funding issues and there needed to be clear proposals for the timescale of the reduction of deficits. It was stated that it was proposed to bring a report to the September JHOSC with a work plan and how the community will be engaged. However, it needed to be recognised that there will be differing views expressed and there may be a need for NHS England to make a decision ultimately on any competing views
- The Chair stated that the key messages were that there is a need to focus on clinical outcomes, proposals needed to be patient centred, and to provide value for money services and to reduce duplication. In addition, clinicians and GPs needed to be in the right place at the right time to deliver the most effective outcomes and early intervention and prevention were key. There is also a need to involve community partners on an equal basis in order to achieve better outcomes
- The view was also expressed that mental health funding should be addressed more equitably across the region and it was unsatisfactory that Enfield and Barnet received substantially less funding for mental health than other boroughs in the NCL region.
- Reference was made to the Barnet, Enfield & Haringey Mental Health Trust site. There was a need for site improvement, and members urged that information be reported back to the JHOSC on this.

RESOLVED:

(a) That Councillor Anne Marie Pearce write to the Minister for Health expressing concern at the disparity in the provision of funding in LB. Enfield and Barnet for mental health as compared to other Boroughs in the NCL region

ACTION – COUNCILLOR ANNE MARIE PEARCE

(b) That a progress report on the Sustainability and Transformation Plan be submitted to the September meeting and consideration be given to future routing of reports to JOHSC and individual Borough Scrutiny Committees at a later date

ACTION – MIKE COOKE (L.B.CAMDEN CHIEF EXECUTIVE)

10. WHITTINGTON HEALTH ESTATE STRATEGY UPDATE

Mike Cooke, Chief Executive L.B.Camden stated that NCL partners were looking at an estate strategy generally and it is important that the NCL partners work together, in order to rationalise the estate provision and to ensure that this is used effectively and to inform Trust's decisions on the utilisation of estates.

It was felt that there is an opportunity for key worker housing to be established on NHS estates, which could provide an opportunity for staff to be retained, given the high cost of housing in London, which is causing staff retention problems.

In response to a question as to the St. Anne's site, it was stated that a clearer position could be reported to the JHOSC at the September meeting.

It was stated that there were many disparate NHS estates and that even if some of these were not appropriate, they should not be considered in isolation for disposal, but consideration should be given as whether any other relevant use could be made of them, given the high cost of renting premises in London. It was important therefore that NCL kept an overview of estates.

Discussion took place as to recent selling off of land at Barnet General and that this had not been used to provide key worker housing. However, it was felt that this could be considered in any future land disposal.

Councillor Klute referred to the Whittington Estates strategy in particular, and that the Trust's previous estates strategy had not been a success and that he was concerned that the Whittington Board had recently disbanded the shadow Board of Governors. Councillor Klute added that he hoped that this was not an attempt to stifle discussion on this issue and that there would be genuine engagement on any proposals.

Councillor Klute added that he felt that the JHOSC should write an open letter to the Whittington NHS Trust asking them to engage more directly on their plans with NCL, the JHOSC and the L.B.Islington Health and Care Scrutiny Committee. The needs of the community needed to be paramount in any proposals.

RESOLVED -

(a) That Councillor Klute be requested to draft an open letter to the Whittington Hospital on behalf of the Committee outlining the concerns raised above and this be circulated to Members for comment

(b) That Councillor Klute be requested to circulate the letter he has received from the Chair of the Whittington Trust, Steve Hitchins, in response to his letter concerning the disbanding of the Whittington NHS Trust shadow board of Governors

ACTION – COUNCILLOR MARTIN KLUTE

11. LONDON AMBULANCE SERVICE QUALITY IMPROVEMENT PLAN

Peter Rhodes, Assistant Director of Operations, and Sean Brinicombe, Stakeholder Engagement Manager at the London Ambulance Service, were present for discussion of this matter and made a presentation to the Committee.

During discussion the following main points were made –

- The Trust was placed in special measures in late 2015 following a CQC inspection, and the inspection had identified issues related to staffing levels, working culture, medicines management, governance and resilience functions
- Additional support has been provided to the Trust to strengthen its executive team, with an Improvement Director appointed
- A buddying mechanism has been formed with Defence Medical Services to provide training and development to senior and middle management
- Specialist expertise is being given in the areas of organisational development, medicines management, culture and governance and a new Chair of the Trust has been appointed
- Progress against the plan has been good with 717 new staff being appointed in 2015/16. The Trust met its recruitment target to hit full establishment of 3,169 at the end of March 2016
- 246 managers have been trained in risk management and risk reporting mechanisms have been modernised
- A 'Vehicle Make Ready' pilot is underway in the NE sector. There has been communication to front line staff to outline the professional requirements on medicines management and to clarify policies and increased clinical audits. It was noted that medicines management was a particular challenge due to risks associated with holding medicines on vehicles
- Phase 1 of the cultural management programme is complete and by 1 April 2016 over 280 managers had been trained in avoidance and understanding of Bullying and Harassment. A bullying hotline had been established, however due to minimal use this had been amalgamated with a more general HR helpline
- The profile of the fleet was changing with 60 new fast response units on the road by the end of June 2016 and 104 new ambulances in production. By the end of March 2017 half of the fleet vehicles will be under 2 years old
- Manager briefing sessions have taken place on the progress plan and progress is being relayed on the intranet and a campaign strategy is to be launched
- Demand for the service has risen significantly; in 2015/16 the LAS attended 20,000 more incidents than in 2014/15
- Performance increased from 59.2% in 2014/15 to 63.3% in 2015/16 for Cat A8 calls and performance in April 2016 was 64.75%
- In response to a question it was stated that although additional support is being provided this is connected to changing the culture in the organisation rather than providing additional financial resources. The service was undergoing unannounced mock inspections in readiness for a CQC inspection and management was confident that the service would be taken out of special measures
- There were significant delays in ambulances being able to deliver patients into A&E departments, such as Barnet and North Middlesex and the Royal Free, which had resulted in ambulances being stuck at hospitals waiting to unload patients for significant periods. Peter Rhodes stated that he would supply the specific figures to the JHOSC for this to be followed up by Members.

Discussion took place with hospitals regularly on this issue; however there is increased pressure on A&E due to the high number of patients requiring treatment, particularly the number of patients self-presenting to A&E. The service was reviewing flow processes with hospitals to identify bottlenecks and to ensure that the handover of patients is as streamlined as possible

- There is difficulty in increasing paramedics due to the high cost of housing in London, however targeted recruitment of foreign paramedics has meant that some staff had been enabled to transfer from Central London to lower cost housing areas in outer London and the suburbs. One challenge associated with this was managing staff visa requirements. It was commented that the service had recently recruited many Australian staff, as there was a strong demand from Australians to work in London
- It was noted that the difficulty of patients being able to get a GP appointment has led to more people accessing A&E
- In response to a question as to whether the outflow of paramedics to join the 111/Out of Hours system had been reduced it was stated that a huge recruitment drive has taken place and there will be a large number of paramedics graduating from University from 2017 onwards. It was hoped that closer partnership work with the 111/Out of Hours service would enable the LAS to supply paramedics to the service, whilst allowing the LAS to retain staff
- Members generally welcomed the progress outlined since the CQC inspection
- The morale of staff and training has been felt to have improved but a staff survey is due to take place shortly
- Reference was made to the fact that public awareness could be increased if ambulance stations were more accessible by having open days etc. however it was noted that this is more difficult in the North Central London region due to the increased number of ambulance station locations, and also that ambulances are on the road constantly and are rarely out of use
- There is a pan-London A&E contract commissioned by Brent.
- Crews are localised as far as possible due to their knowledge of their local areas, however ambulances will move across London throughout the day and staff may cover shifts outside of their local area as required
- Members expressed the view that as the CQC is expected to come back in early 2017 for a re-inspection the JHOSC would wish to consider the results at its March meeting and also to follow up the admission to A&E delay figures referred to earlier. In addition, the JHOSC would wish to consider the issues LAS feels it still needs to work on and the ongoing strategy for dealing with this

RESOLVED –

(a) That a report be submitted to the March meeting, following the re-inspection in early 2017 by the CQC and the strategy to be adopted by the LAS for moving forward

ACTION – PETER RHODES (LAS)

(b) That the figures for delay in transferring patients to hospitals, referred to above be circulated to Members for this to be followed up

ACTION – PETER RHODES (LAS)

12. WORK PROGRAMME

RESOLVED:

(a) That the following work plan be agreed –

30 September
Lower Urinary Tract Clinic – Lead – Councillor Martin Klute
NCL Strategic Transformation Programme – Lead – Councillor Alison Kelly
GP provision in Care Homes – Lead – Councillor Abdul Abdullahi
Dementia Pathway – Lead – Councillor Graham Old

25 November
Royal Free – Relationship with North Middlesex

24 March

Health Tourism at the Royal Free – Lead – Councillor Alison Cornelius
UCLH – Lead – Councillor Alison Kelly
CAMHS – Lead – Councillor Pippa Connor
LAS

ACTION – VINOTHAN SANGARAPILLAI – (CAMDEN COMMITTEE SERVICES)

(b) That there be a standing agenda item on all future agendas on the Whittington Estates strategy

ACTION – VINOTHAN SANGARAPILLAI – (CAMDEN COMMITTEE SERVICES)

Consideration of Quality Accounts

The Chair stated that she was concerned at fact that Quality Accounts from Trusts were not being submitted to Health Scrutiny Committees in suitable time to enable them to comment and that this had recently been the case with the Whittington NHS Trust Quality Account.

The Chair added that she felt that the JHOSC should work with the Trusts to establish a suitable timeframe in order that views can be submitted; however she recognised that there is only a short timeframe whereby Trusts have to submit their accounts.

It was noted that the Barnet, Enfield and Haringey Mental Health Trust Quality Accounts were scrutinised by a JHOSC sub-group consisting of the members from those three boroughs.

