MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 4TH DECEMBER, 2017

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

Councillor Philip Cohen	Councillor Alison Moore	Councillor Caroline Stock
Councillor Val Duschinsky	Councillor Ammar Naqvi	Councillor Laurie Williams
Councillor Rohit Grover		

Substitute Members
Councillors

Maureen Braun	Kath McGuirk	Shimon Ryde
Anne Hutton	Barry Rawlings	Daniel Thomas

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

Andrew Charlwood – Head of Governance

Governance Services contact: Anita Vukomanovic anita.vukomanovic@barnet.gov.uk, 020 8359 7034

Media Relations contact: Sue Cocker 020 8359 7039

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Decisions of the Health Overview and Scrutiny Committee

2 October 2017

Members Present:-

AGENDA ITEM 1

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

Councillor Philip Cohen	Councillor Ammar Naqvi
Councillor Val Duschinsky	Councillor Caroline Stock
Councillor Rohit Grover	Councillor Laurie Williams
Councillor Alison Moore	

Also in attendance

Councillor Helana Hart

1. MINUTES (Agenda Item 1):

The Chairman introduced the minutes of the last meeting and requested that the word "notes" on page two of the minutes be changed to "noted"

Subject to the inclusion of the above amendment, the Committee **RESOLVED to approve the minutes of the meeting of 3 July as a correct record.**

2. ABSENCE OF MEMBERS (Agenda Item 2):

None.

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

None.

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 IN THE NAME OF CLLR. COHEN (Agenda Item 6a):

At the invitation of the Chairman, Councillor Cohen introduced his Member's item and outlined the following points:

- That land adjacent to the old Finchley Memorial Hospital had been sold by Camden with the intention of its being used specifically for community sport but this had not happened.

- That he had raised the issue of the use of this land with the Chief Executive of Barnet Council.
- That he would be interested to discuss in an open forum, the possibility of the use of any such land as a site for accommodation for NHS staff.

The Chairman informed the Committee that an Enforcement Notice on the use of the land was going to be issued the following day, Tuesday 3 October 2017.

The Vice Chairman commented that the use of the land was a matter of public interest and suggested that the Committee invite an Officer from the Estates work stream of the Sustainability and Transformation Plan (STP) to discuss the whole issue of building affordable housing for NHS staff. The Vice Chairman advised that as the Committee had just learned that an Enforcement Notice would be served, it should be allowed to take its course. However, at an appropriate point, the Committee should receive a report on NHS housing and its implications for healthcare provision in Barnet.

Councillor Cohen welcomed the suggestion and requested that this report be received as soon as possible.

The Chairman requested that the Governance Service provide a copy of the Enforcement Notice, as well as information as to the extent of land that the notice applies to. The Chairman expressed the need to be assured that the site would be used in the best interests of the STP in order to deliver health and wellbeing outcomes.

The Chairman invited Councillor Helena Hart, Chairman of the Barnet Health and Wellbeing Board, to the table. Councillor Hart advised the Committee that she had been in touch with Iain Sutherland, Planning Enforcement Manager from Development and Regulatory Services, who had provided the following statement:

"It was a condition of the planning permission for the new Finchley Memorial Hospital that the old Camden playing fields next door be opened to the public and that 3 football pitches be provided and maintained for public use.

The land was opened up but the pitches were not forthcoming. The NHS have informed us that they are keen to see the pitches delivered and maintained and they are in legal dispute with the developers over this failure. We have not heard from the developer.

Although we were content to recognise that the NHS are making all reasonable efforts to fulfil their obligations the planning enforcement team and the Community Health partnership agreed that a 'breach of condition notice' should be issued. The notice will put those served under a legal obligation to provide the pitches. As the notice would be a public document the health partnership would be able to cite its service in proceedings, effectively granting them a degree of leverage that might otherwise be absent. The notice is due to be served tomorrow and extends 9 months to complete the work. At the end of this period those served must either demonstrate compliance or that they have taken every reasonable step to comply.

Unfortunately the ground is not yet suitable for pitches and therefore compliance requires a lot more than putting up some posts and marking out the lines in whitewash."

Councillor Hart informed the Committee that there was a legal obligation to provide the pitches and was pleased the Council should endeavour to enforce this.

Following consideration of the item and having received advice from the Governance Officer, the Committee agreed that they wanted to receive a future report at the earliest opportunity which:

- In the context of the STP, set out the provision for housing for NHS staff within Barnet.
- Would be received by the Committee at their February 2018 meeting, if possible.

Additionally, the Committee requested to be provided with a position statement on the amount of land being covered by the enforcement and any other spare land around the site as soon as possible, but by the end of 2017.

RESOLVED that the Committee provided its instructions as set out above.

8. ROYAL FREE GROUP MODEL UPDATE AND STREAMS TECHNOLOGY (Agenda Item 7):

The Chairman invited to the table:

- Dr. Steve Shaw, Chief Executive of Barnet Hospital.

Royal Free Group Model:

At the invitation of the Chairman, Dr. Shaw provided the Committee with a presentation about the Royal Free London Group. The Committee noted the presentation, which included the following points:

- In 2009 the Royal Free had one of the smallest local hospital services portfolios amongst the 23 London acutes, with a small paediatric service, an equal second smallest A&E and maternity service and below average volumes in general medicine and general surgery. The hospital had major overlaps with UCLH on specialist services.
- In 2012 the Hospital was authorised as a Foundation Trust.
- In 2014 the Trust acquired Barnet Hospital and Chase Farm Hospital
- In 2016 the Trust received accreditation as a Group.
- Within the context of its position within London, the Royal Free currently provides good services at a below-average cost. However, the Trust's aspiration is to provide **outstanding** services at a below-average cost.
- The Group would aim to transition from a standalone hospital model to working with others in a total system provider model
- The Group CEO is Sir David Sloman.

Dr. Shaw informed the Committee that North Middlesex University Hospital NHS Trust had joined as a clinical partner of the Royal Free London Group two weeks ago. Whilst they were not yet full members of the Group, they would take part fully in the clinical practice group whilst retaining their own Board.

Dr. Shaw informed the Committee that the Group would be undertaking work to understand what brought a patient to hospital and how they could be supported to leave

hospital safely and promptly. Dr. Shaw expressed the need to involve colleagues in primary care and social care as part of a whole patient pathway.

Responding to a question from a Member, Dr. Shaw informed the Committee of the need to provide assurance to regulators that there is a plan for the Royal Free, Barnet and Chase Farm Hospitals to deliver financial improvements. The Committee noted that the Royal Free undertakes very complex specialist procedures which require high cost drugs.

A Member questioned how streamlining would fit into the group model. Dr. Shaw informed the Committee that streamlining would be an essential part of the group process because of its impact on the patient experience.

A Member noted the relationship between cost and quality of care and questioned to what extent the Trust could achieve its aspirations independently of how other hospital Trusts are achieving theirs. Dr. Shaw informed the Committee that it would benefit everyone if costs come down so that more money could be reinvested into the NHS.

A Member noted that it seemed sensible to standardise procedures and pool expertise. The Member questioned the extent of variation existing between the same hospitals within a Trust. Dr. Shaw informed the Committee that there was a surprising amount of variation within the NHS, as indicated by the fact that there were 150 different types of prosthetic hips available. Dr. Shaw explained that work looking at the treatment of Pneumonia with antibiotics had shown a variation between hospitals in their amounts, types and costs. Dr. Shaw advised that the Trust had a duty to provide the best care at the lowest cost.

Streams Technology:

The Chairman invited the following to join Dr. Shaw at the table:

- Dr. Chris Laing, Consultant Nephrologist
- Tosh Mondal, IT Director at the Royal Free London NHS Foundation Trust
- Councillor Gabriel Rozenberg.

The Chairman introduced the report and the Committee noted that, in November 2016, the Royal Free London had entered into a five-year partnership with the British technology company, DeepMind, in order to transform care through the use of a mobile application called Streams.

Dr. Laing informed the Committee that the clinical software app was being used to support patients with acute kidney injury (AKI) by getting the right data to the right clinician at the right time. The Committee noted that AKI was responsible for up to 20% of A&E admissions.

The Committee noted that a change in a patient's kidney function can be picked up by a blood test. The Committee noted that the Royal Free London had felt that there was an opportunity to receive real time notifications for blood tests on a mobile platform.

The Royal Free London explained that it would have approximately 2000 blood tests going through the system per day and that the vast majority of these blood samples would be tested for kidney function. The Committee noted that Streams uses a range of patient data to determine whether a patient is at risk of developing AKI and sends an instant alert to clinicians who are able to take appropriate action promptly. Because

patient information is contained in one place, on a mobile application, it reduces the administrative burden on staff and means they can dedicate more time to delivering direct patient care. The Committee noted that within less than a second, relevant information can be notified and actioned.

Tosh informed the Committee that the platform had been safely deployed with consultants at the Royal Free and that access to the data was extremely secure.

A Member questioned if it was possible at this stage to quantify improved outcomes for patients as a result of this app. Dr. Laing informed the Committee that rigorous evaluation of the project would be undertaken and that the app's impact on survival rates would be going through academic service evaluation. He stressed the importance of being cautious about claiming hard clinical benefits before formal evaluation but noted that the early signs were encouraging. He noted that there was huge potential in the long term for leveraging clinical progress.

Responding to a question from a Member, Dr. Laing informed the Committee that Streams technology is really surveillance through more rigorous analysis.

Councillor Rozenberg questioned why the Royal Free London had decided to work with a company that uses independent data tools. Dr. Laing informed the Committee that DeepMind have a number of other skills including security infrastructure and clinical design.

The Chairman questioned if the Streams Technology was currently just operating out of the Royal Free Hospital site. Dr. Laing advised the Committee that the implementation was single site, but it could be activated from the Barnet site. The Committee noted the long term aspiration to standardise this method of working.

A Member questioned how much progress had been made to resolve the concerns raised by the Information Commissioner's Office with respect to the Royal Free acting as a data controller. Dr. Laing informed the Committee that the Trust had certainly learned from the problem and had agreed to carry out the five undertakings that the ICO had requested.

RESOLVED that the Committee noted the report.

9. BARNET HOSPITAL CAR PARK (Agenda Item 8):

The Chairman invited to the table:

- Dr. Shaw, Chief Executive of Barnet Hospital
- Lisa Robbins, Manager, Healthwatch Barnet

The Chairman noted that the Committee had been sent the following information relating to parking by the Royal Free since the publication of the agenda. However, the Chairman pointed out that the information provided stated that 9 spaces were out of use due to the portacabins but that the figure should be 20.

Car Parking Spaced at Barnet Hospital	**2016**	**2017**
Staff Spaces	749	731
Visitor Spaces	251 (including 14 drop off	295 (including 14 drop off

	spaces)	spaces)
Disabled Spaces	39	39
Motorcycles	2	2
Ambulances	5	15
Portacabin area	9 spaces out of use	9 spaces out of use
Total Spaces in use	1056	1082

The Chairman informed the Committee that 200 extra parking spaces had been added in 2012 to accommodate extra patients when Chase Farm Hospital's A&E and Maternity Units closed. However, the current parking problem had arisen because the Hospital had blocked off approximately a quarter of the Patient/Visitor Car Park and re-designated it as a Staff Car Park.

The Chairman reported that she had attended a site meeting with Andrew Panniker, Director of Capital and Estates at the Royal Free, together with Councillor Zinken and Councillor Stock to see where additional spaces could be added. She noted that there were various strips of grass which would be suitable and that she had spoken to a Planning Officer at Barnet Council who had advised that he did not think there would be a problem in submitting a Planning Application for this. The same applied to converting one of the cycle lanes to be used for parking. The Chairman noted that Mr. Panniker had cancelled a further meeting to discuss the issue. Dr. Shaw apologised for this and undertook to look into the matter.

The Chairman advised that Healthwatch Barnet were receiving many complaints from people unable to park at the site and had therefore undertaken a study on the matter. This showed that 53% of people who had driven to the hospital on that particular day had experienced problems with parking.

The Committee noted that the Chairman had previously contacted the Head of Planning at Barnet, who had looked into the planning history of the site and advised that the Portacabin spaces should have been returned to Patient/Visitor parking when the building works were completed. Dr. Shaw informed the Committee that architects and planning colleagues were working with the London Borough of Barnet in order to free up the portacabin area. Dr. Shaw advised that there were currently essential staff working in the portacabins who needed to be moved. The Committee noted that space at the Barnet Hospital site was very constrained and that a new entrance just for ambulances was opened last year. Dr. Shaw undertook to investigate the situation with regards to the portacabins and provide further information to the Committee.

The Chairman informed the Committee that when she had visited the hospital with Councillor Stock, they had been talking to a patient who had missed an appointment previously because she was unable to park. She was now trying to attend the re-booked appointment, but again could not find anywhere to park and had had to abandon her car. The Chairman informed the Committee that the patient was in tears because of the situation.

A Member commented that the parking situation at the hospital was already intolerable but as the Borough has an expanding population, the need for more parking would only increase. The Committee noted that the site was not served well by public transport.

Dr. Shaw apologised that the patient had had such a poor experience and advised that the issue of parking would be ongoing. Dr. Shaw noted that he paid a lot of money to park in the staff car park at the Royal Free and if he did not arrive before 7:30 am, he

would not be able to find a space. He noted the need to find a balance for hospital and staff parking and commented on the need to ask staff and patients if it was necessary for them to arrive by car. He said that he regularly got the bus to work and between hospital sites but recognised this was not always possible for patients. He commented that multi-storey car parks were very expensive to build and assured the Committee that he took the situation very seriously.

The Chairman advised the Committee that when the extra 200 spaces had been added to the site, the hospital's income increased significantly. She noted that there was a piece of wasteland near the entrance to the hospital which could accommodate approximately 80 extra spaces.

The Chairman invited Lisa Robbins to provide the Committee with an update on the engagement work undertaken by Healthwatch Barnet. Ms. Robbins informed the Committee that the engagement exercise was undertaken in May this year. She noted that people were generally very positive about their experience at Barnet Hospital but that there were concerns about parking. She suggested that the hospital provide information about reaching the hospital by public transport in their patient letters. She also advised the Committee that people were experiencing difficulty in registering disabled vehicles and stressed the need to do more engagement on the matter.

The Chairman questioned if the report from Healthwatch Barnet had been sent to the Royal Free. Ms. Robbins confirmed that it had. Dr. Shaw undertook to check with the Director of Nursing about the report and its contents as he had never seen it.

Referring to the issue of people receiving parking tickets because their appointments had run late, a Member suggested that car park ticketing be done under the "pay by foot" system, whereby customers collect a ticket as soon as they park and then pay the correct amount at a machine when they return to their vehicle. Dr. Shaw undertook to look into this option.

The Chairman informed the Committee that she had previously undertaken a site visit to Barnet Hospital to inspect parking signs because they were too high and she was concerned that people parking at the hospital would not see them. She advised that, as a result of the meeting, the parking signs had been lowered.

Dr. Shaw thanked the Committee for inviting him to speak on the matter and stressed his commitment to improving patient experience.

RESOLVED that:

1. **The Committee noted the report.**
2. **The Committee requested to be provided with further information on the use of the space where portacabins are currently located.**

10. FINCHLEY MEMORIAL HOSPITAL UPDATE REPORT FROM BARNET CCG (Agenda Item 9):

The Chairman invited the following to the table:

- Alan Gavurin, Finchley Memorial Programme Manager, Barnet CCG
- Maria DaSilva, Director of Commissioning, Barnet CCG

- Kay Matthews, Chief Operating Officer, Barnet CCG

Ms. Matthews introduced herself as the new Chief Operating Officer and commented that she had successfully recruited a permanent Directors' team who will provide the HOSC with a level of continuity to address and take forward the better utilisation of Finchley Memorial Hospital (FMH)

Ms. Matthews informed the Committee that since joining the CCG three months ago, she had met with local Councillors and Members of Parliament and was well aware of the importance of the better utilisation of the FMH site.

Ms. Matthews advised that she had created a steering group on the matter and that Alan Gavurin had been appointed to support the CCG for the next six months.

Ms. Matthews provided an outline of the CCG's list of priority projects which included the following points:

Adams Ward:
The CCG is currently working with Central London Community Health Services NHS Trust to open Adams Ward as a Discharge to Assess ward in December 2017. There will be 17 beds and these will be used to facilitate the discharge of patients from various acute hospitals, mainly Royal Free London.

Patients discharged to Adams ward will meet the Discharge to Assess Pathway 2 and 3 criteria and will require further assessment to support their long term care. This will reduce delayed discharges from hospitals. The alignment of the two inpatient wards at FMH will ensure that the beds are managed in the most effective way. This development will be particularly important over the winter months.

General Practice:
The CCG is developing a specification for a GP service at FMH. This will be used in a procurement exercise for local GPs to apply to move into FMH. The specification is expected to include some additional enhanced services beyond core primary medical services.

Historically, attempts to attract a General Practice to move to FMH had not proved financially viable. The CCG want to make one more effort and, if this is not successful, will then consider what other opportunities there are for this space.

Breast Screening:
Despite plans for a permanent Breast Screening service at FMH being discussed for some time, they have not yet been concluded. The main reason for this has been financial, as agreement has not been reached regarding the capital costs to convert this space. The Breast Screening service is commissioned by NHS England rather than the CCG, which also creates another level of negotiation.

In spite of all of the preparatory work, the CCG is not confident at this stage that they will be able to reach agreement to complete the capital work by the end of the financial year.

Research project - CT Scanner:
The CCG has been working with University College Hospital to locate a CT scanner at FMH as part of an international research project. The plans for this are developed and at

the stage where final agreements are due to be signed in the near future. It is expected the conversion works for this will be undertaken before the end of the financial year.

Move of CCG headquarters from the North London Business Park to FMH:
The CCG is completing a feasibility study regarding moving its headquarters to FMH. This will report by the end of October 2017 so the Governing Body can make a decision.

The Vice Chairman advised that the Committee had been made aware of the problems that people have in accessing the hospital because of transport difficulties. The footfall currently going to the hospital is not great enough to justify more appropriate public transport provision and that the main way to significantly increase footfall is to have a GP Practice there. He questioned what new factor could be brought into play in order to attract GPs to this site which hadn't been offered in the past. Ms. Matthews advised the Committee that the CCG was looking for creative ideas from staff in order to make the space more attractive.

Referring to the previous item on parking at Barnet Hospital, Ms. Matthews noted that it was interesting to hear that Barnet Hospital is being fully utilised and questioned if it would be possible for the CCG to attract any services from the Barnet Hospital site.

A Member commented that it seemed too expensive for GPs to locate to the FMH site and questioned if it was time to abandon plans to have a GP service operating there. The Member welcomed the idea of the CCG office being given a permanent home but advised that she felt that, at the moment, hospital space was needed for beds, particularly in the context of the forthcoming winter crisis. The Member also noted that the Marie Foster Unit site was up for sale and questioned why the land wasn't being used. Ms. Matthews informed the Committee that the Marie Foster site had been surplus to requirements for a long time.

Ms. DaSilva informed the Committee that there is not a need for more community beds (above what has been commissioned) in Barnet. She explained that a thorough analysis had been undertaken to establish the number of community beds required and that the CCG had commissioned on this basis. Ms DaSilva also confirmed that it is not just the number of beds that is important but also the length of time patients stay. When patients are fit for discharge and a package of care is put in place in a timely fashion, then the bed base can be used more effectively. Ms. DaSilva noted that the future aspiration would be to look at how the number of beds needed could be reduced by investing money in care at home instead.

A Member commented that the rents that would be charged to GPs at the FMH site would be set by a private company based on the square footage and that the offer was not currently financially attractive. Ms. Matthews informed the Committee that the GPs' rent is reimbursed, but the Practice would have to pay the service charge for the site.

Ms. Matthews informed the Committee that in order to open Adams Ward by December 2017, the CCG would require the cooperation of a considerable number of partners. The Committee noted the CCG's concerns around the winter flu season and also that the CCG would be specifically targeting the care of dementia patients and patients in continuing care.

The Chairman suggested that the full utilisation of Finchley Memorial Hospital become a standing item on the Committee's agenda for the rest of the municipal year. The

Chairman requested that the Governance Officer provide the CCG with the Committee paper deadlines and meeting dates which were as follows:

Meeting on 4 December 2017: Deadline is 14 November 2017
Meeting on 5 February 2017: Deadline is 16 January 2018

The Chairman commented that the update on the plans for a permanent breast screening unit was much less positive than at the Committee's July 2017 meeting and expressed concern that the situation had still not been resolved.

RESOLVED that:

1. **The Committee noted the report.**
2. **The Committee requested to be provided with a further update on the utilisation of the Finchley Memorial Hospital site at their meetings in December 2017 and February 2018.**

11. PRESSURE ULCERS UPDATE REPORT FROM BARNET CCG (Agenda Item 10):

The Chairman invited to the table:

- Kay Matthews, Chief Operating Officer, Barnet CCG
- Jennie Williams, Director of Nursing, Haringey CCG.

The Committee were advised that Jenny Goodridge, Director of Quality and Clinical Services, Barnet CCG, had been due to attend the meeting but had had to give her apologies. The Committee noted that Jennie Williams worked closely with Jenny Goodridge.

The Vice Chairman noted that the paper reported on the incidence of pressure ulcers but what was equally important was how pressure ulcers are dealt with. He asked if there were any statistics on how quickly and efficiently pressure ulcers are treated. Ms. Williams advised that Ms. Goodridge chaired a monthly quality review meeting with the Royal Free NHS Trust (RFH)and Central London Healthcare (CLCH) where the issue of the reporting and management of pressure ulcers was monitored.

The Committee noted that the majority of pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time. The Committee was informed that Care Homes do not collect the same information on pressure sores as NHS Trusts.

A Member questioned if there is an explanation as to why the RFH was an outlier in terms of reported grade two pressure ulcers. Ms. Williams confirmed that the responsibility for responding to this rested with the provider but that Ms. Goodridge would request such information at the monthly quality review meetings and seek assurance about the actions being taken to reduce the number of pressure ulcers occurring within the Trust.

The Chairman questioned if it would be possible to receive a report on the incidence and treatment of pressure ulcers in Care Homes and in Primary Care settings. The

Committee noted that pressure ulcers within Primary Care settings are not currently recorded.

Ms. Williams advised that there is limited work currently taking place within Barnet Care Homes on pressure ulcers but noted that colleagues were considering how NCL CCGs could best address the variation of quality and safety in Care Homes. The Committee noted that Ms. Goodridge has recently taken on a system leadership role relating to Care Homes.

RESOLVED that the Committee noted the report.

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

The Chairman invited to the table:

- Councillor Helena Hart, Chairman of Barnet Health and Wellbeing Board
- Dr. Andrew Howe, Director of Public Health (Harrow and Barnet Councils)

Councillor Hart provided the Committee with an update on matters discussed at the Health and Wellbeing Board which included the following points:

- The Board had considered the Public Health Annual Performance Report at their September meeting, which set the response for the working programme and reviewed its achievements on an annual basis. The vast majority of major plans and performance had been rated as green, which was the best in recent years.
- Work was ongoing to bring health into leisure; the HWBB would receive a full report on this issue.

Dr. Howe commented that performance had not been so good in the areas of smoking and childhood obesity, rates of which had both increased in Barnet in the last year. The Committee noted that whilst the rate of smoking in Barnet had increased, the rate was low and Barnet had one of the lowest smoking rates in London. The Committee noted the availability of a new telephone line for London to help people who wish to stop smoking.

Dr. Howe advised the Committee that work was ongoing to tackle childhood obesity, including work for healthy schools and Children's Centres. The Committee noted that the benefits from work within Children's Centres would take some time to come through and included teaching parents about healthy eating and breastfeeding.

The Committee considered the Forward Work Programme as set out in the agenda. The Chairman noted that in addition to the Children's Dental Health in Barnet report, the Committee would also receive future reports on:

- The utilisation of Finchley Memorial Hospital
- Barnet Hospital Car Park
- A mid year update from NHS Trusts and the North London Hospice on their Quality Accounts
- A report on the STP which also provides information on NHS staff accommodation.

RESOLVED that the Committee noted the Forward Work Programme.

13. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 12):

None.

The meeting finished at 10.00 pm

AGENDA ITEM 6

Health Overview and Scrutiny Committee

4 November 2017

Title	**Member's Item – Councillor Cohen: Health and Wellbeing Impact Assessments**
Report of	Head of Governance
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Anita Vukomanovic, Governance Team Leader Email: anita.vukomanovic@barnet.gov.uk Tel: 0208 359 7034

Summary

The report informs the Performance and 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 Phil Cohen has requested that a Member's Item be considered on the following matter:

"This Committee agrees to commission a paper on how Health and Wellbeing Impact Assessments can be included in all new policy and strategic developments initiated by Barnet council.

It would mean that for any policy area officers and members would need to consider what the health and wellbeing impact would be if a particular course of action was recommended. At the moment impact assessments cover areas such as resources, social value, equalities and diversity, but not health and wellbeing.

This would be line with an integrated approach which recognises that there are wider determinants of good or poor health and wellbeing covering policy areas such as housing and regeneration, environment, transport, food standards, community safety and leisure.

Other London local authorities have adopted such an approach, as has the Mayor of London. His draft Health Inequalities Strategy called Better Health for all Londoners published on 23 August 2017 says that health and health inequalities need to be addressed systematically across a wide range of public services.

It is also central to the London health devolution agreement announced on 16 November 2017 between the Mayor, Secretary of State for Health Jeremy Hunt, London councils and the NHS. This places importance in joined-up health and social care and recognises how people's quality of life can be affected by differences in people's homes, education, the local environment, jobs, and access to public services."

2. REASONS FOR RECOMMENDATIONS

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 **Social Value**

5.3.1 None in the context of this report.

5.4 **Legal and Constitutional References**

The Council's Constitution (Article 2 – Members of the Council) 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.

5.4.1 There are no legal references in the context of this report.

5.5 **Risk Management**

5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**

5.6.1 Member's 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.

5.7 **Consultation and Engagement**

5.7.1 None in the context of this report.

5.8 **Insight**

5.8.1 None.

6. BACKGROUND PAPERS

6.1 Email to the Governance Service dated 22 November 2017

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AGENDA ITEM 7

Barnet Health Overview and Scrutiny Committee

4 December 2017

Title	NHS Trusts and North London Hospice Quality Accounts – Mid Year Review
Report of	Governance Service
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Appendix A - CLCH Comments and Response for 2016-17 Appendix B: Royal Free London NHS Foundation Trust Comments and Response Appendix C: Comments to North London Hospice Appendix D: Response from North London Hospice
Officer Contact Details	Anita Vukomanovic, Governance Team Leader anita.vukomanovic@barnet.gov.uk 0208 369 7034

Summary

At its meeting in May 2017, the Committee considered the Quality Accounts from NHS Trusts and the North London Hospice for 2016/17. Health providers are required by legislation to submit their Quality Accounts to Health Scrutiny Committees for comment. NHS Trusts have a requirement to report their Quality Accounts to the Committee. At the meeting, the Committee was asked to scrutinise the Quality Accounts and to provide a statement to be included in the Account of each health service provider.

The Committee have requested that the two NHS Trusts and the North London Hospice provide a response as to what action they have taken following the submission of its comments for inclusion within the final draft of their Quality Accounts last year.

The appendices contained within the report set out a) the comments made by the Committee to the Trust last year, followed by b) the response from the Trusts and the Hospice in respect of those comments.

Recommendations

1. **That the Committee notes the report.**

1. WHY THIS REPORT IS NEEDED

1.1 Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide, mirroring providers' publication of their financial accounts. All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations, must publish an annual Quality Account. The Committee has requested that the organisations that submitted their Quality Accounts last year provide an update on how they have actioned the comments made by the Committee.

1.2 The primary purpose of Quality Accounts is to encourage Boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements which focus on essential standards.

1.3 If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

1.4 Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

- Display a notice at their premises with information on how to obtain the latest Quality Account;
- Provide hard copies of the latest Quality Account to those who request one.

1.5 The public, patients and others with an interest in their local provider will use a Quality Account to understand:

- Where an organisation is doing well and where improvements in service quality are required;
- What an organisation's priorities for improvement are for the coming year;

- How an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

1.6 Commissioners and healthcare regulators, such as the Care Quality Commission, will use Quality Accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be able to see how NHS Trusts and the Hospice have responded to the comments that the Committee asked to be included within the Quality Accounts.

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, it is able to consider if it would like to make any recommendations to the NHS Trusts and the North London Hospice.

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)**

5.2.1 There are no financial implications for the Council.

5.3 **Social Value**

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. 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 (Article 7) 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."*

5.4.3 NHS bodies and certain other bodies who provide health services to the NHS are required by legislation to publish Quality Accounts drafts of which must be submitted to the Health OSC for comment in accordance with section 9 of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended.

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 Health Services in 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.

5.6.3 The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.6.4 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.

5.7 Consultation and Engagement

5.7.1 The Barnet Health Overview and Scrutiny Committee is taking the opportunity to engage with the NHS Trusts and the North London Hospice in relation to their actions following the Committee placing its comments regarding the Quality Accounts on record.

5.8 Insight

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

6. BACKGROUND PAPERS

6.1 Agenda of the meeting held on 16th May 2016, Item 9: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=8377&Ver=4

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CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST (CLCH)

The Committee scrutinised the Draft Central London Community Healthcare NHS Trust's Quality Account 2016-17 and wish to put on record the following comments:

The Committee noted the growth of the organisation and said it was a compliment to the Trust that they were able to take on extra work.
The CQC has recently (in October) inspected the Trust. We are awaiting their final report (expected late November/early December) but during the period of the inspection no major issues were reported to us. This includes inspections of some Merton and Harrow services so we are confident that the acquisition of these services has not caused any major issues and that they are running well.

