MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 5TH FEBRUARY, 2018

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

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

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting 10am, Wednesday 31st January. Requests must be submitted to Anita Vukomanovic anita.vukomanovic@barnet.gov.uk, 020 8359 7034

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

Andrew Charlwood – Head of Governance

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

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	5 - 14
2.	Absence of Members	
3.	Declaration of Members' Interests	
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5.	Public Question Time (If Any)	
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Decisions of the Health Overview and Scrutiny Committee

4 December 2017

Members Present:-

AGENDA ITEM 1

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

Councillor Philip Cohen
Councillor Rohit Grover
Councillor Alison Moore
Councillor Ammar Naqvi
Councillor Caroline Stock
Councillor Laurie Williams
Councillor Shimon Ryde

Also in attendance:

Councillor Helena Hart

Apologies for Absence:

Councillor Val Duschinsky

1. MINUTES (Agenda Item 1):

The Chairman introduced the minutes of the last meeting and noted that the Committee had been e-mailed a copy of the Enforcement Notice relating to the land adjacent to Finchley Memorial Hospital.

The Chairman noted that the Committee would receive a further update from the Royal Free on parking at Barnet Hospital during the meeting.

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

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from Councillor Val Duschinsky who was substituted by Councillor Shimon Ryde.

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

Councillor Alison Moore declared a non-pecuniary interest in relation to Agenda Item 8 (Children and Young People's Oral Health in Barnet) by virtue of being the Chair of the East Central Early Years Locality Advisory Board.

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):

At the invitation of the Chairman Councillor Cohen introduced his Member's Item. He noted that the item suggested that future papers produced by the Council on policy matters should have a section which specifically considered Health and Wellbeing. He explained that a housing policy paper could, for example, also consider wider Health and Wellbeing matters such as GP services and leisure. Councillor Cohen suggested that the Committee could receive a paper on how this could work. The Vice Chairman informed the Committee that he was sympathetic to the points that Councillor Cohen raised and noted that, as the matter had cost implications and was cross cutting, Policy and Resources Committee should be asked to consider it.

Following the consideration of the Member's Item, the Committee:

RESOLVED to ask Policy and Resources Committee to consider the issue contained in the Member's Item as set out above.

7. NHS TRUST QUALITY ACCOUNTS: 6 MONTH REVIEW (Agenda Item 7):

The Chairman introduced the report which provided a mid-year update on the progress made following the receipt of the Committee's comments on the Quality Accounts for the following organisations:

- North London Hospice
- Central London Community Hospital
- The Royal Free London NHS Foundation Trust

The Governance Officer advised the Committee and the representatives of the organisations listed above:

"The National Health Service (Quality Accounts) Regulations 2010 is the relevant piece of law that outlines the requirements for the management of Quality Accounts. It says that HOSCs are required to submit their comments on Quality Accounts for inclusion prior to the Account being published. The deadline for this is 30 June.

Ordinarily, Barnet's HOSC has always sought to send the Committee's comments to the organisations as early as possible. We understand that it is a complex and timely process to produce a Quality Account and that organisations also need to make allowances for their own internal deadlines. However, in May 2018, all Members of the Council will be up for re-election and, as such, they cannot be appointed to Committees until the first meeting of the Full Council. In Barnet's case, this is scheduled to be on Tuesday 22 May. We expect that Barnet HOSC will meet on Thursday 24 May to consider the Quality Accounts, which means that we can draft the comments the following day and ask to Members to review them over the Bank Holiday weekend. We can provide the comments to the Organisations at around lunchtime on Tuesday 29 May. This is later than we would normally submit comments for inclusion within the Accounts, although technically comments submitted up to 30 June are required to be included.

Please be advised therefore that we will be unable to provide you with comments at the usual earlier date.

This is something that will affect all HOSCs in London and so I wanted to take the opportunity to flag this in front of senior Health colleagues from all relevant organisations six months in advance, so that you have time to prepare.

I will contact each organisation outside the meeting about this information. However, I wanted to put this on record at this meeting for the purposes of good governance."

North London Hospice:

The Chairman invited the following to the table:

- Miranda Fairhurst - Assistant Director Quality
- Fran Deane - Director of Clinical Services

Ms. Deane referred to the Hospice's "Hard to Reach Groups" programme, which aims to promote equal access to services for all potential users. Ms. Deane noted that this was a priority for improvement and that the Hospice had been receiving data within all three Boroughs that the Hospice serves.

Ms. Deane noted the when the Committee had reviewed the Hospice's Quality Account last year, they had been informed about the introduction of an "Outcome Star", currently named the "End of Life Star". Ms. Deane informed the Committee that this work had been slightly delayed as the Hospice was waiting for NHS Ethics approval but it was hoped to obtain approval in the new year.

Ms. Deane advised the Committee that a multi-professional group comprised of all hospice professions had been doing work to map their current provision against the Hospice UK Document on Hospice Enabled Dementia Care to inform its Dementia Strategy.

The Chairman asked what proportion of patients at the Hospice had Dementia at any one time. Ms. Deane informed the Committee that the Dementia rate was lower at the In-Patient Unit as the approach for Dementia patients tended to be about providing care at home as it was normally a more suitable environment. The Committee noted that about 7% - 8% of Hospice patients had Dementia at any one time.

The Chairman noted that last year the Committee had expressed concern about the large number of staff leaving the Hospice. Ms. Deane advised the Committee that some clinical staff were retiring and that the Hospice looked for ways to promote staff internally. Ms. Deane also informed the Committee that an Assistant Director for the Inpatient Unit had been recruited to post.

Responding to a question from the Chairman, Ms. Deane advised that when a member of staff left the Hospice, they would complete a face to face interview with HR.

The Chairman questioned what action the Hospice had taken on avoidable pressure ulcers. Ms. Deane informed the Committee that the Hospice identifies both inherited and acquired Stage 1 pressure ulcers, as well as Stage 2, 3 and 4, which allowed the Hospice to understand how ulcers have been obtained. Ms. Deane advised that the

Hospice was also looking at sourcing alternative pressure-relieving mattresses following feedback from patients.

Central London Community Healthcare:

The Chairman invited to the table:

- Kate Wilkins - Assistant Lead for Quality

The Vice Chairman commented that the North Central London Joint Health Overview and Scrutiny Committee had become aware that one of the strands of the Sustainability and Transformation Plan (STP) is for health providers and organisations to work closer together on recruitment and retention strategies. The Vice Chairman noted that CLCH covered four STP areas and asked if that made recruitment and retention more complex for the Trust. Ms. Wilkins advised that recruitment is a huge problem across London and that CLCH is part of the Capital Nurse Programme. Ms. Wilkins explained the role of the Capital Nurse Programme in attracting new nurses. The Committee noted that the Trust was able to offer rotation around different areas of nursing and then provide a job offer at the end. She offered to provide the Committee with further information on the Capital Nurse Programme.

A Member commented that some factors impacting on recruitment and retention would be out of the control of the Trust and asked if retention would be a cheaper option that the Trust would have more control over. Ms. Wilkins agreed.

A Member asked what the Trust's biggest challenge was in terms of retaining staff. Ms. Wilkins said that the organisation had vacancies. Boroughs such as Barnet only pay the outer London weighting rather than the higher inner London weighting, making it harder to recruit and retain staff. Ms. Wilkins undertook to provide the Committee with statistics on nurse retention.

The Chairman noted that Barnet, Enfield and Haringey Mental Health Trust went to Middlesex University to recruit and questioned if CLCH worked with universities. Ms. Wilkins advised that the Trust did.

The Chairman noted that last year the Committee suggested that face to face exit interviews be offered to all members of staff when they leave and that CLCH are now reporting that exit interviews are offered to outgoing staff either with their manager or with HR. The Chairman asked if the Committee could be provided with the percentage of staff that took up the option to either attend an interview or complete a questionnaire. Ms. Wilkins undertook to see if this information was available.

The Chairman noted that the Quality Account for last year had reported that the Trust had not taken part in the Diabetes Footcare Audit due to administrative reasons. She inquired if this had been dealt with. Ms. Wilkins advised the Committee that the Audit had not taken place last year due to a member of staff leaving. Ms. Wilkins reassured the Committee that the Audit would definitely take place this year.

Royal Free London NHS Foundation Trust:

The Chairman invited to the table:

- Professor Powis - Chief Medical Officer, Royal Free London Group

The Chairman congratulated Prof. Powis on his recent appointment as the Medical Director of NHS England and noted that he would take up the post in January 2018.

The Vice Chairman welcomed the work undertaken by the Trust on Cardiotocography (CTG) and said that he would be keen to see further information on this in the Trust's next Quality Account.

A Member questioned how the Trust was performing in relation to four hour waits at A&E. Prof. Powis reported that Barnet Hospital had been performing very well over the last four weeks and was recently tracking around 85% to 90%. Prof. Powis praised the work of the new Executive Team at Barnet and the new work being done by Social Care colleagues to discharge patients. The Committee were pleased to note that Barnet Hospital's performance had improved upon last year's figures. Prof. Powis informed the Committee that recently the Royal Free Hospital had not performed as well and had seen statistics in the lower 80s percentage wise. The Committee noted that the Royal Free Hospital had had significant building work in the last couple of months which was likely to have affected this result to some extent.

A Member noted the Trust's priorities for 2017/18 included the recruitment of 30 patient and family experience partners and questioned the role of a "partner" Prof. Powis undertook to provide further information on this.

A Member asked what more could be done to prevent patients going to A&E unnecessarily. Prof. Powis noted that GPs are also under a huge amount of pressure and if patients could not access their GP then they would go to A&E. Prof. Powis stressed the importance of educating people about different pathways, such as using the 111 Service.

The Chairman noted that the Committee had received a report on the use of "Streams" at their last meeting and congratulated the Royal Free on their excellent work in that area.

The Chairman noted that the Trust had stated that they needed to do work to compare the numbers of C.Diff. cases with other hospitals with similar complex cases and inquired if this work had been done yet. Prof. Powis advised that work was ongoing.

Responding to a question from the Chairman, Prof. Powis noted that as of the end of October 2018, there had been 47 cases of C.Diff. across the Trust against a target of 39 cases. Prof. Powis undertook to provide the Committee with the C.Diff. root cause analysis.

Responding to a question from a Member on the priority for 2017/18 of "To systematically analyse the experience of bereaved families and friends", Prof. Powis undertook to provide further detail of the web-based survey which is going to be launched.

The Chairman noted that the Committee had received an encouraging update on the parking situation at Barnet Hospital from Dr. Steve Shaw at their last meeting. The Chairman advised that the Portacabins were due to be removed which would free up additional space for parking.

The Chairman informed the Committee that there was a plot of land on site which she believed could accommodate 80 – 100 parking spaces and that also there was a section

of waste land and some grass verges that she believed could accommodate additional parking. She informed the Committee that she was still receiving complaints and that the matter would not improve unless serious attention was given by the Management to provide additional parking spaces on site.

RESOLVED that the Committee noted the three reports and requested the information as set out above.

8. CHILDREN AND YOUNG PEOPLE'S ORAL HEALTH IN BARNET (Agenda Item 8):

The Chairman invited to the table:

- Councillor Helena Hart – Chairman, Barnet Health and Wellbeing Board
- Natalia Clifford - Consultant in Public Health
- Selina Rodrigues, - Manager, Healthwatch Barnet

Councillor Hart introduced the report which provided information on the oral health of children and young people in Banet and which also outlined opportunities to decrease rates of decay in children. Councillor Hart informed the Committee that the report highlighted two key issues, which were prevention and treatment.

Councillor Hart informed the Committee that NHS Practices rarely recall patients in order to monitor their dental health as Practices would need to have a sufficient number of unused Units of Dental Activity (UDAs) available to do so. She highlighted the importance of dental ill-health in being an indicator in safeguarding matters. She regretted that patients no longer register with an individual Practice but present for treatment wherever they can find a Practice willing to treat them. This could lead to the loss of the background knowledge so necessary for good safeguarding. Councillor Hart expressed concern that sufficient UDAs are not uniformly available across the Borough.

Referring to the Report, Councillor Hart noted the “Starting Well: A Smile4Life” programme initiated by NHS England to reduce oral health inequalities and improve oral health. NHS England (London Region) would also be working with Public Health England to identify five Boroughs to promote dental access. Councillor Hart suggested that the Committee work with the Council’s Public Health department to assist in the Borough being chosen as one of the five pilot Boroughs. Members of the Committee expressed their support for Barnet putting itself forward as a pilot Borough.

Ms. Rodrigues welcomed the report and advised that Healthwatch Barnet would be very happy to support any such work. She informed the Committee that mystery shopping had shown that it was very hard for patients to get an NHS dental appointment within two weeks. She advised that this also created a barrier for parents with one year old children.

Ms. Clifford informed the Committee that one of the challenges facing dental care is that level of UDAs had not been increased for many years despite the significant increase in the population.

The Chairman noted that NHS England confirmed that Barnet utilised 98.5% of their UDAs and so utilisation is not an issue in Barnet. Councillor Hart advised that one of the problems is that there is no mechanism to move unused UDAs between Practices.

A Member asked if it would be possible to write to NHS England to request a change in the policy so that unused UDAs can be transferred between Practices.

A Member suggested ensuring that Children's Centres and Health Visitors are informing pregnant and new mothers of their entitlement to free NHS Dental care.

Responding to a question from a Member, Ms. Clifford noted that the requirements for the pilot included a need within the Borough, buy-in, and leadership and that Barnet had all three. She informed the Committee that it would cost £59,000 to fund the service and that, subject to receiving approval from Policy and Resources Committee on 5 December, it could be funded.

A Member suggested that Public Health should consider the possibility of commissioning mobile dental units to go into schools and learning centres. She informed the Committee that a dental bus programme was sponsored by Colgate in California where a bus went to schools.

A Member expressed concern about the impact of sugary drinks being sold in schools on young people's dental health.

The Chairman suggested that the Barnet Health Overview and Scrutiny Committee write to NHS England in order to:

1. Welcome the fact that five Boroughs will be chosen as Pilot Boroughs and put the case for Barnet to be one of them.
2. Suggest that NHS England consider the impact of population change on the level of UDAs and suggest that, in addition to the number being increased, they should consider allowing unused UDAs to be transferred between Practices.

A Member suggested that the letter should focus on supporting the bid that Barnet would make, as well as stressing the multidisciplinary work that had been done and the deep dive.

The Chairman suggested that Ms. Clifford draft a letter in collaboration with Ms. Rodrigues and Councillor Hart and that, once it is drafted, Governance circulate the letter to the Committee to review before it is sent.