RESOLVED:

(a) That the following Quality Accounts be scrutinised by the JHOSC –
- Royal Free,
- UCLH,
- Whittington

(b) That other Quality Accounts are intended to be scrutinised as follows –
- Barnet General – to be led by L.B.Barnet
- North London Hospice – to be led by L.B.'s Camden, Barnet, Haringey
- Camden & Islington Mental Health Trust – to be led by L.B.'s Camden and Islington
- North Middlesex – to be led by L.B's Enfield and Haringey

ACTION – VINOTHAN SANGARAPILLAI (CAMDEN COMMITTEE SERVICES)

(c) That the Chair set up a scoping group to look at the timing for consideration of Quality Accounts and engage with the relevant Trusts, to ensure that these fit in with the JHOSC/individual borough scrutiny committee timetables, and if necessary the scheduled March meeting of the JHOSC be rearranged to fit in with the timetable agreed

ACTION – COUNCILLOR ALISON KELLY (CHAIR)

(d) That a report be submitted to the September meeting on the future support arrangements for the JHOSC

ACTION – MIKE COOKE (L.B.CAMDEN CHIEF EXECUTIVE)

13. ANY OTHER BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There was no urgent business.

14. DATES OF FUTURE MEETINGS

The Committee noted the proposed dates of future meetings and suggested that the March 2017 meeting be rescheduled, if necessary, to May 2017 to allow for the scrutiny of Quality Accounts.

It was noted that at present, subject to any possible amendment of the March meeting, the following dates were scheduled for future meetings of the Committee:

- 30 September 2016 (Haringey)
- 25 November 2016 (Barnet)
- 3 February 2017 (Enfield)
- 24 March 2017 (Camden)

The meeting ended at 1.05pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
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MINUTES END

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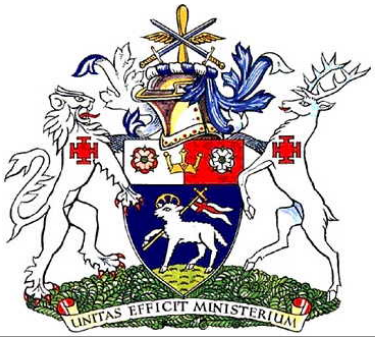
AGENDA ITEM 8

	**Barnet Health Overview and Scrutiny Committee** **6th October 2016**
Title	**Development in Mental Health Care; the Reimagining Mental Health Programme: Exploring Solutions Together**
Report of	Barnet NHS Clinical Commissioning Group
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1: Update on Reimagining Mental Health Programme: Exploring Solutions Together
Officer Contact Details	Paula Arnell, Barnet Clinical Commissioning Group paula.arnell@barnetccg.nhs.uk Anita O'Malley, Governance Team Leader Anita.vukomanovic@barnet.gov.uk 020 8359 7034 Edward Gilbert, Governance Officer Edward.gilbert@barnet.gov.uk 020 8359 3469

Summary

Barnet Clinical Commissioning Group (CCG) have approached the Barnet Health Overview and Scrutiny Committee (HOSC) in order to provide them with an update on the development of mental health care provision.

This report, with the background and update at Appendix A, contains details on the first and second phase of the Reimagining Mental Health Programme, which aims to improve mental health provision in Barnet and supports the introduction of the social work model for mental health.

Recommendations
The following recommendations for future development of Mental Health services: **1. That the Committee note the current development and possible future developments set out in this paper - Reimagining Mental Health: Exploring Solutions Together;** **2. That the Committee note the commitment from all partners to support transformation of mental health pathways;** **3. That the Committee support the ongoing commitment from stakeholders to continue to develop a dedicated model for sustainable service improvement in mental health pathways to well-being;** **4. That the Committee offers comments on the recommendations for the continued development.**

1. WHY THIS REPORT IS NEEDED

1.1 Barnet CCG wish to present a report regarding work being undertaken in respect to mental health care provision.

1.2 The CCG have asked the committee to consider the appended report, which relates to the developments in mental health under the Reimagining Mental Health programme, which aims to improve mental health provision in Barnet and supports the introduction of the social work model for mental health.

1.3 The CCG asks the committee to note the update on the engagement process and planned improvements.

1.4 The CCG would like to invite the committee to provide comments on the current improvements and future plans in order to inform the ongoing work in mental health.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the issues relating to mental health care provision, and specifically the Reimagining Mental Health Programme: Exploring Solutions Together (second phase). The Committee is empowered to make further recommendations of reports should they wish.

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

5.1.1 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

5.3.1 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.

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 changes to the provision of mental health 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.

5.7 Consultation and Engagement

5.7.1 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

6.1. None.

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Appendix 1 –
Update on Reimagining Mental Health Programme: Exploring Solutions Together

1. Background

1.1 The Government has emphasised the need for development of local mental health provision and Barnet CCG and LB Barnet have embarked on an ambitious programme to improve services and pathways. The work undertaken in Barnet since February 2015 has fed into the plans of the sub-regional programme for Sustainability and Transformation for North Central London for primary care mental health development; improvements in the provision of community based approaches, and working together in partnership to embed effective transformation of local services and pathways to well-being.

1.2 The high cost of mental health within acute provision budgets has been highlighted as a spur to driving down costly mental health provision in mainly healthcare settings. Moreover, the need for effective patient care and support to individuals in the local community, delivered as close to home as possible and meeting their needs for physical and mental health care remain key policy drivers from the government's No Health without Mental Health 2011 and the Five Year Forward View 2016.

2. Mental Health Review and Transformation

2.1 In 2014, Barnet CCG and London Borough of Barnet separately reviewed their Mental Health services.

Key findings of both reviews highlighted the:
- Lack of effective crisis planning and community services
- Lack of "early intervention for wellbeing" approaches
- More calls to work in partnership in the community
- The need to use resources more effectively

2.2 Nationally, almost one in four British adults and one in ten children experience a diagnosable mental health problem at any given time – in Barnet the ratio is 1:5 adults with the complexity of co-morbid conditions appearing to be not as high as in other areas in NCL. Mental health problems account for 28% of morbidity nationally, but spending on mental health services is only 13% of total NHS expenditure. The lack of complexity only partly accounts for the difference; for example in Camden complexity accounts for greater use of the highest cost services than in Barnet, but where the investment nearly doubles across all modalities.

2.3 The government's goal is to achieve parity of esteem between physical and mental health provision. There is some additional transformation funding being made available from the Department of Health for Perinatal services (in

bidding phase) and Children's Mental Health services (funding secured). However, this funding is minimally for transformation, and will not on its own be sufficient to deliver services to close the delivery gap. The government has set targets to deliver timely Early Intervention services to people with a first episode of psychosis from the age of 14 by 1st April 2017; similarly there is a target set to deliver 24 hour mental health liaison services in all acute services from the same date (already achieved at the Barnet Hospital site). The work continues on Crisis Concordat and Suicide Prevention Plans to deliver timely intervention at the point of contact with statutory and voluntary services.

2.4 For people who experience mental ill health in Barnet and those at risk, a whole system approach is required in order to deliver the infrastructure to support service improvement - this will ensure that services:

- Support people in maintaining and developing good mental health and wellbeing
- Give people the maximum support to live full, positive lives when they are dealing with their mental health problems
- Help people to recover as quickly as possible from mental illness

2.5 Evidence from the Barnet Joint Strategic Needs Assessment- 2015-20120, shows that people with mental health conditions are much more likely to be socially excluded and to have significant health risks and major health problems including obesity, diabetes, heart and respiratory diseases in addition to a lower life expectancy. The current service transformation is expected to address these inequalities.

2.6 The climate more broadly is extremely challenged across the health and social care economy. Sustainable, efficient delivery in the NCL sector requires the establishment of a coherent vision across sectors with multi-partner transformation. Tri-CCGs have adopted strategic directions in line with NCL plans to develop Primary Care Mental Health services and are discussing ways to follow similar development to embed secondary care provision in the community, that is more closely aligned to primary care, to offer an integrated pathway to people with mental health needs.

2.7 Mental Health Commissioners and providers are working together with NHSE across NC London to align plans for transforming services through a Sustainability and Transformation Planning programme. This is giving greater focus to developing primary care and community mental health services to provide more timely care and support further upstream in the patient/service user journey. By avoiding costly acute care where this is not needed, people with mental health needs will receive support they need, when they need it in order to remain as independent as possible and to live well.

2.8 From a social care perspective, which both impacts upon and ties in with the integrated physical and mental health care approach, the vision is to:

- Deliver more, efficiently, within available resources
- Move away from 'professionalised' models of care towards more community,

home-based, peer-led models

- Re-inforce co-productive, adult relationships built on mutual trust, reciprocity and risk management
- Rebalance the model: orientate professionals towards prevention and early intervention; integrate community and peer groups into specialist care
- Help providers and users to be better at long-term planning, supporting demand rather than rationing supply
- Focus on the quality of relationships (between users and those who support them) and depth of our knowledge about users' needs and assets

2.9 For all people using adult health and social care services, the common thread running through the future approaches is the need to intervene much earlier and in a different way. This will be achieved by services and commissioning working together to improve signposting and pathways; evidence from around the country shows that where this is effective, it reduces the need for more costly care. Barnet CCG, with the Local Authority, has already begun this journey and is working with all stakeholders to deliver service improvements.

3. Consultation and Stakeholder Involvement

3.1 From May 2015, following a workshop with stakeholders in March 2015, Barnet CCG undertook a full engagement and consultation process with statutory, voluntary sector providers and people with lived experience, together with wider stakeholders, to 'reimagine' mental health provision within a phased approach with a focus on:

• A co-production model to deliver better, more targeted health and social care services through a community–based approach;
• Directing resources more appropriately through better collaboration between all organisations
• Continued involvement of people with mental health needs and carers is key to shaping future services

3.2 The Council pursued a parallel process of strengthening community pathways to promote independence and deliver a revised social care model.

3.3 It was recognised from feedback at the initial workshop that the Reimagining Mental Health programme would signal a whole system transformation and feed into the CCG's Quality Innovation, Productivity and Prevention (QIPP) programme.

3.4 Extensive consultation has been undertaken in transforming Mental Health services through a series of Co-design "Breakfast Clubs" and action learning Trailblazers with people with lived experience of mental health, the voluntary sector, statutory sector including Public Health/ Barnet Enfield and Haringey MHT/ Surrey and Borders Partnership FT/ Barnet Adults and Communities Mental Health Services, primary care GPs and practice managers, other mental health Trusts, private not-for-profit organisations, commissioners including CAMHS, the Barnet Police mental health champions, Probation

Services, elected Members and Senior Council officers. Regular reports provide updates to the Health and Well-Being Board, the LBB and CCG Joint Commissioning Executive Group, Barnet CCG Clinical Cabinet, Finance and Performance Committee and Governing Body.

4. Mental Health Pathway development

4.1 Data from the JSNA, UCL Partners review team, the Public Health team, the council's Insight team, Carnall Farrar review 2015, NCL STP Programme alongside full engagement with all stakeholders to identify gaps in service provision and obtain good practice information nationally and internationally on ways to remodel current services have fed into the transformation process. This has helped to determine a vision for more integrated mental health provision in Barnet and to support commissioning intentions to deliver pathway remodelling as part of the programme.