The Committee enquired about the cost of producing this report and was happy to hear that costs were kept to a minimum because the report was published online only. The Committee were pleased that the Trust was using the report as a key document for learning and improvement.
There have been no issues raised with us in respect of the quality account being produced online. Given this we will continue to produce the account this way in the future.

The Committee were also pleased to hear that the Trust had been successful in receiving funding for a new role for a pressure ulcers nurse. The Trust believed this will have a big impact on reducing the number of patients with pressure ulcers in the next year.
The pressure ulcer nurse has been recruited and will be starting in the New Year. This post will co-ordinate pressure management prevention and treatment across the trust. They will also review and implement the Trust's Pressure Ulcer management policy and ensure that the action plan is implemented. Additionally they will review pressure ulcer training and ensure relevant learning is distributed across the Trust.

The Committee asked how the data in the report was used in terms of training and up-skilling of staff. The Trust explained every investigation was used within training programmes and updates to staff were given via regular reports and newsletters.
Learning from incidents, complaints etc. is shared across the Trust via meetings such as the Patient Safety and Risk Group as well as via Trust communications such as *Spotlight on Quality.*

Example of *Spotlight* and the PSRG agenda that demonstrate this are available on request

The Trust also explained that it was part of a national working group on pressure ulcers, but was not sure if information was passed onto voluntary organisations that it worked with, and so it would be looked into.
CLCH hosts a monthly Patient Experience co-ordinating committee; the membership includes CLCH staff and patient representatives and colleagues from the voluntary and community sector. For example the Carers' Network and Age UK. The meeting are primarily held to review progress against the quality objective *a positive patient experience.* The meetings provide an opportunity to share learning and give examples of best practice. Additionally there is a north division quality stakeholders' reference group (QSRG). Along with Trust staff, this meeting is attended by

representatives from Healthwatch Barnet. It provides the opportunity to discuss patient stories and learning from these.

The Committee enquired whether the procedure for end of life care at Barnet was the same as at Merton, as outlined in the report (Page 17 of the CLCH report). The Committee were impressed that this was the case, as this was an example of good practice.
The CLCH district nursing service is comprised of district nurses and health care assistants and amongst other things provides palliative care across the Trust (including in Barnet). The Trust has an End of Life strategy that describes the Trust wide approach to End of Life care. This ensures that there is a consistency of approach to the care provided.

The Trust's End of Life Strategy is available on request.

The Committee commented that the patient stories on dentistry provision were very good. The Committee were also glad to see that diabetes self-management was improving.
No further comment.

However:

The Committee was concerned that the Trust expanding further into new areas could have an impact on maintaining a high quality of standard of care. The Trust explained that the inclusion of Merton and Harrow had been successful and reporting structures had fitted in well with these Boroughs.
As per above no issues were raised by the CQC during the period of their visit, including their visit to Harrow and Merton services. (We don't, at the time of writing, have their inspection report).

The Trust said going forward it would only be bidding for services that it was already experienced in and was not looking to expand further.
The Trust Strategy 2017-20 confirms that `we *wish to remain focused, committed and active partners and so we will not seek to take on new services outside of our four current STP areas'.*

The Committee noted the increase in the number of patients with pressure ulcers. The Trust explained that the situation in Merton and Harrow had led to challenges but it did not believe this was of major concern.
As of the date of writing (11th November) the number of grade 1 pressure ulcers being reported has decreased. Please see the chart at appendix A.

The Committee commented that the figures showed a drop in December 2016 in the Dignity and Respect indicator as well as the Explaining Care indicator as perceived by patients (Pages 3 and 4 of their report) and asked for an explanation of the figures to be communicated to the Committee.
We believe that in part this was caused by an error with our PREMS data. During this period there were sample issues between our business intelligence team (BIPA) and *Picker* (the company previously used by the Trust to independently gather patient feedback). This led to *Picker* having to ask for a second sample (of patient responses) in early January 2017.

This year we have moved from working with *Picker* to using a different company *HealthCare Communications.* Work is ongoing to ensure that similar issues don't reoccur this year.
It may also be that as services were exceptionally busy over the Christmas period this may have caused a more negative feedback during December.
As of October both indicators were achieving the Trust target; 96.3% of patients believing they were treated with dignity and respect and 90.3% agreeing that they had their care explained to them.

The Committee noted there appeared to be issues surrounding the retention of staff at the Trust. The Committee was impressed that the recruitment of Filipino nurses had been so successful and was having a positive impact on the Trust. However, it was concerned that more work was need to recruit and retain UK nurses. The committee noted that the vacancy rates had fallen from 22% to 14% this year. The Committee also raised concerns around the cost of recruiting overseas nurses but was assured by the Trust that the cost was not significantly more than other recruitment.
Recruiting from the Philippines *is* more expensive than UK recruitment. However given the costs of agency staff recruiting permanent staff from overseas makes financial sense. Employing permanent staff also provides continuity of care. The Trust has recently completed a second recruitment campaign in the Philippines, offering 100 posts to individuals.
In respect of recruiting and retaining UK staff a **recruitment and retention group** is in place and meets monthly. Additionally **career clinics** take place throughout the year on a variety of CLCH sites. The clinics provide one to one sessions and participants can ask questions about all aspects of working at CLCH. So far the following has been identified from the clinics: Access to job opportunities within and outside CLCH; flexible working; application and CV preparation; interview presentation and Interview practice; training in leadership/ management and continuous improvement. **Workforce action teams** are also in place and these focus on specific hot spots and actions needed to address these.

CLCH also has a recruitment and retention strategy. It describes how the most common response to staff shortages is to focus increased attention on recruitment however reducing the number of staff leaving the organisation is a much cheaper option and more within our control. Initial analysis suggests the following factors are important to employees: Work life balance; flexible working opportunities; pay and career progression; access to training and development and having a positive workplace culture. These issues are reviewed by the recruitment and retention group.

A copy of the recruitment and retention strategy is available on request.

The Committee suggested that the Trust should conduct an 'exit interview' when a member of staff leaves in order to find out the reasons.
Exit interviews are offered to staff either with their manager or with someone from HR. They can have the option to complete the online questionnaire if they do not wish to meet with someone. The Staff Engagement strategy confirms that exit interviews should be made available to staff.

The Committee noted the increase in the number of serious incidents being reported. The Committee was satisfied that this upward trend in reporting reflected greater transparency and reporting by staff.
Incident reporting is considered to be positive: '*Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.'* (National Reporting and Learning System).

We encourage staff to report serious incidents; incident reporting constitutes part of statutory mandatory training that all staff are required to undertake.

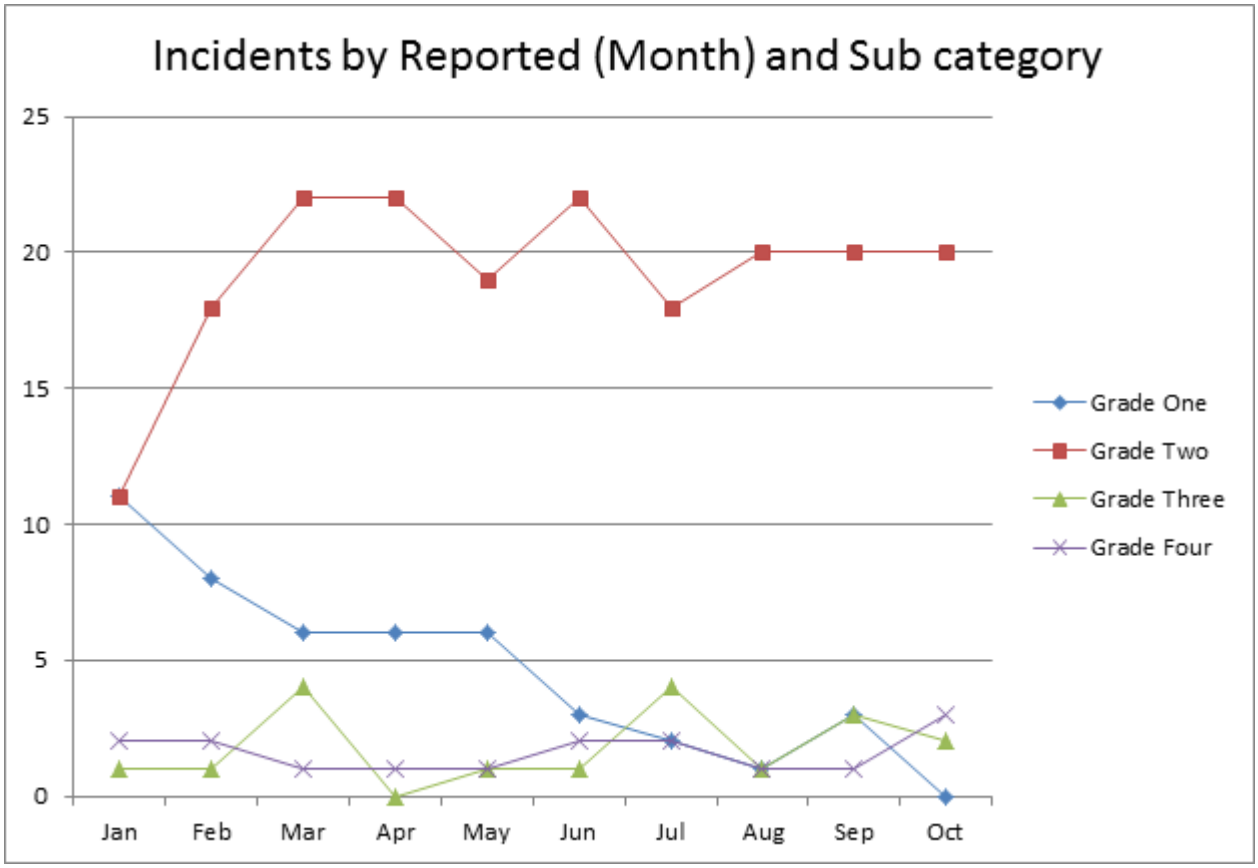
The Committee asked why the Trust had not taken part in the diabetes foot care Audit and requested an explanation for this be presented in the final report.
The final Quality Account explained that the Trust's failure to take part in the audit was due to administrative problems. The clinical audit team have confirmed that CLCH will be participating in the 2017-18 audit.

The Committee commented that the equal opportunities statistics had not improved much since last year's report. The Trust explained that a lot of work had been done on this and it believed this was an issue of staff perceptions. The Trust assured the Committee it would be looking into better ways of publicising how successful the work on increasing equal opportunities had been.
The Trust remains committed to improving these statistics. The Trust has undertaken a Workforce Race Equality Standard (WRES) assessment which is an NHS initiative and was developed to measure improvements in the workforce with respect to BME staff.
An action plan has been put in place to ensure that the issues identified by the assessment are being addressed. The plan is published on the Trust website.
http://www.clch.nhs.uk/media/250587/wres_action_plan_2017_version_7.pdf
In November the Trust held a BME staff conference the theme of which was career progression.

The Committee inquired about the deaths reported on Marjory Warren and Ruby Wards and why these had occurred. The Trust said that after being investigated, these deaths were not unexpected.
No further comment.

Cyberattack update:
The CLCH gave a quick update on how the recent cyberattacks had affected the Trust. The Trust said that it had been unaffected by the attack. CLCH also explained that it had a number of procedures and safeguards in place to protect itself from possible future attacks.
There were no repercussions for CLCH in respect of this attack and the Trust remained unaffected.

Appendix A – Pressure ulcer incidents 2017 (to end of October).



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Royal Free London NHS
NHS Foundation Trust

Update from the Quality Account 2016/17

This report presents an update to Barnet Health Overview and Scrutiny Committee (HOSC) on areas outlined in the quality account 2016/17. The report is divided into two sections:

- Part one: feedback on the points raised by Barnet HOSC (May 2016)
- Part two: update on progress to meet the quality account priorities identified in 2016/17

Part One: Feedback from points raised by Barnet HOSC

In 2016/17, the Barnet Health Overview and Scrutiny Committee (HOSC) reviewed the draft quality account 2016-17 and following comments were recorded. A response from RFL is as follows:

Comment from Barnet HOSC	Response from Royal Free London
The Committee was pleased that the Trust had been rated 'Good' in most areas by the CQC	Thank you for this comment.
The Committee complimented the Trust on their continuing progress on its Dementia Strategy in particular the introduction of a Passport for Carers	Thank you for this comment. Dementia care remains a priority for the trust and several initiatives have been undertaken to support this. As a result of our participation in the national audit of dementia, the audit lead and the dementia nurse have been invited to attend the National Audit of Dementia Event which takes place in London in Dec 2017. This has created the opportunity for staff to discuss the role of the dementia champions and the support they provide at Barnet Hospital. (Further initiatives are outlined on page 7)
The Committee congratulated the Trust on the list of its key achievements over the year.	Thank you for this comment.
The Committee noted the Trust's participation in national clinical audits which it found most informative. Whilst this is prestigious, it is recognised that there is considerable additional work for practitioners. However, the Committee was pleased that the results of the audit are being used to improve local practice	The trust also recognises that participation in national audits is additional work for practitioners and clinicians and their teams are thanked for their hard work, commitment and dedication. Additionally, through our Clinical Pathway Groups (CPGs), the results from national clinical audits are integrated to support the reduction of unwarranted variation in clinical care. (Further information on our CPGs are outlined on page 8)
The Committee acknowledged the efforts made by the Trust to make the data clearer in this year's	Thank you for this comment.

report and found the statistics suggested that the Trust was doing well when its performance is compared with the national average	
The Committee commented that lower levels of diabetes were reported at Chase Farm than expected and queried the reasons behind this. The Trust said there had been an improvement in in-patient foot surveillance, in addition to projects on improved interventions in order to alert staff to dangerous changes in glucose levels. The Trust explained that at any one time up to 20% of patients at the Royal Free can be diabetic and it is a great challenge for the diabetic team to manage all of these.	Through various clinical initiatives, there remains a continued focus on diabetes care across the trust. On particular, the patient safety work stream includes two areas of focus on diabetes. 1. To reduce serious incidents related to uncontrolled glycaemic episodes, hyper and hypo, across all pilots. 2. To increase the percentage of patients who have appropriate blood sugar time to control to 95% on the pilot wards.
The Trust explained they were looking into an alerting system for pre-diabetics and this would be the focus for the next few years. The Committee requested that the Trust bring an update on this back to a future meeting.	The trust has chosen to focus on an app (stream device) for renal patients before other potential uses. The AKI app is discussed on page 9 and 10 of this report.

The Committee noted that the number of reported incidents at the Trust had risen since last year. The Trust explained this was viewed as a positive sign that members of staff were reporting more incidents and the number of serious incidents resulting in harm had actually gone down.	The trust continues to monitor the number of reported incidents and this is reported to our Clinical Performance and Patient Safety Committee. Full details on our performance will be reported in the quality account 2017/18
The Committee queried the accuracy of the figures on Sepsis. The Committee suggested these figures be investigated before the final version of the report is published. The Committee also queried whether a Sepsis intervention programme was currently in place in order to educate all staff about the signs and seriousness of Sepsis. The Committee were assured that all staff were trained to look for signs of Sepsis, especially at the triage stage of care	The final data on sepsis was reviewed prior to the final publication and changes were made accordingly. Our current performance on sepsis is outlined on page 14.
The Committee noted that the c.diff key performance indicator on page 85 of the Royal Free report did not make sense, as it appeared that the Trust was performing better than the highest national performing trust. The Committee suggested these figures were also checked. The Chairman commented that she found last year's table easier to understand. The Committee commented that the c.diff figure	The final data on c.diff was also reviewed and changes made in the overall presentation.

was not clear, making it difficult to understand if the Trust was doing well when compared with its own previous year's figures as well as other hospitals. The Committee asked that the table be made clearer and the figures checked.	It is anticipated that the data would be presented more clearly in the 2017/18 quality account.
The Committee felt that being ranked 23rd out of 25 hospitals for c.diff indicated this was an issue the Trust should look into further. The Trust explained that c.diff is measured in a number of ways and cannot be avoided in all cases, however the aim was to get the number as close to zero as possible. The Trust stated that they needed to do some work comparing its numbers of c.diff cases with other hospitals with similar complex cases.	The trust continues to prioritise work around managing infection control which includes c.diff. Our performance is reported at various forums across the trust which includes the Clinical Governance and Patient Safety Committee (CPPSC) which is attended by our Director for Infection Prevention and Control (DIPC) and chaired by the medical director at Barnet Hospital. Further information will be presented in our quality account (2017/18).
The Committee acknowledged that A&E had experienced a challenging winter which had been affected by social care provision issues, not necessarily caused by the five NCL Boroughs but often by Hertfordshire, which had led to difficulties with discharging patients. The Committee asked whether there appeared to be a trend whereby patients preferred to seek treatment from A&E rather than via other methods of accessing urgent care. The Trust said it was not able to comment on what was causing the trend but there had definitely been an increase in the number of patients attending A&E. The Trust suggested it could be due to the increasing and changing demographics in the population. The Trust explained it was working closely with colleagues in Primary Care and the CCG, as well as local councils, to try to co-ordinate responses across the system in order to ensure patients do not have to wait more than four hours when possible. The Trust also stated work was needed to encourage patients to go to the most appropriate place for care, but did not anticipate this being an easy issue to resolve.	Thank you for this comment.
The Committee questioned the number of 'Never Events' and how these were being managed to prevent reoccurrence. The Trust explained these were mainly incidents in surgery and one was currently under review to establish whether it met the criteria to be classified as a never event. The Committee did however acknowledge there had been a big reduction in these events over the year and encouraged the Trust to ensure these numbers	Details on our surgical safety program are presented on page 10 of this report.

remained as low as possible. The Committee were pleased to hear a surgical safety programme would be continuing and patient safety meetings were due to be held throughout the year.	
The Committee commented that no section had been included in regard to any compliments or complaints. The Committee suggested that a number of these are included in the final report.	Detailed information on our complaints and compliments was presented in our annual report 2016/17. Therefore to avoid duplication it was not repeated in the quality account. It is anticipated that the 2017/18 quality account may include a brief overview on compliments/complaints.
The Committee wished to put on record again their concern regarding the insufficient amount of parking at Barnet Hospital for both patients, visitors and staff. The Committee had mentioned this issue at last year's Quality Account meeting and were disappointed that the Trust had done nothing to improve matters since then. The Committee also expressed its concern that a quarter of the visitor/patient car park had been re-designated as staff parking and that a portacabin was also taking up 18 patient/visitor spaces	A separate report has been sent to Barnet HOSC covering the issue of parking.
The Committee asked specifically about whether the hospital had received complaints in regard to the lack of parking. The Committee explained that at previous Health Overview and Scrutiny meetings suggestions had been made to extend the current car park on the east side of the hospital. The Trust said it would have to look into this. The Committee also suggested the Trust look into the possibility of installing a camera at the exit of the car park which would inform the driver whether they had paid for their parking or not. This would give the person the opportunity to return to the car park and pay for their parking rather than being fined	A separate report has been sent to Barnet HOSC covering the issue of parking.

The Committee asked about whether there was a strategy for parking at the Royal Free Hospital, whilst acknowledging that the site was very restricted for space.	A separate report has been sent to Barnet HOSC covering the issue of parking.

The Trust told the Committee that no viruses had infected the Royal Free computer system. Over the weekend, the Trust had closed down some of its systems that were not key as a precaution, but these were now all back up and running and in-patient services had remained unaffected. The Royal Free said that had also provided support to other Trusts that had been affected. The Trust explained that they constantly reviewed and enforced cyber protection with a number of different anti-virus and encryption tools which were updated regularly. The Trust also ensured that staff were educated on the issue and sent out regular communications on the importance of cyber safety and security. The Trust also explained that it had contingency plans in place in the event of an attack.	No further comment on relation to cyber safety and security.

Part Two: Update of quality account priorities- 2016/17

Following consultation with key stakeholders in January and February 2017, the quality account priorities were agreed. The chosen priorities remain within the three domains of quality; namely patient experience, clinical effectiveness and patient safety and continue to have a designated lead and associated committee where progress is monitored and assurance provided.

Quality domain	Designated trust lead	Associated committees (Group level)
Patient experience	Deputy director for patient experience	Clinical Standards and Innovation Committee (CSI)
Clinical effectiveness/quality improvement	Clinical Pathway Group Director and Director of quality	Quality Improvement and Leadership Committee
Patient safety	Deputy director for patient safety	Clinical Standards and Innovation Committee (CSI)

During the reporting period, the trust has made progress in achieving the quality account priorities. The following information outlines our progress to date and the overall status is defined as 'progress on track' or 'change in methodology'.

Key:

⬆	Progress on track
⬆	Change in methodology

Priority 1: Improving patient experience: delivering world class experience

The patient experience priorities were chosen as they are linked to specific strands of ongoing work which are a part of the patient experience strategy (2015-19). The strategy outlined the trust's vision of being strong leaders of positive patient experience so we can effectively serve our communities.

Our quality priorities for 2017/18 are:

Priorities for 2017/18	Progress	Status
To achieve trust certification for the 'Information Standard' by 2018.	• Following creation of the patient information policy 2016, we now have over 100 patient information resources approved in line with the policy. We also have over 250 leaflets which have been submitted for review and are at various stages of the processes outlined in the policy. • Work is in progress with the radiotherapy, imaging and ophthalmology departments to embed the practice of evidence based information production, a key requirement of The Information Standard. • We are in the process of updating our patient information policy based on feedback from staff and to incorporate changes and new requirements of The Information Standard in readiness for an application in late 2017/early 2018 – this date is pending executive committee approval.	
To improve how patients, carers and families can provide feedback to the trust. Each service must have at least three ways of allowing feedback about a person's experience.	The trust has identified three ways of gaining feedback from our patients regarding their experience. These include: • **The National Department of Health funded approaches -** The uptake of patients using NHS Choices has increased and is regularly used as an engagement tool. • **Social Media** - the trust frequently uses Twitter and Facebook as ways of allowing patients to feed back on their experience of care. • **Patient Advice Liaison Service (PALS) –** the trust is seeking to move from a static PALS approach to one of flexibility around patients and increased response times for email and phone queries.	
To systematically analyse the experience of bereaved families and friends.	The trust chose to explore how the experience of bereaved families and friends could be improved. A bereavement survey is given to all persons who collect a Medical Certificate Cause of Death from the hospital. It is recognised that there may not be an easy time to ask for feedback as the return rates on the survey have been low. Therefore a web based survey is being launched which may be easier for providing feedback.	
To further enhance and support dementia care	During 2016/17, the trust has continued to focus on improving the experience for our patients with dementia and their carers.	

initiatives across the trust through the delivery of the dementia strategy by 2018.	Through the dementia strategy (2017-2019) several key initiatives have been identified and steady progress has been made. This has been monitored through the Dementia Implementation Group (DIG) These include: • **Flexible visiting times for carers in line with the principle of John's Campaign**. In 2016/17 71% of our in-patients wards were compliant. To date, all our in-patients wards (100%) are now compliant with John's Campaign. • **Improving the environment**- Dementia-friendly refurbishment of 10N (in-patient ward) commenced in September 2017. • **Joint working-** The DIG is partnering with associated Clinical Practice Group (CPG) to produce a world class dementia care pathway across organisation (currently in process-mapping phase)	
To recruit 30 Patient and Family Experience Partners	The trust has defined a 'partner' to be a person who: • Wants to help enhance the quality of our hospitals care for all patients and family members. • Gives advice to the hospital based on his or her own experience as a patent or family member • Partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time. Recruitment is underway and Camden Clinical Commissioning Group (CCG) who have advertised the role through their patient communications. Posters have been produced and wider recruitment will commence.	

The trust has a process in place where progress to achieve the set priorities are discussed at our three hospital units committees. Additionally, overall performance and assurance continues to be monitored at our:

- Group executive committee
- Clinical innovations and standards committee
- Quality improvement and leadership committee
- Clinical performance and patient safety committee

Priority 2: Improving Clinical Effectiveness: achieving excellent outcomes

The clinical effectiveness priorities were chosen because they directly align with trust wide plans to focus on the reduction of unwarranted clinical variation, which will strengthen and support the delivery of significant improvements in the quality of patient care.

In July/August 2017, the trust commenced the deployment of a trust-wide methodology to manage unwarranted variation in clinical care, through the creation of Clinical Practice Groups

(CPGs). They led by senior clinicians and are fully embedded into day to day operations and the aim is to develop standardised guidelines for key clinical pathways.

In addition, to support this approach, the trust is implementing a unified approach to Quality Improvement (QI) which will equip and empower local teams to address opportunities to improve the quality of care they deliver both within and outside the scope of CPGs.

Our quality priorities for 2017/18 are:

Priorities for 2017/18	Progress	Status
To have at least 20 key clinical pathways identified with standardised guidelines developed	The trust has made progress in developing the 20 clinical pathways. The CPGs will be further developed through a series of workshops over the next nine months. Topics included in the workshops are: • Governance • global digital excellence • pathway design and planning	
To have at least 50 QI projects in place. (The projects are required to have core features which includes a clear aim, change logic, ongoing PDSA and measurement linked to learning).	Work is underway to develop a Quality Improvement (QI) initiative tracker tool to provide real-time intelligence on status of QI projects across the trust. Additionally, the trust continues to work in partnership with the Institute for Health improvement (IHI) as QI partner: 29 teams, each with a QI project as central to their work and the Improvement practitioner training commenced at the end of September 2017.	

The trust has a process in place where progress to achieve the set priorities are discussed at our three hospital units committees.

Additionally, overall performance and assurance will be monitored at:

- Group executive committee
- Clinical innovations and standards committee
- Quality improvement and leadership committee

Priority 3: Improving patient safety: listening, learning, acting.

Our quality priorities for 2017/18 are:

Falls

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days**.**
- To reduce by 20% the proportion of patients that experience moderate harm or above

Milestones for 2017/18

1. We will evaluate phase 1 of 24/7 Falls Free Care.
2. We will initiate phase 2 of the programme by recruiting 6-7 wards.
3. Implementation and spread of new falls prevention plan and bedrail assessment tool across the trust.
4. Harmonise bedrail policy

Progress to date (August 2017)	Status
During 2016/17, ten wards participated in phase 1 including: Adelaide, Edgware Neuro Rehab Centre, Beech, MSSU, Juniper, 7East A, 7West, 8West, 8East and 10East. Subsequently, Adelaide ward withdrew due to organisational changes and 8East withdrew due to leadership changes. We identified 11 falls with harm in 2015/16 in the pilot wards; in comparison 4 falls resulting in harm in 2016/17; giving a reduction of 63%. During the evaluation phase we identified the successful ingredients for the programme as: • MDT buy-in, especially from the clinical leads • MDT Falls Champions • Allocated time (an hour per week) • Regular feedback of ward data, with display and discussion of data • Looking at local trends and themes, and having a patient story within team meetings During the learning sessions of phase 1 (2016/17) frontline multi-disciplinary staff completed the safety culture survey and over time results of the first three surveys showed that: • Staff feel more involved in safety briefings where falls are discussed • Staff receive a detailed handover of falls risk for patients in their care. • As a team, they discuss learning from falls incidents This learning has now been incorporated in phase 2 of the programme and has included sharing and learning the falls related incident data with divisional teams. Following this, nine new wards will be participating in phase 2: Barnet ED, Canterbury, Damson, 5East B, 7East B, 10South, 10 North, 12South, 12West. These clinical areas have committed to using a 'buddying system' to join two to three wards together with a view to increase collaborative working, and to make it easier to disseminate and share learning among neighboring wards or same divisions.	

Acute kidney injury (AKI)

- To increase by 25% the survival for in-patients.
- To increase by 25% the proportion of patients who recover renal function.
- To reduce by 25% the length of in-patient stay.
- To measure and improve patient experience and wellness scores.

Milestones for 2017/18

1. Through testing of new AKI app at RF site, we will develop an implementation plan for trust.
2. Through PDSAs cycles, we will co-designing AKI proforma to support the local clinical teams to deliver interventions specific to AKI pathology.
3. Identify high prevalence areas and co-design educational package to increase recognition and treatment of AKI.
4. Develop methods for patient involvement into the programme:
    a) To develop and test patients experience survey.
    b) To develop and test AKI patient information leaflet.

Progress to date (August 2017)	Status
Significant further development of the AKI app (stream device) has evolved from incorporating user feedback and troubleshooting technical issues. In this quarter, there has been 2nd update on the streams device following discussions with the RFH renal consultants. Monthly improvement meetings with Google Deepmind Health continue so that technical issues, user issues, clinical responses, alert patterns, workload, patient and local ward team feedback on the device can be raised and addressed. **AKI Clinical proforma:** Additionally in this quarter, further changes to the AKI proforma were made based on the learning from our continual PDSAs cycles. We are currently on version 9 of the AKI proforma which is a printed in sticker form as an aid to provide written handover to the local clinical team. Along with the AKI proforma, we have tested and implemented the new AKI treatment sticker that is placed in the nurses notes (version 4) to help support therapy following an acute AKI renal intervention. An AKI training pack and posters has been developed and delivered to all multi-disciplinary teams on the four wards: 8North, 8West, 8East and 7West on our Royal Free hospital site.	↑

Safer Surgery

- To improve compliance to 95% with each of the five steps to safer surgery
- To reduce by at least 50% the number of surgical never events from 9 to 4

Milestones for 2017/18

1. Spread and Implementation of tested methods to deliver robust processes of care at steps 1 & 5 (brief & debrief)
2. by scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly embed the quality of step 4(counting swabs, needles and instruments)
3. We will help co-ordinate the development of theatre team human factors skills and knowledge. This will include a framework for theatre etiquette and WCC behaviours.