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

9. FINCHLEY MEMORIAL HOSPITAL - UPDATE REPORT (Agenda Item 9):

The Chairman invited the following to the table:

- Dr. Debbie Frost - Chair, Barnet CCG
- Kay Matthews - Chief Operating Officer, Barnet CCG
- Alan Gavurin - FMH Programme Manager, Barnet CCG

Ms. Matthews introduced her report and noted that when Barnet CCG had last attended Committee, they had outlined their progress in relation to five key strategic pieces of work to make Finchley Memorial Hospital what it should be: a centre for excellence and a key strategic asset.

Ms. Matthews provided an update on the key pieces of work, which included:

Adams Ward:

- Adams Ward had opened on 4 December 2017 and the first five patients would be admitted in the first week rising to the full complement of seventeen patients within the first two weeks. The Committee noted that CLCH had assisted in opening Adams Ward by putting in staff and services.

Breast Screening Unit:

- Significant work has been undertaken in order to develop and open the new breast screening facility. The CCG has been working with Community Health Partnerships (CHP) and the Royal Free Hospital (RFL) which runs the North London Breast Screening Service. The main issues had been whether CHP would provide the capital costs and if NHS England would support this move. The CCG is optimistic about opening the facility but is still awaiting final confirmation by all parties before confirming that development of the new unit is going ahead. The CCG and RFL are aiming to open the new Breast Screening Unit in May 2018.

- During the discussion of the above, the Chairman asked if it would be helpful for the Committee to intervene or to invite CHP to a future meeting of the Committee. Ms. Matthews advised that she would contact the Chairman if she considered that it would be useful.

Develop and open the new CT scanner facility:

- Agreements had been reached on the cost of transformation work for a new CT scanner as part of a UCLH research project and that the CCG was waiting on signatures to finalise arrangements. The Committee was advised that the CCG is optimistic about this project and hopes the facility will be opened in May 2018 as planned.

General Practice:

- Since the Committee's last meeting, the CCG's new Director of Care Closer to Home is developing a strategy to attract a General Practice into FMH. The Committee noted that the project was running according to the timeline set out in the report.

Movement of the CCG headquarters from North London Business Park to FMH:

- The CCG have been scoping the possibility of moving the CCG's Headquarters to vacant office space on the 2nd floor at Finchley Memorial Hospital and will report back on the progress of this piece of work when they next attend the Committee.

Improving Utilisation:

- Finchley Memorial Hospital has been identified by CHP to be the site of a pilot project to develop a new centre management service, which will combine new technology and building management systems to collect more accurate utilisation and usage information.

- A Member welcomed the update and inquired if there was a strategy for attracting a General Practice to the site. Ms. Matthews advised that the CCG was at the early stages of a strategy. Responding to a question, Ms. Matthews informed the Committee that the CCG would be looking to bring more services into the community and wrap them around the GP services. The Committee noted that a highly performing GP Practice would be needed.

- Referring to an earlier part of the update, the Chairman noted that Adams Ward had been opened in time for winter pressures and asked if the Ward would now be kept open permanently. Ms. Matthews confirmed that it would.

The Chairman commented that this latest update from the CCG had been a more positive one.

A Member noted that the Government was announcing new targets for access to mental health services and questioned how challenging this would be for the CCG to meet. Dr. Frost informed the Committee that the CCG would be asking Barnet, Enfield and Haringey Mental Health Trust to make early interventions in Psychosis. Ms. Matthews noted that the target focused around waiting time targets and that it would a hard, but good, target.

RESOLVED that the Committee noted the report.

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

The Chairman invited to the table:

- Selina Rodrigues, Manager - Healthwatch Barnet.

Ms. Rodrigues informed the Committee that Healthwatch Barnet had been undertaking some work with their charity partners on adult social care and also a review on mealtimes at the Royal Free Hospital. The Committee noted that Healtwatch Barnet had just finished their first year on a piece of work with Patient Participation Groups. The Chairman requested that Healthwatch Barnet bring a report to the February 2018 meeting to cover:

- Patient Participation Groups
- Cancer Screening
- Mealtimes at the Royal Free Hospital.

A Member noted that the Committee was due to receive a report on the STP in the context of key worker housing and requested it was received at the next possible meeting. The Governance Officer in attendance undertook to arrange for the report to be received as soon as possible.

RESOLVED that the Committee noted the Forward Work Programme.

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

The meeting finished at 21:54

AGENDA ITEM 6a

Health Overview and Scrutiny Committee

5 February 2018

Title	**Member's Item in the name of Councillor Alison: Breastfeeding Support Services in Barnet**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	None
Officer Contact Details	Anita Vukomanovic – Governance Team Leader Email: anita.vukomanovic@Barnet.gov.uk Tel: 020 8359 7034

Summary

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

Recommendations

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

1. WHY THIS REPORT IS NEEDED

1.1 A Member of the Committee has requested that the item tabled below is submitted to the Health, Overview and Scrutiny Committee for consideration and determination. The Committee are requested to provide instructions to Officers of the Council as recommended.

Councillor	Member's Item
Alison Cornelius	Please may the Health Overview and Scrutiny have an update on the situation regarding the provision of breast feeding support services in Barnet.

2. REASONS FOR RECOMMENDATIONS

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

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

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

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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

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

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 The Council's Constitution (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 Risk Management

5.4.1 None in the context of this report.

5.5 Equalities and Diversity

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

5.6 **Consultation and Engagement**

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 24TH NOVEMBER, 2017** at 10.00 am in Enfield Civic Centre, Silver Street, Enfield EN1 3XA

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Martin Klute (Vice-Chair), Alison Cornelius, Abdul Abdullahi, Jean Kaseki, Samata Khatoon, Graham Old and Anne Marie Pearce

MEMBERS OF THE COMMITTEE ABSENT

Councillor Charles Wright

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

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Charles Wright and apologies for lateness were received from Councillor Samata Khatoon.

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Pippa Connor declared the she was a member of the RCN and that her sister worked as a GP in Tottenham. Councillor Alison Cornelius declared that she was a trustee of the Eleanor Palmer Trust, which operated a care home in Barnet.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of any items of urgent business.

5. MINUTES

Consideration was given to the minutes of the meetings held on 19th September and 22nd September 2017.

RESOLVED –

(i) THAT the minutes of the meeting held on 19th September 2017 be approved as a correct record;
(ii) THAT the minutes of the meeting held on 22nd September 2017 be approved as a correct record.

6. DEPUTATIONS

The Committee heard from a deputation led by Dr Kate Middleton on the LUTS (lower urinary tract symptoms) service.

Dr Middleton stated that the LUTS clinic had stopped taking on paediatric patients. This meant that children were missing out on treatment they could have had. She said that the LUTS patients' group had been contacted by parents who were concerned about their children's infections, which were not responding to other treatments.

Siobhan Harrington, the Chief Executive of the Whittington, responded to the deputation. She reiterated the Whittington's commitment to re-opening the clinic to new patients. However, she said that the treatments Professor Malone-Lee had been offering had not been recognised as evidence-based. She said that there needed to be a proper national research study to develop an evidence base.

Councillor Klute asked whether the adult pathway would be in partnership with UCLH. Ms Harrington said that it would be.

Members asked what would be required for the clinic to re-open. Ms Harrington said the Board and the commissioners would have to be satisfied about safety and governance.

Members queried the differing approaches being taken to adult and children's treatment. Ms Harrington said that Professor Malone-Lee had said he would not treat child patients. The deputees said that this was as a result of the restrictions imposed upon him by the Medical Director at the Whittington Hospital. Ms Harrington responded that the guidance from the RCP (Royal College of Physicians) report had been that children be treated under the guidance of a paediatrician in a tertiary setting such as Great Ormond Street Hospital.

Members noted that organisations other than the Whittington would need to be involved in re-starting the service for new patients and that Paul Sinden, the Director of Performance and Acute Commissioning for North Central London, was responsible for the commissioning of the service. They decided to request that service commissioners and representatives of Great Ormond Street Hospital be

invited to attend a future meeting of the Committee to discuss their approach to the LUTS service.

RESOLVED –

(i) THAT the deputation and comments above be noted;

(ii) THAT Great Ormond Street Hospital and commissioners be invited to attend the JHOSC to discuss the LUTS service.

7. WORKING TOGETHER IN NORTH LONDON TO ADDRESS SOCIAL CARE CHALLENGES

Sanjay Makintosh (Programme Lead, North London Councils) and Dawn Wakeling (Director of Adult Social Services, LB Barnet, and Strategic Director for Adults in the NCL STP) addressed the Committee and spoke to their presentation.

They highlighted that there were major social care challenges nationally, and there were staffing shortages which were particularly significant in London.

Mr Makintosh said that there was a drive to secure more nursing home provision. However, one of the difficulties in securing this was the difficulty in recruiting registered nurses to work in nursing homes. There were schemes in place to encourage people with foreign qualifications to sit for UK ones to enable them to be registered.

Councillor Connor commented that although hospitals were keen to move people out of hospital and into care homes, CCG funding often did not move with the patient in sufficient quantities to fund this. She said that care homes were in danger of closing due to insufficient funds, while there was marked demand for their services.

Councillor Cornelius commented that the organisation she was a trustee of was considering turning its care home into a nursing home, as it was running a deficit due to the low price paid for care home provision.

It was noted that the recent budget had allocated £2.8 billion extra to the NHS, with £300 million available for this winter; however officers were not sure yet as to what this would mean in terms of funds for use in North Central London.

Members noted that there had been a decrease in care home beds in Barnet. Officers said that this had been for a number of reasons, including CQC intervention. Councillor Old said that at one point there had been talk of a planning policy in Barnet to restrict the construction of new care homes in the borough due to the pressure they placed on other services. Additionally, due to the greater number of bed spaces available in outer London boroughs such as Barnet, other local authorities placed people from their borough into Barnet care homes.

Members asked about people being discharged from hospitals to go home and whether they were able to be discharged with the relevant equipment. Ms Wakeling said that there was a community equipment service which was jointly funded by the Council and the CCG. Ms Wakeling stated that provision of equipment was not driving delays. People were more likely to be waiting for a home care package to be arranged or for a residential care place. Of particular relevance was the lack of Occupational Therapists who were able to assess the needs of patients. A member commented that there had been an underspend in the community equipment fund in their borough, and said this may have been in part because of the delays in people being assessed as to what equipment they needed.

Members commented that they would like to hear more about social care finances as well as nursing and care homes, workforce planning and the strategic approach being taken in the sub-region.

RESOLVED –

(i) THAT the presentation and the comments above be noted;

(ii) THAT a report come to the JHOSC in six months' time with information about finances, nursing homes, care homes, workforce planning and the strategic approach being taken across the sub-region.

8. PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS

Consideration was given to a report on draft principles of consultation and to a draft consultation paper on Procedures of Limited Clinical Effectiveness (PoLCE).

Will Huxter, Director of Strategy for the North Central London (NCL) Clinical Commissioning Groups (CCGs), introduced the reports. Members commented that they welcomed the principles but had concerns about how information could be conveyed to patients about consultations. There was a danger that the CCGs only heard from a small number of people or groups otherwise.

Members noted that there was a duty on health bodies to consult with health scrutiny committees over a 'substantial variation' of services, and this had to be done over a fixed timescale. If they were unable to resolve their differences with the health bodies over their proposals, health scrutiny committees possessed the power to refer proposals for substantial variations to the Secretary of State.

Members from Enfield reported that Enfield CCG was moving ahead with PoLCE – but that three treatments included in the PoLCE scheme beforehand had been removed. A member of the public commented that they had not been removed but deferred.

Mr Huxter and Jo Sauvage (Chair of Islington CCG and Co-Clinical Lead for North London Partners in Heath & Care) said that each borough's CCG was able to progress PoLCE matters in its own way. However, officers in North Central London wanted to avoid inconsistency and so the other four boroughs would have a similar approach to Enfield. They were simply at an earlier stage in the pre-consultation process than Enfield CCG was.

Members noted that the procedures in the original Enfield document which had been removed in the later one were knee replacements, hearing treatments and scarring treatments. Mr Huxter said that if these procedures were to be added back to the PoLCE list, officers would bring it to the relevant scrutiny body.

Members expressed disappointment with the fact that Enfield seemed to be proceeding more rapidly than the other four boroughs with this. They wanted the CCGs to work together to the same timescales. Mr Huxter undertook to raise their concerns with Enfield CCG.

Members of the public present made a number of comments. They said that mention should be made of the financial factors that were causing increasing attention being given to preventing procedures deemed as of limited effectiveness; they also wanted to see the amount of money that would be saved by adding each treatment to the PoLCE list, and to see figures on the number of people who would be affected and how severely. There was also a request for Equalities Impact Assessments (EIAs) to be produced, as there were concerns that disadvantaged groups could be affected negatively by this policy.

Members emphasised the importance of the PoLCE consultation document being in plain English if it was to go to the general public. They expressed the view that defining whether a procedure was of limited clinical effectiveness was a medical question, not a matter that the public or councillors would be able to meaningfully comment on. They asked about the medical opinions sought on this.

Dr Sauvage said that there were differing levels of medical evidence on the PoLCE procedures. The proposals had gone to the Health & Care Cabinet to get their medical views. There was also someone from the National Institute for Clinical Excellence (NICE) at that meeting. Members asked if the PoLCE guidance would differ from the NICE guidance and, if so, why.

Members asked if referral managers were involved in the process. Dr Sauvage said different CCGs had different methods of handing referrals. However, the aim was to ensure consistency amongst GPs and to encourage them to broach the issue of non-surgical interventions with patients.

Members wanted to see effort made to obtain the views of a range of GPs on the PoLCE policy and their professional views on why there was 'undue variation' in the approach taken to these procedures. Members also wanted to see engagement with

community and voluntary sector organisations and efforts made to contact hard-to-reach groups if the public were being consulted.

Members had significant concerns about the draft consultation paper and the approach being taken by the CCGs. They asked that information come back to the JHOSC about the views of GPs and the EIAs for the proposals. This might be able to take place at the March meeting or it might require a special meeting to be called to fit in with the 12-week timescale for formal consultations if a formal consultation was initiated. In addition, they wished to receive the outcome of the response of the public consultation before agreeing their response, and this would need to be arranged following the end of the consultation period.

RESOLVED –

(i) THAT the reports and the comments above be noted;

(ii) THAT a report come back to the JHOSC giving the views of GPs and the information from Equality Impact Assessments on the PoLCE proposals.