4.2 Current providers were supported by commissioners and the GP clinical lead, Dr Charlotte Benjamin, to work together in a collaborative way and understand partnership approaches to support delivery of co-designed pathways for wellbeing, with a view to better meet the needs of people with mental health at all levels of stepped care. The vision supported the stepped care approach by developing and consolidating planned improvements to support partnership working, close gaps in identifying needs at the first point of contact and signposting appropriately to the least intrusive, most effective intervention.

4.3 DH NICE Guidance expects and sets standards for services to be delivered that will support better care in the following domains:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

Stepped care approaches for this development ensure that people are offered the least invasive treatment and care at the level appropriate to their needs:

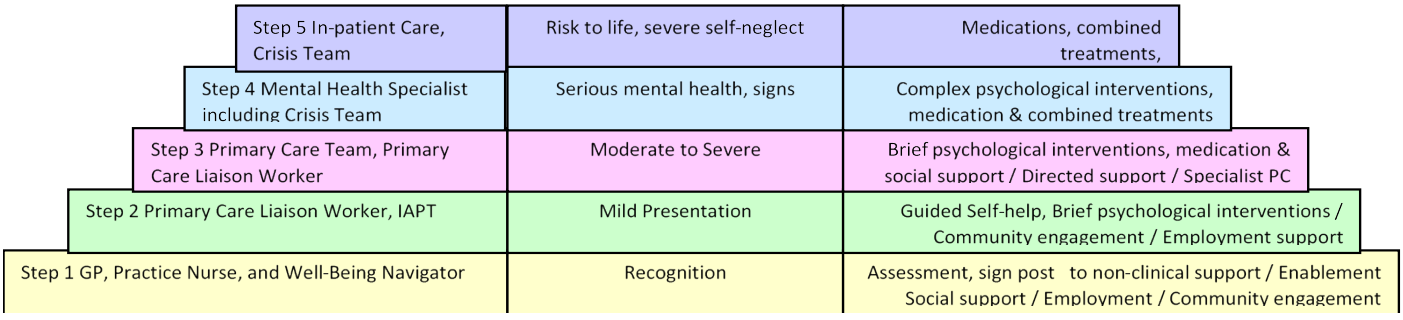
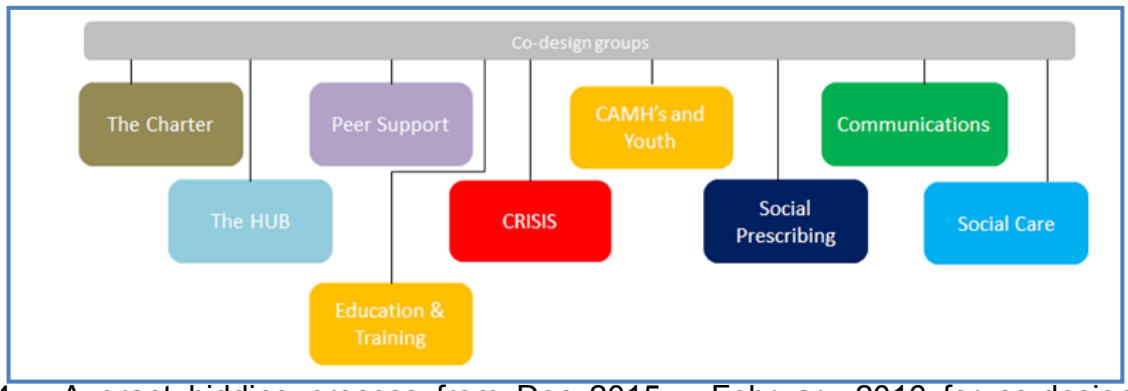


Diagram 1 – Stepped care model for MH transformation

4.3 The CCG set out a budget for transformation funding and agreed designated finance packages to key areas of development, aligning areas of spend to co-design sectors:



4.4 A grant bidding process from Dec 2015 – February 2016 for co-designed transformation projects and allocations was overseen by the Reimagining Mental Health Steering Group. Whilst the broad areas for co-design transformation funding was agreed, the clinical lead, the Director of Integrated Care, and MH commissioning team recommended a further process was required to support organisations to deliver more specific outcomes through an improved Collaborative process to model transformation supported by commissioners and the programme manager for Primary Care Mental Health development.

4.5 This led to a Trailblazer action learning series to develop and deliver robust transformation:

- Through development of a Well-being Hub collaborative
- Through piloting a more community-based Barnet Primary Care Link worker team following the successful South Barnet pilot that delivered clinical support to primary care

4.6 The Trailblazer was delivered by Kind Minds and produced a vision and action plan, incorporating the learning from the South Barnet Pilot and Lambeth Living Well collaborative; and other areas of good practice in developing integrated MH service provision – (Manchester, Cambridgeshire, Suffolk, Norfolk, The Kings Fund Transformation papers: Lessons from mental health 2014 and Mental health under pressure 2015 and other key documents – e.g. No Health without Mental Health 2011; The Five Year Forward View NHS strategy 2014).

4.7 Social care and health care service leads have been fully involved in the process of transformation to ensure integrated approaches to delivery.

4.8 The local developments in Barnet are being designed to meet the requirements for sustainability and to deliver services at the right time, of the right quality, in the right place.

5. Primary Care Mental Health development

5.1 The aim of the Integrated Primary Care Mental Health Network Pilot Service is to increase the number of people whose mental health support is appropriately managed within primary care through the introduction of integrated care, and improved and effective partnership working between NHS providers, the voluntary sector and the local authority.

5.2 The CCG has made available transformation funding, which is non-recurrent and only available through 2016-17 to underpin systemic transformation.

5.3 The Pilot Service is designed to provide high quality support through the provision of dedicated Mental Health Linkworkers to GPs to provide a support service enabling the management of patients with common mental health problems and stable severe and enduring mental health problems within Primary Care. The aim is to reduce the use of secondary health services including, acute and emergency care.

5.4 The PCMH Linkworker service has been developed through the Trailblazer process between Primary Care, BEH MHT and commissioners and commenced on 1st August 2016. It has been embedded in local GP practices in South Barnet and the plan is to rollout to the North and West networks by the end of December 2016,

5.5 The six PC Linkworkers one manager and admin staff are working directly with and as part of the Primary Care teams with the aim of increasing the skill and confidence of GPs and other primary care staff to manage patients through consultation, joint assessment, case management, co-working and training, in addition to delivering direct clinical services to patient. Most clinical work will be through assisting GPs and Primary care staff in case formulation, risk assessment, management plans and self-help plans which are co-produced with the patient.

5.6 A key objective is to support people to receive the best services at point of entry - with service users accessing enabling services, traditionally delivered from hospital settings by secondary services, within a more integrated platform in a localised setting – for example running sessions where feasible in GP practices and also co-locating services in partnership with 3rd sector providers.

5.7 In August, the first month of operation, the service received 51 referrals at medium to high levels of complexity (Step 2 and Step 3 care) and has worked with GPs and other providers to ensure patients have been receiving appropriate interventions. Feedback from GP Practices involved has been positive.

6. Barnet Wellbeing Hub development

6.1 The next phase of the programme has seen the development of the Barnet Well-being Hub. The hub is designed to support the ongoing needs of people with mental health needs from all referrers including Primary Care and Self-referral. The Wellbeing Hub has been developed through a co-delivery, collaborative core group of service providers. Commissioning has provided ongoing guidance following the Trailblazer from April – July 2016 on the required outcomes from the development of a hub. The Trailblazer saw key partners come together to examine good practice information from other similar developments around the country about how to configure better integrated pathways with statutory and community partners.

6.2 The hub is designed to provide a gateway to finding the services that are required at the point of referral and to signpost people to the most appropriate and helpful services to meet their needs.

6.3 The service is due to commence from end September 2016 and initially the centre of operations will be at the Meritage Centre. Other services in the voluntary sector will be providing additional onward support in a hub and spoke model of care:

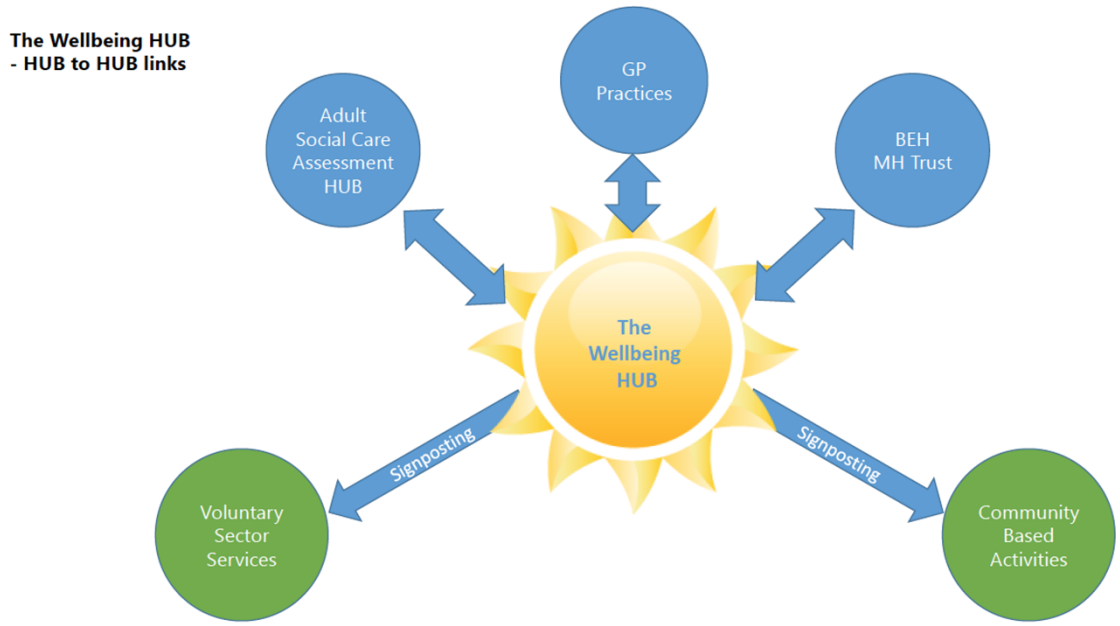


Fig 1 Barnet Well Being Hub and spoke model

6.4 The aim for the Barnet Wellbeing Hub is to support adults of working age (16 – 65 years old) with common and long-term conditions and/or social care needs to become involved in community activities, and support community groups so they can welcome more people with care needs. The specific activities carried out by the hub to meet this aim will be:

- To act as a Single Point of Access for statutory referrers such as GP Surgeries, Link Workers, BEH MH NHS Trust, Barnet Council Adult Social Care, Barnet IAPT, CMHT, Barnet Police Service, London CRC Probation and others.