Progress to date (August 2017)	Status
In quarter 1 a total of 10 theatres have tested the running debrief tool; accumulatively now this has been used >1880 times, currently tested on version 17. Data captured through the running debrief include: - Brief (step1) achieves all team 'buy in' on average 91% of the time - Debrief (step 5) achieves all team 'buy in' on average 47% of the time. Due to the re-design of the debrief data collection tool, measurement of 'buy in' has been less robust.	↑

The running debrief PDSA output includes locally designed 'escalation ladders'; which have enabled theatre teams to feel better empowered to recognise and action a variety of issues in more timely manner; with clarity on who to ask for assistance depending on the issue. The RFH maternity team have continued to test and re-designed a transfer sticker used for invasive procedures and transfer of mothers on labour ward. Data have been captured to scope the scale and opportunities within labour ward that mums may require when transferred and at risk of retained objects (e.g. massive haemorrhage or post-partum haemorrhage) incidents. These occur on average 15 times per month; although the use of invasive objects is very rare (only 1-2 times per month). In April 2017, the team undertook a snap shot retrospective look back on cases that required transfer to theatre within the maternity setting and required a procedure. 21 cases were reviewed and the team found accurate documentation 91% of the time. Current observational data of procedural 1st, mid and final count is captured from a random sample of 10 procedures from each site and was found to be achieved in RFH Theatres 75%; RFH Maternity 92%; BH 99%; and CFH 100% of the time. In Q1 scoping with the workforce team has begun to build a 'Theatre Etiquette Framework'. This framework will describe agreed World Class Care behaviours for the crucial points of the surgical checklist as recommended by NHSE National Standard for Invasive procedures (NatSSIP).	

Deteriorating patient

- To reduce the number of cardiac arrests from 1.17 at Barnet Hospital (Apr15-Mar16) and 2.4 at Royal Free Hospital (Apr14-Dec14), to less than 1 per 1,000 admissions (as measured for ICNARC) at both Barnet and Royal Free Hospitals by 31 March 2018

Milestones for 2017/18

1. We will use one primary pilot ward to test continual PDSA cycles to improve processes & mechanisms to enhance timely communication within and between teams through the use of SBAR handover tools & enhanced ward rounds, board rounds and safety huddles
2. We will use ward-based metrics such as cardiac arrest rates, PARRT referral and numbers of Multidisciplinary team meetings triggered to track progress
3. We will develop the 'champion' role further in this pilot area to enable long term sustainability
4. Implementation and spread of tested communication mechanisms and processes to other areas in the organisation

Progress to date (August 2017)	Status
Collaborative weekly meetings with 10W team and PARRT continue to iteratively learn from PDSA cycles of the co-designing the new 'white board' communications board. These board round tool triggers the discussion of "bigger complex decisions" for complex patients. The PARRT team have been working closely with the cardiology team to review current processes, patterns in data and re-establish a common purpose for the MDT board rounds. Thematic analysis of cases presented at Palliative Care/PARRT team co-lead MDT have been shared for learning with clinical teams and departmental audit days. These themes have influenced the development of a bundle of interventions to support this work: **'SURe Bundle'** *Supporting Uncertain Recovery for everyone (staff, Patients and families/friends)* • A regular place for MDT to talk	

○ including other teams about patients they are looking after – e.g. weekly MDT or similar • Communication/human factors education ○ Non-technical skills training • Patient/family/staff information ○ Pre-emptive expectation management - written & verbal • Decision making support framework ○ Planning implementation of *'Deciding Right' App* • Creation of 'Difficult conversations Support' faculty ○ clinicians made available to support clinicians with difficult EoL conversations with patients and their families • Local testing of implementation of 'Respect' document ○ Support the documentation of treatment escalation plans for establishing appropriate and safe ceilings of care Due to the complex nature of implementation of the different elements of this bundle of interventions, they have been tackled separately. The weekly 10W Palliative Care/PARRT MDT thematic analysis triggered the initiation of a case note review of all patients who have had more than two cardiac arrests on 10W/CCU over the past 12 months to explore themes to draw into this improvement work. The PARRT team have developed a Non-technical skills training day. The first official session will be delivered in Q2. An evaluation will be shared on completion for the purpose of iterative improvement of content design and delivery. The *Deciding Right'* App is being tested on a small scale with the 10W/CCU MDT meetings to understand if this is appropriate for scaled implementation within the Trust to support complex clinical decision making.	

Deteriorating unborn baby

- To reduce by 50%, the number of claims relating to deterioration of the unborn baby from a mean of 2 per year to a mean of 1 per year.

Initiate planning phase following thematic analysis of (1) Unexpected admission of term babies to Neonatal unit and (2) Unexpected intrauterine death: Reducing smoking in pregnancy- The milestones include:

Milestones for 2017/18

1. Scope current processes around Elective caesarean sections performed before 39 weeks gestation and identify areas that could be improved to reduce preventable C Sections
2. Improve team communications of potential expected admission to NICU – through adopting PDSA cycles to implement team huddles, SBAR handovers
3. Undertake staff confidence survey associated with CTG interpretation; using this information to Co-design teaching and skills package to improve CTG confidence in staff
4. Using PDSA cycles we will plan methods of standardising the administration of Oxytocin infusion

Progress to date (August 2017)	Status
The Maternity team are participating in the NHS Improvement collaborative, which aligns well with Patient Safety deteriorating unborn baby improvement work, and the Clinical Pathway Group (CPG) discussions. The work will also involve adopting a validated Safety Culture data tool to collect data across the 120 participating organisations Peer review from consultants occurs across both sites has been harmonised and an agreement	

that elective caesarean sections will be booked after 39 weeks unless clinical indication for them to be undertaken earlier. Elective caesarean section rates are monitored as part of monthly dashboard at both divisional and directorate board.

Using the results from the thematic analysis of unexpected admission of term babies to Neonatal Intensive Care Unit (NICU), the clinical pathway group team have started mapping and designing reliable pathways of care for the 'normal expected' birth, this will help identify unwarranted variation in the system. In Q1 the team have started to capture baseline data on trust-wide rate of unexpected NICU admissions per 100 births. We plan to use this baseline data along with some external benchmarking to ascertain a 'SMART' aim for reducing unexpected admissions.

To introduce remote integrated team working; planning and rapid 'Plan-do-study-act' testing cycles have been undertaken within maternity & neonatal services to:

- Enhance team communications;
- Optimise a culture of collaboration cross site and cross speciality;
- Build a sense of community & feeling connected to each other -allies working towards a common goal;
- Promote feelings of increased accountability & empower teams to speak up - encouraging culture of collaboration

Huddles

The 10 minute huddle starts at 11am each week day with a structured format and required MDT attendance. During June & July there have been 31 opportunities to conduct huddles; and this has been achieved 100% of the time.

Information discussed at the huddle includes:

- Identified high risk babies e.g. small for gestational age; abnormal scans
- Identified high risk mothers e.g. complex medical conditions, other pathology.
- Safety critical information

CTG Capability

During Q1, The National Institute for Clinical Excellence published the agreed national recommendation for fetal monitoring. This has been reviewed by our local maternity team and aligned with information from previous local 'CTG confidence survey' undertaken, in Q4 2016/17.

A 'CTG working group' has been established to agree the final version of our local guidance that will influence the design of *a 'CTG capability package'* that will address:

- Identifying normal or suspicious and pathological readings.
- Rationale for starting/stopping CTG monitoring
- Standardisation of language
- Planning of CTG workshops -that will include theory of baby physiology in wider context of expecting mothers' physiology
- Identify gaps in current system and innovate with clinical teams ideas to be tested through rapid PDSA learning cycles
- Identify and measure in real-time if changes should be adapted, abandoned or adopted into the system.
- Design of a CTG pathway decision tool/sticker

The oxytocin guideline has been harmonised across both units. CTG Teaching is undertaken on a weekly basis where administration of oxytocin is also discussed and management options reviewed by the Consultant Obstetrician.

Sepsis

- To reduce by 50% severe sepsis-related serious incidents across all sites from 1 in 2014/15 to zero in 2017/18
- To increase survival by 50% for those patients on the sepsis bundle across all sites from a mean of 83% (2014/15) to a mean of 91% (2017/18).

Milestones for 2017/18

1. We will be further consolidating sustained improvement in existing pilot areas
2. We will be planning and implementing a sepsis workstream plan of spread across the organisation with all key stakeholders, including establishing mechanisms to continue monitoring progress beyond the formal life of the workstream
3. We will be sharing the learning from the 10 pilot sites in the workstream with everyone involved and impacted by this spread, including further expansion of the 'champion' role to support long term sustainability

Progress to date (August 2017)	**Status**
The sepsis improvement work is in the following pilot areas: • RFH: ED, Paediatric ED, 10S, 10E, 8N, 6E, 7W, Labour ward and • BH: ED and Labour ward During Q1 we have engaged with teams from the following areas for the next pilots: • BH & RFH Paediatric Emergency Departments • Urgent Care Centre (UCC) at CFH • BH & RFH PARRT teams These teams will co-design and develop local sepsis pathways to test through PDSA cycles. This work has included mobilising of teams, building will, recruiting improvement champions, sharing learning and local data and co-designing implementation plans. Sepsis capability is also currently being developed through E-learning packages and tools appropriate to each clinical area. The package is currently in draft format; planning to be disseminated in quarter 2. BH emergency department improvement champions and their teams have identified that the practical capacity to collect data has become a huge challenge. The significant clinical demands of the department and the current data collection methods are being reviewed to find a more sustainable and synchronised way of sampling e.g. electronic tools at triage.	

The Committee scrutinised the Draft Quality Account from the North London Hospice for the year 2016-17 and wish to put on record the following comments:

- The Committee was pleased to find the North London Hospice had been rated "Good" by the Care Quality Commission (CQQ) following three separate inspections of their Finchley, Winchmore Hill and Haringey services. The Committee congratulated the Hospice on the rating. The Chairman also congratulated the Hospice on its 25th anniversary.
- The Committee commented that improvements had been made in terms of the layout of this year's Quality Accounts.
- The Committee noted plans to introduce a 'Hard to Reach Groups' programme to promote equal access to services for all potential users. The Hospice explained that although this was still being finalised, a group had now been established to work on the project and was planning meetings throughout the year. The Committee requested that information on the programme be brought back during the mid-year Quality Account's review.
- The Committee was happy with the quality of the Account and the inclusion of feedback from users. The Hospice explained it uses the feedback to keep track of how it is improving and to highlight areas where it can make further improvements. The Hospice explained that once the Dementia Strategy had been implemented, steps would be taken to investigate how the strategy was meeting the needs of the population. The Committee asked that data on the Dementia Strategy be included in the 2017/2018 Quality Account.
- The Chairman expressed how impressed she was that the Hospice had 980 volunteers across all its services.
- The Committee also praised the Hospice for their continuing work to reduce the number of patient falls, which this year is down from 36 to 27, whilst acknowledging the Hospice deals with very frail patients. The Hospice said there was ongoing work being carried out around falls and staff were trying to maintain a balance between preventing falls and allowing individuals to remain as independent as possible.
- The Committee commended the Hospice on the 277 compliments received and said it was pleased to see some examples included in the report.
- The Committee also noted that the Hospice's goal of supporting people to die in their own homes, if this is their preferred choice, appeared to be a success having increased year on year.
- The Committee noted the introduction of an Outcome Star, currently named The "End of Life Star", and asked for more information about it. The Hospice explained that the Star is a collaborative piece of work with various organisations to achieve better training in hospices.
- The Committee congratulated the Hospice on having achieved zero cases of Clostridium difficile (C.diff) and other infections over the past four years.

However

- The Committee queried the figures surrounding bed usage and asked for clarification on whether the closed bed days had been excluded from the calculations. The Hospice confirmed closed bed days had been excluded and said it had been working hard throughout the year to improve the turnaround period, but it was often a balancing act.
- The Committee enquired whether issues related to plumbing, which had been the sole reason for the 39 closed bed days, had now been rectified. The Hospice recognised it was a continuing problem due to the nature of the services they provide.
- The Committee expressed concern about a large number of staff leaving the Hospice. The Hospice explained that these were mainly bank care assistants and nurses, but the substantive members were not leaving. The Hospice said they were working with the HR Director to meet challenges around retaining staff.
- The Committee noted that pressure ulcers were still a cause for concern with higher numbers of patients suffering from them compared with other hospices of a similar size. The Committee also asked for clarification around the definition of 'avoidable' and 'unavoidable' pressure ulcers and the implications for them and how this was being implemented into care. The Hospice said changes in recording had been implemented so that it could be seen that everything possible is being done to decrease the number of avoidable pressure ulcers . The Committee acknowledged that turning and moving patients in the last few days of their life may not be practical or kind.

In addition:

- The Committee queried how much it cost the Hospice to produce such a detailed report. The Hospice explained that the document is kept in PDF form only and so there are no printing costs incurred. The Hospice also explained that this was a key document for them and was used throughout the year within the organisation as a learning tool and was also useful information for the Board of Trustees.
- The Committee raised some concerns that the Hospice could potentially be over stretching its resources. The Hospice explained that it always works in partnership where possible and is engaged in various work streams as well as working with the STP team.
- The Committee commented that there had been a significant increase in reported incidents of patient safety at the Hospice. The Hospice explained that it viewed this as a positive consequence of staff being more forthcoming in reporting all incidents.
- The Committee also noted the increase in medicine incidents. The Hospice said this again suggested an improvement in honest and open reporting and that none of the incidents had been classified as major.

The Chairman thanked the North London Hospice for attending.

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Barnet Health Overview and Scrutiny Committee comments can be found on Page 42-43 of North London Hospice (NLH) published Quality Account.

The actions taken on the committees comments are highlighted in bold below:

"The Committee noted plans to introduce a 'Hard to Reach Groups' programme to promote equal access to services for all potential users. The Hospice explained that although this was still being finalised, a group had now been established to work on the project and was planning meetings throughout the year. The Committee requested that information on the programme be brought back during the mid-year Quality Account's review."
The Steering Group has overseen an initial exploration of priorities identified by CCGs, Local Authorities and other organisations like Hospice UK. Broad categories of need are described around end of life but there are no specific initiatives to respond to. Adopting the general categories, NLH has undertaken a variety of internal surveys with clinicians in order to form a picture of NLH's current response. These are currently being analysed and will inform further prioritisation. Alongside this, fruitful meetings have taken place with Substance Misuse and Mental Health providers in Barnet where some more tangible need has been identified. From this NLH are panning mutual training which could inform new models of practice.

The Committee noted the introduction of an Outcome Star, currently named The "End of Life Star", and asked for more information about it. The Hospice explained that the Star is a collaborative piece of work with various organisations to achieve better training in hospices.
Following collaborative workshops a draft "Preparation Star" has been designed and organisations involved trained to commence piloting the process. Those with NHS funding require ethics approval which has been submitted. Therefore, NLH is unable to proceed with piloting. It is hoped this will start in early 2018.

November 2017
Fran Deane, Director of Clinical Services
Giselle Martin Dominguez, Assistant Director - Quality

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AGENDA ITEM 8

Barnet Health Overview and Scrutiny Committee

4 December 2017

Title	**Children and Young People's Oral Health in Barnet**
Report of	Public Health Consultant for Children and Young People
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A: Children and Young People's Oral Health – Recommendations from the Oral Health Working Group Appendix B: Oral Health Data Paper
Officer Contact Details	Sarah Gashier (Health Improvement Officer): sarah.gashier@harrow.gov.uk

Summary

The purpose of this report is to provide Barnet Health Overview and Scrutiny Committee (HOSC) with information on the oral health of children and young people in Barnet. The report also includes opportunities to improve rates of decay in children. A summary of the discussion by the Oral Health Working Group and the emerging recommendations are highlighted in Appendix A. The working group was established in response to the high rates of tooth decay in young children.

Recommendations

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

1. WHY THIS REPORT IS NEEDED

This report is a response to a request to update the Committee on the findings from the newly established Oral Health Working Group in Barnet.

2. REASONS FOR RECOMMENDATIONS

2.1 The Report provides the Committee on the challenges and opportunities to improve child oral health in Barnet.

2.2 The deep dive data highlighted three areas of concern in relation to the oral health of children in Barnet:

2.2.1 There is a high rate of tooth decay in young people and children leading to a lower Quality of Life (QoL).

2.2.2 There are increasing rates of hospital-based tooth extraction requiring general anaesthesia. This is more costly in terms of healthcare resources in Barnet.

2.2.3 The number of children visiting a dentist in Barnet over the last 12 months was lower than the London and national averages. NICE Guidelines recommend that children visit the dentist at least twice a year.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not Applicable.

4. POST DECISION IMPLEMENTATION

4.1 The views of the Health Overview and Scrutiny Committee will be considered by the Oral Health Working Group in their next meeting.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.11 The Corporate Plan 2015 – 2020 Indicates that the Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can improve 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

5.1.1 The Oral Health Working Group's recommendations correspond with the themes of Barnet's Health and Wellbeing strategy 2015-2020:

  - Preparing for a healthy life Improving outcomes for babies, young children and their families
  - How we live
  - Encouraging healthier lifestyles

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

5.2.1 NHS England commission all dental practices and inpatient services in Barnet. The total dental patient charge for Barnet CCG was £2,814,875 for the 16/17 financial year[1].

5.2.2 Children and Young People's Oral Health has a budget of £59,000 within the 2017/18 ringfenced Public Health Grant.

5.2.3 There are no additional financial implications of the recommendations.

5.3 **Social Value**

5.3.1 Not Applicable.

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 (Article 7)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**

The Units of Dental Activity (UDAs) have been fixed since 2005, yet the population of Barnet's 0-19 year olds has increased dramatically. The population is expected to increase over the next 25 years. This will be a challenge to dentists in the borough to treat residents if UDAs are not changed in line with the population increase.

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. There is an explicit difference between most and least deprived children and levels of tooth decay.

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

[1] NHS Digital, Dental Statistics, 2016/17

need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.6.3 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 This paper provides an opportunity for the Committee to be updated on children's and young people's oral health in Barnet

6. BACKGROUND PAPERS

6.1 Report to Health Overview and Scrutiny Committee – Oral Health in Barnet, 3 July 2017
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=9289&Ver=4

6.2 Report to Health Overview and Scrutiny Committee, Healthwatch Barnet Dental Report, 29 September 2015
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=8372&Ver=4

Oral health in Barnet – Recommendations from the Oral Health Working Group

Background

Earlier in 2017, Barnet's public health team presented an oral health update paper to the Barnet Health Overview & Scrutiny Committee (HOSC), recommending a deep dive exercise to understand the challenges and opportunities to improve the oral health of Barnet's children. Public Health established an Oral Health Working group to lead this work, which met on 16th October 2017. This was chaired by a local dentist and with attendees including Public Health, NHS England, Public Health England, Healthwatch and the Chair of the Local Dental Committee. It is widely acknowledged that dental decay is preventable, yet a third of young children in Barnet are suffering from tooth decay. Good oral health is integral to a child's overall general health.

Poor oral condition has an impact on quality of life affecting health and intellectual development through pain, impaired speech, embarrassment in smiling and laughing, poor child growth and low weight gain causing significant morbidity to the child and financially in turn to the family and society . Oral diseases are seen as a marker of wider health and social care issues. The working group has made a number of recommendations for action which its believes will have a positive impact on children's oral health in Barnet.

In 2015, Healthwatch investigated both the issues of accessing a dentist by the residents of Barnet and the transparency of costs of dental treatments. 69% of NHS patients responding to the survey reported that treatment costs were explained prior to treatment, while only 6 out of 44 private practices contacted had a list on display pertaining to treatment costs. In the refresher report published in 2016, it was reported that 47% of practices contacted (25) were unable to offer children an appointment under the NHS.

The data deep dive (Appendix B) conducted by the Barnet Public Health Intelligence team highlighted that 45% of children in Barnet had accessed a dentist in the last year.

There is an upward trend in the number of children being admitted to hospital for tooth extractions under general anaesthesia. This causes distress to children and parents alike, leads to children missing at least 5 days of school and places a significant financial drain on healthcare resources.

Oral health concerns are linked with obesity levels with sugar being the common risk factor. It is also linked to being underweight- possibly indicating neglect, particularly in younger children. Children who are underweight are more susceptible to infectious diseases such as tooth decay due to compromised immune system. Barnet has a higher than national and regional average of underweight children. According to recently published local National Child Management Programme data, the proportion of underweight reception children (aged 4-5 years) in Barnet (1.9%) is higher than the average national rate (1.0%) and the London average (1.5%) (Appendix B). There is evidence to show that children who have decay in primary dentition are also underweight with frequent snacking and sugary drinks consumption.

What does the data tell us?

Appendix B presents an analysis of primary and secondary dental decay and support. It showed that tooth decay affected almost one third of children in Barnet, which was higher than the national average. Although rates of tooth decay are improving in England, they remain constant in Barnet.

The data paper highlighted three areas of concern which are summarised in the analysis.

1. High rates of tooth decay in 5-year olds

2. Increasing rates of admission to hospital for tooth extraction requiring general anaesthesia

3. Lack of children visiting a dentist in the last 12 months

These observations suggest that children in Barnet have poor oral health and oral health related behaviours (low frequency of toothbrushing, low fluoride intake and high sugar in the diet, etc.). Moreover, it suggests that there is a lack of oral health related knowledge in the local population which could be due to the low dental attendance in Barnet.

In addition, stark oral health inequalities exist. Both tooth decay and hospital admissions for tooth decay show wide inequalities, with children from some of the most vulnerable and deprived families suffering the highest level of dental disease. The rate of in-patient tooth extraction was almost four times higher amongst children living in the most deprived areas of Barnet than children living in the least deprived areas.

There is a link between children's diet and their risk of decay including increased consumption of long-term bottle use with sugar sweetened beverages. In Barnet, 8% of 5-year-olds had incisor caries (aggressive dental decay associated with long-term bottle use with sugar-sweetened drinks) (Appendix B).

Breastfeeding exclusively for 6 months and the introduction of complementary foods with continued breastfeeding up to 2 years of age, as recommended by WHO , is a protective factor that can improve dental health . Rates of breastfeeding are higher in Barnet than in London but they are decreasing in comparison to previous years.

The Healthwatch report suggests that residents have difficulty accessing dentists. Following our discussion with the working group it was concluded that there was a problem with the utilsation of Units of Dental Activity (UDAs) and the ability to accept new NHS patients. The current Dental Policy Booklet provides commissioners with the discretion to carry forward or pay a contractor extra income for over delivery. Commissioners may allow a tolerance of up to 2% of UDAs per year (i.e. up to maximum 102% of contracted UDA activity). NHS England confirmed that Barnet utilises 98.5% of its UDAs suggesting that UDA utilisation is not an issue.

Challenges

1. Growing population - It is estimated that between 2017 and 2040 the net population of Barnet's children aged 0-19 years will increase by 11.5 % (11,400), peaking in 2025 to a predicted 106,000 children and young people. This poses a challenge because of the fixed level of UDAs. UDAs have been fixed since contracts were established in 2005. However, the population has increased by 19.3% between 2005 and 2016, with an estimated 98,200 residents now under the age of 20 (the second largest children and young people's population in London .) This has led to the accessibility issue faced by residents that was highlighted in the Healthwatch reports.

2. Level of NHS England (London Region) Primary Care Budget- The budget that NHS England (London Region) has for primary care dental services is based on contracts that are already in place and there is currently no new funding for new or additional services.

3. Poor diet - The increasing availability, accessibility and affordability of sugary foods and sugar-sweetened beverages (SSBs), particularly to children and low-income communities of Barnet, contributes to tooth decay and obesity. There is an established link with SSBs and fruit juices which may often be perceived as 'healthy' options, not recognising that such options are high in sugar content and low in fibre in contrast to eating a whole fresh fruit.

4. Language difficulties - Barnet has a high percentage of households with multiple ethnicities and multiple languages spoken. Not only is the population increasing but the number of residents from minority ethnic groups is also increasing and there will be more languages in the borough. This makes it more complex to communicate health messages to address the issue of lack of knowledge of oral health.

Opportunities

Potential opportunities identified by NHS England

NHS England (London Region) Targeted Areas

NHS England in collaboration with partners is introducing "Starting Well: A Smile4Life Initiative", a programme of dental practice-based initiatives that aim to reduce oral health inequalities and improve oral health in children under the age of 5. Within NHS England (London Region) the borough of Ealing was identified as one of the high priority areas.

In addition to "Starting Well" NHS England (London Region) will be working with Public Health England to identify five boroughs to promote Dental Access. These five areas have not yet been selected and the decision will be based on a range of criteria, it is hoped to explore the possibility that Barnet could be one of these areas. This initiative would include collaborative working with all stakeholders. It will focus on promoting oral health improvement in areas of high oral health need (decay rates and increasing acute referrals for General Anaesthetic extractions), where patient uptake numbers have reduced drastically, especially young children and families.

First Dental Check by One (Starting Well core contract)

This is an initiative that has been proposed by the Office of the Chief Dental Officer whereby all NHS practices will be encouraged to see additional children under the age of one.

“First Dental Check by One” is fundamental to NHS England’s focus on addressing health inequality. The approach is fully aligned with the direction set by the NHS England 2017-18 Mandate and is aligned with the NHS England Five Year Forward View to transform out of hospital care. The proposal supports NHS England’s corporate priorities of ‘Strengthening Primary Care’, ‘Tackling Obesity and Preventing Diabetes’, and “Delivering Better Oral Health”. .Full details for this scheme have not yet been announced however NHS England (London Region) would look to implement this and will provide further details once available.

Other opportunities

1. Providing a map of NHS dentists and when and how to access them. This would have to be updated by NHS England but could be very useful and informative for residents to see where their nearest dentist is, especially if information was available on availability of appointments.

2. Link to 0-19 programme and locality hubs- Early Years Services advocate healthy lunches and snacks and provide information on local dentist services. As part of the Healthy Early Years Awards programme, areas with high rates of dental decay could be encouraged to focus on oral health in order to achieve their award. NHS choices could be promoted to raise awareness of where residents can get information on oral health.

3. Improve dental attendance. It is recommended that a child visits the dentist after the eruption of the first tooth. From then on the child should attend the dentist at least twice a year and up to four times a year if appropriate according to NICE guidelines. It has been shown that people who use dental services more regularly (i.e. their dental attendance is higher), have a higher frequency of toothbrushing than people who do not use dental services more regularly . Moreover, it has also been shown that adolescents who brush their teeth twice a day are more likely to do so throughout their adulthood and have also been shown to attain higher educational achievements in later life.

Key ways to promote dental attendance are:

(i) Promote dental attendance to pregnant women and all parents. Parents who attend the dentist are more likely to bring their child to a dentist.

(ii) Ensure all parents and carers know how to access a local dentist and know that it is free for children and young people.

(iii) Update the E-Redbook to contain a checklist for the health visitor to tick off that a child has been seen by the dentist

4. Link with National Childhood Measurement Programme (NCMP) check in Reception and Year 6 when weight is measured. Teeth could also be checked. This would require training nurses to do the oral health check.

5. Link with local weight management programmes such as 'Alive n Kicking'; work with these providers to include oral health promotion in activities that educate children on the recommended amount of daily sugar intake.

6. Utilising social media - increased social support through social networks and increased reach of health promotion communications. Link with mobile phone apps such as "Change4Life sugar smart" and online forums such as 'Mumsnet' that have access to hard to reach groups in the borough that are potentially more at risk of decay.

7. Dental kit- Provision of a free dental kit containing a toothbrush is a cost-effective intervention. This would include a tube of 1000 ppm fluoride toothpaste and an infographic leaflet. It would be distributed in schools and communities. This could be targeted at the most at risk populations.

8. Oral health champions in children centres are already in place – these should continue to raise awareness of good oral health and supervised tooth brushing. Continue to support targeted oral health promotion in primary schools.

9. Application of fluoride varnishes for children aged 3+ years in the most deprived areas of Barnet. This would greatly reduce the inequalities in dental health in Barnet as shown in a previous national level programme- "Childsmile", initiated in Scotland in 2006.

Recommendations from the Oral Health Working Group

#		Recommendations	Evidence base
1	**Strategic**	Introduce universal dental check by aged 1	**Chief Medical Officer/ LDC** The rationale for this preventive initiative is that decay is appearing in children under the age of 5. General anaesthetic rates are high in Barnet and are costly to the NHS. With improvements in the community, this could reduce the burden of children requiring hospital treatment.
2		Target oral health messages to high risk groups including areas with high levels of deprivation	It is recognised that early visits for children under the age of 3 years are vital for delivering key preventive messages, acclimatisation and beginning a positive, lifelong relationship with NHS dentistry. Chief Dental Officer- England (NHS England) (22nd Sep 2017)[1]

[1] British Society Paediatrics Dentistry: Dental Check by 1 http://bspd.co.uk/For-Patients/Dental-Check-by-One accessed 24th October 2017

3		Dental kit and application of Fluoride varnish.	Fluoride varnish to children aged >3 years in the most deprived areas of Barnet, would greatly diminish oral health inequalities.
4		Targeted oral health promotion in children centres and primary schools including supervised tooth brushing by the school staff.	The schemes of tooth brushing in schools are informed by the experience of similar programmes in Scotland.[2] Health promotion activities in schools can be used in achieving better oral health outcomes in children[3]
5	**Communications**	Develop a communications plan to: - promote increased access to NHS/ free dentistry in pregnant women and nursing mothers (1 year postnatal), include signposting by HVs in child progress checks and GP PN immunisation visits - Increase check up by age 1 - Ensure a multi-disciplinary approach (GPs, healthcare assistants, nurses, neonatal and NCT classes) to support the dental check by aged 1 - Promote PHE guidelines, breastfeeding and weaning and household routines - Promote location of NHS dentists using social media	**PHE guidance** National guidelines from the Public Health England entitled "Delivering better oral health" is an evidence-based toolkit for prevention.