9. ESTATES STRATEGY

Consideration was given to a report on the NHS estate in North Central London.

The Chair expressed disappointment with the lack of information in the paper. Another member commented that the appendix was 18 months old and that he hoped matters had moved on since then.

Members expressed concern that the Whittington seemed to be taking its own individual approach to estates, as did the Camden and Islington NHS Foundation Trust. They wanted to see more alignment of the estates strategies of different organisations.

Members said that they wanted to see a link between NHS estates and the housing strategy. They were concerned about the need to improve the provision of housing for staff and residents.

Councillor Klute expressed concern that the Department for Health was presuming that £2 billion of estates would be sold. This seemed a high target.

The Chair commented that she welcomed the commitment David Sloman had made at a previous meeting that the Royal Free NHS Foundation Trust would be reinvesting the revenue from land sales.

Officers highlighted that a memorandum of understanding had been reached on estates devolution, which would mean that revenue from the sale of NHS estate in

London, even if it was not owned by foundation trusts, could be used within the capital.

Members of the public spoke on this item. One individual expressed disappointment that the report did not mention the Naylor Report. He said there was pressure for sales of NHS land and buildings in London because of the high land values in the city. He argued that surplus NHS estate should be used for primary care facilities or for affordable housing. There was concern that only 14% of the housing on the St Ann's site would be 'affordable housing'.

Members wanted to see senior Local Authority officers having a 'greater line of sight' into the NHS estates process. They did not feel this was happening at the moment.

The Committee wanted to see a more detailed report on estates at its January meeting.

RESOLVED –

(i) THAT the report and the comments above be noted;

(ii) THAT a report come to the 26 January 2018 JHOSC meeting on the NHS estate in North-Central London.

10. WORK PROGRAMME

Consideration was given to the Work Programme report.

Members agreed that the agenda items for the January 2018 meeting would be:

- Risk Register
- NHS estates
- LUTS services (involving Great Ormond Street and commissioners)

Councillor Kelly would lead on the risk register and estates items and Councillor Klute would lead on the LUTS item.

Items for the March meeting would be:

- Ambulance Services
- Joint Commissioning
- Adult Social Care
- PoLCE consultation (if available at that time and if a special meeting is not required for it).

Councillor Abdullahi would lead on ambulance services, Councillor Kelly on joint commissioning and Councillor Connor on adult social care.

It was suggested that the July 2018 meeting have items on GP services in care homes and the NHS 111 out-of-hours service.

RESOLVED –

THAT the amended work programme be agreed.

11. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no other items of business.

12. DATES OF FUTURE MEETINGS

Future meetings of the JHOSC will be on:

- Friday, 26th January 2018 (Camden)
- Friday, 23rd March 2018 (Islington)

The meeting ended at 1pm.

CHAIR

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

MINUTES END

Decisions of the Health & Wellbeing Board

9 November 2017

Board Members:-

AGENDA ITEM 8

*Cllr Helena Hart (Chairman)
*Dr Debbie Frost (Vice-Chairman)

* Kay Matthews	* Chris Munday	* Cllr Reuben Thompstone
* Dr Charlotte Benjamin	* Cllr Sachin Rajput	Dawn Wakeling
* Dr Andrew Howe	* Ceri Jacob	Dr Clare Stephens
* Mathew Kendall (substitute)	* Julie Pal (substitute)	Chris Miller
		Selina Rodrigues

* denotes Member Present

1. MINUTES OF THE PREVIOUS MEETING (Agenda Item 1):

Councillor Helena Hart, Chairman of the Health and Wellbeing Board opened the meeting and welcomed all attendees including representatives from People's Choice, Inclusion Barnet and Barnet Mencap.

Matters arising from the previous minutes:

- The Chairman noted that following submission to NHS England, the Better Care Fund Plan has received full approval by NHSE and she thanked the Joint Commissioning Team for its work in producing the plan.
- She welcomed Ms Ceri Jacob NHSE to this meeting. Ms Jacob informed the Board that Mr Danny Batten has been appointed as her formal substitute on the Health and Wellbeing Board.

It was RESOLVED that the previous minutes of the Health and Wellbeing Board meeting held on 14th September 2017 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from:

- Ms Dawn Wakeling, as she was chairing the London Safeguarding Adults Board. She was substituted by Mr Mathew Kendall
- Ms Selina Rodrigues who was substituted by Ms Julie Pal
- Dr Clare Stephens
- Mr Chris Miller

Since the previous meeting, it was noted that Mr Chris Miller had stepped down both as Chairman of the Barnet Safeguarding Children's Board (BSCB) and of the Safeguarding Adults Board (SAB). The Chairman on behalf of the Board thanked Mr Miller for all his contributions and wished him well for the future.

The Chairman announced that the BSCB has been renamed as the Barnet Safeguarding Children's Partnership. She informed the Board that Mr Andrew Fraser has been

appointed as the Chairman of the Barnet Safeguarding Children's Partnership. The Board noted that Mr Fraser will be invited to join the HWBB as an Observer-Member with speaking rights. (**Action**)

The Chairman of the Safeguarding Adults Board is yet to be appointed but will also be invited to join the HWBB as an Observer-Member once appointed.

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

Councillor Helena Hart declared a personal non-pecuniary interest in relation to Care Closer to Home - which is referred to under Item 6, JHWBS Implementation Plan and includes reforms to secondary care - by virtue of her son being a Consultant at the Royal Free Hospital which could be affected in the future by any such reforms.

Dr Debbie Frost made a joint non-pecuniary declaration on behalf of Barnet CCG Board members; Dr Clare Stephens, Dr Charlotte Benjamin and herself, in relation to the Items on the agenda which refer to GP practices, by virtue of being impacted through their respective GP practices.

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

None.

5. PUBLIC QUESTIONS AND COMMENTS (IF ANY) (Agenda Item 5):

None were received.

6. JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION PLAN (2015 – 2020) ANNUAL PROGRESS REPORT (Agenda Item 6):

The Chairman introduced the report which sets out the annual progress made towards the delivery of the Joint Health and Wellbeing Strategy. She commended the positive achievements made by Partners and highlighted the areas of focus for continued improvement.

The Board received a presentation from Dr Andrew Howe, Director of Public Health. For each theme, Dr Howe noted the achievements made as well as highlighting areas where there are gaps and which remain a priority in 2018.

In reference to the Health Profiles for 2016 and 2017, Dr Howe noted the progress made in reducing the number of TB cases over the last two years and highlighted the ongoing work to further reduce the rates for TB and STI's.

<u>Theme: Preparing a Healthy Life</u>

The Chairman commended the improvements in Health Assessments for Looked After Children and thanked everyone involved in their work towards achieving this. The Board highlighted the importance of continuing to improve services in this area.

Mr Chris Munday, Strategic Director of Children & Young People highlighted the progress made in relation to Initial Health Assessments (IHA) for children and noted that all IHA have been made within the timeframe.

The Chairman referred to the IHA performance for 2017 in February and queried the drop in rates and whether this could be expected for 2018. Mr Munday referred to the setup of the system which occurred in early 2017.

Mr Munday briefed the Board about the development of the Integrated Hubs for Children, Families and Young People. He noted that the first hub has been up and running for a few months and that the initial feedback has been positive.

Theme: Wellbeing in the Community

The Chairman noted the significant progress made on mental health and wellbeing which has been a top priority area in 2016-17. The Board was asked to note the significant progress made and the positive outcomes that are being achieved for residents – in particular, the support services provided by Linkworkers and other Community Providers and the increase in employment.

The Board noted that the improvement of mental health of children and adults will be a continued focus.

The Chairman noted that there is more work to be done, particularly with the IAPT services and on the development and quality improvement of CAMHS.

In respect to Adult Mental Health services, Dr Charlotte Benjamin Barnet CCG, highlighted the progress made in this area by virtue of the joined-up partnership working between the services involved. Dr Benjamin also noted the development in links between the Wellbeing Hub and the Network mental health enablement service.

Ms Julie Pal, CEO CommUnity Barnet welcomed the new way of working to continue to deliver services across the Voluntary and Community sector working alongside partners and to develop relationships with other organisations.

Ms Pal briefed the Board about the launch of the seminar programmes with the aim to promote understanding and access to the services available. The programme will be launched in the new year and includes a variety of courses on offer.

Following a query about promoting the programme, Ms Pal noted that a variety of communication channels will be utilised to cascade information as widely as possible – including through GP newsletters and CommUnity and Healthwatch networks. The Board welcomed the opportunity to support the promotion of the programme.

Mr Kendall highlighted the ongoing work to support working age adults with social care needs into employment. This includes supporting adults towards developing key skills and helping people find employment opportunities.

Theme: Encouraging Healthier Lifestyles

The Chairman referred to the healthy weight programme and welcomed the recommendation that maintaining a healthy weight and reducing excess weight is a key

priority for the JHWB Strategy for the coming year. The Board is due to receive a detailed report in 2018 on the matter.

The Chairman welcomed Chimeme Egbutah, Public Health Strategist. Ms Egbutah informed the Board about the positive impact that the Healthy Weight Nurse service and the Alive N Kicking programme has had in respect of behavioural patterns. She also noted the positive impact of the programmes on improving both mental and physical health.

Ms Egbutah spoke about the variety of exercise programmes available. She noted the success of the Mayor's Golden Kilometre initiative which has been running for 18 months and encourages pupils to undertake physical activity on a daily basis.

Following a comment from the Board, Ms Egbutah also noted the importance of involvement from secondary schools and their pupils. She stated that a variety of methods are being looked at. This includes taking a family approach and encouraging the use of trackers which record and encourage physical activity.

Dr Debbie Frost, Chairman of Barnet CCG welcomed the continued focus on screening and noted the continuing work to increase screening uptake. She suggested that detection of hypertension, atrial fibrillation and diabetes should also be reflected as priorities for the year ahead.

Ms Pal informed the Board about the consultation which will commence around areas of difficulties for cancer screening within communities.

Theme: Care when needed

The Board noted the update on the Burnt Oak pilot scheme of the Care Closer to Home Integrated Networks. Mr Kendall referred to the suggested areas of focus for 2018.

The Chairman thanked the Board for the discussion. It was **RESOLVED:**

1. **That the Health and Wellbeing Board noted and commented as above on the progress and performance to deliver the Joint Health and Wellbeing Strategy (2015-2020).**

2. **That the Health and Wellbeing Board noted and commented as above on the analysis of Barnet's Health profile for 2016 and 2017.**

3. **That the Health and Wellbeing Board commented as above and agreed the revised priority areas for the year 2017-2018, as set out in section 1.5 of this report.**

7. HEALTHWATCH BARNET - INCLUSION BARNET - BARNET MENCAP: LEARNING DISABILITY CARE AND BLOOD TESTING (Agenda Item 7):

The report was welcomed by the Chairman who highlighted the importance of understanding the experiences of residents who use local health and social care services - particularly the need to access good quality support for people with learning disabilities.

The Board received a presentation from Ms Pal who spoke about the contents of the report. They also welcomed representation from Barnet Mencap.

The Board heard about the experiences from a Barnet Mencap service user and staff member. The speaker highlighted the importance of ensuring that the level of interaction is right which will in turn help break down any barriers in communication between staff and service users.

Mr Kendall welcomed the report and noted that housing and employment needs are also looked at as part of the whole-life approach, in addition to health needs. He also reiterated the message around spending more time with service users and for staff to limit mobile phone calls as much as possible while with service users.

The Board received a briefing about the actions taken in response to the recommendations which includes reminding staff about basics of effective communication and to refresh the training programme for staff. As part of the improvements, it was noted that partnership working will be strengthened to enable service users to feel freely in sharing any issues they may experience.

Mr Kendall spoke about the development of My Health document which has been developed with health partners for people with learning difficulties. This is a helpful document for staff and service users who are able to take ownership of it.

The Board received a presentation about Blood Tests in Barnet as set out in Appendix 2 to the report. Dr Frost welcomed the report and encouraged further partnership working to ensure that the issues are resolved by making adjustments and sharing information.

The Chairman thanked the guest speakers for sharing their experiences and commended the recommendations within the report which should be part of the daily working of support staff.

It was **RESOLVED**:

That the Health and Wellbeing Board noted and commented as above on the content of the report and appendices.

8. UPDATE REPORT ON THE OFSTED IMPROVEMENT ACTION PLAN IMPLEMENTATION PROGRESS (Agenda Item 8):

Mr Munday presented the report and drew the Board's attention to the recent November publication of the Children's Services Improvement Action Plan Update report.[1]

Mr Munday briefed the Board about the update report and spoke about the work of the Improvement Board. It was noted that the Improvement Action Plan had been agreed with Ofsted as satisfactory. The Board also noted that overall the implementation of improvements has been a continuous process. Mr Munday highlighted concerns around inconsistency of quality which is reviewed regularly and noted the actions which are taken to address this.

[1] Children, Education, Libraries and Safeguarding Committee Agenda, 15 November 2017 - https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=697&MId=8694&Ver=4

Mr Munday referred to the triple loop audits which had been undertaken and reviewed externally by Essex. The Board heard about the increase in the number of children from 6 to 18 who are privately fostered. It was noted that improvements had been made by virtue of a more dedicated service and the work of the designated private fostering social worker.

In relation to homelessness, Dr Frost queried the support available for young people. Mr Munday referred to the new Housing Protocol for Homeless 16 and17 year olds which is aimed at young people at risk of homelessness and to ensure that they are appropriately supported. Mr Munday informed the Board that this will continue to be monitored.

It was **RESOLVED:**

1. **That the Health and Wellbeing Board noted and commented as above on the content of the report and the appendices 1-4.**

2. **That the Board noted the actions that have been taken to respond to recommendations within the Ofsted report as set out in paragraphs 1.20 to 1.31.**

9. REVISED TERMS OF REFERENCE AND MINUTES OF THE JOINT COMMISSIONING EXECUTIVE CARE CLOSER TO HOME PROGRAMME BOARD (Agenda Item 9):

Mr Kendall noted the standing item on the agenda which details the updated Terms of Reference of the JCE Care Closer to Home Programme Board as well as the minutes of its meeting of 20th July 2017.