- It will also accept referrals from voluntary organisations, and self-referrals.
- The service will formally link with the Adult Social Care Assessment hub after the initial development of the service at a later date. It is hoped to employ a social worker in the hub to support onward referral at the first point of contact. This would support the Council's development of Assessment Centres in the community to ensure people are assessed at the point of contact.

6.5 The Well-being Hub was developed through the Trailblazer programme and involves the following providers within a collaborative approach:

Voluntary/Community Organisations		Statutory Organisations	
Already engaged (core group)	**Already engaged (not core group)**	**Already engaged**	**Proposed partners**
BMER Charities e.g. MWS, BRS and BAWA	Barnet and Southgate College	BEH MH NHS Trust / Link Workers	Barnet Housing Team
Barnet Voice	Barnet CAB	Barnet Adult Social Care	Barnet IAPT
Barnet Carers Centre	Alzheimer's Society	GP Surgeries	Barnet MHT CMHT
CMHA	Community Centres (e.g. Multicultural Centre, Sangam Centre and Altogether Better)	London CRC Probation	Barnet Police Service
Community Barnet	Community Focus	Westminster Drug & Alcohol Service	Job Centre Plus
Eclipse / Richmond Fellowship	Future Path	Barnet Hospital Psychiatric Liaison	Home Start Barnet
Inclusion Barnet	Faith Groups i.e. Hendon Mosque		
JAMI, JVN	Genesis Housing Support / Outreach Barnet		
MIND in Barnet	Homeless Action in Barnet		
One Housing Support	Restart, Relate		
Timebank			
Age UK Barnet			

Table 2 – Collaborative Partners

6.6 The development group reports to the Steering Group (which fed into the trailblazer process and which will now become the Reimagining Mental Health Sub-Committee which will sit under the CCG's Clinical Quality and Risk Cttee. The group comprises:

6.7 Development Lead for the community collaborative for the Re-Imagining Mental Health programme is Julie Pal at CommUNITY Barnet which is Barnet's local infrastructure organisation whose primary role is to work with and support community organisations delivering services to Barnet residents. Community Barnet was resourced initially through the original funding allocations process:

- To identify potential providers,
- Promote services and
- Shape the local supplier base to deliver the highest quality of services for the borough.

6.8 Community Barnet also acts as a partnership facilitator to support the continued development of the service to meet the wider and long term needs of the Barnet population.

6.9 The other collaborative organisations delivering core elements of the hub to residents:

- Inclusion Barnet and Eclipse: working with CMHA to develop the Wellbeing Team to embed the principle of social prescribing. Will host two hub workers in phase one.
- The benefits to adult social care embedding SW into community based mental health teams have been evidenced nationally. Although this is a future aspiration, Adult Social Care is engaged in discussions to support the work of the wellbeing centre and ensure that social issues are identified and addressed at the earliest opportunity. The role would ensure direct advice to wellbeing staff to offer the right service at the time to individuals and the most appropriate decision is made in terms of social care needs at the first point of contact for the individual using the service. The role would also ensure early intervention, close working relationships and understanding between the Wellbeing and the Enablement teams and the wider social care services.
- Timebank Barnet: lead on time-banking opportunities; providing a range of opportunities.
- Jewish Volunteer Network: lead on all supported volunteering
- Barnet Voice: peer support through Space2Be programme
- MIND in Barnet: support with a one day per week Mental Health Advocate
- Jewish Association for Mental Illness (JAMI): Staff training and support in terms of utilising the Emotional Health checks

6.10 All delivery partners will be responsible for the delivery of agreed outcomes to the Lead Provider, who will be responsible in turn to Commissioners.

6.11 The lead delivery provider is the Chinese Mental Health Association run by Mr Leon Lee Leon Lee.
The role of the Lead Provider is to:

- Employ some of the staff team
- Support the recruitment and training of peer support volunteers in partnership with other interested providers to deliver 'supported access' to services
- Record and monitor progress and outcomes using agreed tools e.g. Emotional Health Check

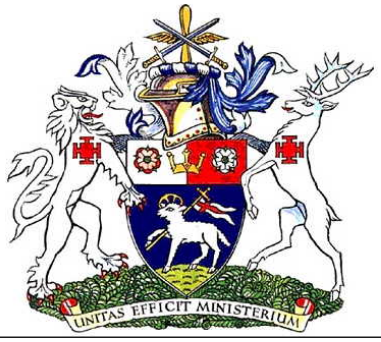
- Facilitate meetings amongst Link Workers who work within the localities and Wellbeing Centres. These meetings are crucial in terms of building the team around the person
- Utilise the Council's VCS directory and promote the Hub's usage and development
- Provide infrastructure (i.e. premises, helpline, email etc.) for referrers and individuals
- Work with partners to strengthen pathways

7. Ongoing development

7.1 The third phase of the Reimagining Mental Health Programme will take shape after these initial developments have had time to embed learning from the pilot phase. This will inform commissioners throughout about the possibilities and learning from each area and support the infrastructure for further developments under the forthcoming Sustainability and Transformation Plan for NCL. The programme has already contributed to the proposals and will continue in its turn to inform this wider programme development.

7.2 The statutory sector is already involved in the key developments for the NCL STP and the Reimagining Mental Health programme has been developed in a flexible way to ensure that ongoing development can be incorporated as development progresses. The CCG thanks all stakeholders for their involvement that has seen the successful developments in primary care and well-being services. This will only continue however, through the continued commitment of organisations and stakeholders to engage with ongoing discussions and plans to improve the current pathways and embed new dedicated ways of working to support services to deliver better outcomes.

AGENDA ITEM 9

	**Barnet Health Overview and Scrutiny Committee** **6th October 2016**
Title	**Barnet CCG Update Report**
Report of	Barnet NHS Clinical Commissioning Group
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None.
Officer Contact Details	Anita O'Malley – Governance Team Leader anita.vukomanovic@barnet.gov.uk Edward Gilbert – Governance Officer edward.gilbert@barnet.gov.uk

Summary

Barnet CCG has requested to attend the Barnet Health Overview and Scrutiny Committee in order to provide a brief verbal update on different pieces of work.

Neil Snee, the newly appointed Interim Director of Commissioning at Barnet CCG will be in attendance on the evening in order to provide the update to Committee Members. Members of the Committee will be asked to note the update and will have the opportunity to answer any questions.

Barnet CCG wish to update the Committee on matters including

- The East Barnet Health Centre
- Primary Care related support for care homes
- Finchley Memorial Hospital

Recommendations
1. That the Committee note the report.

1. WHY THIS REPORT IS NEEDED

1.1 Barnet CCG have requested to attend a meeting of the Health Overview and Scrutiny Committee to provide a short verbal update on:

- The East Barnet Health Centre
- Primary Care related support for care homes
- Finchley Memorial Hospital

1.2 Neil Snee, Interim Director of Commissioning at Barnet CCG has stated that he will be in attendance on the evening in order to provide the update to Committee Members

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the issues relating to the East Barnet Centre and Primary Care related support for care homes. The Committee is empowered to make further recommendations of reports should they wish.

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

5.1.1 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**

5.3.1 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.

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 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.

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

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5.7 Consultation and Engagement

5.7.1 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

6.1 None.

AGENDA ITEM 10

Barnet Health Overview and Scrutiny Committee

6 October 2016

Title	Health Tourism
Report of	Barnet Clinical Commissioning Group
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Executive Summary from Department of Health Guidance on implementing the overseas visitor hospital charging regulations 2015
Officer Contact Details	Leigh Griffin, Barnet Clinical Commissioning Group leigh.griffin@barnetccg.nhs.uk

Summary

The Health Overview and Scrutiny Committee has requested an update report from the Barnet Clinical Commissioning Group on the topic of health tourism.

Introduction:

The NHS is built on the principle that it provides a comprehensive health service, based on clinical need, not ability to pay. However, regulations impose a charging regime in respect of NHS hospital treatment for persons who are not ordinarily resident in the UK. The charging regime provides for some categories of non-residents to be exempt from charges, and EU regulations and other international agreements provide reciprocal healthcare that benefits visitors from and to participant countries.

Hospital care:

Once a patient is identified as chargeable for NHS treatment, the treating clinician decides

whether the medical treatment is deemed as immediately necessary, urgent or routine (as per Department of Health guidelines). If the treatment is routine then it is not provided until payment is received, or the patient is advised to seek private treatment.

If treatment is deemed immediately necessary or urgent then an invoice is raised. Where possible the Overseas Visitor Team (OVT) takes payment prior to, but without delaying, treatment. Otherwise payment is obtained immediately after treatment.

For patients with an insurance policy the OVT contacts the insurance company to secure payment.

Eligibility for hospital care:

The hospital carries out checks based on those recommended in the Department of Health Guidance on Implementing the Overseas Visitor Hospital Charging Regulations 2015. In order to establish a patient's nationality, passports and ID cards are requested from the patient. If necessary, and provided the patient is from outside the European Economic Area (EEA), the Home Office may be contacted to confirm any further details regarding the patient's status.

Eligibility for free NHS treatment relies on whether a person's lawful Ordinary Residence is in the UK, they have appropriate EEA documentation such as a European Health Insurance Card or S2 form, or they fall into an appropriate exemption category (such as a medical exemption or a visa exemption).

When patients first attend hospital for treatment, staff establish eligibility according to the Department of Health rules, which are not simply whether a patient is a British national.

If a patient is not eligible, staff contact the OVT. If a referral letter from a GP or another NHS organisation advises that the patient may not be eligible, then the appointments centre or relevant staff contact the OVT.

Financial:

The responsible CCG concept relates to the borough in which the hospital headquarters is based. So Barnet CCG is responsible for payment of any invoices that are deemed not recoverable by the Royal National Orthopaedic Hospital (RNOH) for all such patients treated at RNOH.. Similarly, Camden CCG will be responsible for payment of activity undertaken by the Royal Free NHS Foundation Trust, the headquarters of which are in Camden.

Please note that the financial information given below represents all health tourism activity undertaken by the hospital in question. As these patients are not 'ordinarily resident' in the uk, they are visitors and therefore have no 'residency' status recorded, for the specific purpose of this report this means that a component cannot be identified as Barnet 'residents'.

Please note that the process of recovery for any hospital is not limited to a particular financial year and the hospital will continue to pursue payment until it has exhausted the possibilities for payment.