[2] Macpherson LMD, Anopa Y, Conway D, McMahon AD, 2013, National supervised toothbrushing programme and dental decay in Scotland. Journal of dental research 92(2) 109-113.

[3] Curnow MC, Pine CM, Chesters RL et al. A randomised controlled trial of the efficacy of supervised toothbrushing in high- risk children. Caries research 2000, 34 : 349.

6	**Technical**	Explore options in e-Redbook and hard red book to prompt discussion on oral health Explore option of dentist sign off the red book and health visitor check this regularly	**https://www.eredbook.org.uk/** The PCHR is a document that is followed by parents and guides health visitors into what they need to check to ensure baby is growing healthily. Although there are health promotion messages in the red book, we could go a step further and ensure that the dental check by aged 1 is a checkpoint that must be ticked off by health visitors.

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Oral Health insights paper

1. The issue: dental decay, oral infection and tooth extractions

- The proportion of dental courses of treatment involving extractions in 0-17-year olds by NHS dentists in Barnet (5%) is lower or similar to statistically neighbouring London boroughs, London and similar to levels in England.
- 32% of 5-year olds in Barnet had decay experience in 2014/15; this was higher than England (25%) but statistically similar to London (27%) neighbouring boroughs.
- Number of teeth with decay has remained similar between 2007/8 and 2014/15 in Barnet, however it has improved in London and England.
- Tooth extraction is the most common reason for hospital admission of 5–9 year old children, and is completely preventable.
- The number of in-patient extractions due to decay in 0-10 years olds has increased from 2011-12 to 2016/17 (by more than 50% in 0-5 year olds and almost 75% in 6-10 year olds)
- This could be due to tooth decay not being diagnosed and treated appropriately in primary care, or because children are seeking dental treatment when decay is at an advanced stage.
- Also, it could be that preventative measures such as reducing sugar consumption and brushing teeth at least twice a day need to be improved
- According to Health Matters: Child Dental Health, hospital based tooth extractions cost the NHS over £50 million for children under 19 in 2015-16.

2. Protective factors and risk factors: breastfeeding, gender, age, ethnicity and deprivation

- The percentage of mothers who breastfed within 48 hours of delivery decreased from 91.5% in 2010/11 to 85.1% in 2014/15.
- Levels of breastfeeding were higher than London up to 2012/13 but lower in 2014/15
- Breastfeeding in Barnet has remained higher than the England average throughout the most recent 5 years of data.
- The rate of in-patient tooth extraction was four times higher among children living in the most deprived versus the least deprived areas in Barnet.
- In-patient tooth extractions for dental decay were significantly higher in 6-10-year olds compared to 0-5-year olds.
- There was no difference between boys and girls in Barnet for in-patient tooth extractions
- We need data and mapping on oral health and ethnicity to show which Barnet ethnic groups have worse dental decay.

3. Dental care

- The number of NHS dentists has increased in Barnet from 2012/13 to 2016/17 compared to England.
- NICE guidelines recommend that children visit the dentist at least once every year.
- Children should be registered with a dentist as soon as their first teeth appear and should visit regularly (as often as their dentist recommends).
- However, the number of children in Barnet who accessed a dentist in the last 12 months was lower than neighbouring boroughs, London and England
- Possible reasons for this could be that parents are unsure when to register their child with a dentist or that they have issues with accessing a dentist
- The HealthWatch survey 2014/15 suggests that Barnet dentists are not taking on new NHS patients.

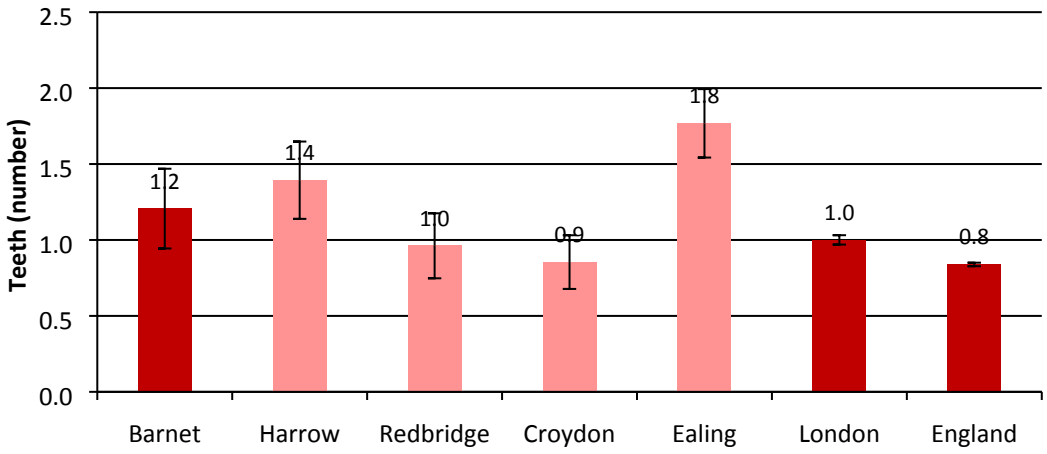
Complete Data Report

Barnet Public Health Intelligence team Nov 2017

Note: Comments refer to statistically significant differences unless otherwise specified

1. Dental decay, oral infection and tooth extractions

Average number of teeth with decay experience in 5 yr olds in Barnet, 4 statistical neighbours, London & England, in 2014/15



Source: Public Health England (Dental Public Health Epidemiology Programme)

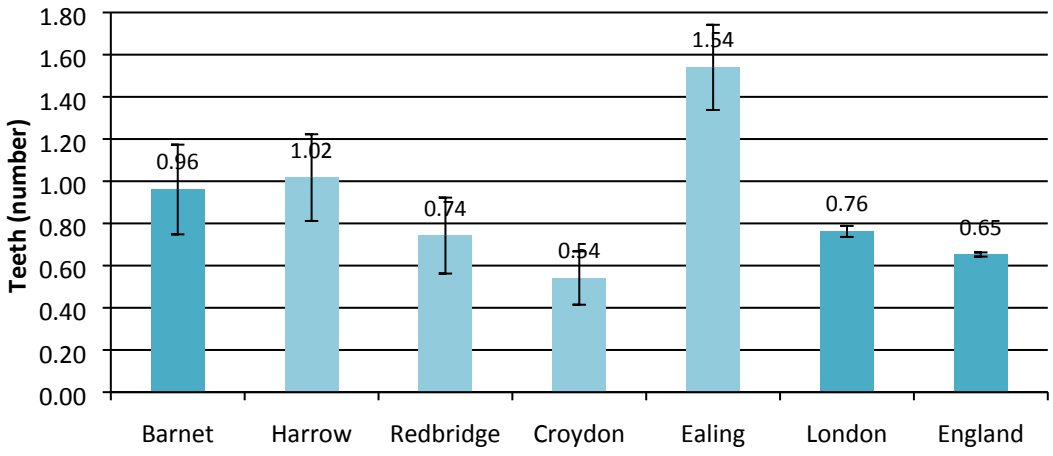
This shows:

• In 2014/15, Barnet 5 yr olds had an average 1.2 teeth each with decay experience (i.e. decayed, filled, or missing due to dental extraction for decay).

• This was higher than in England but similar to London and three of Barnet's four closest statistical neighbours.

Appendix B: Oral Health Supporting Data

Average number of decayed teeth in 5 yr olds in Barnet, 4 statistical neighbours, London & England, in 2014/15

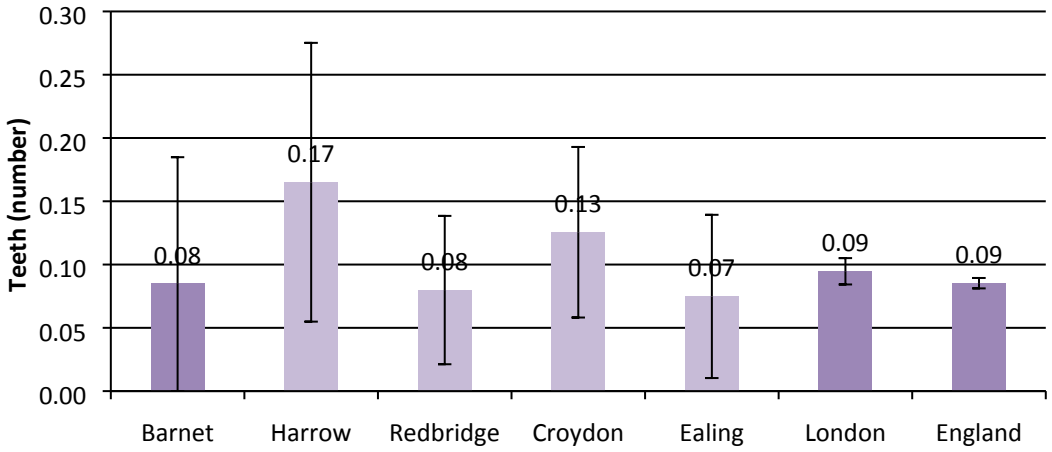


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, Barnet 5 yr olds had an average 1 decayed tooth each
- This was higher than in England but similar to London and two of four statistical neighbours.

Average number of missing teeth in 5 yr olds in Barnet, 4 statistical neighbours, London & England, in 2014/15

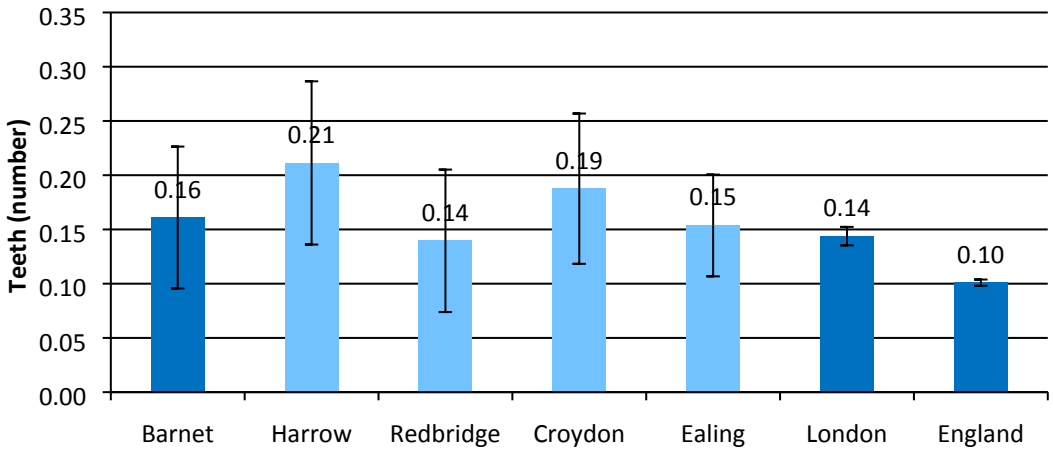


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, Barnet 5 yr olds had an average 0.08 missing teeth (due to extraction for dental decay) each.
- This was similar to levels for London, England and four statistical neighbours.

Average number of filled teeth in 5 yr olds in Barnet, 4 statistical neighbours, London & England, in 2014/15

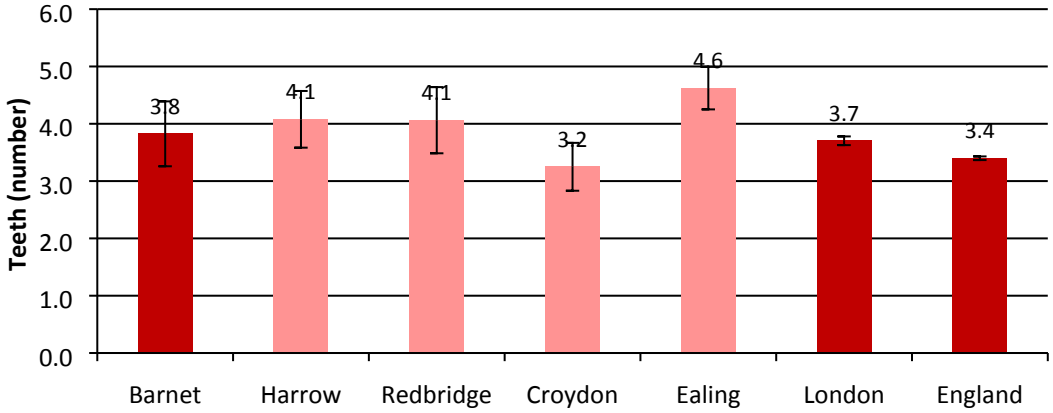


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, Barnet 5 yr olds had an average 0.16 filled teeth each.
- This was similar to levels in London, England and four statistical neighbours.

Average number of teeth with decay experience, in 5 yr olds with any decay experience, in Barnet, 4 statistical neighbours, London & England, in 2014/15



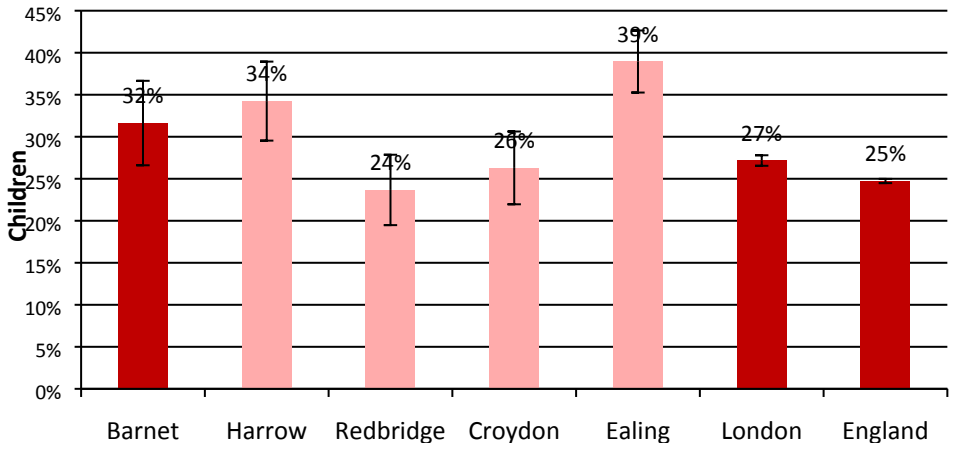
Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, Barnet 5 yr olds with any dental decay experience had an average 3.8 teeth each with decay experience.
- This was similar to levels in London, England and four statistical neighbours.

Appendix B: Oral Health Supporting Data

Proportion of 5 yr olds with decay experience in Barnet, 4 statistical neighbours, London and England, 2014/15

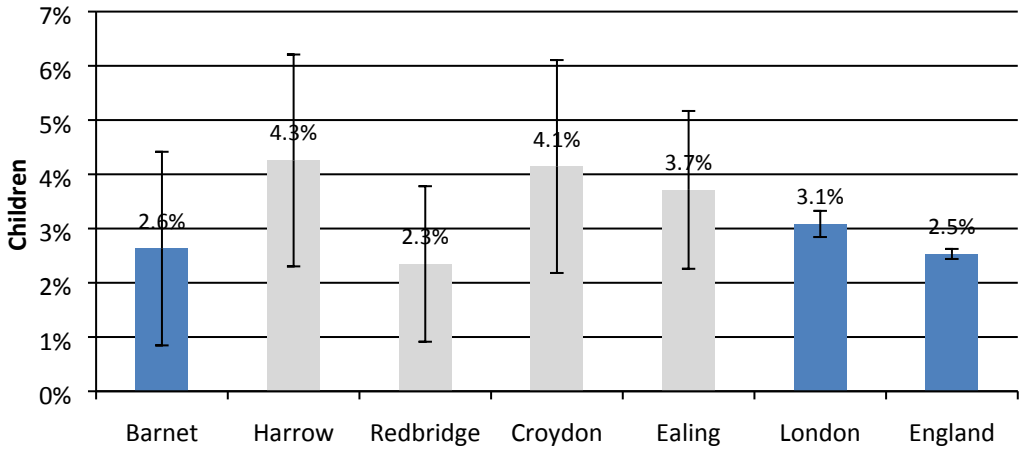


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, almost one-third (32%) of Barnet 5 year olds had decay experience
- This was more than in England, but similar to London and four statistical neighbours.

Proportion of 5 yr olds with missing teeth in Barnet, 4 statistical neighbours, London & England, in 2014/15

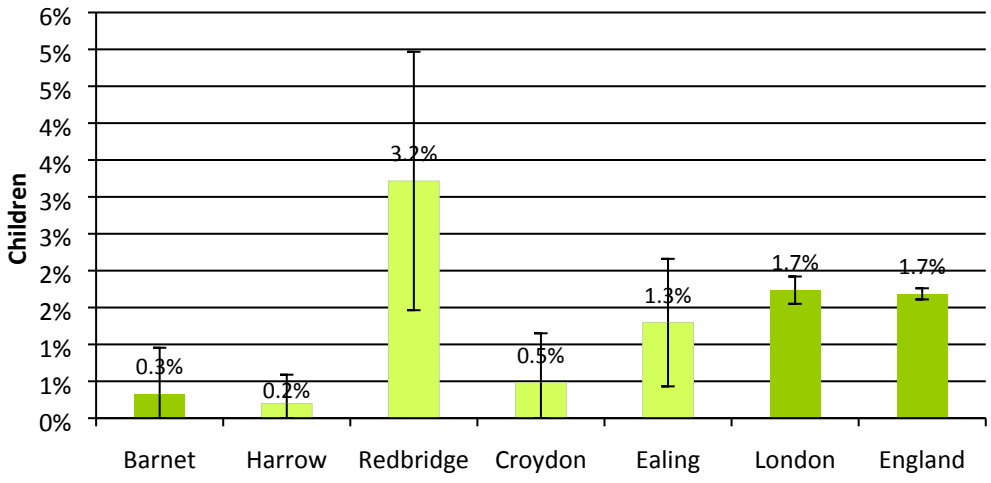


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, 2.6% of Barnet 5 yr olds had missing teeth due to extractions for dental decay.
- This was similar to levels in England, London and four statistical neighbours.

Proportion of 5 yr olds with substantial plaque, in Barnet, 4 statistical neighbours, London & England, in 2014/15

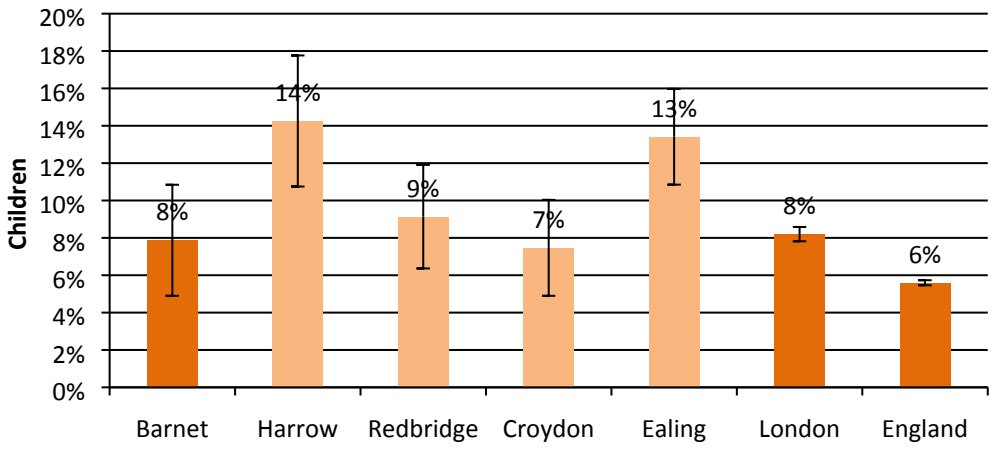


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, 0.3% of Barnet 5 yr olds had substantial plaque (a proxy measure for children who do not brush their teeth, or brush them rarely).
- This was better than in London and England, and similar to three of four statistical neighbours.
    - This indicates that brushing of teeth among children is better than in London and nationally whilst other charts show that different types of decay are not.

Percentage of 5 yr olds with incisor caries in Barnet, 4 statistical neighbours, London & England, in 2014/15

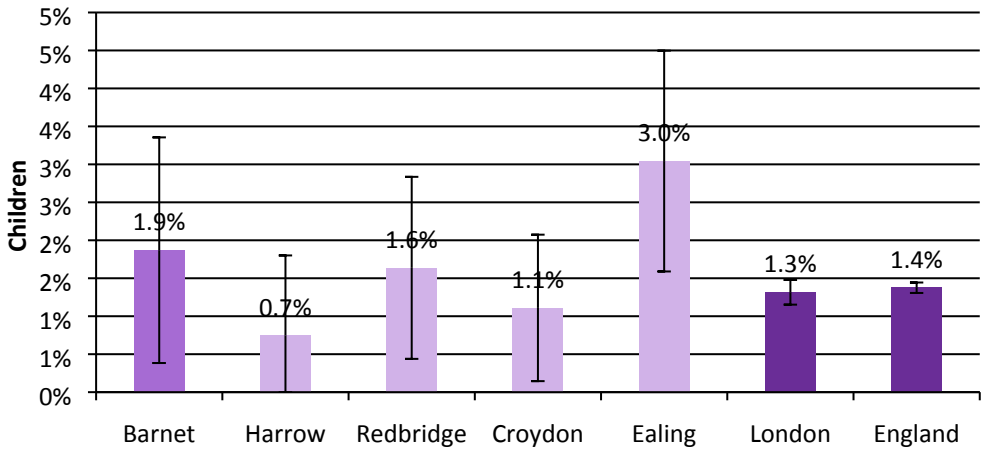


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, one in 12 (8%) of Barnet 5 yr olds had incisor caries (aggressive dental decay associated with long-term bottle use with sugar-sweetened drinks).
- This was similar to levels in London, England, and three of four statistical neighbours.

Proportion of 5 yr olds with oral sepsis in Barnet, 4 statistical neighbours, London & England, 2014/15

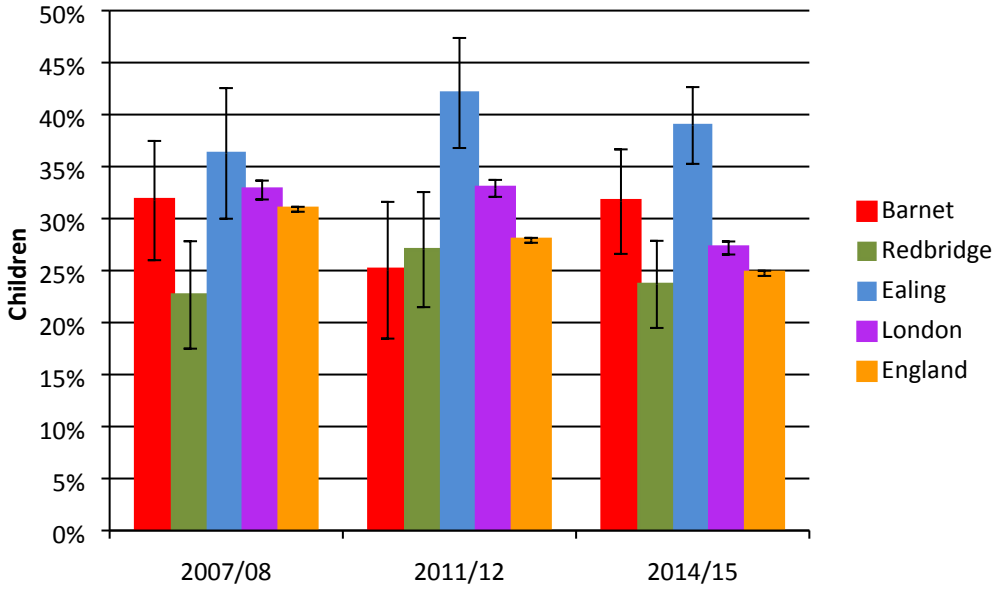


Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In 2014/15, nearly 2% of Barnet 5 yr olds had oral sepsis (increasing their risk of more serious infections).
- This was similar to levels in London, England and four statistical neighbours.
- Nearly all oral sepsis in 5 yr olds is due to dental decay and is completely preventable.

Proportion of 5 yr olds with decay experience, in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 & 2014/15



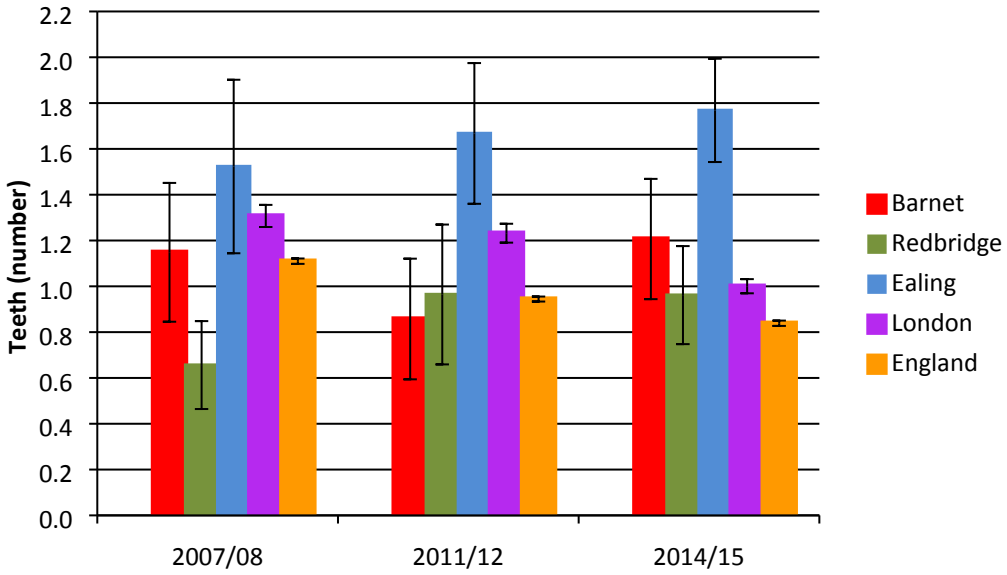
*Those with complete records (Redbridge and Ealing)

Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In recent surveys (2007/08, 2011/12 and 2014/15), the proportion of 5 yr olds with dental decay experience has not changed significantly in Barnet or in two statistical neighbours.
- However, levels have fallen in London (by one-sixth) and England (by one-fifth).

Average number of teeth with decay experience in 5 yr olds in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 and 2014/15



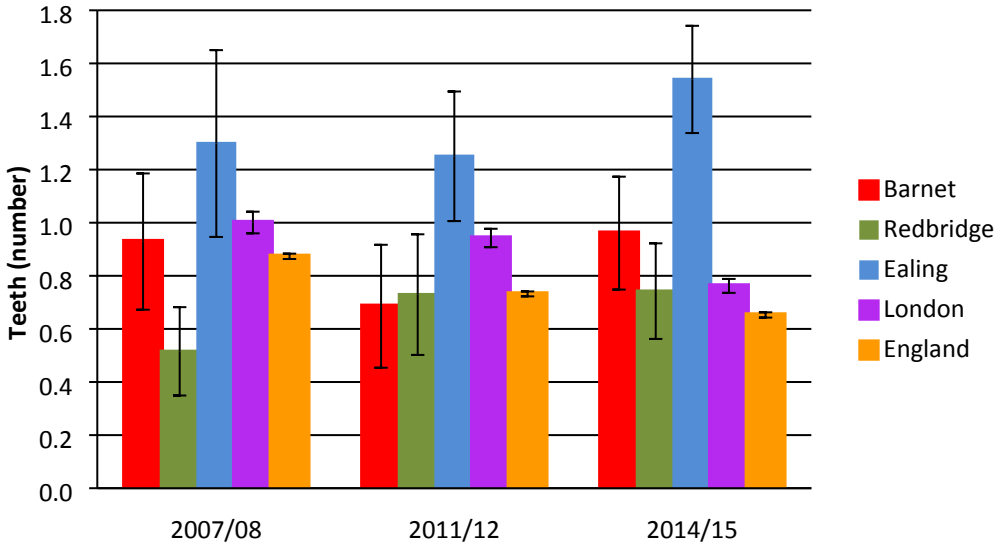
*Those with complete records (Redbridge and Ealing)

Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In recent surveys the average number of 5 yr olds' teeth with decay experience has not changed significantly in Barnet or in two statistical neighbours.
- However, levels in London and England have fallen significantly (by almost one-quarter).
- Barnet levels have deteriorated compared with London and England: they were lower than London's in 2011/12 but similar in 2014/15; and they were similar to England's in 2011/12 but higher in 2014/15.