RESOLVED:

1. **That the Health and Wellbeing Board approved the minutes of the Joint Commissioning Executive Care Closer to Home Programme Board of 20 July 2017 (Appendix 1).**

2. **That the Health and Wellbeing Board approved the revised Joint Commissioning Executive Care Closer to Home Programme Board Terms of Reference (appendix 2).**

10. FORWARD WORK PROGRAMME (Agenda Item 10):

The Chairman noted the items included within the Forward Work Programme and invited Board Members to make suggestions. The following additions were made:

- Implementing Barnet's Carers' Strategy
- Development of Care Closer to Home Integrated Networks (CHINs) in Barnet
- Children' Service Improvement Action Plan as reported to the most recent CELS Committee (standing item)

It was **RESOLVED:**

That the Health and Wellbeing Board considered and commented as above on the items included in the Forward Work Programme (see Appendix 1).

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

None.

The meeting finished at 11.40 am

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AGENDA ITEM 9

Barnet Health Overview and Scrutiny Committee

5 February 2018

Title	The Sustainability and Transformation Plan for Barnet
Report of	Strategic Director for Adults, Communities and Health
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix A – The Sustainability and Transformation Plan for Barnet
Officer Contact Details	Anita Vukomanovic Governance Team Leader Anita.Vukomanovic@barnet.gov.uk 0208 359 7034 Will Huxter Director of Strategy, North Central London CCGs **will.huxter@nhs.net**

Summary

At their meeting on 2 October 2017, the Committee received a Member's Item in the name of Councillor Philip Cohen.

Following the consideration of the Member's Item, the Committee resolved request a report that:

- Set out the implications of the STP for Barnet; and
- In the context of the STP, set out the provision for housing for NHS staff within Barnet.

The report attached at Appendix A has been provided by the Director of Strategy of the North London CCGs and addresses these points.

Recommendations

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

1. WHY THIS REPORT IS NEEDED

1.1 The Committee have requested to receive a report which sets out the implications of the STP for Barnet and also contains information on the provision for housing for NHS staff within Barnet.

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.

Social Value

5.2.2 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.

5.3 **Legal and Constitutional References**

5.3.1 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

5.3.2 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 **Risk Management**

5.4.1 There are no risks. Not receiving this report would present a risk in that the Committee might not be properly appraised of STP and its implications for the provision of healthcare within Barnet.

5.5 **Equalities and Diversity**

5.5.1 Equality and Diversity issues are a mandatory consideration in decision making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must fulfil its equality duty when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

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

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

5.5.3 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 **Consultation and Engagement**

Not applicable.

5.7 **Corporate Parenting:**

Not applicable.

6. BACKGROUND PAPERS

6.1 Member's Item and Minute Extract from the meeting of the Health Overview and Scrutiny Committee on 4 October 2017: https://barnet.moderngov.co.uk/mgAi.aspx?ID=23007

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Barnet Health Overview and Scrutiny Committee

STP: Update and implications for Barnet

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Contents of pack

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Purpose of paper

This paper is designed as briefing for the Barnet Health Overview and Scrutiny Committee on the North Central London (NCL) sustainability and transformation plan (STP). It outlines the programme and the ambitions of the plan as well as the clinical leadership from across north central London.

To demonstrate the impacts of the plan for Barnet residents, this presentation outlines four of the largest workstreams as examples. For each, it sets out recent achievements that will impact on local residents and some next steps for each programme of work.

It also outlines the consideration being given to key worker housing within the programme.

If required, a more detailed narrative of each of the plans can be found by clicking here.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Ambition of the STP

Ambition for the STP is built on existing CCGs values and strategy

Improve the health of the local population

Reduce health inequalities

Maximise care out of hospital

A partnership of the NHS and local authorities, working together with the public and patients where it's the most efficient and effective way to deliver improvements.

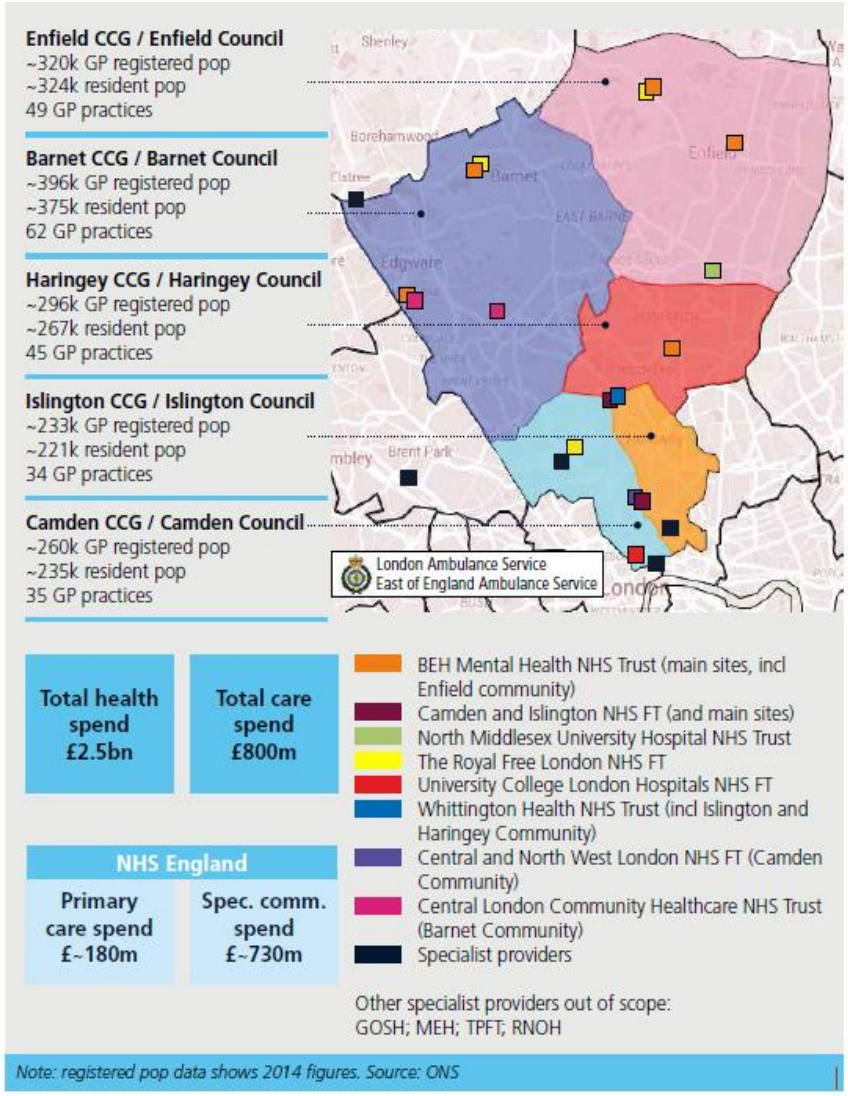
NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

North London Partners context:

1. Diverse populations with some common and some varied challenges
2. Complex health and social care landscape with overlaps between hospital areas and borough boundaries
3. Providers, commissioners and local authorities all in different financial positions
4. Five NCL CCGs now working under joint arrangements with a single accountable officer and chief finance officer
5. Need to transform, improve and integrate care where this improves health and wellbeing outcomes and sustainability of services
6. Potential to share best practice, innovate and benefit from economies of scale



NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Our financial challenge

In our plan in June 2017, we projected that if we do nothing, by 2020/21 the financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m(1).

Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services. In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap.

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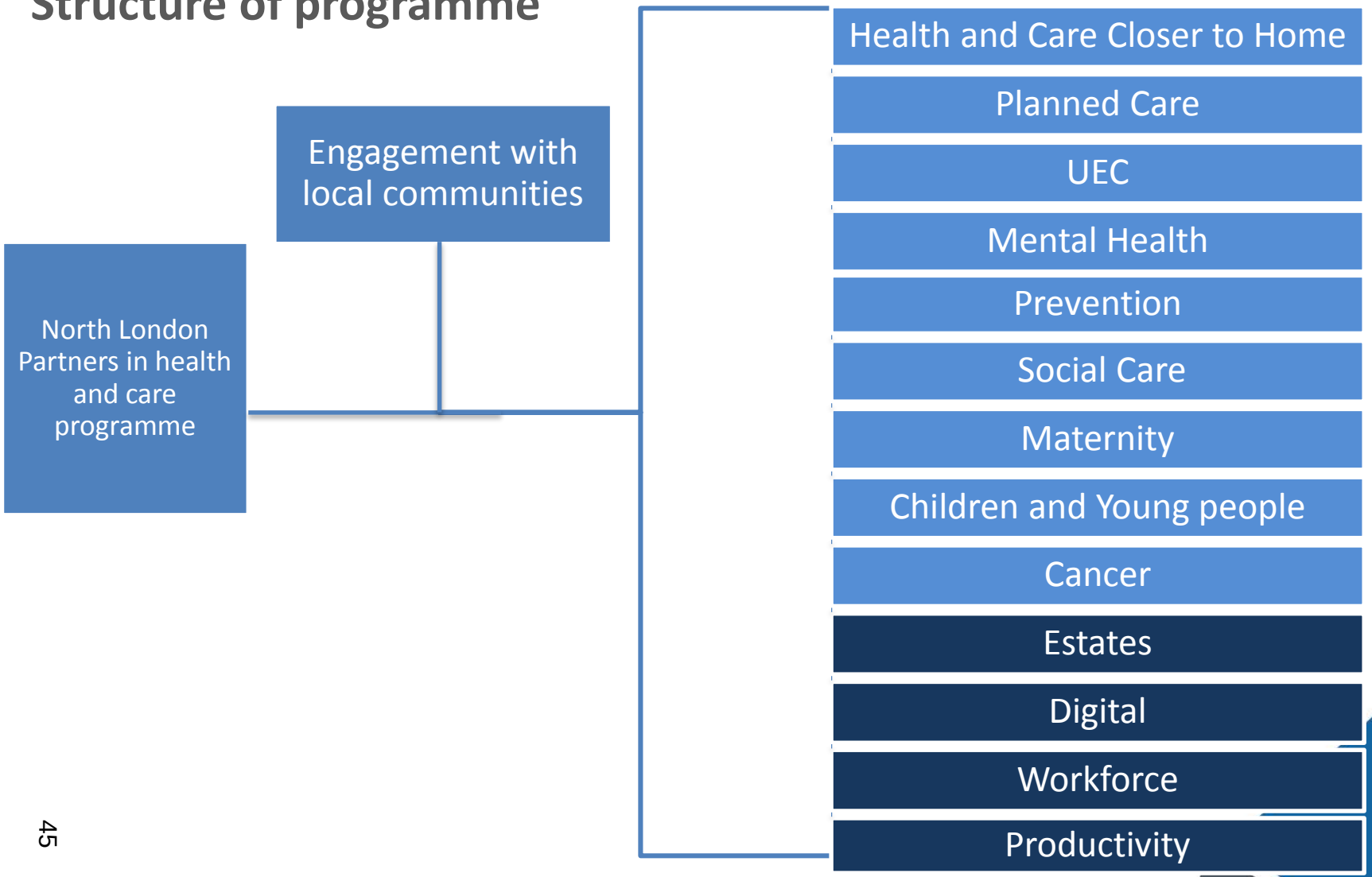
(1) http://www.northlondonpartners.org.uk/downloads/plans/NLPHC-STP-Strategic-Narrative-June-2017.pdf

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Structure of programme



NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Clinical and leadership across North London Partners

- Fundamental to development and implementation of every aspect of the STP
- Clinical Input into each workstream essential – with leadership across NCL CCGs (Barnet clinical leads for Planned Care and Cancer)
- Challenge and assurance of STP initiatives via Health and Care Cabinet (NCL CCG chairs and medical directors)
- STP Advisory Board includes Chairs of all CCGs
- Looking at systematic approach to quality improvement across all of the STP, with initial focus on Health and Care closer to Home

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Clinical and leadership across North London Partners

NCL Advisory Board – all NCL CCG Chairs and Cllrs

Input and membership of clinical working groups from across NCL CCGs and Providers

Clinical workstreams	Prevention	Planned care	Health and care closer to home	Mental Health	Children and young people	Maternity	Cancer	Urgent and Emergency Care
Clinical leads	Dr Karen Sennett (Islington) Dr Tom Aslan (Camden)	Dr Richard Jennings, (Whittington) Dr Ahmer Farooqi (Barnet)	Dr Katie Coleman, (Islington)	Dr Vincent Kirchner (C&I) Dr Jonathan Bindman (BEH) Dr Alex Warner (Camden)	Dr Oliver Anglin (Camden)	Professor Donald Peebles Mai Buckley (Royal Free)	Professor Geoff Bellingan (UCLH)	Dr Samit Shah (Islington) Dr Chris Laing (UCLH)
SROs	Dr Julie Billet (Camden and Islington)	Prof. Marcel Levi (UCLH)	Tony Hoolaghan (H&I)	Paul Jenkins (TAVI)	Charlotte Pomery (Haringey LA)	Rachel Lissauer (Haringey)	Kathy Pritchard Jones UCLH Dr Clare Stephens (Barnet)	Sarah Mansuralli (Camden)

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System wide working

- Changes to focus on the outcome for population and wider system, not on individual organisations/institutions
- Co designing services with patients, providers, clinicians, CCGs and Local Authorities.
- Aim is to speed up local implementation and spread of good practice through 'fastest first principle'
- NHS provider organisations agreeing joint programme of work on productivity, over and above individual organisation savings plans (e.g. patient transport, facilities)
- CCG Commissioner Leads co-ordinating the co-design of services for improved outcomes and system efficiencies (e.g. Barnet CCG leading work on Urology, Stroke, Chronic Kidney Disease
- As the STP covers the whole of North Central London, lead responsibility for scrutiny of the STP overall sits with the Joint Health Overview and Scrutiny Committee; the Barnet representatives are Cllrs Alison Cornelius and Graham Old.