Below is information on the current position in respect of invoiced activity for the Royal Free NHS Hospital FoundationTrust.

Royal Free Hospital Overseas Visitors April 2016 – September 2016

Total no of invoices raised	Total monetary value	Paid	Outstanding
311	£725,156	£128,800	£596,356

Service Line	April	May	June	July	August	%
Acute Medicine	5,942	19,058	37,403	29,025	42,458	15%
Breast Surgery			1,080			0%
Cardiology	12,240	51,180	5,963	28,468	7,680	12%
Critical Care Medicine	4,500					1%
Dermatology						0%
Divisional Management Uc						0%
Elderly Medicine			3,578	8,348		1%
Endocrinology		338				0%
Ent	1,193				2,173	0%
Finance	9,353	3,555	4,449	1,530	28,261	5%
Gastroenterology	3,578	6,300	938	18,338	675	3%
General Surgery	2,985	26,790	3,788	6,503	1,193	5%
Haematology					50	0%
Haemophilia		338		540	405	0%
Infectious Disease		3,915	18,048	2,385	13,118	4%
Liver Services					4,530	1%
Maxillofacial	338	540	408			0%
Neurosciences	338	338				0%
Obstetrics & Gynaecology	16,698	45,005	38,667	40,045	36,513	20%
Oncology		2,385		600	10,733	2%
Ophthalmology	540	338	540	338	540	0%
Paediatrics			1,193	6,240	2,513	1%
Plastic Surgery	540	9,900	6,825	5,370	8,013	3%
Private Patients						0%
Radiology	338					0%
Renal Services		36,120	2,385		14,430	6%
Respiratory Medicine	1,193			8,948		1%

Rheumatology			2,160			0%
Stroke					9,540	1%
T&O	1,593	5,310	8,100	11,010	50,945	9%
The Institute & Pitu						0%
Therapy Services	1,148		338		203	0%
Urology			2,385			0%
Vascular Surgery			338		72,270	8%

Overseas Visitors April 2015 – March 2016

Total No of Invoices Raised	Total monetary value	Paid	Total Outstanding
467	£2,347,219	£508,447	£1,838,772

For invoices raised in 2015/16, the Royal Free Hospital continues to chase payment. For each outstanding invoice all due processes are followed and the debts which are submitted for write off are those that are uncollectable for reasons outside of the Royal Free London NHS Foundation Trust's control.
Each case would have been referred to a debt collection agency and collection efforts exhausted.

In respect of the Royal National Orthopaedic Hospital, in relation to 2015/16, Barnet CCG made payment of £408,794. The CCG received an additional allocation of funding to cover the total value. Similarly Camden CCG receives an additional allocation for it's costs incurred.

GP Care:

Under the terms of their primary medical services contracts, GP practices cannot refuse an application to join its list of NHS patients on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

Other than that, they can only turn down an application if:

a) the commissioner (NHS England) has agreed that they can close their list to new patients,
b) the patient lives outside the practice boundary ;or
c) they have other reasonable grounds.

In practice, this means that the GP practice's discretion to refuse a patient is limited.

Any practice that requests documentation regarding a patient's identity or immigration status must apply the same process for all patients requesting registration.

As there is no requirement under the regulations to produce identity or residence

information, the patient MUST be registered on application unless the practice has reasonable grounds to decline.

Registration and appointments should not be withheld because a patient does not have the necessary proof of residence or personal identification. Inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient.

If a practice suspects a patient of fraud (such as using fake ID) then they should register and treat the patient but hand the matter over to their local NHS counter-fraud specialist.

A patient does not need to be "ordinarily resident" in the country to be eligible for NHS primary medical care –this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge.

Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone; eligibility for free care will be assessed by the receiving organisation.

Recommendations

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

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health Overview and Scrutiny Committee have requested to receive a report on the issue of health tourism.

2. REASONS FOR RECOMMENDATIONS

2.1 By this update, the Committee will be kept up to date on the issues relating health tourism. The Committee is empowered to make further recommendations of reports should they wish.

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 National Health Service (Charges to Overseas Visitors) Regulations 2015 form the basis of this paper.

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

"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 situation in regard to health

tourism.

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 the 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.

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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.

APPENDIX A

Executive summary – Guidance on implementing the overseas visitor hospital charging regulations 2015

1. The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6th April 2015 and apply to all courses of treatment commenced on or after that date. The Regulations have subsequently been amended, with changes coming into effect on 1st February 2016.
2. The NHS is a residency-based healthcare system and eligibility for free NHS hospital care is based on the concept of "ordinary residence". An overseas visitor is any person who is not "ordinarily resident" in the UK. A person will be "ordinarily resident" in the UK when that residence is lawful, adopted voluntary, and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration. Nationals of countries outside the European Economic Area (EEA) must also have indefinite leave to remain in the UK in order to be ordinarily resident here. A person who is ordinarily resident in the UK must not be charged for NHS hospital services.
3. The Charging Regulations place a legal obligation on NHS trusts, NHS foundation trusts and local authorities in the exercise of public health functions[i] in England, to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges. When charges apply, a relevant NHS body must make and recover charges from the person liable to pay for the NHS services provided to the overseas visitor. A list of exempt services and exempt categories of overseas visitor is provided in Chapter 1, with a more detailed list of exempt services at Chapter 4.
4. Significant changes have been made to the exemption categories by these Charging Regulations. An exemption for temporary migrants coming to the UK for six months or more from outside the EEA has been introduced because such visitors are now required to pay the immigration health charge (referred to as the health surcharge). Certain temporary migrants may also be exempt from paying the health surcharge or will have payment waived; these individuals will generally also be exempt from NHS charges. Payment of, or exemption or waiver from, the health surcharge entitles the person to free NHS hospital services on the same basis as an ordinarily resident patient while their visa remains valid, which means they must not be charged for NHS services. More on this group and how to recognise them can be found in Chapter 5.
5. Overseas visitors who are visiting the UK for six months or less, including on a multiple entry visa, or who are in the UK without permission, must be charged for services they receive at the point of accessing care, unless exempt from charges under other categories of the Charging Regulations. Overseas visitors who reside in an EEA state (including non EEA nationals) may be insured under the public healthcare insurance system in their resident member state, or country of work for frontier workers. They will consequently be exempt from charges for any medically necessary treatment they receive under the Charging Regulations, as long as they present the appropriate EEA healthcare document. This is because the UK can recover the cost of their care from the relevant insuring member state, if the details of their healthcare form are recorded.

6. The way in which a person qualifies as insured varies depending on their country of residence (or country of work if they are a posted worker). However, in every case where someone is insured under the public system they will have, or should be entitled to hold, a European Health Insurance Card (EHIC) or Provisional Replacement Certificate (PRC) from the EEA state in which they are insured. Each family member, including children, will have their own EHIC or PRC. EEA residents may also be issued an S2 form if they wish to seek preplanned treatment abroad.

7. If the visitor has not come to England specifically to seek healthcare, and cannot show their EHIC, they may instead produce a PRC to prove entitlement to free healthcare in the UK under the EU Regulations. It should be for the patient or their representative to arrange the issue of the PRC from the EEA state/Switzerland that would issue their EHIC, but the OVM may assist with this if needed.

8. EEA residents who are visiting the UK on a temporary basis or to pursue a course of study, and who are insured by their resident state, should present a valid EHIC or PRC from that country to access free medically necessary treatment. This includes British nationals who are insured in another EEA state. The EHIC/PRC is issued by the country of residence or work, not country of citizenship. The UK will recover the cost of that healthcare from the relevant member state.

9. Those visitors from the EEA to the UK who do not have a valid EHIC, PRC or S2 and who are not covered under another exemption category under the Charging Regulations, must be charged for services they receive at the point of accessing care.

10. The information above sets out the general position only. These general principles do not apply in all cases, and relevant NHS bodies must ensure that they understand the full scope of the Charging Regulations when making and recovering charges from overseas visitors.

11. A relevant NHS body also has human rights obligations, so chargeable treatment which is considered by clinicians to be immediately necessary must never be withheld from an overseas visitor, even when that overseas visitor has indicated that they cannot pay. This does not mean that the treatment should be provided free of charge. Charges will still apply, and, if not yet recovered, should be pursued after the treatment is provided. Treatment which is not immediately necessary, but is nevertheless classed as urgent by clinicians, as it cannot wait until the overseas visitor can be reasonably expected to return home, should also be provided regardless of the patient's ability to pay. Every effort should be made to obtain payment or a deposit in the period before treatment starts. Non-urgent, or elective treatment should not begin until full payment has been received. See Chapters 11 and 13 for more important information about how and when to ask for payment from chargeable overseas visitors.

12. All relevant NHS bodies, as public authorities, must comply with the public sector equality duty in the exercise of their functions. More details on this, and on resources which can be used to assist NHS organisations to do this, can be found in Chapter 11.

13. When a relevant NHS body treats an EEA insured patient they must inform the Overseas Healthcare Team at the Department of Work and Pensions of details of the

EHIC/PRC/ S2 document held by that person. This information is necessary to allow the UK to recover the cost of treating EEA residents from the relevant EEA country. See Chapter 9 for more information.

14. This guidance does not cover treatment provided by a general practitioner (GP), dentist or optician, although there is some comment on GP registration in Chapter 11. Nor does it concern charging arrangements in Wales, Scotland and Northern Ireland as these are governed by separate legislation under the jurisdiction of the respective devolved administration.

15. A relevant NHS body in England may seek help and advice about any aspect of the Charging Regulations and this guidance by using the OVM online community.2 Ultimately, the decision that a patient is liable for charges legally rests with the relevant NHS body providing the treatment. In cases where a patient's circumstances are unclear, unusual or appear not to be provided for in this guidance, relevant NHS bodies should seek their own legal advice as to the application of the Charging Regulations to the patient.

16. This guidance may be amended on occasion to reflect changes to the Charging Regulations. Relevant NHS bodies should ensure that they refer to the latest version. The Department of Health has also published a toolbox of supporting information. The aim of the toolbox is to help trusts discharge their cost recovery duties more effectively and it contains a wide range of documents including standardised best practice pre-attendance forms for all patients to fill in when being admitted. The Charging Guidance and toolbox is available at www.gov.uk/dh/nhscostrecovery. Relevant NHS bodies should check the website and toolbox regularly for information which may update and augment this document. A table of subsequent changes made to this guidance will be compiled as they arise, and will appear in any updates. A list of other relevant materials is set out below.