Average number of decayed teeth in 5 yr olds in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 & 2014/15



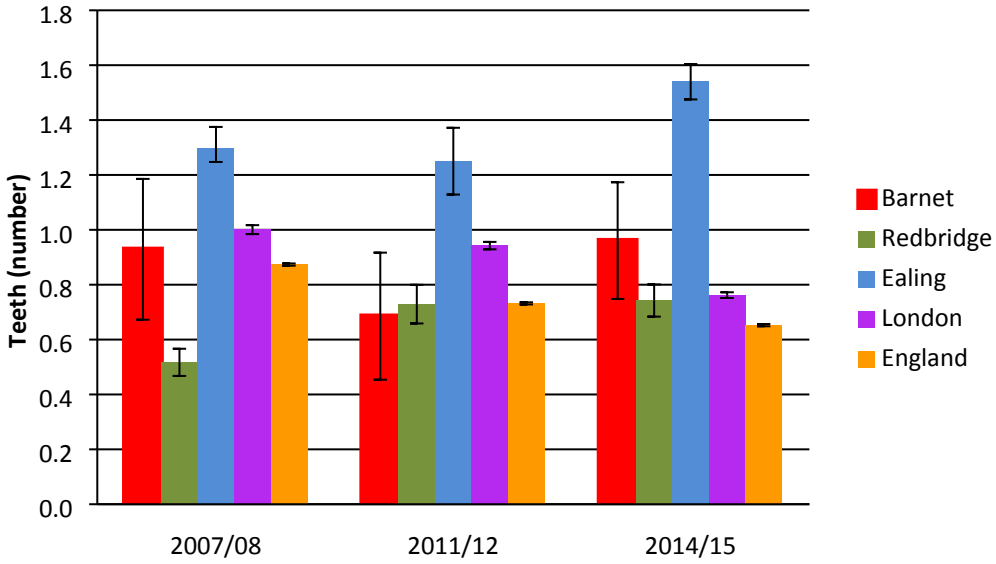
*Those with complete records (Redbridge and Ealing)

Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In recent surveys, the average number of decayed teeth in 5 yr olds has not changed in Barnet or in two statistical neighbours.
- However, levels in London and England have fallen by one-quarter.
- Barnet has deteriorated compared with England: Barnet levels were similar to England's in 2011/12 but higher in 2014/15.

Average number of missing teeth* in 5 yr olds in Barnet, 2 statistical neighbours, London & England, in 2007/08, 2011/12 & 2014/15**



*Due to dental extraction

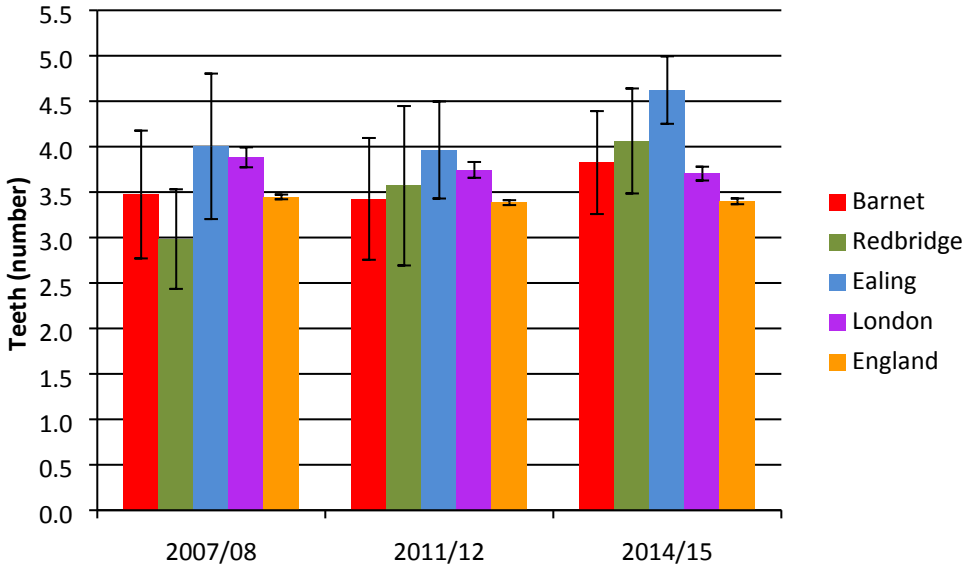
**Those with complete records (Redbridge and Ealing)

Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In recent surveys, the average number of missing teeth in 5 yr olds has not changed significantly in Barnet, but levels in two statistical neighbours have risen.
- In contrast, levels have fallen in London (by over one-third) and England (by almost one-third).
- Barnet levels have deteriorated compared with England: they were similar to England's in 2007/08 and 2011/12 but higher in 2014/15.

Average number of teeth with decay experience, in 5 yr olds with any decay experience, in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 & 2014/15



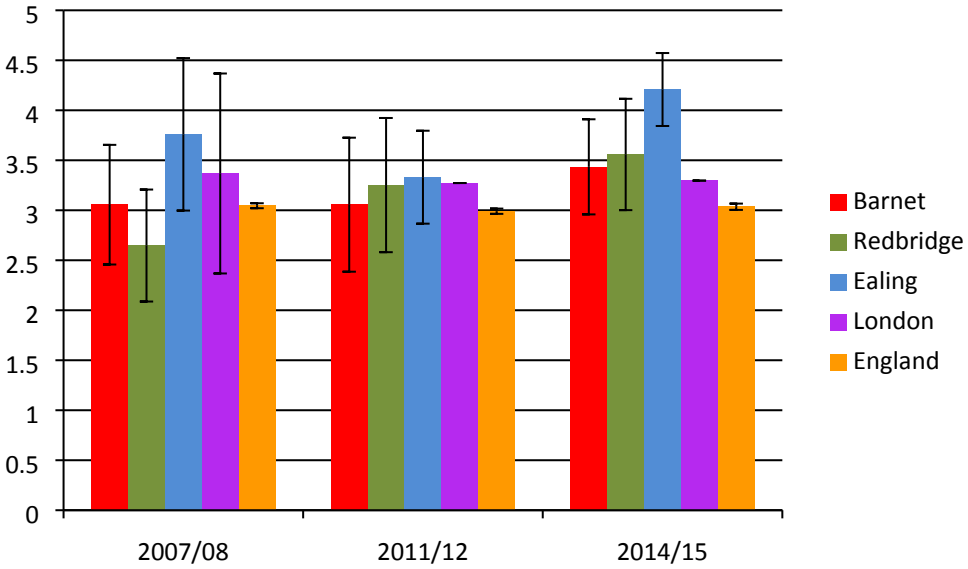
*Those with complete records (Redbridge and Ealing)

Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

- In recent years, there has been no significant change in the mean number of teeth with decay experience in 5 yr olds with any decay experience, in Barnet, two statistical neighbours, London or England (London's downward trend was not significant).
- Barnet levels were similar to London's and England's over this period.

Average number of decayed teeth in 5 yr olds with decay, in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 & 2014/15



*Those with complete records (Redbridge & Ealing)

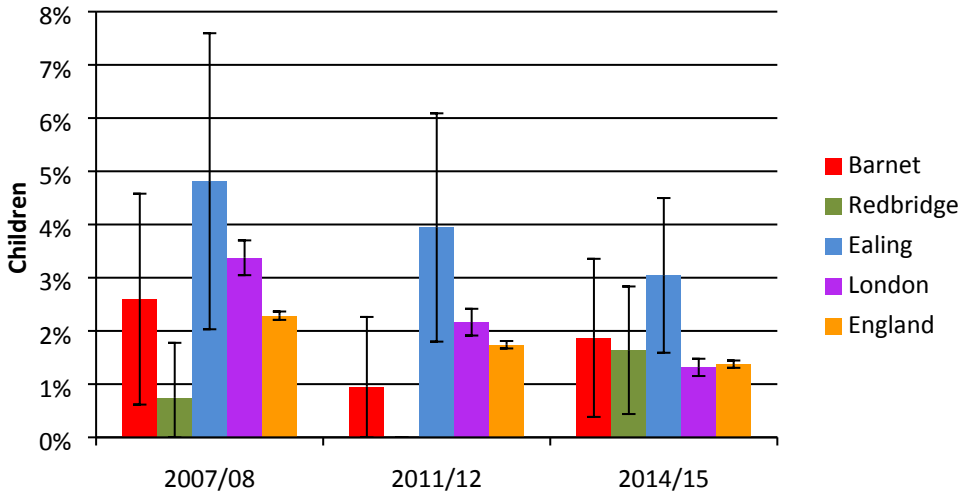
Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

• In recent years, there was no significant change in the average number of decayed teeth among 5 yr olds with decay, in Barnet, two statistical neighbours, London or England.

• Barnet levels were similar to London's and England's over this period.

Proportion of 5 yr olds with oral sepsis in Barnet, 2 statistical neighbours*, London & England, in 2007/08, 2011/12 & 2014/15



*Those with complete records (Redbridge and Ealing)

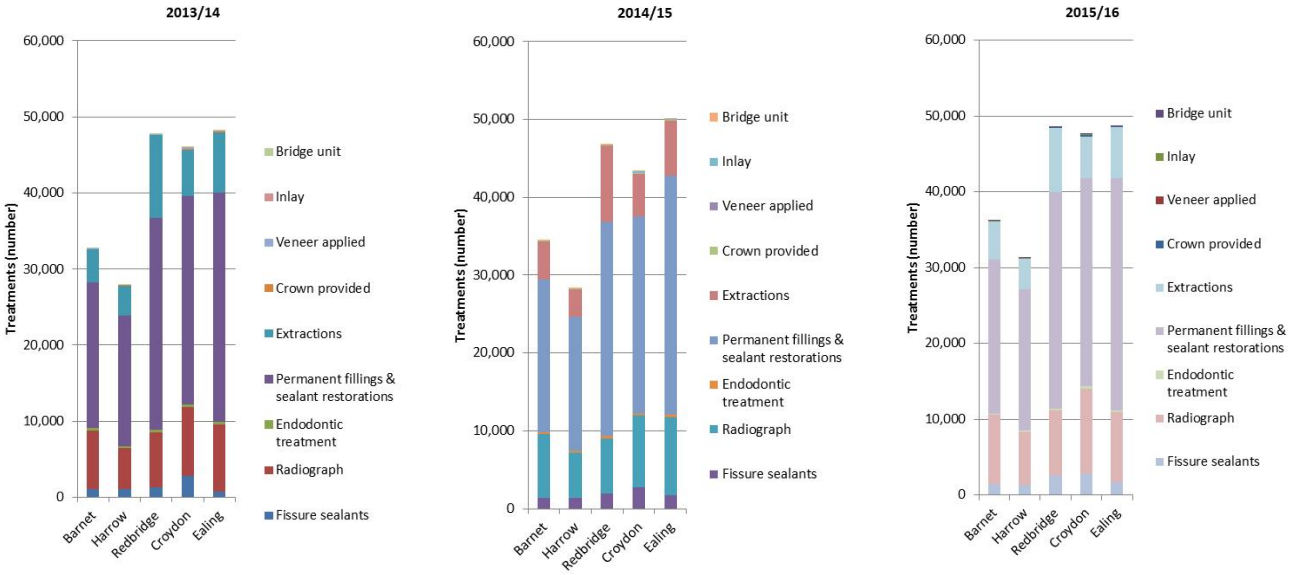
Source: Public Health England (Dental Public Health Epidemiology Programme)

This shows:

• In recent years, there were no significant changes in the proportion of 5 yr olds with oral sepsis in Barnet or two statistical neighbours.

• However, levels fell in London (by almost two-thirds) and England (by over one-third).

Estimated number of clinical treatments to 0-17 yr olds by NHS dentists in Barnet and 4 statistical neighbours, by treatment type



Source: NHS Digital (NHS Dental Activity Statistics)

Estimated number of permanent fillings & sealant restorations, extractions, and total clinical treatments*, to 0-17 yr olds by Barnet NHS dentists in 2013/14, 2013/14 and 2015/16

	Permanent fillings & sealant restorations	Extractions	Total clinical treatments*
2013/14	19147	4366	32,773
2014/15	19589	4904	34,483
2015/16	20268	5042	36,221

*Including clinical treatments not shown

Source: NHS Digital (NHS Dental Activity Statistics)

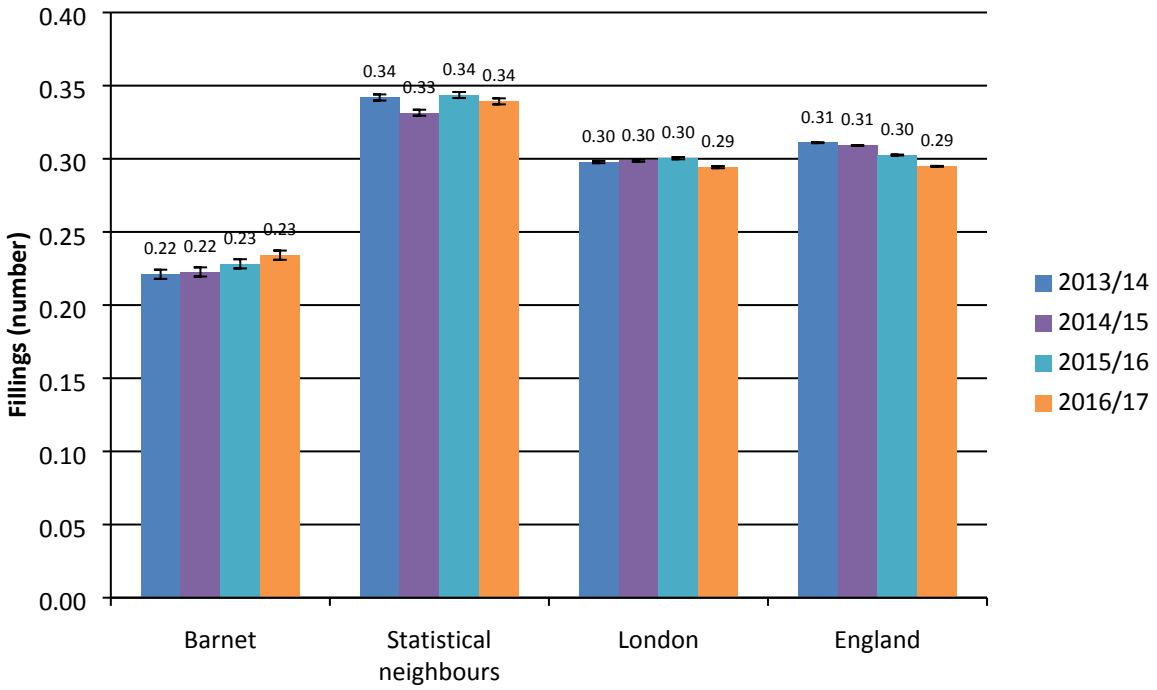
This shows:

• The estimated number of permanent fillings, extractions and total clinical treatments given to 0-17 yr olds in Barnet has increased between 2013/14 and 2015/16.

• The same pattern is seen for four close statistical neighbours.

(Results not statistically assessed)

Average number of fillings* by NHS dentists per 0-17 yr old, in Barnet, statistical neighbours aggregate, London & England, 2013/14 to 2016/17



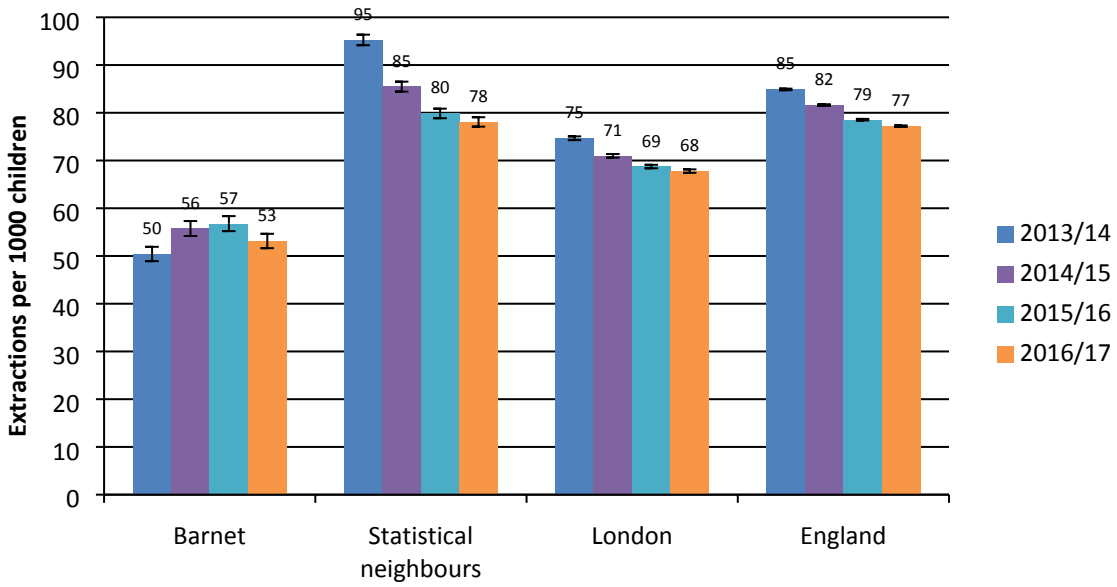
*Permanent fillings or sealant restorations

Sources: NHS Digital (NHS Dental Activity Statistics), Office for National Statistics (population mid-year estimates)

This shows:

- From 2013/14 to 2016/17, the average number of permanent fillings or sealant restorations per 0-17 yr old, done by NHS dentists, rose significantly in Barnet but fell significantly in London and England.
- However, levels in Barnet stayed significantly lower than those in a statistical neighbours aggregate (i.e. average results for Harrow, Croydon, Redbridge & Ealing combined) and in London and England – in 2016/17, Barnet levels (0.23 fillings per child) were one-fifth lower than London and England levels.

Average number of dental extractions by NHS dentists, per 1000 0-17 yr olds, in Barnet, statistical neighbours aggregate, London & England, 2013/14 to 2016/17

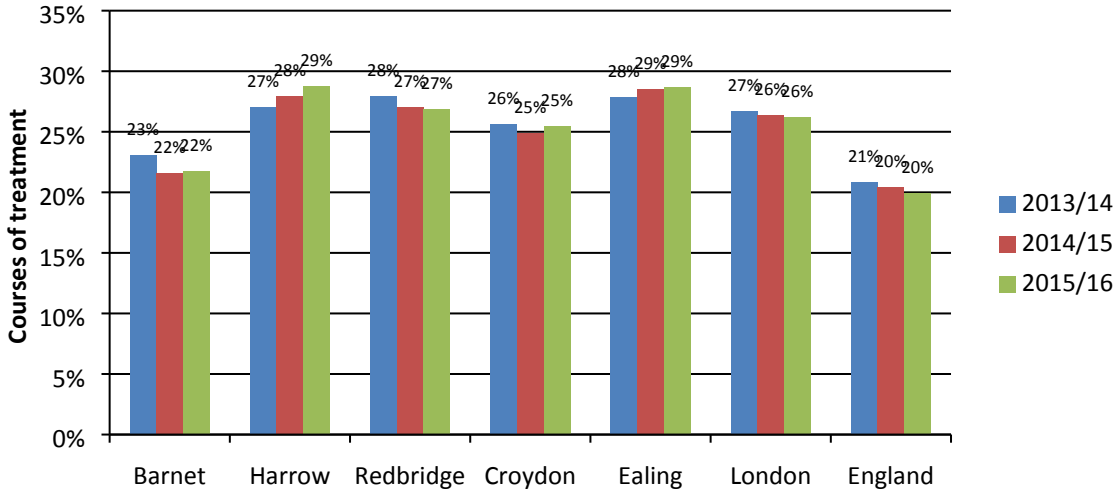


Sources: NHS Digital (NHS Dental Activity Statistics), Office for National Statistics (Population mid-year estimates)

This shows:

- In recent years the rate of extractions per 1000 0-17 yr olds, performed by NHS dentists, rose in Barnet up to 2015/16 but then fell in 2016/17.
- Levels in a statistical neighbours aggregate, London and England fell from 2013/14 to 2016/17.
- Throughout this period, levels in Barnet remained lower than in the statistical neighbours aggregate, London and England.

Proportion of dental courses of treatment involving permanent fillings*, for 0-17 yr olds, by NHS dentists in Barnet, 4 statistical neighbours, London & England, 2013/14 to 2015/16



*Permanent fillings and sealant restorations

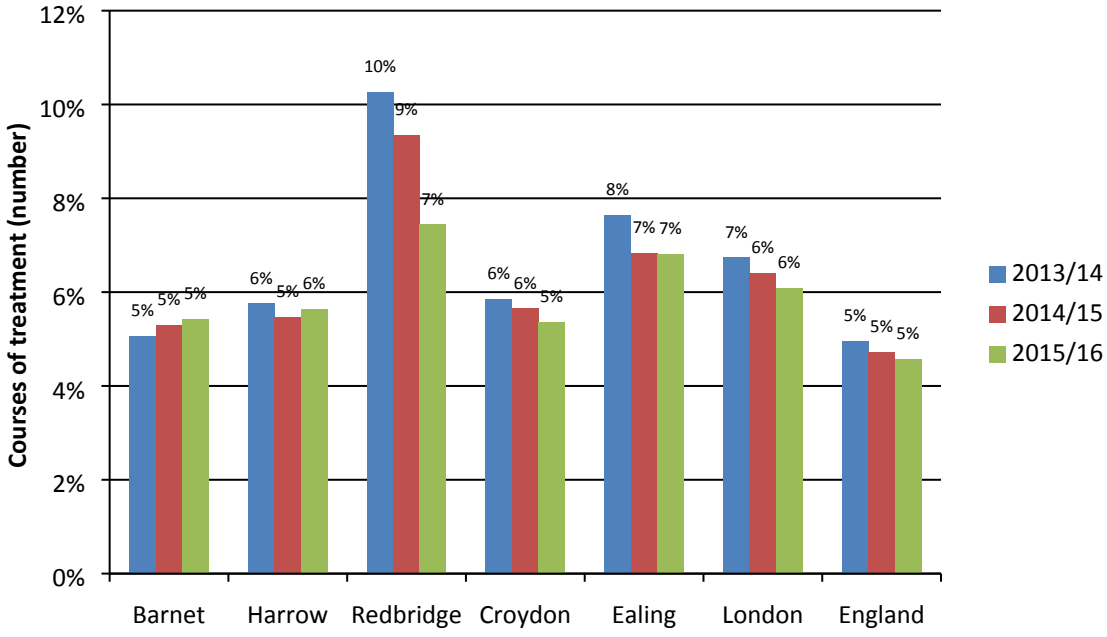
Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- From 2013/14 to 2015/16, the percentage of child dental courses of treatment involving permanent fillings in Barnet

(about one-fifth) was lower than in four statistical neighbours and London, but higher than in England.
(Results not statistically assessed)

Proportion of dental courses of treatment involving extractions, in 0-17 yr olds, by NHS dentists in Barnet, 4 statistical neighbours, London & England, 2013/14 to 2015/16

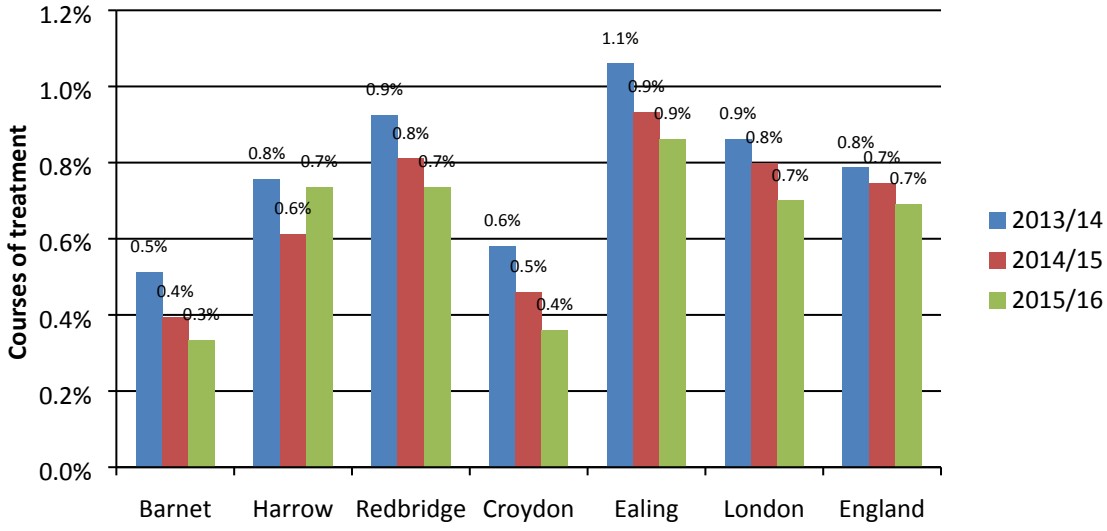


Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- In recent years, the percentage of child dental courses of treatment involving extractions, performed by Barnet NHS dentists, was about 5%.
- This was either lower than or similar to four statistical neighbours, lower than London levels, and similar to England levels. (Results not statistically assessed)

Proportion of dental courses of treatment involving antibiotic prescribing, for 0-17 yr olds, by NHS dentists in Barnet, 4 statistical neighbours, London & England, 2013/14 to 2015/16



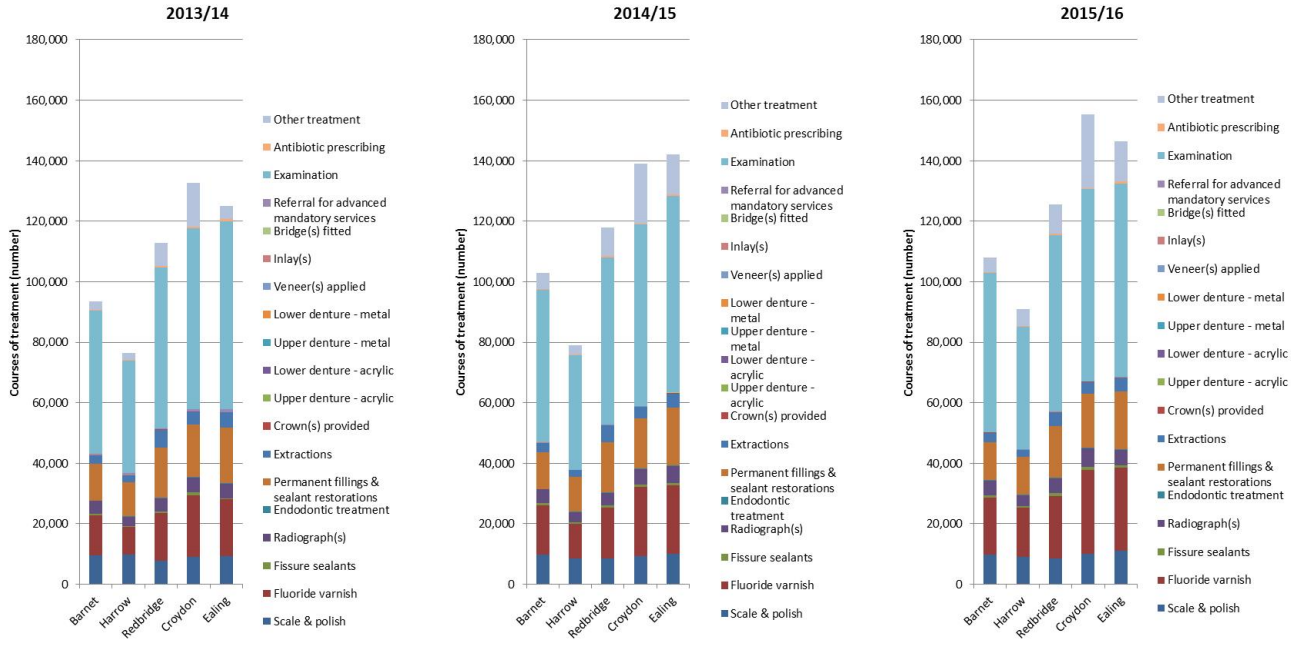
Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

• In recent years, the proportion of child dental courses of treatment involving antibiotic prescribing, done by dentists in Barnet (about 0.4%) was lower than or similar to levels in four statistical neighbours, and lower than in London and England.