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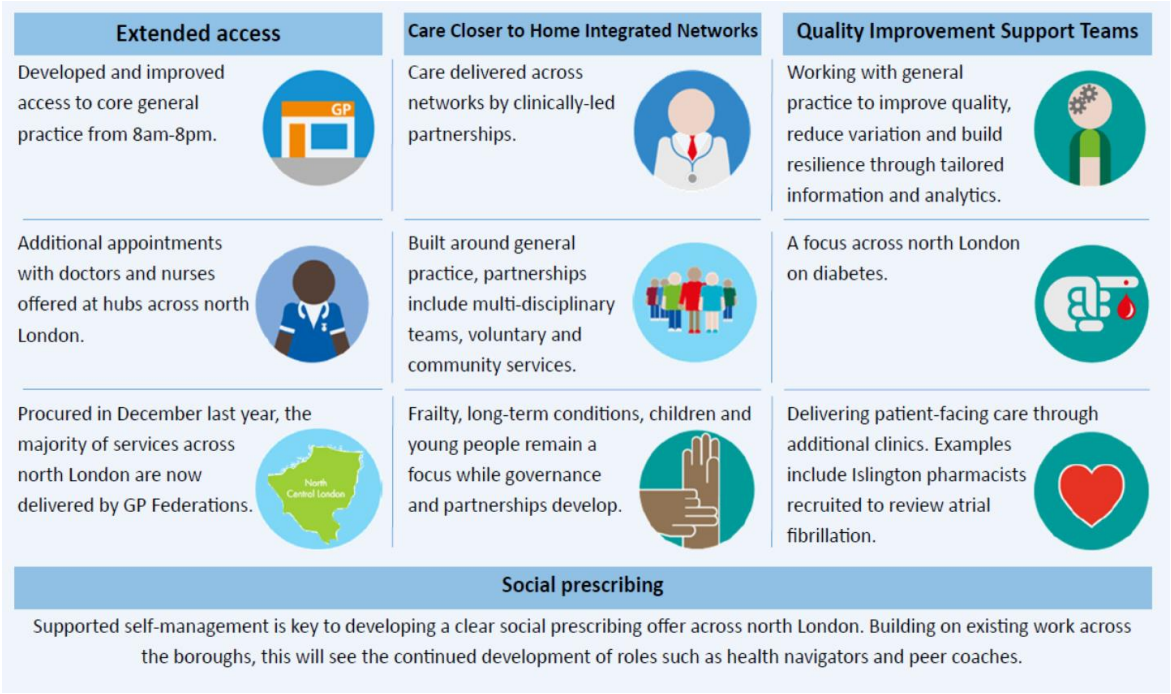
Example 1: Health and Care Closer to Home



- Barnet has one network established and another 3 planned (two further go live March 18)
- The clinical focus of the one established is diabetes.
- These will develop to include physical and mental health care delivery as well as aspects of social care and prevention within the community based on a core and locally defined offer.
- Initial approach is linked to particular population segmentation expanding as the models develop.

Achievements so far:

- **Extended access to GP appointments through** hubs operational since April 2017 across Barnet (8am-8pm)
- Progress in setting up care networks across NCL – focusing on areas from frailty, to mental health (1 established I Barnet) – including close links with social care team locally

Next steps:

- Embedding quality improvement approach across primary care and sharing good practice from across boroughs
- Focus on access to ensure this meets local needs
- Establish remaining 3 integrated care networks in Barnet
- Maximising inputs of elements such as social prescribing

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Example 1: CHINS development status

Burnt Oak CHIN

Clinical lead: Dr Aash Bansal
Focus: *Diabetes*
Population: *40,000*
Involving: *5 practices*
Operational since: *Jan 18*
Road map: *All system partners involved by April 2019*
Contract with: *Federation*
Contract: *Heads of Terms*

Established

CHIN 2

Clinical lead: Dr Anita Patel
Focus: *Long Term Conditions*
Population: TBC
Involving: *7 practices*
Go live: Mar 18
Road map: *All system partners by April 19*
Contract with: TBC
Contract: *TBC*

To be established in 2018

CHIN 3

Clinical lead: Dr Alexis Ingram
Focus: *Long Term Conditions*
Population: TBC
Involving: *5 practices*
Go live: Mar 18
Road map: *All system partners by Apr 19*
Contract with: TBC
Contract: *TBC*

To be established in 2018

CHIN 4

Final CHIN, which would complete full borough coverage is to be defined

To be established in 2018

Barnet QIST

Clinical lead: Dr Anuj Patel
Focus: Diabetes
Operational since: Feb 2018
Contract with: *Federation*
Contract: *Heads of Terms*

Established

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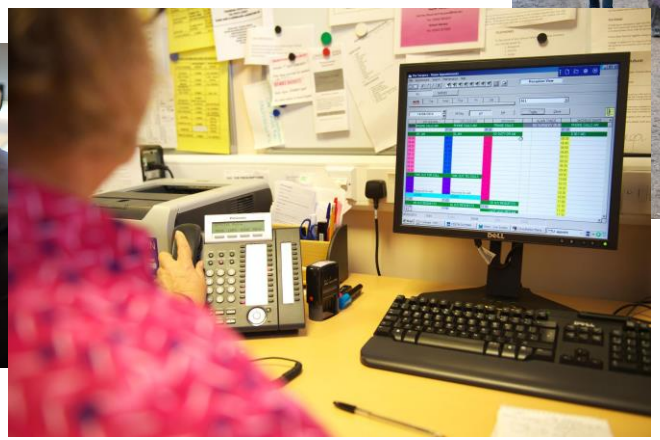
Example 2: Planned Care



Achievements so far:

- Barnet approach to improving how GPs order tests (and reduce waste) implemented across borough and now being extended to NCL
- Tele-Dermatology – new technology for examining skin complaints piloted at Royal Free to be rolled out across NCL
- Urology pathways across NCL being redesigned with specialists from Royal Free Hospital and implemented from Jan 2018
- New model of GPs being able to access specialist advice implemented at XXXX in Jan, other hospitals to go live through 2018

Next steps:

- Clinical redesign of the following pathways to focus on preventative, proactive care:
  - Chronic Kidney Disease
  - Musculoskeletal Disease
  - Urology
  - Cardiology
- Further work to minimise unnecessary testing and trips to hospital through better use of technology

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Example 3: Urgent and Emergency Care

1: Integrated urgent care	2: Admission avoidance	3: Simplified Discharge	4: Last Phase of Life
To bring together and enhance current urgent care services which are outside of hospital, in order to create a single, unified urgent care service for NCL citizens	To develop same day emergency care services in both acute and community settings to enable rapid assessment, diagnosis and treatment – and avoid the need for overnight stays in hospital	To develop improved discharge processes to reduce delays in patients leaving hospital when they are medically stable	To bring specialist advice to staff who are looking after patients in the last year of their lives, in order to ensure best possible care and support to patients and reduce inequalities of care provision

Achievements so far:

- NCL is one of the first areas nationally to launch the new integrated urgent care model (this includes warm transfers for mental health and "star divert numbers" for clinical professionals)
- Piloting new improved discharge processes to prevent delays at all NHS trusts in NCL (discharge to assess pathway)
- A single NCL-wide referral form for rehabilitation services after hospital stays – reducing delays across boroughs
- Patients phoning NHS 111 out of hours can be booked directly into a GP appointment if necessary in Barnet

Next steps:

- Patients phoning NHS 111 will be able to be booked directly into a GP appointment if necessary in hours (across NCL)
- Continued implementation of pathways that mean patients do not have to wait to be assessed before leaving hospital
- New Ambulatory Care models will mean people can receive emergency treatments without being admitted to a hospital bed overnight
- Redesign of community service to prevent admissions to hospital
- Implementation of nursing support to care homes and Single Point of Access for specialist palliative care advice

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Example 4: Social care

The five local authorities in North London face a financial pressure of £110m in adult social care by 2021/21.

During 2017 we have been working together to identify our shared challenges across five boroughs and where a shared response would deliver greatest benefit to local people. We have agreed 4-5 key areas for further work in 2018, working alongside NHS and wider partners as part of the STP. N.B. This work would have equal benefit in Barnet as the other five boroughs.

Social care analysis report recommendations (Apr '17)	Shortlist of specific actions (Oct '17)	Areas for further exploration (Nov '17 onwards)
1. Streamline health and social care processes around the hospital	1. Increase direct payment take up 2. Align reablement processes 3. Provide intensive care home support 4. Streamline hospital discharge processes	1. Improve consistency in the social care element of the hospital discharge process
2. Develop a sustainable social care market	1. Share pricing strategy for purchasing care 2. Align/share brokerage activity 3. Develop more O65 nursing home capacity	2. Build more capacity in the nursing home sector looking at options for joint-capital investment to build more homes; 3. Joint brokerage of health and social care packages of care, looking at options to combine the existing operations run by Councils and CCGs; and
3. Develop a sustainable social care workforce	1. Focus on nursing recruitment and retention 2. Focus on independent sector workforce recruitment and retention 3. Develop shared practitioner training and development across health and social care 4. Focus on occupational therapist recruitment and retention	4. Develop a joint approach to recruitment and retention of staff in health and social care, focusing on nursing and the independent sector;
4. Look at specific support to people with learning disabilities	1. Establish NCL-wide operational forum for case management 2. Ensure annual health checks are taken up across GP practices 3. Establish LD provider forum jointly with CCGs 4. Review complex needs provision, focusing on young people transitions and/or working age adult complex needs 5. Develop LD/autism/challenging behaviour accommodation/support capacity	5. Develop a stronger provider market to support people with LD and challenging behaviour, focusing on prevention of needs escalating into the 'transforming care' cohort and those transitioning from children to adulthood.

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Key worker housing:

- There are no current specific health projects being led by the estates workstream of the STP on this.
- However, work is currently underway to understand key drivers for attracting and retaining staff in North Central London – which will include lifestyle factors such as housing amongst other issues.
- Therefore, it is being actively considered as part of both the estates worktream and the worksforce worktream as elements of future planning.
- As part of this, the STP estates workstream and workforce are taking part in some national policy development work around key worker housing to understand how we can work effectively in this area. This will help inform our strategy on this.
- With regards to ongoing local developments, Barnet, Enfield and Haringey Mental Health NHS Trust is anticipating some on-site affordable housing being made available to staff through the redevelopment of the St Ann's site.

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Next steps for the Programme in 2018/19

Work with all our partners and public to design plans	Ensure plans are clinically led and evidence based	Communicate with our stakeholders and communities about the changes ahead	Align our plans and ensure these contribute to financial sustainability	Continuing to explore scope for NCL working and greater impact

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Continuing to work with you

- We want to work more closely with you to refine and enhance our collective ambition and models of care across the workstreams, to ensuring we are providing the best possible outcomes for the residents of Barnet.

- Are there particular aspects of the programme that can be recommended to the JOSC for future meetings?

AGENDA ITEM 10

Health Overview and Scrutiny Committee

5th Feb 2018

Title	**Suicide Prevention in Barnet**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix A - Suicide prevention report 2018
Officer Contact Details	Jeffrey Lake, Consultant in Public Health Jeff.lake@harrow.gov.uk

Summary

This report provides a summary of local arrangements for suicide prevention and progress in delivering the 2017/2018 action plan. In the light of national guidance it is suggested that committee review progress annually.

Officers Recommendations

1. **That the committee note the suggestions of the Health Select Committee Inquiry into Suicide Prevention, local arrangements for suicide prevention and progress in delivering the 2017/2018 suicide prevention action plan ahead of it being refresh for 2018/2019.**

2. **That the committee receives an annual report on suicide prevention.**

1. WHY THIS REPORT IS NEEDED

1.1 The Government published a response to the Health Select Committee Inquiry into suicide prevention in July 2017 and indicated that Local Authority Health Overview and Scrutiny Committees should be involved in the review of local suicide prevention action plans.

1.2 A multi-agency working group was created to develop and review an annual suicide prevention action plan in 2014.

1.3 Annual reports on actions have been reviewed by the Director of Public Health and the 2017/18 report was presented to the Health and Wellbeing Board in July 2017.

2. REASONS FOR RECOMMENDATIONS

2.1 To ensure local governance arrangements in line with those proposed nationally in response to the Health Select Committee Inquiry.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

4.1 It is intended that a report will be brought to the committee annually to review progress and identify any challenges.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Corporate Plan includes a commitment to ensure that people with mental health issues receive support in the community to help them stay well.

5.1.2 The Health and Wellbeing Strategy includes focus on improving mental health and wellbeing for all and makes specific reference to the suicide prevention action plan.

5.1.3 The Joint Strategic Needs Assessment identifies the suicide rate in Barnet and compares this with the national rate.

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

5.2.1 The suicide prevention action plan is delivered within existing staffing and financial resources in Public Health and its partner agencies.

5.2.2 There are no dedicated financial resources for suicide prevention and attention has been drawn to this nationally. NHS England has indicated that it will distribute £5 million to CCG for suicide prevention in 2018/2019 and a further £10m in each of the next two years. The details of how this are expected to be distributed in due course.

5.3 **Social Value**

5.3.1 N/A

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**

5.5.1 The scope and delivery of the actions outlined in the suicide prevention action plan are dependent on partners' willingness and capacity as there is no statutory authority for councils to require partners to take action.

5.5.2 Six monthly reviews meetings of the working group have been introduced to ensure opportunities for partners to flag any delivery challenges at an early stage and to allow partners to anticipate any impacts.

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.

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.

5.6.4 Variations in suicide rates by age and sex are described in the report. Attention has been paid locally to other characteristics but low numbers make it impossible to make any statistically robust conclusions. National analysis of suicides suggests higher than average rates amongst the LGBT community and new mothers.

5.7 **Corporate Parenting**

5.7.1 A review of suicide prevention arrangements for children and young people will take place this place and implications for corporate parenting identified.

5.8 **Consultation and Engagement**

5.8.1 A voluntary sector representative sits on the suicide prevention local work group to ensure that their views, those of mental health service users and the broader community are represented.

5.8 **Insight**

5.8.1 The data presented in the suicide prevention report is taken from Office of National Statistics, Public Health Outcomes Framework and from an audit of local coroner office records.

6. BACKGROUND PAPERS

6.1 The suicide prevention action plan for 2017/2018 was discussed at the Health and Wellbeing Board:

https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=9140&Ver=4

Suicide Prevention Report in Barnet: A report to the Health Overview Scrutiny Committee – December 2017

Purpose of Report

In April 2016, the Commons Health Select Committee published a national enquiry into suicide prevention[1]. The enquiry report concluded that whilst the government strategy is essentially sound, it is felt that it has been inadequately implemented by local areas. It included a number of recommendations as presented in Appendix 1. These included the suggestion that local scrutiny committees should be involved in ensuring effective implementation of local suicide prevention plans.

This report provides an overview of suicide prevention work in Barnet to date ahead of the annual refresh of local actions.

Introduction & Background

Suicide is preventable. Yet since 2007 rates in England have increased, making suicide the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost.

The cross-government National Suicide Prevention Strategy[2] for England was published in 2012 and progress was reviewed in January 2017[3]. The strategy aims to reduce the national suicide rate by 10 per cent by 2020/21. This ambition was echoed in the NHS's Five Year Forward View[4].

The 2012 National Strategy committed to tackling suicide in six key areas for action, with the scope of the strategy later expanded to include a further key area, addressing self-harm:

1. Reducing the risk of suicide in high risk groups;
2. Tailoring approaches to improve mental health in specific groups;
3. Reducing access to means of suicide;
4. Providing better information and support to those bereaved or affected by suicide;

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[1] https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/108702.htm
[2] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
[4] https://www.england.nhs.uk/five-year-forward-view/

5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;
6. Supporting research, data collection and monitoring;
7. Reducing rates of self-harm as a key indicator of suicide risk.