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AGENDA ITEM 11

Health Overview and Scrutiny Committee

6 October 2016

Title	**Healthwatch Barnet Enter and View Report – Lady Sarah Cohen Care Home**
Report of	Governance Service
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Lady Sarah Cohen Enter and View
Officer Contact Details	Anita O'Malley – Governance Team Leader anita.vukomanovic@barnet.gov.uk – 020 8359 7034 Edward Gilbert – Governance Officer Edward.gilbert@barnet.gov.uk – 020 8359 3469

Summary

The report at Appendix A provides the Committee with an outline of an Enter and View report conducted by Healthwatch Barnet in Lady Sarah Cohen Care Home.

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

Recommendations

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

1. WHY THIS REPORT IS NEEDED

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

2. REASONS FOR RECOMMENDATIONS

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

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

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

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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 The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet**.** The Healthwatch contract value is £197,361 per annum. The contract commenced on 1 April 2013 and the contract sum received was £592,083. The contract was extended in March 2016 for a period of two years; the contract value was decreased to £128,000 per annum.

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

5.3 Social Value

5.3.1 Not relevant to the purpose of the report.

5.4 Legal and Constitutional References

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

5.4.2 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."

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

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

5.5 Risk Management

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

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

5.6. 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.

5.7 Consultation and Engagement

5.7.1 None.

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.

Name of establishment:	Lady Sarah Cohen House
Staff met During Visit:	Ms Denise Cooper – Interim Manager 9 other members of staff – including the visiting Rabbi 8 relatives (plus 12 questionnaires received) 7 residents
Date of visit:	4 May 2016
Healthwatch authorised representatives involved:	Mrs Tina Stanton Mr Jeremy Gold Ms Marion Kafetz Mr Derek Norman

Introduction and Methodology

This is an announced Enter and View (E&V) visit undertaken by Healthwatch, Barnet's E&V Volunteers, as part of a planned strategy to look at a range of care and nursing homes within the London Borough of Barnet to obtain a better idea of the quality of care provided. Healthwatch E&V representatives have statutory powers to enter Health and Social Care premises, announced or unannounced, to observe and assess the nature and quality of services and obtain the views of the people using those services. The aim is to report the service that is observed, to consider how services may be improved and how good practice can be disseminated.

The team of trained volunteers visit the service and record their observations along with the feedback from residents, relatives, carers and staff. Questionnaires are provided for relatives/carers who are not

able to attend on the day of the visit but wish to give their feedback. They compile a report reflecting all of these, and making some recommendations. The Report is sent to the Manager of the facility visited for validation/correction of facts, and for their response to the recommendations. The final version is then sent to interested parties, including the Head Office of the managing organisation, the Health Overview and Scrutiny Committee/Adults and Safeguarding Committee, CQC (Care Quality Commission), Barnet Council and the public via the Healthwatch website.

DISCLAIMER: ***This report relates only to the service viewed on the date of the visit, and is representative of the views of the staff, visitors and residents who met members of the Enter and View team on that date, and those who completed and returned questionnaires relating to the visit.***

General Information

Lady Sarah Cohen House is a purpose built Jewish residential care home managed by Jewish Care providing nursing care situated on the Betty and Asher Loftus Centre site near Friern Barnet. The Centre also includes Rosetrees, The Sam Beckman Dementia Day Centre, Kun Mor and George Kiss Home. The site also contains a synagogue, shop and hairdressers with a communal garden and separate outside area. Residents of Lady Sarah Cohen House are able to use the facilities of the neighbouring homes and site facilities. The exterior of the premises is well maintained and has recently undergone renovation works. There are parking facilities on site.

The reception area houses a café and shop for both Lady Sarah Cohen Home and Rosetrees; there is a signing in book and hand gel available for visitors. We were pleased to see several notices announcing our visit.

Lady Sarah Cohen House is spread over three floors each with its own manager and dedicated staff team. Every floor has a communal lounge, dining room and activity area. The first floor has 40 rooms, 8 of which are currently undergoing refurbishment. The second and third floors also each have 40 rooms. This home has capacity for 120 residents, but only 112 whilst the refurbishment takes place; there were 101 in occupation at the time of our visit. All rooms have en-suite facilities containing a wet room and are equipped with a call system; there is wi-fi throughout the building. The home appeared to be very clean and well laid out with wide corridors. We were told that

there were four lifts, and saw that entry to the other floors by the stairs was accessed through a door with a catch, so that residents could not accidentally open them. We observed one of the lifts to be out of order while we were visiting.

Some of the residents on the first floor have a diagnosis of dementia, but not all severe, whilst residents on the second and third floors are largely physically frail but have mental capacity, although some would also have dementia, which may have developed whilst they were at the home. If residents wanted to smoke they could smoke outside with adequate supervision; currently there are no smokers in residence.

On the first floor the door of each resident's room had their name, a photograph and a memory box (unless the resident did not want this). Residents could personalise their rooms and supply their own furniture if they wished to. On the second and third floors rooms often had a photograph outside, unless the residents did not want this. The majority of bedrooms have small refrigerators, TVs, and residents own furniture, once checked for safety can be brought in.

Each of the units has its own small kitchen and dining area, equipped with sufficient tables for all of the residents to eat at the same time. There is a lounge and television in each unit; we noticed that the televisions were all on at the time of our visit, with not particularly interesting or appropriate programmes on. In one lounge the TV was on (with sound off), with music playing at the same time.

One of the relatives commented: 'There is almost constant use of the tv, and sometimes it is left on a channel that the carers want. Residents can't possibly follow or like some of the stuff that's left on. They need lively things they can relate to such as cookery, quizzes or music; why not play DVDs more often instead?'

At the time of our visit there was an interim manager in place and she was deputising for the previous interim manager who had to take leave for personal reasons. The home is in touch with IQICH (Integrated Quality in Care Homes Team, at Barnet)[1] and are proposing to go on a study day on pressure ulcer prevention.

1 The Integrated Quality in Care Homes Team at Barnet Council support care homes in maintaining quality at local care homes.

The Healthwatch team tries to engage with as many residents and relatives as possible when conducting an Enter and View visit. The Managers are sent copies of the 'questions for residents/relatives questionnaires' to distribute to relatives in advance of the visit; stamped addressed envelopes are provided, addressed to Healthwatch Barnet, so that these are received directly and not returned to the Home. Information from the 12 forms that were received from residents/relatives and comments from interviews held with relatives during the visit, are included in this report.

Care Planning

On application for a place at the home, Jewish Care will ask for certain paperwork to be completed. Whilst this is being done the family and / or potential resident, are invited to visit the home. If the family / potential resident are happy, then the individual is assessed, either by the Home Manager, the clinical Nurse manager or a Care Manager.

All new residents have a six week period to see if they are happy living at the home before the formalities are put into place for them to move in.

All care plans identify a named nurse for each resident, and the use of 'champions' has been introduced to help staff write the care plans in a more person centred way as it was previously felt that the plans had been too task oriented; care plans would now be more person-centered and would be reviewed every 4 weeks. We were told that residents, care staff, visiting professionals and family members would have access to care plans if the residents with capacity were agreeable. (or the person with Lasting Power of Attorney if they do not have capacity)

When we asked residents and relatives 'do you understand your relative's care plan – are you regularly involved in planning their care'? We were told:

- 'I am kept in touch and informed of my mothers' condition and welfare by the home'
- 'Staff do not ask me to look at the care plan regularly, no regular review is taken with relatives; I would have to ask to read it - and then comment'.
- 'I am only involved with care planning if I ask'
- 'Initially I was involved re a care plan, but not recently'

- 'When I requested a meeting to go through it, I felt that staff were defensive – it was a matter of trying to impress on us how well she is looked after rather than sharing specifics with us'
- 'If I have concerns I have to find someone and make a point – it feels like I'm complaining, so this feels very awkward'
- 'I would like to be involved, my requests are not always followed e.g. dress them according to the weather, i.e. no warm clothes during a heatwave etc.'
- 'Not regularly'
- 'yes, because we ask, and visit daily'
- Two relatives said: 'yes,yes'
- One relative said 'We were told that it's not normal for the care plan to be looked at', another resident said that they were not sure what a Care Plan was.

We would therefore recommend that there is a review on the use of care plans to ensure that both residents, when able to, and relatives understand them and are involved in care planning as far as possible.

Management of Residents' Health and Wellbeing

The GP visits on three separate occasions each week to conduct a surgery once on each floor, he will also visit residents on the other two floors to see if there are any concerns.
Any resident with a pressure ulcer would be seen at least weekly by the clinical nurse manager and would have a 'wound care' plan in place. If necessary this will be more often and the individual will be referred to a tissue viability nurse if needed. The home would access the rapid response team or if they do not have a nurse prescriber on duty will contact 111.

We were told by some that the residents and relatives found the resident GP lacking in empathy and unapproachable. One relative reported that if a resident's name was not on the list it was very difficult to get the GP to see them. One relative commented that staff did not always respond if their relative said they were feeling unwell.

The home has a visiting optician and chiropodist; where possible residents visit their dentist and the home is negotiating with a dentist to provide a regular surgery. We were told that staff are instructed on how to clean hearing aids and check they are working before being used by a resident. But one relative commented that:

‘it would improve their relatives experience if more attention was paid to the use of hearing aids. (Know how/when to change the battery and check regularly)’. Another relative told us they had found the optician unhelpful.

We were told that residents are weighed once a month, or weekly if there are any concerns. One relative commented that the family had not been informed when their parent had lost a significant amount of weight in a few weeks, and no action had been taken.

We were told that residents can choose when to get up and go to bed, and one relative commented that their parent would sometimes like to go to bed a bit later. Other relatives commented that this was not the case, but it also would depend on the residents’ condition. One relative said that the usual response to their loved one feeling unwell was to put them to bed.

One person said their relative was kept in bed because staff said they feared pressure sores if left sitting up. The staff turned the relative every two hours, but the visitor felt that medical advice from the hospital was that this could be managed equally well by being allowed to sit in a chair. For the same reason the resident was rarely taken to activities such as discussion groups and therefore missed the stimulation which these provide. The relative felt that the real difficulty was that staff were under too much pressure and that keeping people in bed was an easy solution.

Two relatives said that no use was made of the garden unless a relative takes a resident out there. This was reflected by our observations on our visit, which was a lovely day but the garden was hardly used.

A member of staff said that the “Living Well” team who support all the facilities on the site were available to take residents to the garden, but a relative said this might be what is supposed to happen but it does not in practice.

Relatives also commented that the lifts are slow and it was very time consuming to take residents down for activities. This added to the pressure under which staff had to work and reduced their availability to attend to residents' urgent needs. However the lifts are traction controlled lifts which are the fastest approved ones, with a ‘door dwell’

time (ie the time that the door remains open) that can accommodate the needs of the client group.