(Results not statistically assessed)

Estimated number of dental courses of treatment by clinical type, for 0-17 yr olds, by NHS dentists in Barnet and 4 statistical neighbours, 2013/14 to 2015/16



Source: NHS Digital (NHS Dental Activity Statistics)

Estimated number of dental courses of treatment involving permanent fillings & sealant restorations, extractions, antibiotic prescribing, and total*, for 0-17 yr olds, by NHS dentists in Barnet, 2013/14 to 2015/16

Year	Permanent fillings & sealant restorations	Extractions	Antibiotic prescribing	Total
2013/14	12,185	2671	270	93,606
2014/15	12,185	2983	222	103,020
2015/16	12,499	3127	192	108,067

*Including courses of treatment involving activities not shown

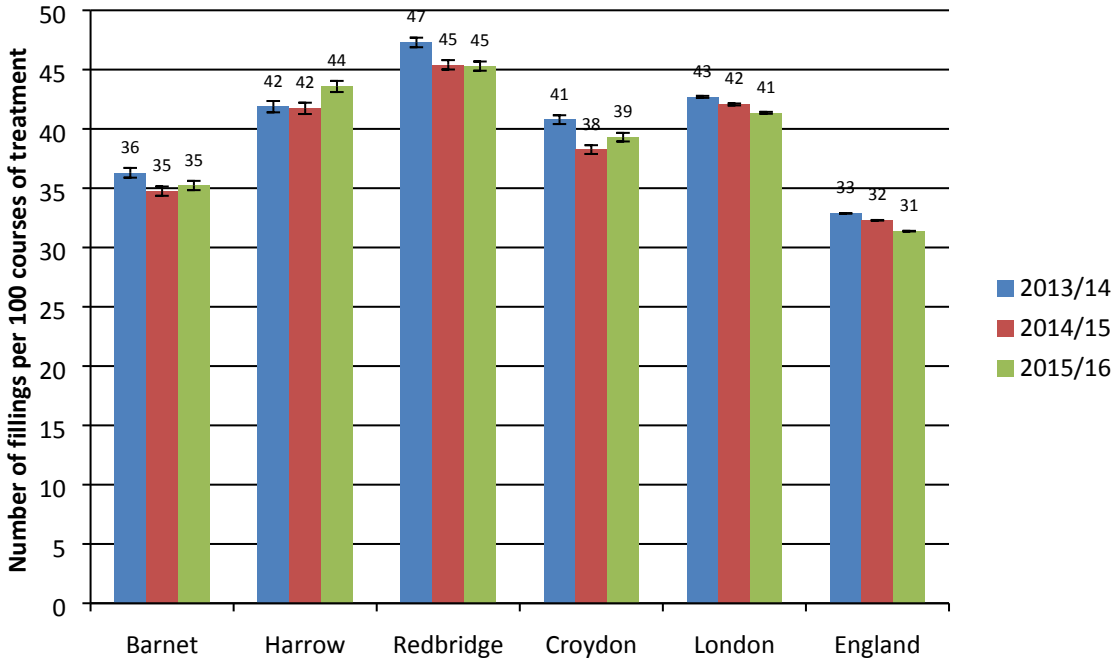
Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- Between 2013/14 and 2015/16, the number of courses of treatment involving permanent fillings and extractions, and the total courses of treatment, increased in Barnet, while the number involving antibiotics prescribing decreased.
- Over this same time period, the total number of dental courses of treatment increased in the four closest statistical neighbours.

(Results not assessed statistically)

Number of permanent fillings* per 100 courses of treatment for 0-17 yr olds, by NHS dentists in Barnet, 3 statistical neighbours, London & England, 2013/14 to 2015/16



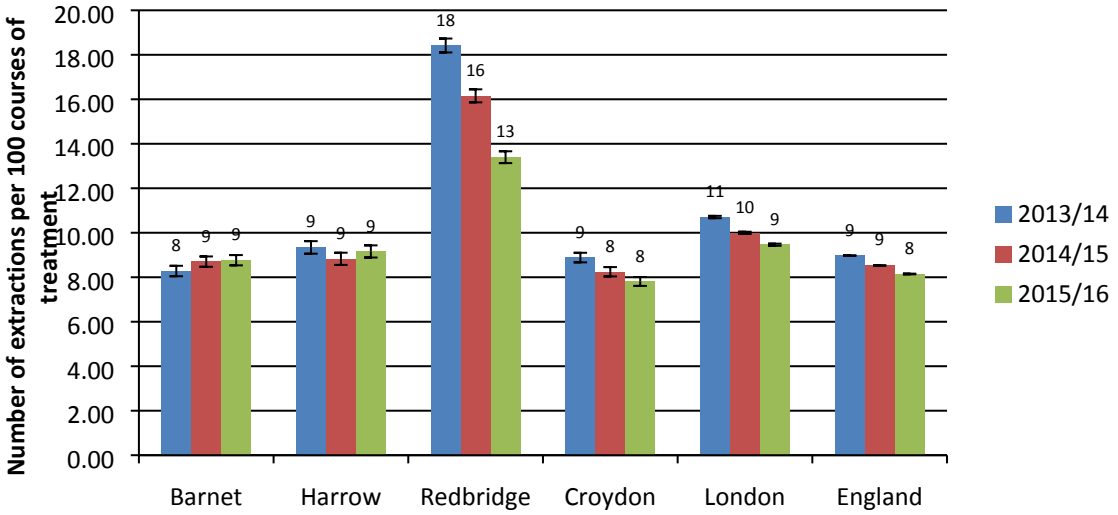
*Permanent fillings and sealant restorations

Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- In recent years, the number of permanent fillings per 100 courses of treatment done in 0-17 yr olds by NHS dentists fell significantly in Barnet, in two of the three closest statistical neighbours, and in London and England.
- Over this period, Barnet levels were lower than in London and in the three closest statistical neighbours, but higher than in England.

Number of extractions per 100 courses of treatment for 0-17 yr olds, by NHS dentists in Barnet, 3 statistical neighbours, London & England, 2013/14 to 2015/16

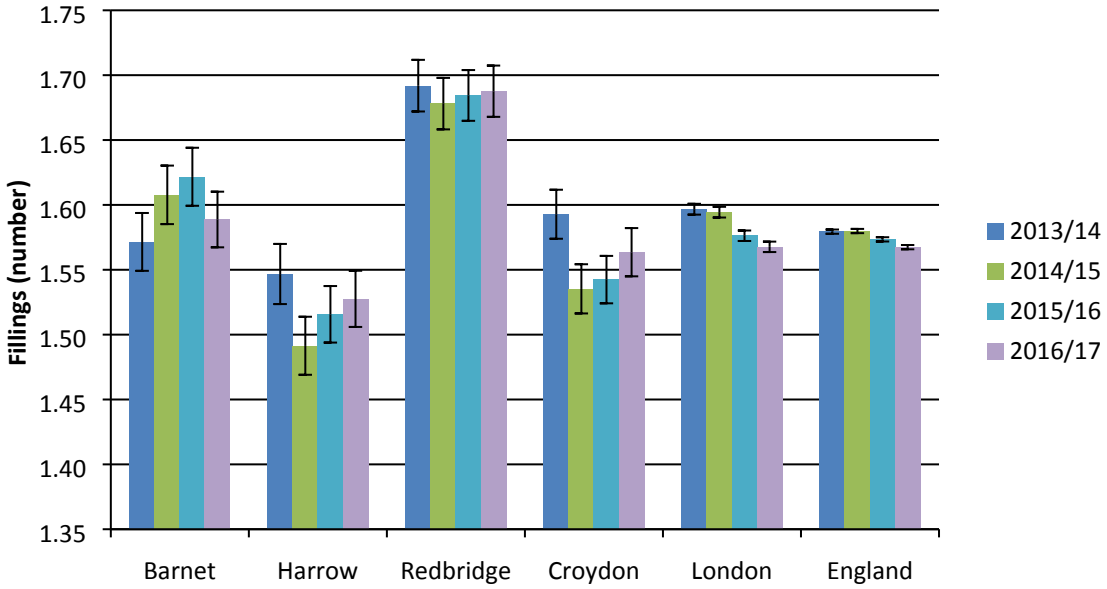


Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- In recent years, the number of extractions per 100 courses of treatment in 0-17 yr olds, done by NHS dentists, rose in Barnet but fell in two of the three statistical neighbours, and in London and England.
- In 2013/14, Barnet levels were lower than London and England levels, but by 2015/16 Barnet levels had risen above England levels.

Average number of fillings* done in courses of treatment where they occurred, in 0-17 yr olds, done by NHS dentists in Barnet, 3 closest statistical neighbours, London & England, 2013/14 to 2016/17



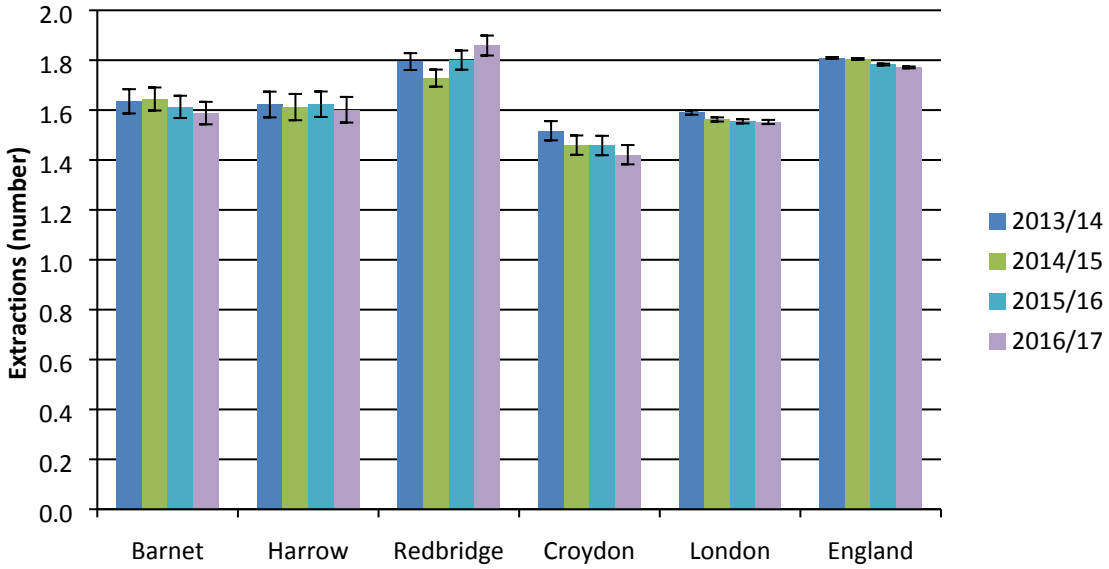
*Permanent fillings or sealant restorations

Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- From 2013/14 to 2016/17, the average number of permanent fillings and sealant restorations per courses of treatment in which they occurred, in 0-17 yr olds, done by NHS dentists, did not change significantly in Barnet or in its 3 closest statistical neighbours but fell in London and England.
- In 2016/17, levels were similar in Barnet, London and England.

Average number of extractions done in courses of treatment where they occurred, in 0-17 yr olds, done by NHS dentists in Barnet, 3 closest statistical neighbours, London & England, 2013/14 to 2016/17

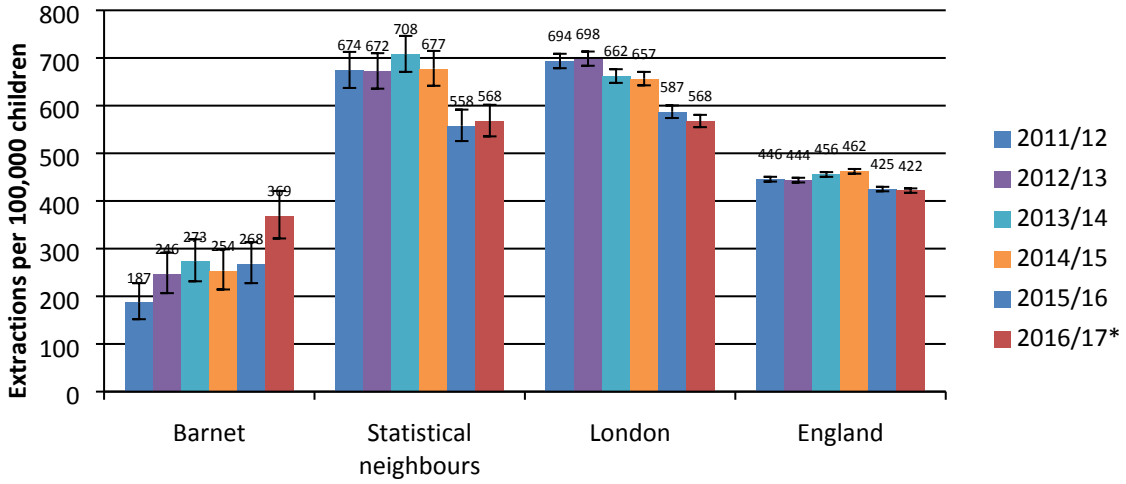


Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

- From 2013/14 to 2016/17, the average number of extractions done in courses of treatment in which they occurred, in 0-17 yr olds, by NHS dentists, was unchanged in Barnet and in 2 of the 3 closest statistical neighbours.
- However, levels fell in London and England.
- In 2016/17, Barnet levels were similar to London's and lower than England's.

Inpatient tooth extractions due to decay in 0–10 yr olds per 100,000 population, in Barnet, statistical neighbours aggregate, London & England, 2011/12 to 2016/17*



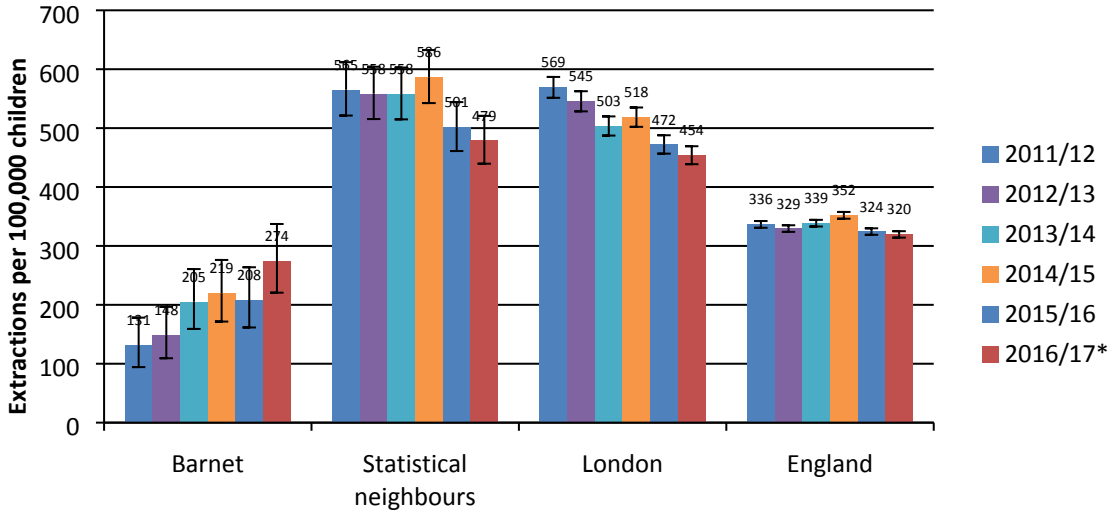
*2016/17 data is provisional (to be confirmed Nov 2017)

Sources: NHS Digital (NHS Outcomes Framework, Hospital Episodes Statistics), Office for National Statistics (population mid-year estimates)

This shows:

- From 2011/12 to 2016/17, the prevalence of inpatient tooth extractions for dental decay amongst Barnet 0-10 yr olds almost doubled (from 187/100,000 to 367/100,000). However, numbers remain lower than London and neighbours.
- Over the same time period, levels in London and in an aggregate of the four closest statistical neighbours fell by one-sixth; levels in England also fell.
- From 2011/12 to 2015/16, Barnet levels were below those in England, London and the statistical neighbours aggregate. ,
- Between 2015/16 and 2016/17, Barnet levels have risen by over one-third.

Inpatient tooth extractions for dental decay in 0–5 yr olds, per 100,000 population, in Barnet, statistical neighbours aggregate, London & England, 2011/12 to 2016/17*



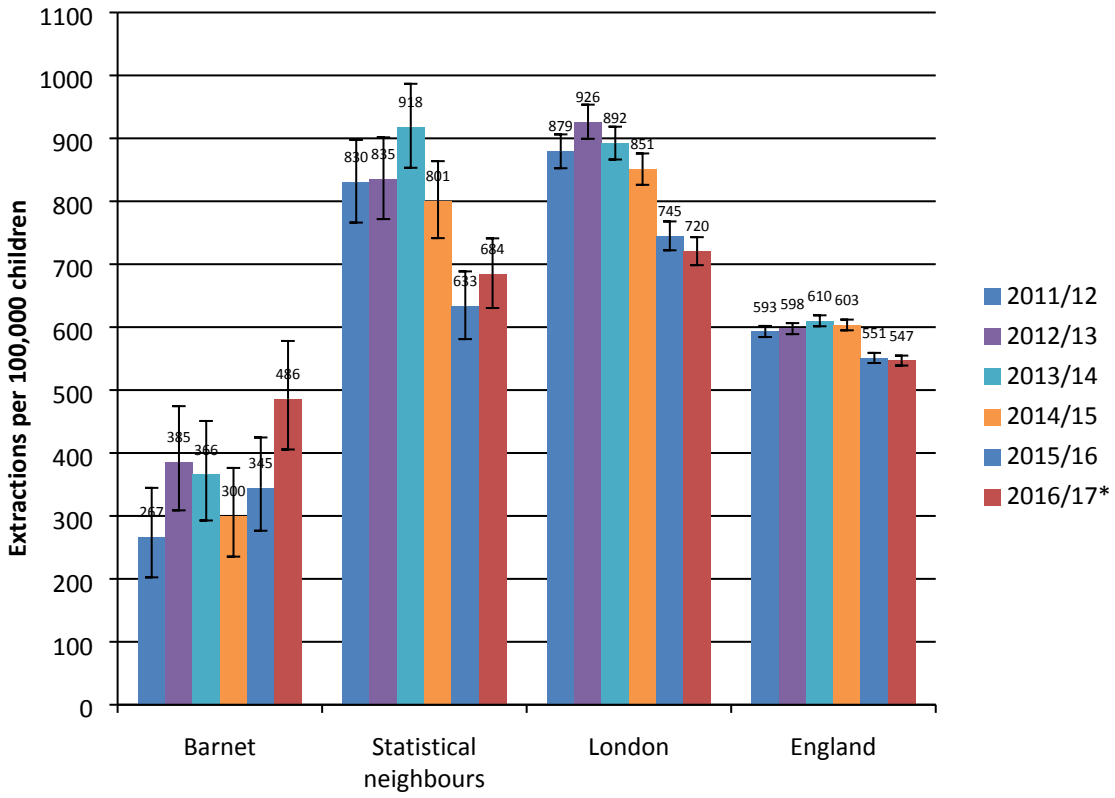
*2016/17 data is provisional (to be confirmed Nov 2017)

Sources: NHS Digital (NHS Outcomes Framework, Hospital Episodes Statistics), Office for National Statistics (population mid-year estimates)

This shows:

- From 2011/12 to 2016/17, the rate of inpatient tooth extraction for dental decay in 0-5 yr olds per 100,000 population more than doubled in Barnet (from 131/100,000 to 274/100,000).
- Over the same period, levels fell significantly in England, in London (by one-fifth) and in an aggregate of 4 closest statistical neighbours (by one-sixth).
- From 2011/12 to 2015/16, levels in Barnet were below those in England, London and the statistical neighbour aggregate, but by 2016/17 Barnet levels were similar to England levels.
- Between 2015/16 and 2016/17, Barnet levels have risen by almost one-third.

Inpatient tooth extractions for dental decay in 6–10 yr olds per 100,000 population, in Barnet, statistical neighbours aggregate, London & England, 2011/12 to 2016/17*



*2016/17 data is provisional (to be confirmed Nov 2017)

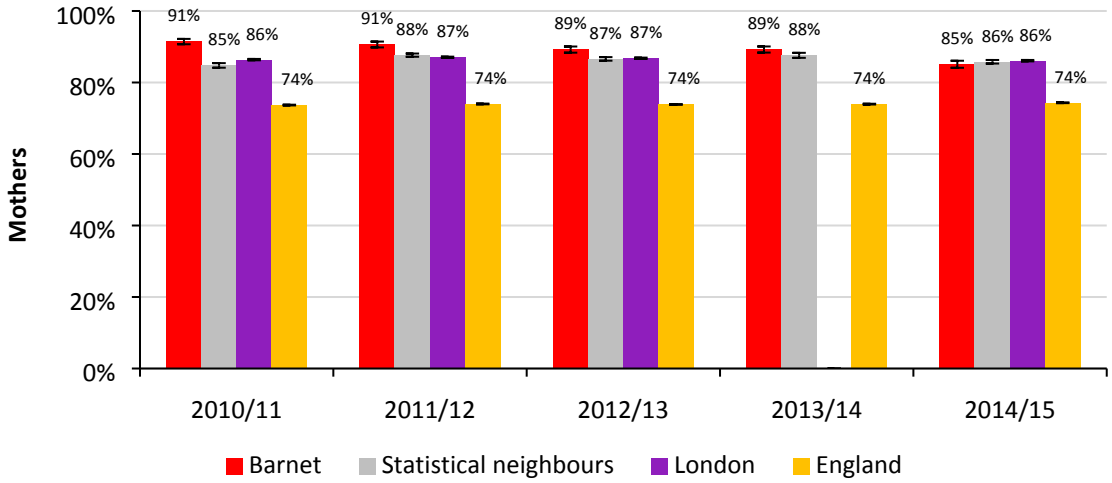
Sources: NHS Digital (NHS Outcomes Framework, Hospital Episodes Statistics), Office for National Statistics (population mid-year estimates)

This shows:

- From 2011/12 to 2016/17, the rate of inpatient tooth extractions for dental decay in 6-10 yr olds per 100,000 population increased by almost three-quarters in Barnet (from 267/100,000 to 486/100,000).
- However, levels fell in England, London (by one-sixth) and a statistical neighbours aggregate (by one-sixth).
- Between 2011/12 and 2015/16, levels in Barnet were below those in England, London and the statistical neighbours aggregate, but in 2016/17 Barnet levels appeared to be similar to England.
- Between 2015/16 and 2016/17 alone, Barnet levels appeared to increase by over one-third.

2. Protective factors and risk factors: breastfeeding, gender, age, ethnicity and deprivation

Proportion of mothers who breastfeed within 48 hours of delivery, for Barnet, statistical neighbours aggregate*, London & England, 2010/11 to 2014/15**

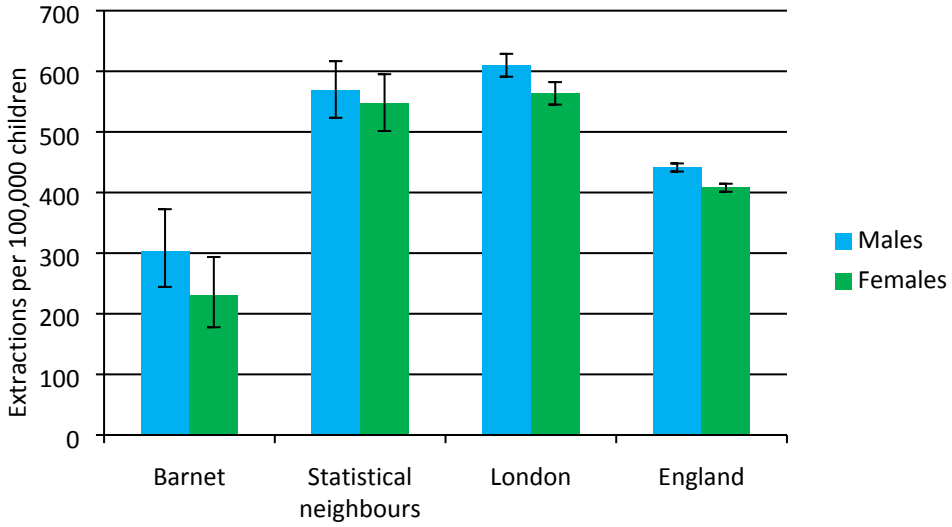


*Croydon, Ealing, Harrow and Redbridge (2010/11 value excludes Ealing data; 2013/14 and 2014/15 values exclude Croydon and Redbridge data)
**2013/14 value not published for data quality reasons
Source: Public Health England (Public Health Outcomes Framework)

This shows:

- Breast-feeding initiation levels in Barnet remained higher than England throughout the five years.
- Barnet levels decreased from 91.5% in 2010/11 to 85.1% in 2014/15.
- Barnet levels were higher than London's up to 2012/13, but lower in 2014/15.

Inpatient tooth extractions for dental decay in 0–10 yr olds per 100,000 population, by sex, in Barnet, statistical neighbours aggregate, London & England, 2015/16

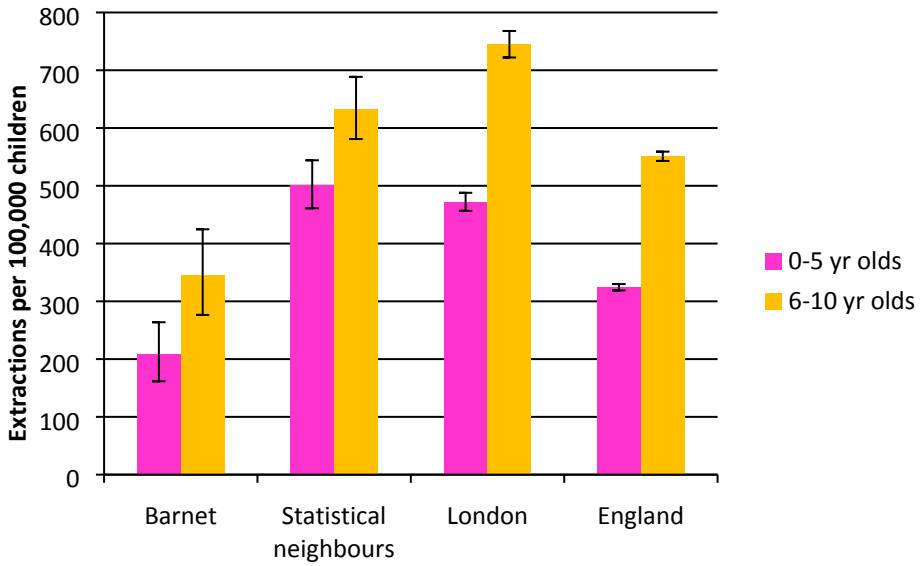


Sources: NHS Digital (NHS Outcomes Framework, Hospital Episode Statistics), Office for National Statistics (population mid-year estimates)

This shows:

- In 2015/16, the rate of inpatient tooth extraction for dental decay in 0-10 yr olds per 100,000 population was similar in boys and girls in Barnet and a statistical neighbours aggregate.
- However, in London and England levels were significantly higher for boys than girls.

Inpatient tooth extractions for dental decay in children by age group, in Barnet, statistical neighbours aggregate, London & England, in 2015/16

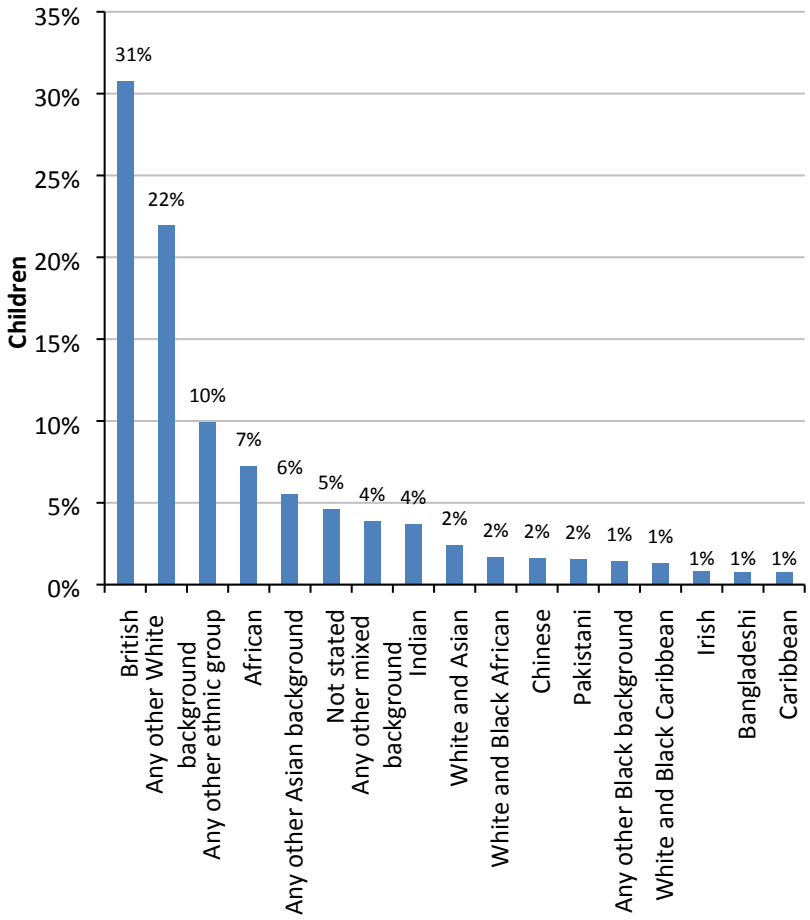


Sources: NHS Digital (Hospital Episode Statistics), Office for National Statistics (population mid-year estimates)

This shows:

• In 2015/16, the rate of inpatient tooth extraction for dental decay per 100,000 population was significantly higher among 6-10 yr olds than 0-5 yr olds, in Barnet (by two-thirds), in a statistical neighbours aggregate (by one-quarter), in London (by over half) and in England (by over two-thirds).

Proportion of 4-5 year olds attending Barnet schools, by ethnic group, in 2015/16

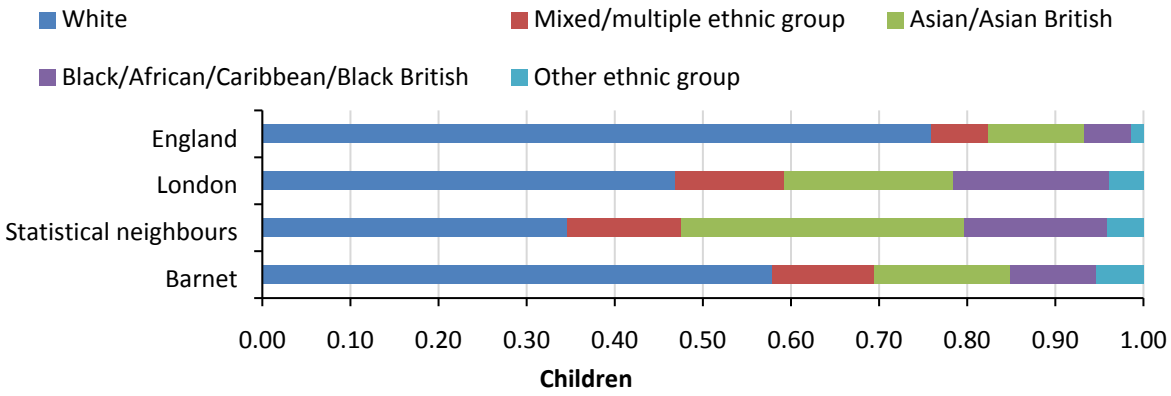


Source: Public Health England (National Child Measurement Programme, Pupil Enhanced Dataset)

This shows:

- Among Barnet 4-5 year old school pupils in 2015/16, 2% were from Chinese ethnic groups and 22% were from 'any other white' groups. (Results not statistically assessed)
- Note: In the 2015 Dental Public Health Epidemiology Survey, across England, 5 yr old children from Chinese and Eastern European backgrounds had higher prevalence, severity and extent of dental decay than other ethnic groups.