In January 2015, The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an "Inquiry into Local Suicide Prevention Plans in England"[5]. The APPG considered that there were three main elements that are essential to the successful implementation of the national strategy for suicide prevention.

The report states that all local authorities must have in place:

- Suicide audit work to understand local suicide risk
- A suicide prevention plan in order to identify the initiatives required to address local suicide risk
- A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local action plan.

Barnet Public Health initiated a multi-agency working group to create a suicide prevention plan in 2014. It brought together a range of local partners including representatives from the CCG, Coroner's office, Police, Ambulance services, NHS, Children's and Adult Social Care, Network Rail, and the Voluntary and Community Sector. The group provides a platform for partners to share intelligence, identify and review local suicide prevention activities, to explore opportunities for future collaboration between the partners and agree actions.

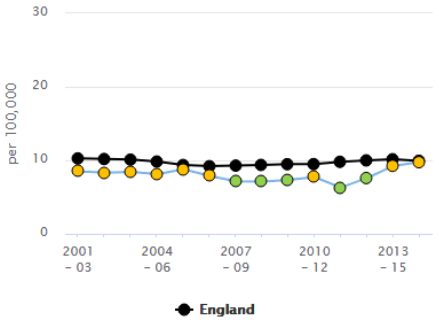
The Barnet Suicide Prevention Report and Action Plan were completed in March 2015 and have been refreshed annually. The 2017 report was presented to the HWBB in July 2017 along with a briefing on the Mayor of London's Thrive programme. Thrive identifies suicide prevention as one of the priority areas for action on mental health in the capital along with understanding of mental health, community resilience, targeted prevention for children and young people and employment support. The report also summarised the audit of suicides that was completed in 2017 after access to coroner's records was secured.

Suicide in Barnet

The most recent Barnet Suicide prevention report presents ONS data available from 2016 and reflects the deaths that were registered in that year rather than those that took place in the year.

[5] http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf

Suicide rate (Persons) Barnet — Directly standardised rate - per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	London	England
2001 - 03		71	8.5	6.6	10.8	10.1	10.3
2002 - 04		68	8.3	6.4	10.6	10.0	10.2
2003 - 05		69	8.4	6.5	10.7	10.0	10.1
2004 - 06		66	8.1	6.2	10.4	9.7	9.8
2005 - 07		74	8.8	6.9	11.1	9.2	9.4
2006 - 08		67	7.9	6.1	10.1	8.8	9.2
2007 - 09		63	7.1	5.4	9.2	8.5	9.3
2008 - 10		64	7.1	5.4	9.1	8.5	9.4
2009 - 11		69	7.3	5.7	9.3	8.4	9.5
2010 - 12		71	7.7	6.0	9.8	8.4	9.5
2011 - 13		58	6.3	4.8	8.2	8.0	9.8
2012 - 14		68	7.6	5.9	9.7	7.8	10.0
2013 - 15		84	9.3	7.3	11.5	8.6	10.1
2014 - 16		91	9.7	7.8	12.0	8.7	9.9

Source: Public Health England (based on ONS source data)

The data show a slight increase in the rate of suicides in Barnet (for those aged 10 and over) from 9.3 per 100,000 (95% CI 7.3-11.5) population in the period 2013-15 to 9.7 per 100,000 (95% CI 7.6-12.0) in the period 2014-16, although this is not statistically significant. Whilst the Barnet rate is higher than London and lower than England, the difference is not statistically significant.

The rate for males in 2014-16 was 15 per 100,000 and for females 5 per 100,000. As for all people, these rates are not statistically different to London or England and reflect national trends.

Comparing Barnet with Enfield and Haringey, with whom the borough shares mental health services, the overall age-standardised suicide rate is not statistically significantly different[6].

Suicide Rate (age standardised per 100,000) 2013-2015	Barnet (95% CI)	Enfield (95% CI)	Haringey (95% CI)
All	9.3 (7.3-11.5)	6.9 (5.1-9.0)	10.8 (8.2-13.9)
Male	14.2 (10.7-18.5)	11.0 (7.9-14.9)	18.2 (12.9-24.6)
Female	Calculation of the rate would be unreliable due to the low numbers involved	Calculation of the rate would be unreliable due to the low numbers involved	Calculation of the rate would be unreliable due to the low numbers involved

Table 4. The age-standardised suicide rates per 100,000 population in Barnet, Enfield and Haringey.

[6] Suicide Prevention Profile. Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000007/ati/102/are/E09000002

Barnet Suicide Prevention Group

Suicide prevention is the shared responsibility of a wide range of agencies. The borough action plan is the product of the Barnet multi-agency suicide prevention group. Partners' commitments and delivery of those actions is the responsibility of the respective partners. A six monthly progress review meeting is held to identify any delivery issues.

Early work by the Suicide Prevention Group identified the need to undertake a suicide audit for Barnet to provide more detailed intelligence on the factors affecting suicide in Barnet. The aim of the audit was to increase understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

An audit was carried out based on data gathered from files available from the local HM Coroner's Office. Records were accessed for all Barnet residents who had received a Coroner's verdict of suicide, open verdict, alcohol/drug related where there was evidence of intent, self-harm related.

Results of the audit indicated that demographic trends were consistent with those reported nationally. Whilst there were suggestions of potentially higher rates amongst certain groups, numbers were too small to allow us to determine if these were statistically significant differences or might be the result of random variations.

Circumstances of suicide were also consistent with those observed nationally with hanging the most common method of suicide followed by rail fatalities. The audit also provided information on risk factors and contact with services prior to suicide. It found:

- 51% had a history of mental health problems
- 21% had a history of self-harm
- 14% had a history of substance use. Of which 72% had a co-morbid mental health condition
- 42% were known to have been seen by mental health services within seven days prior to their death
- Almost a quarter had been in contact with their GP within one week prior to death

It should be noted however that on many records, there was an absence of medical history and substance misuse history. This makes it impossible to conclude whether these individuals had no history or whether the information was missing.

Understanding the history of mental ill health and self-harm, potential risk factors and previous contact with services of people who take their own lives may identify opportunities to learn and improve practice at a local service level. However, the Barnet audit has shown that the numbers are too small to identify clear trends or associations beyond what could reasonably be expected through random variation.

Data collection across Barnet, Enfield and Haringey, or at a London-wide level would offer stronger analysis to appropriately direct interventions and is being explored.

Local Suicide Prevention Actions:

Achievements in delivery of previous Action Plans include:

- The referral pathway from British Transport Police into the local authority for people with needs under the Care Act 2014 was clarified;
- Specific support for people bereaved by suicide has been commissioned and is being delivered by the Barnet Bereavement Service;
- The local position on freedom passes for people with mental health conditions was clarified;
- A pathway into substance misuse services from the British Transport Police was established;
- A process was established for reviewing the suitability of accommodation for patients with support needs being discharged;
- Self-harm and suicide prevention training was delivered to Adult Social Care Staff;
- Samaritans engaged with local press to ensure responsible reporting.

The Action Plan for 2017-18 was agreed in March 2017 and reviewed in September. Progress against this plan can be seen in **Appendix 2.** Delivery to date has mostly been to plan with many items completed.

The Plan includes:

- Improving the way in which suicides are reported on by local press
- Improving learning in general practice from suspected suicides and suicide attempts
- Developing e-safety work, ensuring strategic engagement with schools and parents
- Understanding suicide prevention guidance for children & young people
- Supporting DWP to implement their ‘six point plan” for suicide prevention
- Improving workforce knowledge regarding suicide prevention

The plan aligns with national guidance and includes many of the recommendations highlighted by the Commons Health Select in their national enquiry. Based on recent policy and literature, new priorities are likely to include:

1. More attention to Children & Young People, in particular reviewing:
    a. suicide prevention pathways for schools
    b. support for young people who are bereaved by suicide
    c. specific support for vulnerable groups including LGBT and looked after children (LAC)
    d. mental health in colleges and universities

e. self-harm amongst young people

2. Self- Harm
    a. Developing a pathway for patients who present at A&E with self-harm

3. Identifying sources of support for people vulnerable to suicide
    a. Ensuring all relevant services are recorded on the Barnet Community Directory
    b. Ensuring services are promoted locally, particularly to those less likely to access traditional services
    c. To ensure that impacts on people vulnerable to suicide are considered in health impact assessments
    d. Working with partners to identify a way that those bereaved by suicide can receive a copy of "Help is at Hand" within 48 hours, but where possible, when contact is first made with the family/friend of the deceased individual.

4. Working with CCG commissioning leads for Mental Health to:
    a. Understanding the inpatient discharge process and ensuring 3 day follow up
    b. Review the offer for patient accessing IAPT who are experiencing suicidal ideation

5. Further exploring opportunities for suicide prevention at a London level
    a. Supporting the Thrive LDN suicide prevention work which includes developing a co-ordinated system for reporting data from coroners and other sources (such as the police) that could act as an early warning system.

Challenges and Next Steps:

Whilst there has been progress in a number of areas within the Barnet Suicide Prevention Plan there can be challenges in securing engagement from partners. This is not exclusive to Barnet and is echoed by other areas.

Having said this, there have been a wide range of partners engaged to date with a number of positive outcomes. The annual suicide prevention plan is due for review in March 2018, at which time new opportunities will be explored with partners and priorities will be set for 2018/19.

Appendix 1: Recommendations from Commons Health Select Committee national enquiry into suicide prevention[7]

Implementation

1. We welcome the Secretary of State's promise that the Government "will put in place a more robust implementation programme to deliver the aims of the

[7] https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/108702.htm

National Strategy as recommended by the HSC [Health Select Committee]" and we urge him to publish details of the implementation programme as soon as possible.

Quality of local authorities' plans

2. We welcome the fact that 95 per cent of local authorities have a suicide prevention plan in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place.

3. It is essential that there is a strong and clear quality assurance process to ensure that local authorities' plans meet quality standards. This will also enable more support to be provided to local authorities where it is needed. In its response to this report, the Government should set out how the quality assurance process will work; who will be responsible for it; how it will report; how often it will be carried out; and when it will start.

4. We recommend that Public Health England's suicide prevention planning guidance for local authorities should be developed into quality standards against which local authorities' suicide prevention plans should be assessed.

5. We consider that oversight of nationwide implementation [of local authorities' plans] could usefully be carried out by an implementation board, as recommended by Samaritans and Hamish Elvidge (Chair of the Matthew Elvidge Trust (a trust aiming to tackle the issue of depression in young people) and the Support after Suicide Partnership). As well as ensuring implementation of local authorities' plans, the implementation board should have responsibility for overseeing the implementation of the other aspects of the Government's suicide prevention strategy.

6. We recommend that health overview and scrutiny committees should also be involved in ensuring effective implementation of local authorities' plans. This should be established as a key role of these committees. Effective local scrutiny of a local authority's suicide prevention plan should reduce or eliminate the need for intervention by the national implementation board.

7. The Government should consult the National Suicide Prevention Strategy Advisory Group on whether the implementation board should also be responsible for the quality assurance process of local authorities' plans, or whether that responsibility should rest with another body. (Paragraph 30)

Funding

8. We welcome the provision of funding for suicide prevention guaranteed for 2018/19–2020/21. However, unless it is supported by other funding already committed by the Government to mental health, and unless that funding actually reaches the front line, we are concerned that it will not be sufficient to fund the suicide prevention activity required both to meet the Government's target of a 10 per cent reduction in suicides and to implement the strategy.

9. We note that there are currently important steps which could be taken to reduce suicide but which cannot be acted upon due to the lack of significant additional resource. The Government should make a clear commitment to assuring the funding for every action outlined in the suicide prevention strategy. In order to demonstrate this commitment, the Government should make an estimate of the cost of each activity referred to in the strategy, and indicate what funding is currently allocated to each. This will allow the funding gaps to be identified and addressed.

10. The Government must make clear who has overall responsibility in each area (whether that is the CCG, the director of public health, or another body) to ensure that the money is allocated in the right places within the area to fund both NHS initiatives and public health activity. The Government should set out how the additional funding will be distributed and accounted for so that local authorities and CCGs can plan their suicide prevention work effectively. If there is insufficient funding, the Government should be realistic about what is achievable on existing resources and set out the evidence on prioritising resources.

Services to support people vulnerable to suicide

- **People not in contact with any health services**

11. We recommend that local authorities keep and maintain a record of services of a suitable standard (both in the voluntary sector and commissioned services) to which individuals can be signposted for both practical and emotional support. Part of the work of health overview and scrutiny committees in scrutinising local authorities' suicide prevention plans should be ensuring that these records are created and maintained. There should also be an annual review of the impact of any loss of these services.

12. Local authorities should promote a joined-up, multi-agency collaborative approach to suicide prevention to improve data sharing and knowledge between different sectors which will ultimately lead to more efficient and effective action on preventing suicide.

13. We recommend that organisations and services at high risk locations, including the police and Network Rail (as well as other organisations such as

the RNLI where appropriate), should be involved in the development and implementation of local authorities' suicide prevention plans.

14. We recommend that local authorities should include in suicide prevention plans a strategy for how those who are at risk of suicide but are unlikely to access traditional services will be reached. This should include up-to-date knowledge about what services are available in the voluntary sector.

- **People in contact with primary care services**

15. We recommend that the GMC should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as depression. We also recommend that the Royal College of General Practitioners and Health Education England should include the assessment of depression and suicide risk in the training and examinations for GPs. The Government should monitor progress on the addition of these competencies to medical school and Royal College exams.

16. Strong and coordinated national leadership is required to ensure that GPs and primary care nurses receive adequate ongoing training in detecting suicide risk. We recommend that NICE guidelines and other training resources should be promoted and made readily available for practitioners by Public Health England and Health Education England. There should be national oversight by Public Health England to ensure that all practitioners involved in the assessment of those who could be at risk of suicide are accessing this training.

- **Drug treatments and suicide**

17. We urge the Government to ensure that NICE guidelines on the appropriate use of drug treatments for depression are promoted and implemented by clinicians.

- **People under the care of specialist mental health services**

18. We repeat our recommendation that all patients being discharged from inpatient care should receive high quality follow up support within three days of discharge. We recommend that this should be in addition to a further instance of follow up support within the first week post-discharge. The Government must ensure sufficient funding for crisis resolution home treatment teams to ensure that they have enough resource to provide adequate support.