Mental Capacity
Residents were assessed for mental capacity by use of a 'mental capacity assessment form', if the resident was found not to have capacity a 'best interest form' would be completed with a family member. There are currently 34 DoLs (Deprivation of Liberty Safeguards[2]) in place. There had also been 4 refusals for DoLs to be issued. The Interim Manager told us that there were some concerns when a resident died who had a DOLS, as informing all of the agencies about the death could delay the homes procedures following this circumstance.

The Manager commented that they had difficulties when residents were discharged from hospital without their prescribed medication. On one occasion the nurse then had to phone the hospital to ask for the medication to be sent to the home. This was then sent by taxi to the home with instructions on the medication and the transfer letter, rather than the resident and manager having the information explained to them in person.

End of Life Care
The home works closely with the Kings Fund and North London Hospice to ensure that staff have the necessary skills to carry out end of life care. They also liaise with the palliative care team. The GP sees residents and families with regards to advanced care planning needs. The Rabbi may be asked to visit if the family wishes so that he is known to them before a resident's condition deteriorates; the family would be encouraged to stay with the resident at the end of life.

Staff

We were told that the staff to resident ratio was 1:4 but the Manager told us that where residents require a 1:1 care package, or if a floor has residents whose needs are particularly demanding, the staffing level would be increased; currently the third floor has two extra staff from 0900 – 1600 for this reason.

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2 Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We were told that there are always 2 nurses on each floor day and night. For 40 residents there would be a minimum of 4 care staff at night and 8 during the day. At night the norm is 2 nurses plus 4 care assistants, plus 1:1 as required. There are some families who supply their own carers for their family member so that they have 1:1 care. The Interim Manager told us that were still a couple of staff vacancies needing to be filled, but the situation was much improved.

Agency staff are used if they cannot cover a shift with their own or bank staff and following the recent CQC report which mention concerns about the induction and orientation of staff; the Interim Manager said that a new induction and orientation programme had been implemented following this inspection.

Several comments from both residents and relatives cited lack of staff as a serious problem and that the recent increase was insufficient. Things were worse when agency staff were used; their contribution was limited by their lack of knowledge of the residents and regular staff had to take time to help them.

Staff pointed out the high dependency needs of many of the residents. Two staff were needed for hoists in conjunction with wheelchairs, which meant that movements around the home for group activities, including meals, were very slow and left residents waiting around for a long time. A staff member said "When I started half the residents could walk on their own or with a frame – now it is three out of forty." Likewise, they said that the number of residents with dementia had increased; most could not articulate their thoughts so it was more difficult – and therefore took more time – to work out their needs.

Another said "We are getting residents who are very ill with high needs. To take people to their room after meals, attend to their needs and get them settled can take thirty minutes, so others have to wait." Other staff, and many relatives, spoke in similar terms.

Staff training

All staff receive an induction training week held at the head office of Jewish Care which includes training in the Jewish culture, specialist training, (such as in care of people with Huntingtons) and the use of specialised mattresses. Nurses are supported in their requirements for revalidation. There was an awareness of safeguarding.

We were told that supervision was carried out every two months although they were aiming for monthly. Staff had not been receiving

appraisals, and the appraisal system was currently being reviewed by the Jewish Care Board and would be implemented once received.

Many of the residents and relatives praised the Managers and staff, and were happy with the care provided. However, most of the staff and relatives that we spoke to felt that the home would benefit from additional staff, with particular need for more support at meal times, evenings and weekends.

We were told that staff are encouraged to sit with residents and talk to them as much as possible, though we were told by one member of staff that in practice this was not possible due to the work load.

When relatives were asked **if staff had the right skills and experience** all said that staff were caring and doing their best, but comments included:

- 'They seem to be very caring, there is nursing staff at all times as well as carers'
- 'The floor management need supervision, and to be more alert in recognising symptoms of a resident being unwell'
- 'The family are more aware of the subtle signs and symptoms indicating illness than some of the care staff'
- 'Only the long serving members of staff'
- 'Staff lack courtesy and compassion and are demoralised by not being supported by management'
- 'Yes but agency staff can be problematic'
- 'Although some staff have the right skills and experience there are not enough of the right kind of staff, and they are not provided with direction by the management'. (This relative believed that another 3 or 4 full time carers would improve the situation on the 2nd floor)
- One relative felt management 'need to show leadership and interact with residents and families - never available – always doing paperwork'

- One resident said the home is understaffed leading to long waits to be helped eating, toileting, washing (sometimes up to 1 hour), drinks not always available, and clothes going astray.

- 'My family member had to wait a long time for assistance, but likes the carers once they arrive' - this relative said that there

were two few carers and it was unacceptable to wait for 40 minutes to be taken to the toilet.

- ‘She does not like having to wait to be taken to the toilet’
- 'He would be all the time in bed if I did not prevent it'
- 'No-one comes to you if you are bed-bound'

Some of the residents’ key workers worked at nights so it was not always possible for relatives to be in regular contact with them.

One relative informed us that the issue of leaving clients without regular toilet trips was raised at the recent relatives meeting; from their observation, this does not seem to have been addressed.

Another relative said that only the permanent staff had the right skills and experience; this relative was very concerned about the number of agency staff, especially at the weekends; they commented that the temporary staff then depended on the permanent staff to direct them. It was difficult to judge the abilities of temporary staff, and it was very important to residents’ wellbeing to get to know the staff.

One relative said that although the staff were willing to chat, it was difficult as they had a very heavy workload and it was sometimes difficult to speak to the Nurse or Manager as they were very busy.

Cleanliness around the home
When asked **what do you think about cleanliness around the home** most relatives were happy:

- ‘Very good indeed’
- ‘Generally speaking very good, the rooms are cleaned daily, bedding changed daily’
- ‘Adequate’

One relative said ‘only visible parts are clean, behind the bed is filthy’

Activities

There was a schedule posted in the lift and elsewhere showing the activities. The living well team, led by the living well manager are responsible for managing the activities within the home. We were told that there is a team of 6 full-time and 2 part-time members of staff including a holistic and speech therapist. Residents are involved in developing the programme of activities by suggesting things which

they would like to take part in. There are poetry groups, discussion groups, classical music sessions and exercise sessions based on suggestions from residents; one resident who was previously in the RAF had requested in outing to the RAF Museum. This was arranged and several of the ex-service residents attended.
The Synagogue is also used for activities including music and films.

On our visit we observed a couple of discussion groups taking place. We were told that for residents with advanced dementia there was a focus on small group and 1-1 work, including reminiscent work, creative writing and storytelling as well as music movement, puppetry, animation and entertainment. External facilitators and volunteers also provide sessions including ceramics, gardening and visual arts.

One relative said that the activity programme was not being delivered they would like some classical music and more variety of films. Another resident said that the activities were OK – the reminiscence session and the classical music in the Pavilion was good. They would like some more creative activities – art/ sculpture. One relative commented that it would be good if more outings could be arranged.

Our observation of two activity sessions (on floors 1 and 2) was that they looked well organised and interesting – engaging the interest of all participants.

Religious/Spiritual needs

Religious services are held in the synagogue every Saturday morning and High Holy days are run by the volunteers. We were told that residents are encouraged to stay in touch with their local synagogue communities, with outings to the local synagogues and by inviting Rabbis into the home to meet residents and to be involved in festivals. There are regular visits from the Rabbi, who provides important and valued pastoral and religious support for residents and their families and staff.

The Rabbi was visiting when we were there. He said he visits the home several times a week and sees himself as a bridge between families, staff and residents. He feels that he can provide important end of life support to families – regardless of religious affiliation. He seemed to have a good rapport with the residents, one of whom stopped him as we walked through the dining room and asked him to perform a

blessing – which seemed to be conducted with good humour and was enjoyed by all at the table.

A relative said that the practical difficulties of taking residents around the building meant that the number of people who were able to attend the synagogue was limited.

Food and Drinks

There is a dedicated catering team, with food being cooked in one central kitchen for residents for all the establishments on the site. Each floor has its own dining area with a small kitchen for light refreshments. There were menus on the table, and alternatives are provided if residents did not like what was on the menu that day. The kitchen is informed of any special diets and there are lists in the staff office.

During the day a variety of drinks are served; we were told that residents can choose to eat whenever they wanted, and could eat in their room if desired.

We saw both relatives and staff assisting with food and talking to residents. We were told that more staff than usual were assisting residents with their food on the day of our visit.
Most residents and relatives told us that the food is very good and that there are choices at every meal.

We asked: **What do you/your relative think of the food here?**

- 'pureed food well presented, weight gained since residing here
- 'the food and quality is excellent'
- 'adequate'
- 'fine – could be a bit more imaginative'
- 'she enjoys it and thinks it is very good indeed'
- 'bad'
- 'half the time specially requested foods are not delivered'

One relative commented that it would be helpful if the café also catered for residents dietary needs, particularly for conditions such as diabetes so that they could also benefit from going to the café.

We were told that drinks were always available with staff encouraging residents to drink. There was regular monitoring of fluid intake with fluid intake charts completed if a resident appears to be at risk.

When we asked relatives:
Can residents always get access to a drink if they want one?
The following comments were received:

- 4 respondents said - 'Yes'
- 2 said - 'No.'

Other comments received:

- 'My mother sometimes has to wait until lunchtime to get a drink of water'.
- 'Insufficient attention to fluid intake'.
- 'Residents do not always ask for drinks, and staff do not suggest drinking enough; residents should always be provided with hot drinks after meals'.
- 'My mother cannot ask for anything so if it isn't offered she cannot get it. Consequently she is getting drinks only at set times. Whenever I visit I get her a drink as she always wants one. I have seen less impaired residents who can ask for a drink be given one'.

Engagement with Relatives/Residents/ Carers

We were told that resident satisfaction was monitored by an annual survey and regular relative and resident meetings, the last meeting being held a couple of weeks previously. Records are kept and action plans followed through; a recent discussion had been around updating the 'Reminisce room' which would be updated and residents and relatives would have a say in choosing colour and curtains. The interim manager told us that she had an open door policy and that senior staff should be a visible presence on the floors.

We were told that there were regular review meetings, phone calls and face to face discussions, any changes or concerns being noted.