Proportion of 0-4 yr olds by broad ethnic group, in Barnet, statistical neighbours aggregate, London and England, 2011



Source: Office for National Statistics (Census 2011)

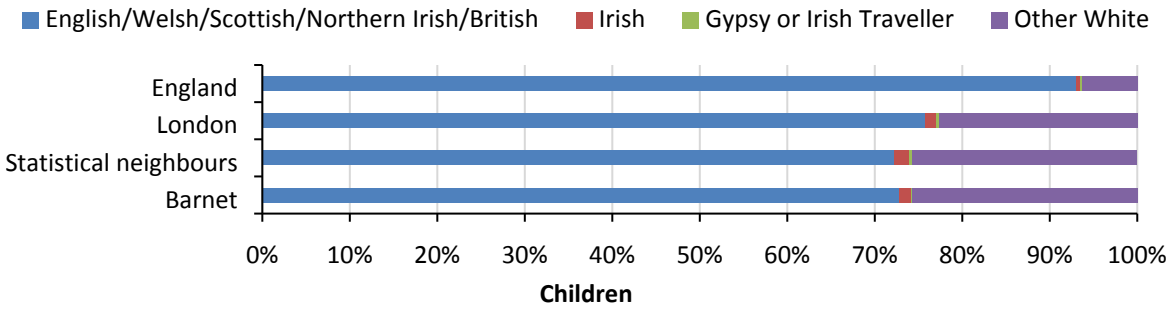
This shows

• In the 2011 Census, Barnet had a higher proportion of 0–4 yr olds from White backgrounds than in an aggregate of four closest statistical neighbours, and in London, but less than in England.

• In the 2011 Census, Barnet had a lower proportion of 0–4 yr olds from Asian backgrounds than in the statistical neighbours aggregate and in London, but more than in England.

(Results not assessed statistically)

Proportion of white 0-4 yr olds by ethnic sub-group, in Barnet, statistical neighbour aggregate, London and England, 2011



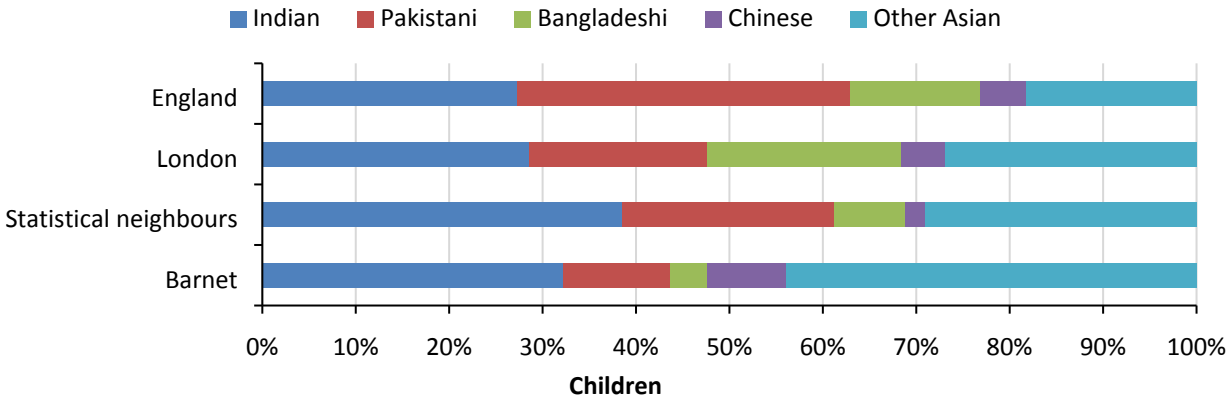
Source: Office for National Statistics (Census 2011)

This shows

• In the 2011 Census, Barnet had a similar proportion of 0–4 yr olds from 'other white' backgrounds compared with a statistical neighbours aggregate, but more than in London and England.

(Results not statistically assessed)

Proportion of Asian 0-4 yr olds by ethnic sub-group, in Barnet, statistical neighbours aggregate, London and England



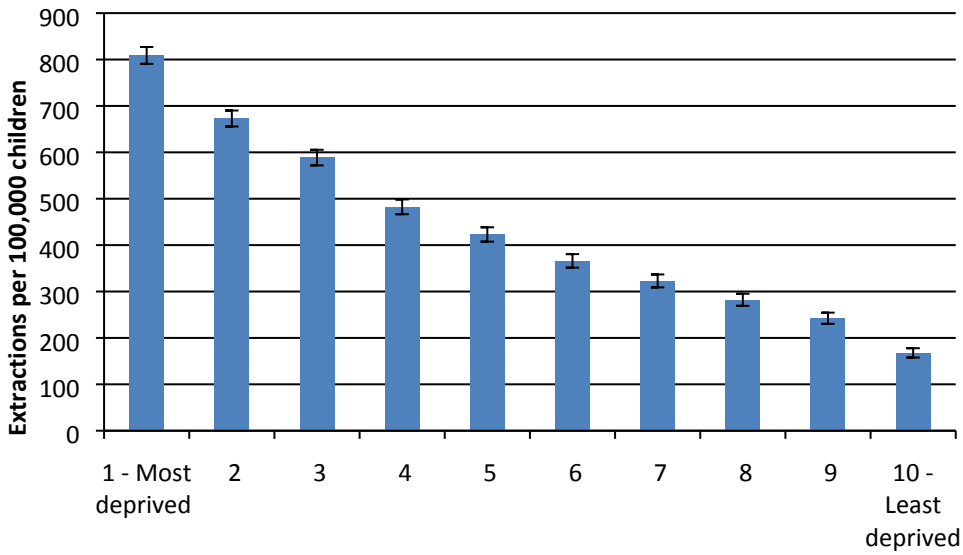
Source: Office for National Statistics (Census 2011)

This shows

• In the 2011 Census, Barnet had a greater proportion of 0–4 yr olds from a Chinese background compared with a statistical neighbours aggregate, London and England.

(Results not statistically assessed)

Inpatient tooth extractions for dental decay in 0-10 yr olds in England, by 2015 Index of Multiple Deprivation decile, 2014/15

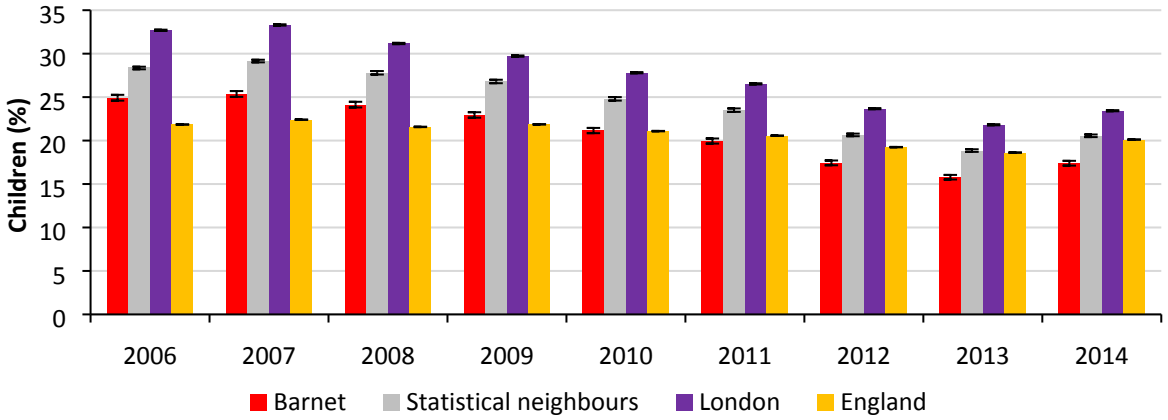


Source: Health & Social Care Information Centre (NHS Outcomes Framework)

This shows:

- England-wide in 2014/15, the rate of inpatient tooth extractions among 0-10 yr olds per 100,000 population was four times higher among children living in the most deprived versus least deprived areas.
- Levels steadily decreased as local deprivation reduced.
- Note: Although data is not available for Barnet, England-wide evidence suggests that a similar pattern would be observed.

Proportion of 0-15 yr olds in low income families* in Barnet, statistical neighbours aggregate, London and England, 2006 to 2014

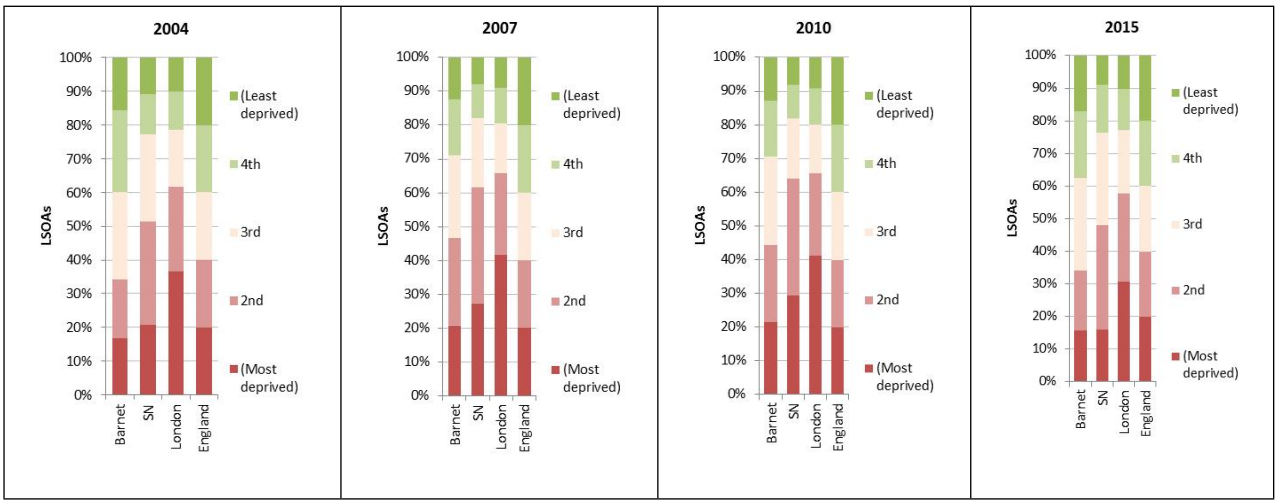


*Children living in families receiving child tax credit, which have an income less than 60% of the median income, or which receive income support or income-related Job Seekers Allowance.
Source: Public Health England (Public Health Outcomes Framework)

This shows:

- From 2006 to 2013, the proportion of 0-15 yr olds living in low income families fell steadily in Barnet.
- Since 2011, Barnet levels have been lower than statistical neighbours aggregate, London and England levels.
- However, between 2013 and 2014 Barnet levels rose for the first time.

Proportion of 0-17 yr olds by quintile rank* of Income Deprivation Affecting Children Index (IDACI) score, in Barnet, statistical neighbours aggregate, London & England, in 2004, 2007, 2010 & 2015



SN = aggregate of 4 closest statistical neighbours
Source: Department for Communities and Local Government (English Deprivation Indices)

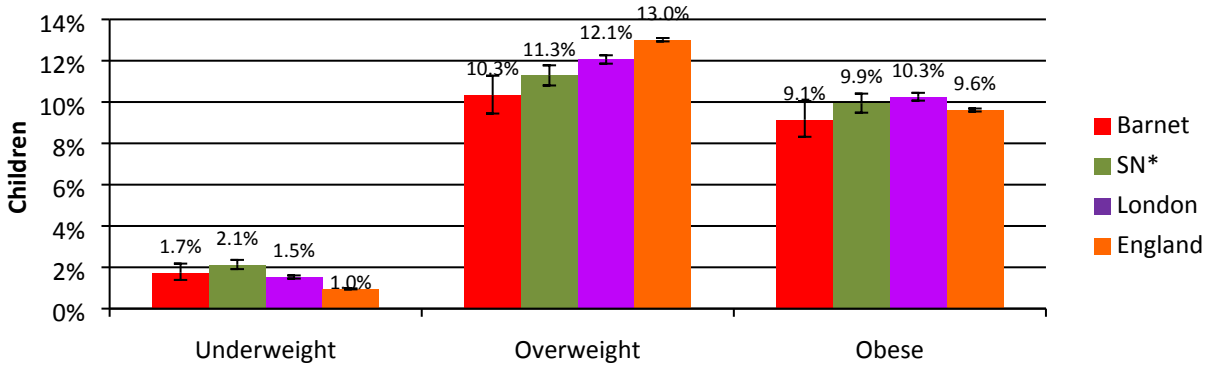
This shows:

• From 2004 to 2010, the proportion of children living in the most deprived fifth of areas (for income deprivation affecting children) rose, then fell in 2015 to a similar level to 2004.

• Between 2010 and 2015, the proportion of children living in the most deprived fifth reduced, and the proportion of children living in least deprived two-fifths increased.

(Results not statistically assessed)

Prevalence of underweight, overweight and obesity in Reception Year pupils in Barnet, statistical neighbours*, London & England, 2016/17



*SN = composite of four closest statistical neighbours (Harrow, Redbridge, Croydon & Ealing)

Source: NHS Digital (National Child Measurement Programme, England 2016/17 School Year)

This shows:

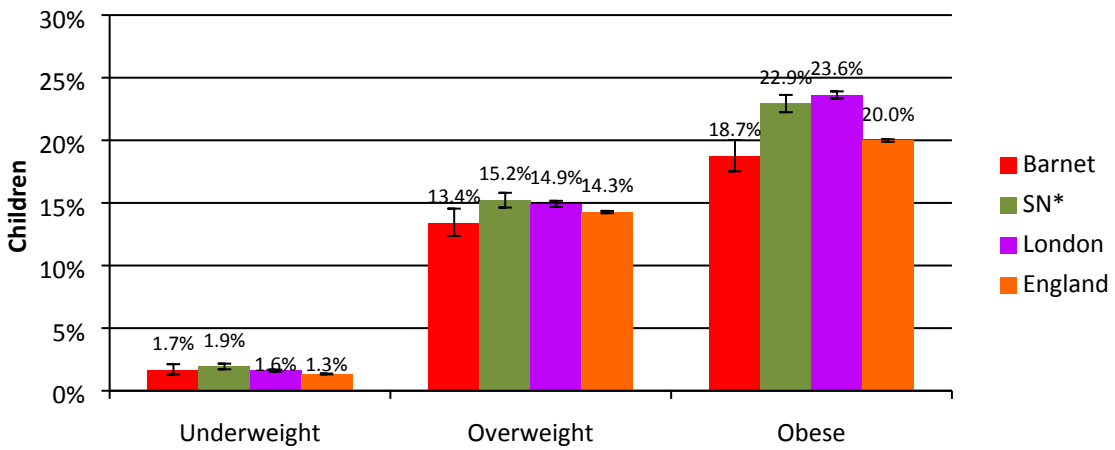
• In 2016/17, the prevalence of underweight was over three-quarters higher in Barnet 4-5 year olds compared with the England average.

• Levels of overweight were lower in Barnet than in London and England.

• Barnet obesity levels were comparable to those in statistical neighbours, London and England.

• Note: obesity has a weak to moderate correlation with dental caries in five year olds (Public Health England, 2015)

Prevalence of underweight, overweight and obesity in Year 6 pupils in Barnet, statistical neighbours*, London & England, 2016/17



*SN = composite of four closest statistical neighbours (Harrow, Redbridge, Croydon & Ealing)

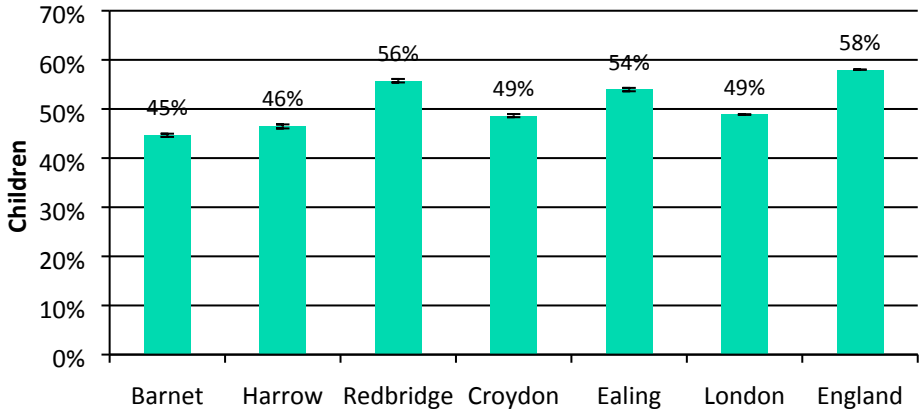
Source: NHS Digital (National Child Measurement Programme, England 2016/17 School Year)

This shows:

- In 2016/17, levels of underweight in Barnet 10-11 yr olds were comparable to those in statistical neighbours, London and England.
- Levels of overweight and obesity were lower in Barnet than in statistical neighbours and London.
- Note: it is not known whether obesity influences dental caries rates in older children (Public Health England, 2015).

3. Dental care

Proportion of 0-17 yr olds seen in the past 12 mths by NHS dentists in Barnet, 4 statistical neighbours, London & England, 2015/16

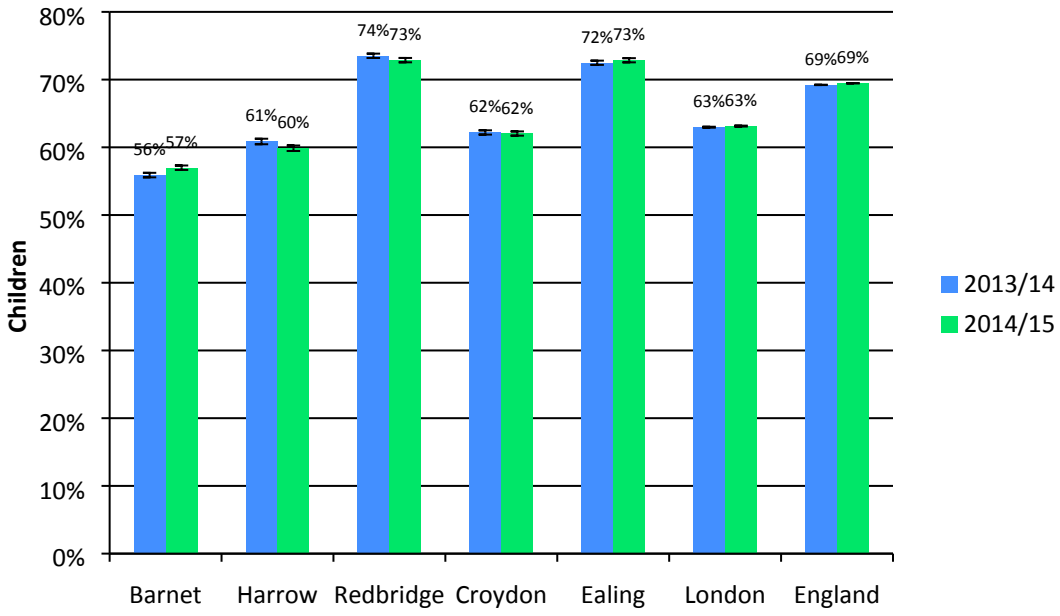


Source: NHS Digital (NHS Dental Activity Statistics)

This shows:

• In 2015/16: the proportion of 0-17 yr olds seen by a dentist in the last 12 months was lower in Barnet than in its four closest statistical neighbours, London and England – Barnet's level was almost one-quarter less than England's.

Proportion of 0-17 yr olds seen in the past 24 mth* by dentists in Barnet, 4 statistical neighbours, London & England, in 2013/14 & 2014/15



*This statistic was unavailable after 2014/15

Source: NHS Digital (NHS Dental Activity Statistics)

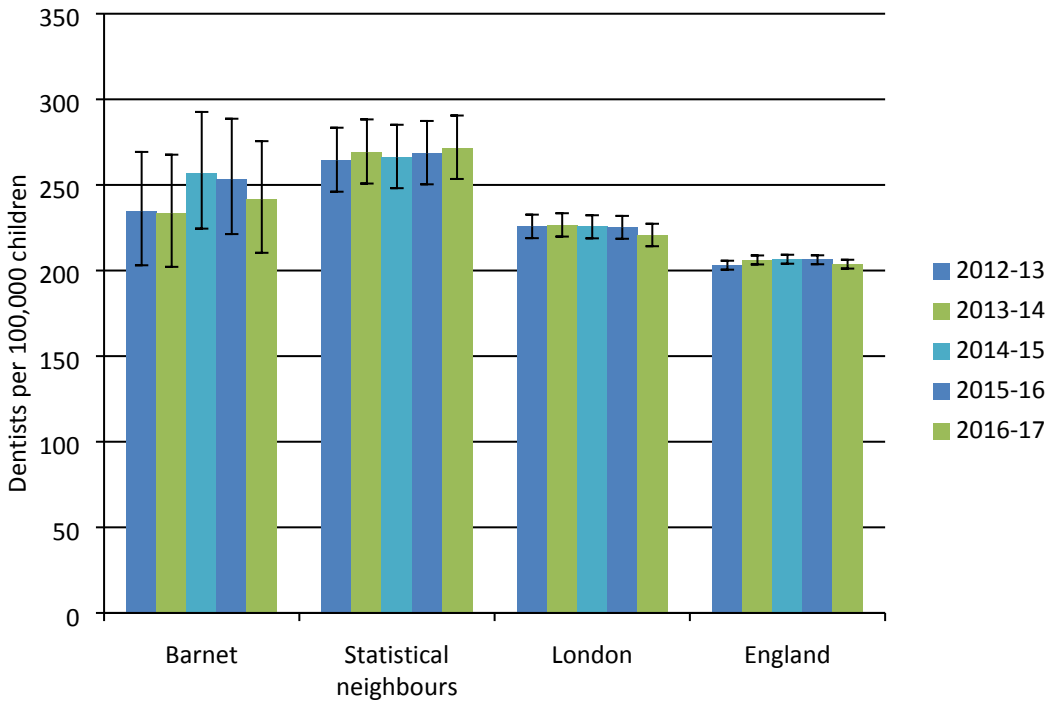
This shows:

• In 2013/14 and 2014/15, the proportion of 0-17 yr olds seen by a dentist in the past 24 mths was lower in Barnet than in four statistical neighbours, London and England.

• Barnet levels were one-fifth lower than England levels in 2013/14 and almost one-fifth lower in 2014/15.

• However, Barnet's levels rose from 2013/14 to 2014/15, as did levels in London and England (levels in the four statistical neighbours either fell or did not change).

NHS Dentists per 100,000 0-17 yr population in Barnet, statistical neighbours aggregate, London & England, 2012/13 to 2016/17



Sources: NHS Digital (NHS Dental Activity Statistics), Office for National Statistics (population mid-year estimates)

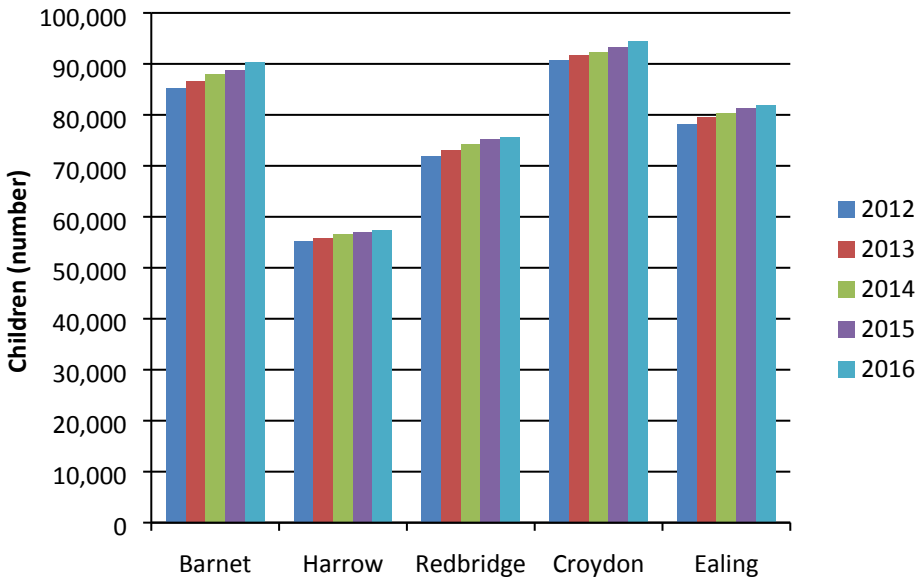
This shows:

• From 2012/13 to 2016/17, the number of NHS Dentists per 100,000 0-17 yr olds did not alter significantly in Barnet, a statistical neighbours aggregate, London or England.

• Over this period, Barnet levels remained similar to statistical neighbour aggregate and London levels, but rose significantly compared with England levels (Barnet levels were similar to England's in 2012/13 and 2013/14 but significantly higher thereafter).

4. Demographics

Estimated 0-17 yr population in Barnet and 4 statistical neighbours, 2012 to 2016



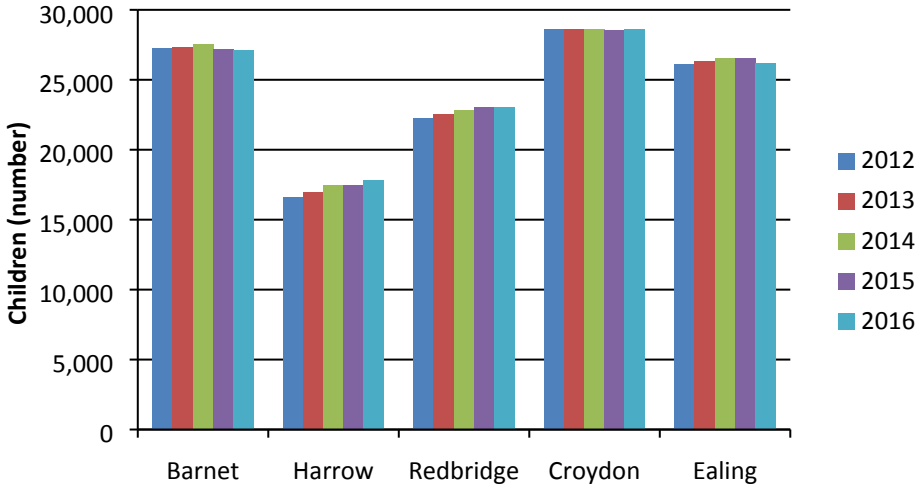
Source: Office for National Statistics (population mid-year estimates)

This shows:

• From 2012 to 2016, the estimated child population increased steadily in Barnet and in four statistical neighbours.

(Results not statistically assessed)

Estimated 0-4 yr population in Barnet and 4 statistical neighbours, 2012 to 2016



Source: Office for National Statistics (population mid-year estimates)

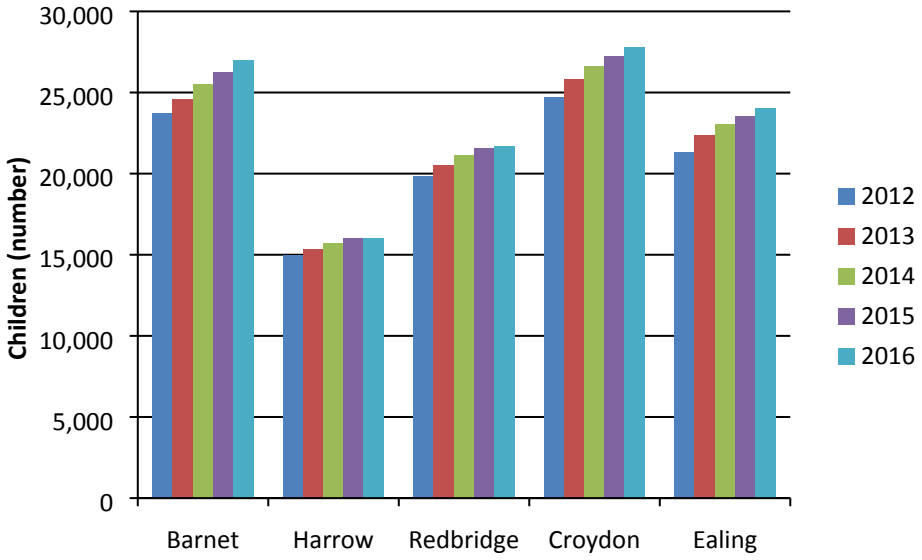
This shows:

• From 2012 to 2016, the 0-4 yr population in Barnet fell by over 100, while levels generally rose in its closest statistical neighbours.