19. We urge the Government to ensure that there are enough trained staff to establish and sustain liaison psychiatry services in every acute hospital.

20. More broadly, the Health Education England Mental Health workforce strategy must set out what the Government is going to do to ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations.

21. We welcome the Government's expansion of the Improving Access to Psychological Therapies (IAPT) programme. However we urge the Government to ensure that it is properly integrated into mental health teams supporting people with complex mental health conditions, to ensure that patients being supported by the IAPT programme who experience suicidal ideation can be supported effectively and quickly.

- **Self-harm**

22. All patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines. Patients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up. We urge the Government to set out its plans for ensuring that the workforce is sufficient to meet these objectives.

Confidentiality and consent

23. We are disappointed that the Government has not included any proposals for action on the Consensus Statement in its report on the strategy. We recommend that there should be a named responsible individual within Government to support the NSPSAG in discussions with the Royal Colleges and to ensure progress in raising awareness of the Consensus Statement and training of staff in this area (including training on how to seek consent).

24. We recommend that further discussions between the NSPSAG and the Royal Colleges on the Consensus Statement should involve representatives from trust legal departments, legal authorities and defence unions, in order to ensure consistent guidance.

25. Training for medical staff on the Consensus Statement and on how to seek consent should include educating medical professionals on the importance of action when a patient has given consent for information to be shared with a friend or family member.

Support for those bereaved by suicide

26. We recommend that ensuring high quality support for all those bereaved by suicide should be included in all local authorities' suicide prevention plans. Bereavement support should be a key criterion on which local authorities' plans are quality assured.

27. We recommend that those bereaved by suicide should receive a copy of 'Help is at Hand' within a maximum of 48 hours, but where possible when contact is first made with the family/friends of the deceased individual. Further support, including information about counselling but also support for the practical problems that bereaved individuals will face (including coroners' inquests and incident reviews), should be offered as soon as is practicable. The next of kin should have access to a victim liaison officer to support them through the inquest.

Media

- **Guidelines for responsible reporting of suicide**

28. We note the lack of detail [in the third progress report] on the action that may be taken if concerns [about irresponsible media reporting of suicide] are escalated to PHE and we recommend that PHE should include options for action in its partnership agreement with Samaritans.

29. We urge the Department of Health and Public Health England to be vocal and proactive in their support for the work ensuring responsible reporting of suicide. We recommend that there should be a nominated person within the Government/Public Health England who is ultimately responsible for ensuring that the Government has a firm grasp of the current media situation and for supporting Samaritans and other organisations and individuals in their work with the media.

30. A clear message must be sent to the media that the Government supports Samaritans' media guidelines and the work that Samaritans do in helping journalists report suicide responsibly.

- **Local media**

31. We recommend that when producing and updating suicide prevention plans, local authorities should include work with local media to ensure good practice in local media sources and to ensure timely follow-up discussions when a guideline has not been followed.

- **Regulation**

32. We recommend a change to the IPSO Editors' Code of Practice to replace the term "excessive detail" with "unnecessary detail".

33. We recommend that the Ofcom Broadcasting Code should be strengthened to ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible.

- **Social media and the internet**

34. We recommend that the Government should clearly set out its expectations of social media companies and relevant stakeholders relating to processes for dealing with harmful content on social media. There should be responsibility within Government for ensuring that these organisations have robust processes in place and for monitoring adherence to the processes.

35. We note the research projects relating to the online environment, in which Samaritans are involved. We urge the Government to closely examine the findings of that research and to report back to us on the action that it proposes to take as a result.

Data

- **Standard of proof**

36. We recommend that the standard of proof for conclusions of death by suicide should be changed to the balance of probabilities rather than beyond reasonable doubt.

- **Coroners' conclusions**

37. We recommend that the Chief Coroner should be given adequate resourcing to allow clear oversight of the variation in the recording of suicide. We also recommend mandatory training for all coroners, both those already in post and newly appointed, on the use of short form and narrative conclusions, to ensure consistency across England and Wales.
38. We suggest that the Government should explore whether information about lethal methods of suicide could be made available to statistical agencies and public health teams, but withheld from public view.

39. We recommend that training for coroners on suicide should include the importance of including sufficient detail in a narrative conclusion about the deceased individual's intent and method used in order to minimise the number of hard-to-code narrative conclusions. Accurate data is crucial to the understanding of what approaches work best in reducing suicide. We suggest that this training could be given by experts in the field of data and suicide prevention.

40. We recommend that training and guidance for coroners should include material about the importance of timely information sharing with public health and mental health teams where appropriate in order to identify possible clusters and the proliferation of emerging new methods of suicide.

Suicide Prevention Plan 2017-18 - Reviewed in January 2018

Action & Topic Area	Lead partner/s	Status & timescale	Progress	Closed
Communications				
1. To raise concerns about irresponsible reporting of deaths resulting from self-harm in the local press with Samaritans as these occur; and engage with the local media where appropriate to ensure that deaths are reported in line with the Samaritans media guidelines.	PH	Ongoing Green	*Monitoring action*	N/A
Pathways and access				
2. To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts.	PH/CCG	March 2018 Amber	Contact has been made with Urgent Care Lead for CCG who is exploring with Royal Free Trust how this can be taken forward.	
3. PH to raise the possibility of collecting data at a BEH and London-level to explore suicide rates in migrant populations and according to occupation status with relevant colleagues.	PH	September 2017 Amber	The outcomes of the local audit have been shared at London level via the Thrive London Suicide Prevention group. A London approach to data collection is being considered by Thrive. This will take some time to deliver and a schedule is expected to	

			be delivered by Thrive London.	
4. BTP and drug & alcohol services to communicate regarding the alcohol and drug related incidents on the railways to identify entry into care pathways.	WDP and BTP	Carried over from 16/17 – to be resolved ASAP Amber	WDP have fed back that BTP's preference is to refer to their local provider in Westminster who would refer the case on. WDP report that this is not effective so discussions have been reopened with the aim to agree a direct referral pathway into Barnet services. Schedule to be agreed with BTP by Feb 2018.	
5. To develop a template to enable data collection following significant events, including suspected suicides and suicide attempts, involving patients under the care of General Practice.	PH/Charlotte Benjamin	September 2017 Amber	The CCGs GP lead and Mental Health Commissioner are reviewing an example template. For consideration at annual review meeting.	
6. Barnet, Enfield and Haringey MH CCG commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.	Enfield CCG	January 2018 Amber	In progress following appointment of a new MH lead in December 17. For consideration at annual review meeting.	
7. To develop e-safety work in Barnet through the Barnet Children Safeguarding Board (BCSB) e-safety subgroup, ensuring strategic engagement with schools and parents.	PH LCSB e-safety subgroup	Nov 2017 Green	The LSCB have merged the e-safety work into the Digital Resilience Workstream under the Resilient Schools Programme. A Digital Resilience Award is being rolled out to the pilot primary schools. This will	

			incorporate online safety and online healthy indicators. The Digital Resilience Award has 3 levels: bronze, silver, gold award for schools. It is also being expanded to be appropriate to Secondary and SEND schools.	
To work with relevant partners to understand schools' needs around suicide prevention; and to develop a suicide prevention pathway for schools and partners, linking with the Resilience and Healthy Schools programmes.	Public Health/ Mental Health Priority Group	March 2018 Green	PH presented the annual CDOP report to the Safeguarding Executive Board and the findings from the suicide cases over the past 3 years. The Safeguarding Executive Board has agreed to carry out a thematic review into school-based support for Self-Harm and early indicators of suicidal thoughts. There will be an independent chair with support from PH. The ToRs will be agreed by the Executive Group at the February meeting. The review will commence immediately and conclude by July 2018. HLP recently produced suicide prevention guidance for children & young people, including recommendations for schools on developing suicide prevention pathways which we intend to review in the year ahead. We also plan to ensure alignment with the Resilience and Healthy Schools programmes	

			as that programme develops.	
8. Workforce				
9. BEH MHT to create a resource for GPs and other healthcare professionals to support them to manage people with self-harm and suicidal ideation.	BEH MHT	September 2017 Amber	Awaiting BEH feedback on progress.	
10. BEH MHT to work with Primary Care to develop and deliver suicide prevention training for GPs.	Charlotte Benjamin/BEH MHT	September 2017 Green	Training delivered at GP conference in Sept 17. Future plans to be considered at annual review.	
11. To liaise with the DWP for BEH MHT to review their 'six point plans' and provide training to DWP staff to support the implementation of the plans.	PH/BEH MHT/DWP	To revisit with DWP in 2018 Amber	DWP had no capacity in 2017 due to implementing the benefit changes. This action will be revisited in the annual review meeting.	
12. To liaise with relevant partner organisations (e.g. Barnet Homes, older people's services) to ascertain training needs around identifying suicide risk.	PH	March 2018 Amber	Underway. Training plan to be delivered by March.	

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AGENDA ITEM 11

Barnet Health Overview and Scrutiny Committee

5 February 2018

Title	Update Report: Healthwatch Barnet
Report of	Healthwatch Barnet
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix A – Support for Patient Participation Groups in Barnet Appendix B: Mealtime Observational Visits at Royal Free Hospital
Officer Contact Details	Anita Vukomanovic Anita.Vukomanovic@barnet.gov.uk 0208 359 7034

Summary

At its meeting on 4 December 2017, the Committee heard from Healthwatch Barnet during the consideration of the Children's Dental Health Report. The Committee requested that Healthwatch Barnet attend their next meeting and provide them with an update on the following pieces of work:

- Mealtimes Investigation at the Royal Free Hospital
- Patient Participation Group work.

This update has been provided by Healthwatch Barnet and is attached at Appendix A. Representatives from Healthwatch Barnet will be in attendance on the evening to present the report and respond to any questions from Members.

Healthwatch Barnet also mentioned one further piece of work on Cancer Screening to the Committee which is currently in progress. Healthwatch wish to inform the Committee of the progress to date as below and report in full at a future date.

Cancer Screening Update:
A review of cancer screening services will be undertaken by Barnet Mencap, a charity partner to Healthwatch Barnet. Barnet Mencap staff will work with people with learning disabilities to review services, patient experience, accessible information and referral management with a particular focus on breast, cervical and bowel cancers. They will use established and tried and tested evaluation tools for this review. A full report will be produced in late Spring 2018. Healthwatch Barnet and Barnet Mencap would be able to come to Committee at a later date to present the report, which will include any recommendations and a response from providers.

Recommendations

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

1. WHY THIS REPORT IS NEEDED

The Committee requested an update on the work of Healthwatch Barnet which is relevant to the Health Overview and Scrutiny Committee

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 (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**

5.5.1 There are no risks. Not receiving this report would present a risk in that the Committee might not be properly appraised of the work of Healthwatch Barnet.

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.

5.8 **Corporate Parenting:**

Not applicable.

6. BACKGROUND PAPERS

6.1 None.

Briefing for Barnet Health Overview & Scrutiny Committee

Support for Patient Participation Groups in Barnet

What are Patient Participation Groups (PPGs)?

PPGs are groups associated with local GP practices comprising staff members of the practice and a cohort of registered patients from the practice who volunteer to 'represent' the wider patient community. The PPG acts primarily as a conduit for communications between the practice and the patients enabling issues and ideas related to health service provision to be discussed and, hopefully, resolved at practice level. Some PPGs extend their role to provide complementary services at the practice. It is important to note that all GP practices are contractually obliged to create a PPG and that the CQC takes an interest (e.g. requests meeting with PPG Chair) in patient engagement during its practice inspections.

Why is support needed for PPGs and who provides it?

Staff in GP practices are generally unfamiliar with working with volunteers and the concept of patient engagement is relatively new.
Many comprehensive 'toolkits' to support practices with implementing the requirement for a PPG are widely available many practices in Barnet have not established PPGs. Barnet CCG decided to provide face-to-face support for the development of local PPGs and commissioned CommUNITY Barnet, working closely with Healthwatch Barnet, to deliver this function in the form of a 12 month project commencing March 2017.

What activities are undertaken by the PPG support project?

The information available about local PPGs was quite limited at the start so that the focus throughout has been on establishing links with both practices and patient representatives, identifying their needs and responding to them as constructively as possible. Ongoing support activities include:

- undertaking a series of on-line surveys to identify the baseline position with existing groups and the needs of PPGs
- publishing a 6-weekly e-newsletter – PPG ENGAGE – for PPG members containing useful health-related information, ideas for developing your PPG and details of local PPG activities
- creating a series of short information briefings on specific topics in response to requests from practices and publishing them on the Healthwatch Barnet website
- creating generic promotional material for recruitment of patient representatives and customising it for use by individual practices
- face-to-face meetings with individual practice managers/patients and PPGs to discuss support needs and agree future actions
- actively contributing to the work of the emerging pan-Barnet PPG network
- facilitated a networking of PPGs including a formal meeting of the Barnet CCG Lay Member for Patient and Public Engagement (Ian Bretman) and PPG Chairs

- training events designed for both patients and practice in support of PPG development
- extensive and ongoing follow-up of all practices including those that have not engaged with the project

Findings arising from the PPG Support Project

Some of the findings that have arisen in the project are:

- Creating a successful PPG requires the active collaboration of both parties (i.e. practice staff and patients) in what is effectively a joint enterprise
- Practice managers are most often the 'lead' person from the practice in regard to the PPG but their efforts need the active support of the GP partners at the practice to ensure that this area of work is prioritised. GP and practice staff capacity is often an issue: however there are positive relationships and constructive work where staff and patients have collaborated.
- Although practices have a contractual obligation to create a PPG, patients are voluntary participants and in some locations it is difficult to recruit (particularly for an organisation not familiar with recruiting volunteers) PPGs are intended to be patient-led and chaired by a patient representative but membership details are not in the public domain and initial contact with a PPG can only be made via a practice.
- Some PPGs have a limited view of their role (i.e. quarterly committee-style meetings) whereas successful PPGs have found it easier to engage the interest of patients in more practical tasks that are of direct benefit to patients and complement the work of the health professionals

CommUNITY Barnet/
Healthwatch Barnet January 2018

healthwatch Barnet

Mealtime Observational Visits at Royal Free Hospital

Summary Report

Contents

Introduction

Healthwatch Barnet is part of a national network set up by the Health and Social Care Act of 2012 and led by Healthwatch England that aims to help local people get the best out of their health and social care services. Healthwatch enables residents to contribute to the development of quality health and social care services.