When we asked: **Do you attend residents/relatives meetings regularly and see any follow-up?**

- 'Yes'
- 'No personal problems are allowed to be aired, they are a waste of time'
- 'The invite is usually emailed out with only a short notice period and it is not enough time to organise myself'
- It is difficult to attend the relatives meeting when they are held at night, actions are not followed through

- I get the impression the priority is to protect the carers
- Yes, little follow up actions
- 'We are not allowed to complain'

When we asked: **Do you feel you and your relative have a say in how the home is run day to day?** Many of the relatives were very satisfied

- 'I feel there is an openness to share information'
- 'there has been no need to question the running of the home'
- 'They would take note and if practical carry it out'

Other comments received were:

- 'No there is a fixed rigid routine'.
- 'Comments are always welcomed but little is then implemented and feedback is not received to any suggestions'.
- 'No despite considerable attempts to make suggestions to the management'.
- 'No'.

Compliments/Complaints/Incidents

The complaints procedure was on each notice board opposite the staff office, residents and their families are informed of the compliments/ complaints/incidents process when they go through the admissions procedure. Any incidents or accidents would be recorded on each floor and then transferred to a central database. A new form was being developed for this purpose.

Do you/your relative/friend know what to do if you have a complaint?

- 'Not particularly – I would like to know more of a process of what to do'
- 'Complainants are either placed with empty assurance or stonewalled'
- 'No feedback given to relatives for verbal and non-verbal complaints as to action taken with regards to the complaint'

Some of the comments that were received from relatives about what they liked about the home:

- 'She is as happy as she can be'

- ‘My mum particularly enjoys that everything is taken care of to quote her own words! She doesn’t have to worry about anything’
- ‘There are always a lot of people around, staff, volunteers and they like the interaction’
- ‘My mother is treated well and with dignity and respect’
- ‘Nothing could better what my Mother receives from the staff at the home’
- ‘Generally enjoy it very much’
- ‘She likes the food, she feels safe’

What would improve your relative’s experience here?

- ‘Nothing could better what my mother receives from the staff at the home’
- Unfortunately I feel that the manager on the floor is not receptive and not a good manager’
- ‘She seems contented but would sometimes like to go to bed a bit later’.
- ‘Getting a new wheelchair, Barnet wheelchair referral is very slow’
- ‘More permanent staff and additional people for caring, transporting to activities and just chatting!’
- ‘Increase the number of carers, increase staff at mealtimes, prompt toileting’.
- ‘Better communication by management – often feel that we are being ignored if we complain’
- ‘More staff time, fewer agency staff, staff simply rush though their allocated tasks often cutting corners’
- ‘A bit more overview of her care and attention to her personal cleanliness. It is upsetting to see her wet herself or sit covered in the remains of her dinner’.
- ‘Better care at night and first thing in the morning, cleaner’.

When we asked relatives who we spoke to or who completed questionnaires:

Would you recommend this home to a friend/relative needing care? The majority said they would:

- ‘Yes, very much so’
- ‘Yes because they are very kind, I feel any shortcomings spring from understaffing rather than a lack of will to do their best’

- 'Yes, with comments, on the whole they are caring, especially the nursing staff'

However others said:

- 'Never'
- 'With many reservations, standards have visibly declined in the years that I have been visiting this home'
- 'Not sure'

Conclusions

The team found this home to be clean and bright with a pleasant welcoming atmosphere. However, after speaking to residents, relatives and staff, we felt there was a definite need to review the staffing**.** It was apparent that residents and relatives would like to be more involved in care planning. Resident/relatives meetings should be reviewed as well as any feedback received to ensure that they have more of a say in how the home is run.

Recommendations for Lady Sarah Cohen

1) To review staffing and consider taking on additional permanent staff in light of the needs of the current residents who are mainly high dependency.
2) To review staff appraisal procedures and ensure that staff understand and implement these.
3) To review the use of care plans to ensure that both residents, when able to, and relatives, understand them and are involved in care planning
4) To give feedback to residents and relatives regarding any queries and concerns.
5) To review the use of the television, perhaps surveying residents and relatives for their views.
6) To review the relationship with the visiting GP to address concerns of the residents and relatives.
7) Pay more attention to the use of hearing aids (know how/when to change the battery and check regularly).
8) Where residents are unable to get themselves a drink for themselves, for staff to monitor and assess on an individual basis, and to record in the care plan at what time intervals to offer a drink.

9) To publicise that the interim manager has an open door policy where relatives have the opportunity to pop in to see her if they so wish.

Recommendations for Healthwatch Barnet

1. To alert Barnet CCG to the comments about the lack of medication following discharge from hospital at this Home.
2. To alert Barnet's IQICH team about supporting the home when someone with DoLS dies.

Response from Manager

Thank you for sending me the Enter & View report that was generated by the visit on the 4th May 2016. You have already given me the opportunity to correct any factual errors, and I have sent these to you separately.

I am pleased to say that I have been offered and have accepted the permanent position of Manager at Lady Sarah Cohen House. At the time of the visit I was the interim Manager and am now pleased to be in the position to use the recommendations of the report as part of my development plan for the home.

Thank you for the opportunity to comment on your recommendations. I know that the volunteers spoke with both residents and family members on the day and that other family members completed questionnaires.

I will address each recommendation in turn.

To review staffing and consider taking on additional permanent staff in light of the needs of the current residents who are mainly high dependency.

Jewish Care staffing ratios are higher than industry standards and we take account of dependency levels when we are assessing residents for admission. We are challenged by the growing dependency needs and the fact that the fees we receive from local authorities and CCGs fail to cover the actual cost of care. We are monitoring the challenges we are facing, and are trying to use staff and volunteers more effectively at times of the day when there is greater need.

This is an ongoing issue for all care and nursing homes: the current financial strictures on social care mean that we need to engage with you to be able to put pressure on the statutory authorities to help us deal with the increasing levels of dependency of people who come to live at Jewish Care.

Meanwhile we are trialling a new dependency tool, which will demonstrate the high levels of dependency we are currently facing. This tool will give us evidence of the serious underfunding to present to the statutory authorities to make our case even more forcefully.

To review staff appraisal procedures and ensure that staff have implemented these.
As explained in the interview, appraisals for the year have commenced and supervisions are being conducted according to Jewish Care Policy, with every member of staff having a supervision at least every two months.

To review the use of care plans to ensure that both residents, when able to, and relatives, understand them and are involved in care planning
We take the care of all of our residents very seriously. We are writing to family members inviting them in to review the Care Plans, if this is appropriate. All our Care Plans are being thoroughly reviewed to become more person centred and therefore more pertinent to the resident as an individual.

To give feedback to residents and relatives regarding any queries and concerns.
I personally meet with as many people as possible when they raise a concern or query, or I will answer them by letter or e-mail. I ensure my senior staff do the same. There is a programme of residents' and relatives' meetings which I attend together with senior members of my team.

To review the use of the television, perhaps surveying residents and relatives for their views.
Staff are reminded to ensure that the TV and radio are on at only appropriate times and according to the wishes of the residents. The use of TV during meal times is closely monitored and, unless a resident particularly wants it on (for example if they do not wish to sit

in the dining area and eat), it is turned off. We will put this on the agenda for the next round of residents' and relatives' meetings.

To review the relationship with the visiting GP to address concerns of the residents and relatives.
As discussed at our meeting, the demands on the GPs' time are many and their priority has to be to see ill residents. The GPs, although they allocate a certain time for each visit, will see any resident who needs to see them. They do not always have time to see relatives, however they will call or meet with relatives if there is a need for urgent discussion.
We will ensure that this is put this on the agenda for the next round of residents' and relatives' meetings.
The issue of GP support in nursing homes is major point of discussion/concern in the sector generally and in the borough. It is something which we think Healthwatch Barnet could assist us in dealing with by bringing to the fore with the relevant health authorities.

Pay more attention to the use of hearing aids (know how/when to change the battery and check regularly).
Training has been accessed by Jewish Care and is being cascaded to all of the care staff.

Where residents are unable to get themselves a drink for themselves, for staff to monitor and assess on an individual basis, and to record in the care plan at what time intervals to offer a drink.
Our procedure is that the healthcare assistant who is responsible for the lounge must always monitor a resident's fluid intake and ensure that all residents are offered adequate fluids.
Where a resident is in their room or away from the floor, all staff are aware that they must check regularly that the resident has had a drink. Where a resident is reluctant to drink, the refusal must be documented and another drink offered a short while later. Where there is concern for a person's fluid intake, the resident is monitored by the use of a fluid balance chart.

To publicise that the interim manager has an open door policy where relatives have the opportunity to pop in to see her if they so wish.

As noted above I have accepted the role on a permanent basis.
I have put the notice below on each floor and will aim to meet with any family member who wishes to see me, either to "say hello" or to hear their concerns.

LADY SARAH COHEN HOUSE

Hello,

My name is Denise Cooper and I am the Manager of Lady Sarah Cohen House.

My office is on the ground floor, immediately opposite the main lift (once you come through the automatic doors) and I invite you to please feel free to come and say hello.

(However, if the blind is down, I request that you come back a little later as this is my "do not disturb" sign.

Should you wish to make an appointment please ring 020 8920 4400.

I look forward to meeting with you

Regards

Denise

I hope that this has provided an answer to your recommendations, but if I can be of any further assistance, please do not hesitate to contact me.

Report Date: July 2016

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AGENDA ITEM 12

Health Overview and Scrutiny Committee

6 October 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.

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London Borough of Barnet Health Overview and Scrutiny Committee Forward Work Programme October 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)**
5 December 2016			
Eating Disorders & Body Dysmorphia	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.	Barnet CCG	**Non-key**
NHS Trust Quality Accounts: 6 Month Review	Committee to receive and consider an update report from NHS Trusts six months on from their last review.	NHS Trusts	**Non-key**
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.	Barnet CCG	**Non-key**
Legal Highs	Committee to receive a report regarding Legal Highs.		**Non-key**
6 February 2017 15 May 2017			
NHS Trust Quality Accounts	Committee to consider and comment upon NHS Trust Quality Accounts	NHS Trusts	**Non-key**
Items to be Allocated			

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
Sustainability and Transformation Plan (STP)	Once the North Central London Sector Joint Health Overview and Scrutiny Committee has received the latest report on the STP, the Barnet HOSC have requested to receive an update report.	Camden CCG / Commissioning Director for Adults and Health	**Non-key**
Colindale Health Project	At their meeting in July 2016, the Committee noted that business cases for the project would be reviewed by NHSE in Autumn 2016. Following the review of the business case by NHSE, the Committee have requested to receive an update report from NHSE and LBB.	LBB and NHS England	**Non-key**
Healthwatch Report: Dementia	Committee to receive a report from Healthwatch regarding Dementia.	Healthwatch Barnet	**Non-key**

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