Appendix B: Oral Health Supporting Data

(Results not statistically assessed)

Estimated 5-9 yr population in Barnet and 4 statistical neighbours, 2012 to 2016



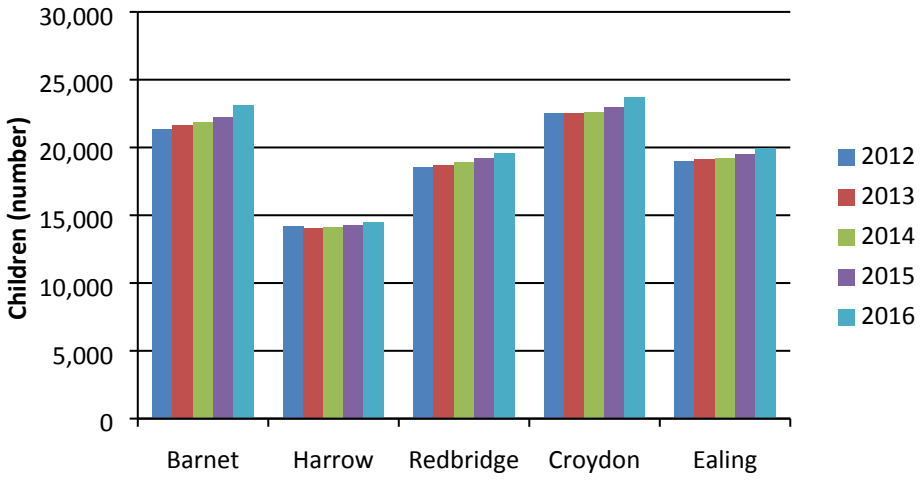
Source: Office for National Statistics (population mid-year estimates)

This shows:

• From 2012 to 2016, the 5-9 yr population rose by over 3300 in Barnet, a bigger increase than in any of its four closest statistical neighbours.

(Results not statistically assessed)

Estimated 10-14 yr population in Barnet and 4 statistical neighbours, 2012 to 2016



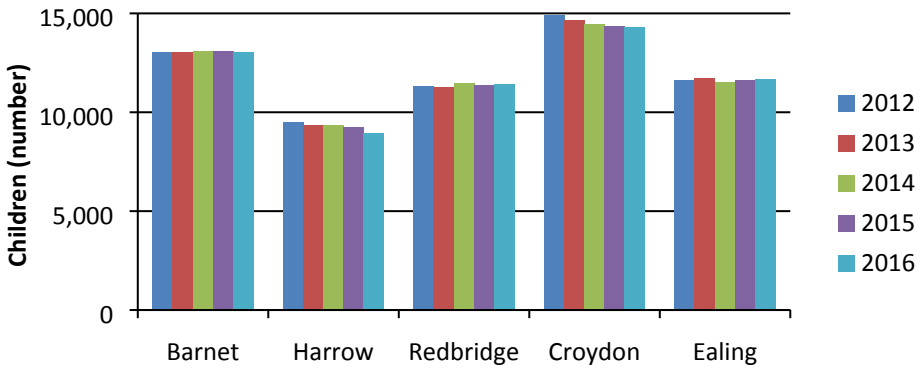
Source: Office for National Statistics (population mid-year estimates)

This shows:

• From 2012 to 2016, the 10-14 yr population rose by over 1800 in Barnet, a bigger increase than in any of its four closest statistical neighbours.

(Results not statistically assessed)

Estimated 15-17 yr population in Barnet and 4 statistical neighbours, 2012 to 2016



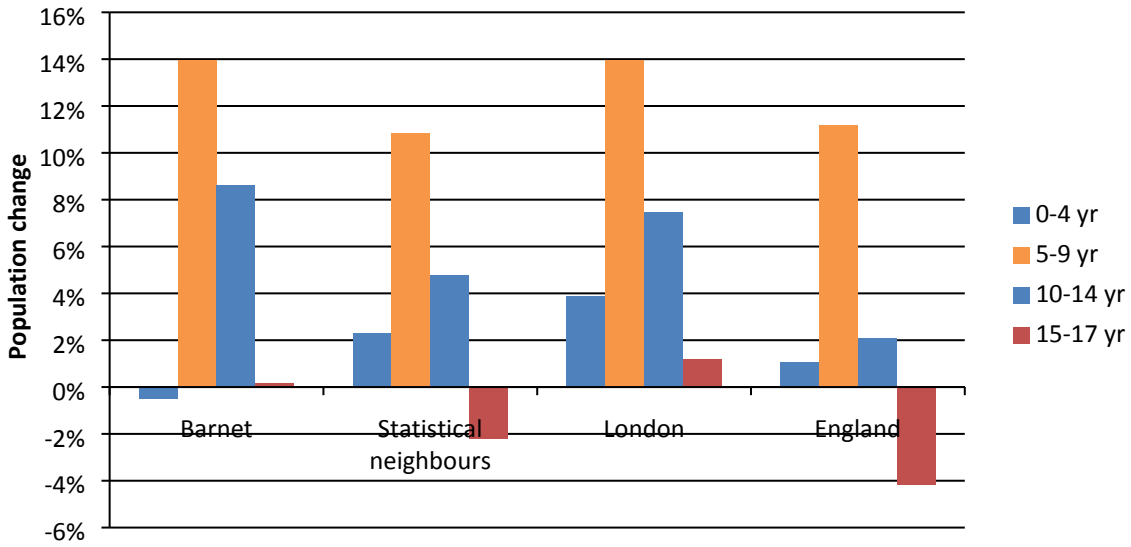
Source: Office for National Statistics (population mid-year estimates)

This shows:

• From 2012 to 2016, the 15-17 yr population remained stable in Barnet.

(Results not statistically assessed)

Proportional change in child population in Barnet, statistical neighbours aggregate, London and England, by age group, 2012 vs 2016



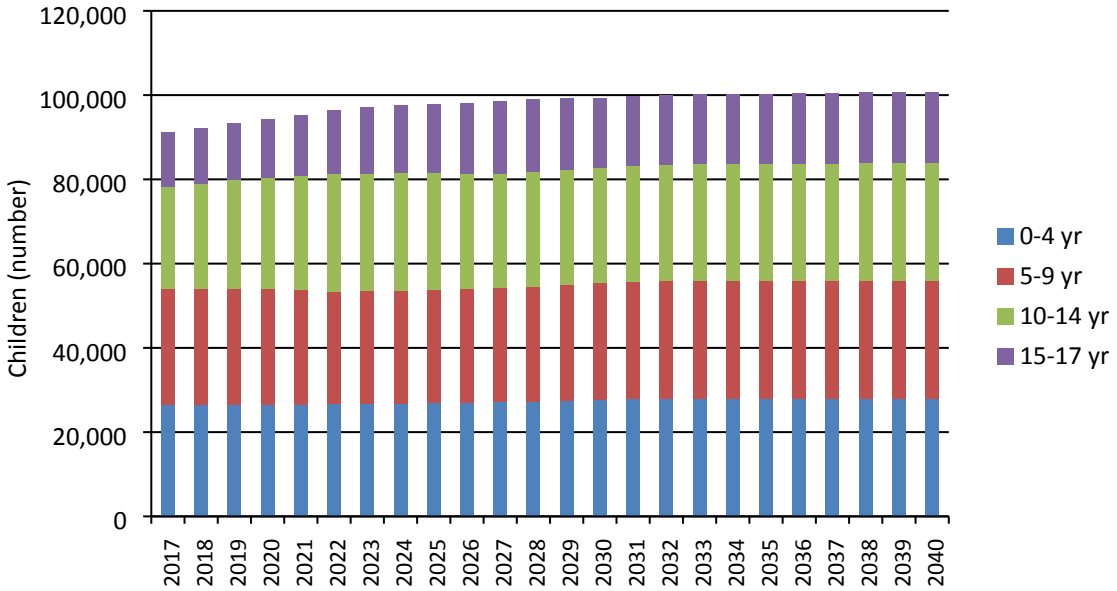
Source: Office for National Statistics (population mid-year estimates)

This shows:

• Between 2012 and 2016, the proportionate rise in the 5-9 yr population was almost one-third greater in Barnet than in a statistical neighbours aggregate. The proportionate rise in Barnet's 10-14 yr population was over three-quarters greater than in the statistical neighbours aggregate.

(Results not statistically assessed)

Projected Barnet child population 2017 to 2040, by age group (housing-led model*)



*Population projections incorporating expected births, deaths and migration plus future development expectations based on the 2013 Strategic Housing Land Availability Assessment (SHLAA) survey.
Source: Greater London Authority (SHLAA)

Projected increase in Barnet child population from 2017, total and by age group (housing-led model)

	To 2020	To 2025	To 2030	To 2035	To 2040
0-4 yr	86	432	1302	1522	1478
5-9 yr	-226	-720	-67	334	376
10-14 yr	2413	3700	3450	3785	4028
15-17 yr	952	3361	3453	3599	3713
Total	3224	6772	8138	9240	9595

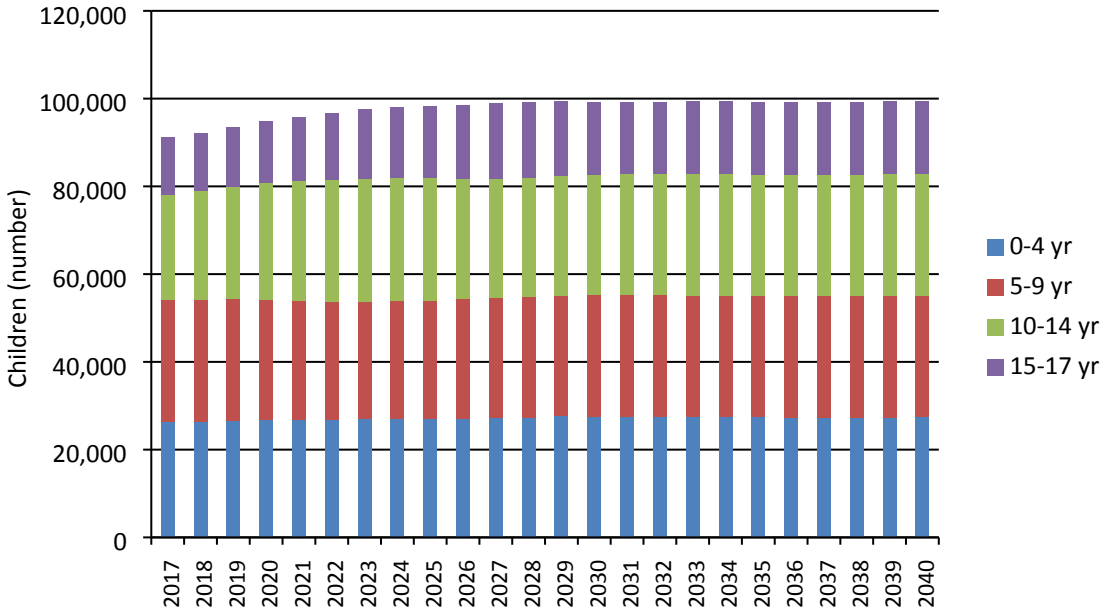
(Source: Greater London Authority (SHLAA)

This shows:

- Between 2017 and 2040, the total Barnet 0–17 yr population is expected to increase by almost 9600, based on the SHLAA population growth model.
- The greatest increase is expected in 10–14 yr olds.

(Results not statistically assessed)

Projected Barnet child population 2017 to 2040, by age group (Borough-Preferred Option model*)



*Population projections incorporating expected births, deaths and migration plus future development expectations supplied by the London Borough of Barnet.

Source: Greater London Authority (Borough-Preferred Option)

Projected increase in Barnet child population from 2017, total and by age group (Borough-Preferred Option model)

	To 2020	To 2025	To 2030	To 2035	To 2040
0-4 yr	296	602	1234	1010	1088
5-9 yr	-108	-575	-25	9	-82
10-14 yr	2505	3790	3500	3648	3712
15-17 yr	1002	3407	3452	3531	3607
Total	3695	7224	8161	8199	8326

Source: Greater London Authority (Borough-Preferred Option population projection)

- Between 2017 and 2040, the total Barnet 0–17 yr population is expected to increase by over 8300, based on the Borough-Preferred Option model.
- The greatest increase is expected in 10–14 yr olds.

(Results not statistically assessed)

5. Notes on methods

Bar chart whiskers indicate 95% confidence intervals. These are based on statistical calculations, and mean that we can be 95% confident that the true value of the statistic (i.e. whatever is being measured) will fall somewhere within this range.

Comments on difference between values are based on statistical significance unless stated otherwise.

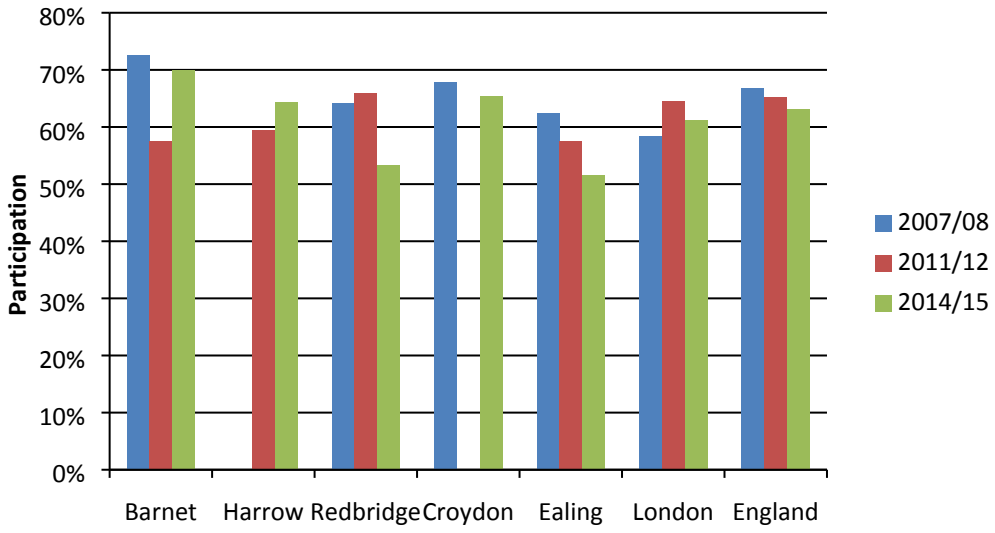
'Statistical neighbours' refers to the four London boroughs which are statistically closest to Barnet (Harrow, Croydon, Redbridge and Ealing), as calculated by the Chartered Institute of Public Finance Accounts (CIPFA) 'statistical neighbours' tool, default setting (based on factors such as population, age structure, income and illness rates).

Dental Public Health Epidemiology Programme

This survey uses a measure of decay which is widely accepted to under-represent the actual prevalence of disease. Participants were 5 year old children attending mainstream schools, and were ascribed to their local authority of residence. Children in the 2007/08, 2011/12 and 2014/15 surveys required the positive consent of their parents (i.e. the survey was 'opt in'), in contrast to earlier surveys.

In Barnet in 2014/15, only 70% of children invited to participate in the survey actually took part; this was better than averages for London (61%) and England (63%). Results for local authorities were weighted to more accurately reflect the distribution of deprivation in the area, so that results could be compared to other areas.

DPHEP participation rates* in Barnet, 4 statistical neighbours, London & England, for 2007/08, 2011/12 and 2014/15 surveys
(source: Public Health England (Dental Public Health Epidemiology Programme))



*The proportion of selected children who actually participated in the survey. DPHEP = Dental Public Health Epidemiology Programme.

Different rates of participation may bias (i.e. introduce systematic error into) dental measurement results collected from different areas. The researchers randomly selected children in each area to enter the survey. However, actual participation of those children required: (a) their parents to 'opt in' by giving written consent; (b) the child to be present at school on the day of dental examination; and (c) the child to agree to dental examination. Children who participated in the survey may have different dental health, as a group, compared with those who did not participate. Survey results from areas with low levels of participation (e.g. 50% or less) are more likely to be affected by this problem.

Breastfeeding

Between April 2013 and October 2015, breastfeeding data was collected and reported by NHS England (through Unify2 data collection tool), via maternity providers, midwives in acute trusts and information recorded at delivery. Previously, data has been directly requested from all Primary Care Trusts (PCTs) by the Department of Health.

Appendix B: Oral Health Supporting Data

In order for data to be validated and published, Public Health England (PHE) requires three criteria to be met:

- The number of mothers initiating breastfeeding combined with the numbers of mothers not initiating breast feeding should be equal to or less than the number of maternities submitted via Unify2
- The number of maternities submitted via Unify2 must be within +20% / -10% of the live births of that particular area.
- The total number of mothers for whom breast feeding status is unknown must be less than 5%

New breastfeeding at 6–8 weeks indicator from 2015/16: Since October 2015, data on breastfeeding at 6–8 weeks has no longer been collected by NHS England. Instead, data is collected by Public Health England (PHE), through an interim reporting system set up to collect health visiting activity data at a local authority resident level; data is submitted by local authorities on a voluntary basis (PHE, 'Breastfeeding at 6 to 8 weeks after birth: annual data'. https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-annual-data, viewed 1/9/17). Because of these changes in data collection, data for 2015/16 onwards is not comparable to earlier data. This move to residence based reporting requires joint working between neighbouring local authorities to ensure children on authority borders are included in the correct data return form. In 2015/16, data on breastfeeding at 6–8 weeks was published for only 72 out of 150 local authorities, as 78 failed PHE validation. No data is available for 2015/16 Barnet prevalence of breastfeeding at 6–8 weeks (i.e. using the new collection method), due to data quality issues.

6. References

Chartered Institute of Public Finance Accountants: Nearest Neighbours tool, 2017. http://www.cipfastats.net/resources/nearestneighbours/profile.asp?view=select&dataset=england

NHS Dental Statistics for England: Dental Activity, 2017. https://data.gov.uk/dataset/nhs-dental-statistics-for-england-units-of-dental-activity-by-ccg

NHS Digital: NHS Outcomes Framework, 2017. http://content.digital.nhs.uk/nhsof

Office for National Statistics: Census 2011, 2017. https://www.ons.gov.uk/census/2011census

Office for National Statistics: mid-year estimates (datasets), 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

Public Health England, 2015. The relationship between dental caries and obesity in children: an evidence summary. https://www.gov.uk/government/publications/dental-caries-and-obesity-their-relationship-in-children

Public Health England: Dental Public Health Epidemiology Programme, 2017. http://www.nwph.net/dentalhealth/

Public Health England: National Dental Epidemiology Programme for England: Oral health survey of five-year-old children: A report on the prevalence and severity of dental decay, 2016. http://www.nwph.net/dentalhealth/14_15_5yearold/14_15_16/DPHEP%20for%20England%20OH%20Survey%205yr%202015%20Report%20FINAL%20Gateway%20approved.pdf

AGENDA ITEM 9

Barnet Health Overview and Scrutiny Committee

4 December 2017

Title	Finchley Memorial Hospital Update
Report of	Barnet CCG
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix A – Finchley Memorial Hospital Update Report from Barnet CCG
Officer Contact Details	Anita Vukomanovic Anita.Vukomanovic@barnet.gov.uk 0208 359 7034

Summary

At its meeting in October 2017, the Committee considered a report from Barnet CCG which provide an update on the issues surrounding Finchley Memorial Hospital.

The Committee noted that the issues surrounding Finchley Memorial Hospital were still not yet resolved and requested to be provided with a further update report at its December 2017 meeting. The details of the discussion had at the Committee's October meeting are outlined in the minutes of the last meeting (Agenda Item 1 in this agenda pack)

The report provided at Appendix A provides this update report on Finchley Memorial Hospital. Representatives from Barnet CCG will be in attendance at the meeting and will be able to respond to questions from Members.

Recommendations

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

1. WHY THIS REPORT IS NEEDED

The Committee requested an update on the issue of Finchley Memorial Hospital.

2. REASONS FOR RECOMMENDATIONS

2.1 The report provides the Committee with the opportunity to be briefed on this matter.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 The views of the Committee in relation to this matter will be considered by the Health Overview and Scrutiny Committee.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.11 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 Not applicable.

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 There are no risks.

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.

5.6.3 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**

Not applicable.

6. BACKGROUND PAPERS

6.1 None.

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NHS
Barnet
Clinical Commissioning Group

Report to Barnet Health Overview and Scrutiny Committee – 4th December 2017

Update on plans for Finchley Memorial Hospital

1. Introduction

At the October 2017 meeting of the Health Overview & Scrutiny Committee (HOSC) Barnet Clinical Commissioning Group (CCG) reported on plans to improve the use and occupation of Finchley Memorial Hospital (FMH). HOSC members asked that the CCG report on progress to its following meetings to ensure that members were kept updated on the CCG's projects and their progress.

2. The CCG's priority projects to develop Finchley Memorial Hospital

As reported in October, the CCG's list of priority projects remain:

a) Open Adams Ward as a "Discharge to Assess" ward

b) Develop and open a new Breast Screening facility

c) Develop and open the Cancer project New CT Scanner facility

d) Develop a new service specification for a General Practice

e) Move the CCG headquarters from NLBP to FMH

In addition there is an ongoing focus on improving utilisation in the bookable spaces and clinical rooms.

This paper provides updates on these five projects and provides, where known, timelines.

3. Opening Adams ward

The CCG is working with Central London Community Health Services NHS Trust (CLCH) and Community Health Partnerships (CHP) – the Department of Health Company who holds the head lease and provides management services at FMH – to open Adams Ward as a "Discharge to Assess" ward. This will be a 17 bedded ward and will complement the rehabilitation ward with which it is co-located and will provide "discharge to assess" beds. These are for patients to be discharged whom no longer require acute hospital care but do require a period of further assessment and time for their discharge to be planned and put in place.

This is a complex project that involves multiple workstreams to get the ward operational eg furnishing, staffing, support services establishing catering and cleaning, etc. This project is proceeding well and is on target to open as planned in December 2017.

4. Develop and open the new breast screening facility

The CCG has been working with CHP & the Royal Free Hospital (RFH) North London Breast Screening Service to progress this project. At the previous HOSC it was clarified to the Committee that there were two outstanding issues which prevented opening a breast screening facility in FMH. These were:

- Securing the capital money to finance the conversion of the rooms
- Paying the rental cost for the space.

Significant progress has now been made in both of these areas. A conversion cost appraisal has been commissioned to identify the capital costs required to convert two consulting rooms into a new breast screening suite, changing cubicles, administrative space and waiting area. When this sum has been confirmed CHP will consider identifying the capital to pay for this work from a fund it has to support "transformational" projects. Confirmation that this funding has been secured still currently remains outstanding.

The Royal Free Hospital, which provides the North London Breast Screening Service, has confirmed its support to move into a new FMH Breast Screening Facility. The RFH believes doing this will provide a superior facility for patients and improve patients' experience and service satisfaction. The RFH has agreed to pay the rental costs for this facility.

NHS England, which commissions this service, has also confirmed its support for this change.

This change is now subject to CHP confirming the capital money to support the space conversion. If this can be confirmed this facility could be operational by May 2018.

5. Develop and open the cancer project new CT scanner facility

The CCG is working with University College Hospital to locate a CT scanner at FMH as part of a major research project to secure earlier diagnoses for lung cancer.

Barnet residents in the target group (heavy smokers) will be offered an enhanced package of services to those normally available on the NHS – specifically, a CT scan as part of a programme for preventative diagnosis.

As well as providing additional services to Barnet residents, the UCL CT scanner project will help the CCG financially by renting five clinical rooms that are currently empty.

The research project will fund the capital costs for the conversion and development of this facility and will also pay the rent for the space.

This facility is scheduled to be operational in May 2018.

6. High level project plan for developing the breast screening and CT scanning facilities

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Agree specification with UCL (CT Scanner)	14-Nov							
Agree specification with NLBSS (Breast Screening)	16-Nov							
Agree capital costs with CHP & LIFTCo		16-Dec						
Agree funding with UCL (CT Scanner)		08-Dec						
Agree funding with CHP (Breast Screening)		08-Dec						
Instruct lawyers to prepare legal agreements	16-Nov	Dec	Jan					
Formal approvals			31-Jan					
Let contract and commence construction				Feb	Mar			
Complete construction					31-Mar			
Commission new CT and Breast Screening equipment						April		
Commence new service							01-May	

7. General Practice

Since the last HOSC meeting the CCG's new Director of Care Closer to Home has developed a strategy to attract a General Practice into FMH. This builds on the CCG's Care Closer to Home strategy.

HOSC members will recall that the CCG's Chief Operating Officer explained that this hasn't been achievable historically because it was not considered a viable business opportunity for General Practice. However, the CCG is committed to exploring this one further time and is exploring a number of options.

This project is at the early stages of its development. The following timetable is indicative and subject to change.

General Practice Timeline

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
FMH Options paper - draft paper to be agreed														
Options to be considered by Primary Care Committee														
Clarification of requirements to apply e.g. rated good or above by CQC														
Discussions with local GPs/engagement														
Financial appraisal														
Expression of interest/market engagement														
Review of expressions of interest														
Appoint preferred provider														
Engagement with appointed provider														
Patient consultation														
Review of patient consultation														
Practice/s move (Work up move and associated actions)														moved by 1/12

8. Move the CCG headquarters to FMH

The option of whether the CCG headquarters could move to FMH is being explored. This project is currently at the scoping stage. Further detail will be provided to the Committee at the next FMH HOSC update.

9. Improving Utilisation

The CCG has previously reported to the HOSC that the workstreams outlined above are part of a broader project to improve utilisation of FMH.

As well as the priority projects the CCG is working with CHP to improve the building management by better managing utilisation and promotion of available space to other services and local community groups in line with the original vision for the building.

The CCG is also pleased that CHP has selected FMH as the site of a pilot project to develop a new, more agile centre management service, which will combine new technology and building management systems to collect more accurate utilisation and usage information. This will enable improved accurate booking and billing but also allow the CHP centre management team to proactively use spare space for other uses, often at short notice when spare space becomes available. In particular the CCG is keen to see the building used more intensively in the evenings and at weekends.

10. Review of Services at FMH and activity information

The following services are currently provided from FMH:

- Marjorie Warren Ward (34 beds) rehabilitation & assessment (Central London Community Health)
- Adams Ward (17 beds - *opening December 2017*) Discharge to Assess (CLCH)
- Walk-in Centre (CLCH)
- Diagnostics - X-Ray & Ultrasound (Royal Free), Phlebotomy (CLCH), Audiology (UCLH)
- Breast Screening (NL Breast Screening Service – Royal Free - currently mobile unit)
- Mobile MRI scanner (InHealth)
- Falls prevention and bone health clinic (CLCH)
- Chemotherapy & Infusion suite (12 chairs) (Royal Free)
- NHS Community Pharmacy
- Out of Hours (NHS111) GP centre

The following service lines are also provided:

Royal Free Outpatients	CLCH Outpatient Services	Other providers
Consultant Obstetrics	Podiatry	ENT (Concordia)
Gynaecology	Urology	Dementia café (vol sector)
Community Midwifery	Tissue Viability (leg ulcers)	Pregnancy Advisory Service (NUPAS)
Dermatology	Orthotics	
Women's Health counselling	Diabetes	
Cardiology	Biomechanics	
Elderly Falls Clinic	Stoma care	
Pain Clinic	Spirometry	
Neurophysiology	Dietetics	
Endocrine	Pulmonary Rehab	
Breast Oncology	Respiratory COPD	
Urology		
Orthopaedics		
Rheumatology		
Nurse Assessment (general)		
Physiotherapy		

Activity

There are approximately **200,000 patients using FMH each year**.

Approximately 750 each weekday and 100 each day at the weekends.

This includes 56,778 patients attending the phlebotomy service and 56,656 patients attending the Walk-In Centre.

11. Summary

The CCG has made significant progress improving the occupation and utilisation of FMH so that it is now becoming the key strategic healthcare asset that it was always intended to be.

As well as the activity figures listed above, the unoccupied areas of the building are now being addressed and – once the new Adams Ward opens in December – the percentage of the hospital let to service providers will rise from 75% to 89%.

Prepared by Barnet CCG

November 2017

London Borough of Barnet Health Overview and Scrutiny Forward Work Programme December 2017 – May 2018

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

AGENDA ITEM 10

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
December 2017			
Deep dive of children's dental health in Barnet	Committee to receive a report from Public Health on Children's Dental Health in Barnet	Public Health (Barnet)	**Non-Key**
Quality Accounts: Mid Year Review	Committee to receive a mid year update on the work undertaken against the comments made on the Quality Accounts of the following organisations for the year2016/17: - CLCH - North London Hospice - Royal Free	NHS Trusts and North London Hospice	**Non-Key**
Finchley Memorial Hospital Update Report	Committee to receive a report from Barnet CCG on the full utilisation of Finchley Memorial Hospital	Barnet CCG	**Non-Key**
February 2018			
Thrive LDN - Government's response to the Health Select Committee enquiry into Suicide Prevention paper	Committee to receive a report from Public Health on Thrive LDN - Government's response to the Health Select Committee enquiry into Suicide Prevention paper	Public Health Team	**Non-key**

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
Update Report: Finchley Memorial Hospital	Committee to receive an update report as a standing item on Finchley Memorial Hospital	Barnet CCG	**Non-key**
To be allocated			
Enter and Revisit reports	Report on the enter and revisit reviews by Healthwatch.	Healthwatch Barnet	**Non-key**
STP	Committee re receive an update report regarding the Sustainability and Transformation Plan	TBC	**Non-Key**
Barnet Hospital Car Park	Committee to receive an update on the car parking situation at Barnet Hospital	Royal Free London NHS Foundation Trust	**Non-Key**

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