Healthwatch undertake 'Enter and View' visits to Health and Social Care services that are used by local people, to talk to service users, patients, their relatives or carers to hear their feedback about the care and support received.

In February/ April 2017 trained Enter and View Volunteers from Healthwatch Barnet visited 7 wards at the Hampstead site of Royal Free London NHS Foundation Trust, to investigate the food and mealtime support that was offered to patients. The volunteers visited a number of wards, in pairs, to observe a mealtime and to talk to patients, staff, relatives and carers. A variety of meal times were observed, on weekdays and at weekends.

The findings of these visits and the resulting recommendations were shared with the Director of Facilities and the Head of Patient Environment.

Methodology

The project was discussed with the Director of Facilities and Head of Patient Environment in advance. It was agreed that the small teams of volunteers would visit a number of different wards at different times of the day, to observe a variety of mealtimes, and to talk to patients, relatives and carers about their experiences. The team of Healthwatch Barnet Enter and View volunteers worked in pairs to visit wards. Some teams visited one ward on two occasions, at different times of the day and on different days of the week, and other teams visited a ward just once. At the specific request of the Hospital management, they were informed of the dates of the visits, and the names of the volunteers involved, but were not informed of the wards that they intended to visit or the visiting times. Therefore although the ward managers were aware of Healthwatch coming to the hospital they did not know where, and at what time, they would be visiting. Healthwatch would have preferred not to inform the hospital of the exact dates they were visiting but acceded to the specific request after consideration.

At this hospital site they operate a "cook chill" bulk meal service delivered to the wards and stored in regeneration trolleys which reheat the food to serving temperature. There are two main menu options and a vegetarian option. Patients are shown the menu early in the day and given the opportunity to order their choice (a number of portions of each menu option are available on each ward). If all portions of the patient's choice have been allocated, they will be offered the options that are remaining. Specialist diets are ordered individually. At mealtimes, the food is plated and served on the appropriate coloured trays which are then delivered to the patients by nurses or healthcare assistants. Serving is generally done by the housekeeper, At weekends the service is completed by the ward staff and overseen by the nurse in charge.

The first part of each visit involved the team observing the preparation, serving, and support for eating offered during a mealtime, from start to finish. The team observed the hospital's protocols on infection control and tried to minimise their impact on the operation of the ward by being unobtrusive during this phase.

The second part of the visit took place once the meals were finished and cleared away, the volunteers spoke to patients, relatives and carers and asked a set of standardised questions about their experience and opinions of the food and the support they received to eat during their stay in hospital.

This information was collated and presented in a report for each ward, and the information is summarised here in one overall report. The ward reports were sent to the Head of Patient Environment for her comments and to check for factual accuracy. Their comments are included in the final report.

As per our normal protocol the reports are sent to the Care Quality Commission, Health Overview and Scrutiny Committee, Barnet Clinical Commissioning Group, and will be available to the public on the Healthwatch Barnet website.

The team of volunteers undertook the following visits:

Ward Number	Description of Ward	Date of Visit	Comments
10 North	Elderly Care	22 February - lunch	
10 North	Elderly Care	4 March - lunch	
7 West	Surgical	28 February – evening meal	
9 West	Liver/HPB	1 March - lunch	
6 South	Stroke/ Neurology	19 March – breakfast	Entry to ward refused so visit was not able to go ahead.
11 South	Haematology/Oncology	20 March – evening meal	
10 East	Renal	14 April – evening meal	
10 South	Renal	23 April - lunch	

Findings

Cleanliness and Hygiene The teams felt that the wards were clean. We were pleased to note that hand-wipes were provided for patients who were not mobile and therefore unable to wash their hands. However we observed that these were not always used, mainly as patients were unsure what they were for. We felt it would therefore be helpful to ensure that where possible they are opened and patients are encouraged to use them.

Protected Mealtimes Some of the wards that we visited had a barrier or sign in place and details explaining protected mealtimes. The protocols appeared to be being followed and working well. However, this was not happening consistently on all of the wards that we visited, and 4 (9W, 10E, 10S, 11S) did not have any obvious protected mealtime in place. On the Elderly care wards, we observed that although information was given about protected mealtimes, visiting was all day and many relatives were supporting patients to eat which appeared of value to all.

Green Tick System This appeared to be very inconsistent and was not seen to be operating fully on any of the wards that we visited, although we were told in advance that it was in operation. (This system is a way of care staff indicating that a patient has finished eating and their tray can be collected/removed). As we did not see it in operation it was difficult to assess if it seemed effective, but we appreciate the reasoning behind the system and feel that if carefully managed it could be beneficial to the smooth running of mealtimes.

Menu System There were again some differences in the opinions of patients about this across the wards we visited. Elderly care wards felt the process worked well for them. They were very positive about the help they are given and the staff who have gone the extra mile, to purchase sandwiches from elsewhere, for example, at the patients request. However in other wards the patients told us that they rarely saw a menu and that it was usually read out to them by a staff member, which made them feel rushed in making choices. The majority would prefer to see a menu to consider in advance. Some who had seen a menu found the format quite confusing.

We were informed that the menu system works on the basis that a predicted amount of each menu option is available to each ward, and although patients have been asked for their preferences, if their preferred option has run out, they will then be able to order the other options on the menu. Consequently several patients told us that they did not get their first preference meal as it had run out by the time they placed their order.

Several patients complained that portions were too large, while a few said they were not sufficient. We felt that it should be possible for staff to use more judgement in portion sizes once they had got to know patients' needs, ensuring that patients are not deterred by being served inappropriate portions and there is less waste. Some relatives also suggested that they could give more insight into what their relative would like to eat, and thus improve their nutritional intake, if they had the opportunity to do this.

Quality of Food A number of patients told us they felt the food was acceptable for hospital food but not appetizing. Some felt the vegetables were particularly unappetizing – such as hard cabbage and tough green beans. Several patients felt that they would appreciate fresh fruit more regularly, and the pots of tinned fruit offered were not a substitute and were often not available.

Some patients suggested that it would be good to have the option of a lighter sandwich/salad lunch, rather than main meal options twice a day.

One person commented that the Halal food was very good.

A vegetarian patient reported that there was very little choice for them, and they would have appreciated a larger selection of vegetarian food.

Some patients requested more detail about ingredients of meals should be available, e.g. meatballs contained pork which they were not aware of before they ordered the meal. We wondered if this was due to the patients not actually seeing the menu itself, and having had the options read to them.

Very few patients were aware that snacks were available between meals. Some commented that the time between lunch and dinner was very long and a snack would have been welcomed. A number of patients reported that friends or relatives brought food in to the hospital to supplement their diets. This was particularly fresh fruit, and where patients disliked the food on offer. Some said that they needed this additional food to supplement the food which was not to their taste.

Serving of Food We observed different systems of serving food. On one ward (10 North) the ward manager at the weekend served the food from the trolley. We felt that this made it difficult for them to have an effective overview of the whole mealtime on the ward.

On a couple of wards, the tea trolley went round before or during the mealtime, whereas patients would prefer tea/coffee after their meal.

We observed that main meals were covered when they were delivered to patients. However the puddings were not covered and if warm they had cooled significantly by the time the patient was ready to eat it. It would be helpful if the puddings could be covered as well to ensure they stay warm where appropriate.

Specialist Diets We spoke to three patients who had been told to follow specialist diets (high protein) as a result of their health conditions. They did not feel they had been supported in doing this whilst in the hospital and they felt they had not received sufficient information or menu options supporting it.

Clearing Up After Meals We observed in the majority of wards that finished plates were removed in a timely manner from the patient's tables. However on one ward (11S) they had not been removed an hour after being served although patients had finished well before then.

On two wards we observed notes being taken of how much patients had eaten, but this was not observed in all wards.

Support for Eating The teams were generally very positive about the support that patients were observed to be receiving at mealtimes. They generally saw patients being helped appropriately where it was needed. Where red trays were in use the patients were well supported in a timely manner.

Refused Entry Visit Our team of two volunteers were refused entry to 6 South stroke/neurology ward at 7am on Sunday 19 March. This was due to a misunderstanding within the hospital management and the ward staff had not been informed. This was very unfortunate and disappointing. The hospital has apologised for the inconvenience caused and are fully aware of Healthwatch's statutory right to undertake Enter and View visits within our protocol. We were not therefore able to observe a breakfast service at the hospital.

Key Recommendations

As a result of our visits we have drawn together a list of key recommendations based on the feedback and observations:

1. Ensure that protected mealtime is operated effectively and adhered to on all wards.
2. Review if the green tick system is beneficial and if so, ensure that it is used and operated consistently on all wards.
3. Review the process of ordering/serving meals to ensure that all patients who wish to, have sight of a menu, and where possible preferred meals are available. This will ensure that all patients will be able to see details of ingredients in meals.
4. Explore if it is possible for relatives/carers who are closely involved in their relative's care, to support choices and portion sizes.
5. Vary portion sizes individually according to personal needs and preferences.
6. Ensure that hand wipes are available and opened for those who need that support.
7. Ensure that all patients are aware of the snack menu and its' availability.
8. Ensure that the tea trolley is in operation after meals have been finished.
9. Explore covering hot puddings when they are served to keep them hot until eaten.
10. To consider the needs of patients requiring specialist diets, for example protein rich or low sugar, to coordinate menus with a dietician, or specialist to ensure optimum nutrition is provided to aid recovery. Also to provide more variety for vegetarians.
11. To review the quality of meals to try and improve their appeal, particularly considering provision of fresh fruit and vegetables.
12. To ensure that staff are aware of Healthwatch and their statutory rights to undertake Enter and View visits to services.

Final Comments

The volunteers who visited the wards were generally pleased with the care and support that they observed. The majority of patients and relatives that they spoke to were positive about care, though many felt that the food was just about adequate. With one exception, the volunteers were welcomed by the staff and their visits were facilitated positively by the ward teams.

We hope that the feedback will help the hospital improve the food service and can be taken into consideration when the services are developed/retendered in the future.

Acknowledgements

We would like to thank all of the patients, their relatives and carers, staff and volunteers who helped facilitate these visits and gave us their feedback and suggestions.

A final thank you to the following volunteers who so generously gave their time and expertise in carrying out these visits and writing the reports. The volunteers who took part were: Derrick Edgerton, Ellen Collins, Tina Stanton, Monica Shackman, Margaret Peart, Alan Shackman, Janice Tausig and Jeremy Gold.

Response from Royal Free Hospital

Following the submission of the ward reports and the summary report to the Royal Free, Healthwatch representatives met with the Director of Facilities and the Head of Patient Environment, a dietician, and the catering manager to discuss the findings and recommendations. This was a very constructive meeting and the Trust were very positive about the reports that had been produced.

We have received the following Action Plan from the Trust:

Findings	Actions	Action Owner
Protected meals times	• Reiterate to staff the use of the protected meal times stands • Where necessary purchase new stands for wards that they are missing or damaged	Matrons/Ward Manager/ HoPE
Green tick system	• Ensure consistent use of "Green ticks" across all sites • Escalate to the Director of Nursing across all sites for to reinforce the importance for the use of green tick system	DoN/Matrons/ Ward Manager/ HoPE/PEM
Menus	• Menus to be left at patient bed sides at all times • OCS to provide menus for when menus go missing from wards etc. • housekeeper and ward staff to request menus from OCS • Staff assisting patients to read menus if required	Housekeepers/ Clinical ward staff/ OCS patient feeding services Ad-hoc audits HoPE/PEM/PEA
Food ordering and Quality of food	• Training to be provided for staff for food ordering • OCS to provide training on the wards for staff members to understand portion control • Staff to serve portions according to patients request • Improve communication to all wards and staff as to what is available for patients and for Relatives of patients to be encouraged to view the menu and assist in meal choices for patient ➢ Menu choices ➢ Lighter choice options ➢ Snack menu ➢ Fresh fruit	OCS patient feeding services/ PEM/HoPE Clinical ward staff/Housekeepers HoPE/PEM/OCS patient feeding services

Findings	Actions	Action Owner
	➢ Menu fatigue options ➢ Special dietary requirements ➢ Salad choices	
Specialist Diets	• All specialist diets are requested via the dieticians, requests then sent to OCS caterers • OCS to provide training on the wards for staff members to understand portion control (including portioning equivalent amounts of carbohydrate and protein parts to a meal) Ensure milk is included on the snack menu and that patients are aware of what snacks are available/a snack menu available to patients • Dietitians to use nursing handover to highlight nutritional recommendations • If it is a patient's life choice of preferred food rather than a health condition the housekeeper or ward staff can organise with OCS catering department for the patient choices.	Dieticians/OCS patient feeding services OCS patient feeding services/ PEM/HoPE Dietitians Clinical ward staff/OCS patient feeding services
Hand wipes for patients	• Ensure that hand wipes are provided for patients, • Staff to assist with opening the wipes if required • Staff to highlight to patients wipes are available	Matrons/ward managers
Serving patient Beverages	• Beverages trolleys have set times for drinks to be served to patients, these times will be reiterated to all staff in the team meetings and also volunteers who may assist on occasions with beverage rounds	DSM/PEM/HoPE Domestic/housekeeper/ Volunteers/clinical ward staff
Clearing up after meal service	• Patient's trays should be cleared in a timely manner, reminders and training to be	DSM/PEM/HoPE Domestic

Findings	Actions	Action Owner
	provided to Domestic staff about this issue.	
Hot desserts	• Review the meal service for two options ➢ Serve the main course and the dessert separately ➢ To source a cover for the dessert to maintain the temperature while patient easting main course	PEM/HoPE/OCS patient feeding services

Key People for Actions:

Director of Nursing on all 3 sites (DoN), Matrons, Ward Managers, Clinical ward staff, Head of Patient Environment (HoPE), Patient Environment Manager (PEM), Domestic Services Manager (DSM), Housekeepers, Domestic staff, OCS patient services, Dietitian teams and Volunteers.

Enter and View Reports

Report 1 – Ward 10 North – Elderly Care, 38 Beds

Healthwatch Authorised Representatives: Alan Shackman and Monica Shackman

Dates of Visits:

Wednesday 22 February 2017 – lunch

Saturday 4 March 2017 - lunch

Patients/Visitors spoken to: 9 visitors and 3 Patients

This report reflects the two visits that were made to this ward on a weekday and a weekend, both at lunchtime. As the ward offers care for older people it uses a menu that specifically supports older people and aids their recovery. (Known as HSEP Menu)

Findings

Phase 1: General Observations The housekeeper explained to the team that the housekeepers are on duty from 7.30am to 3.30pm. They take orders from all of the patients in person in the morning. The food trolley and food is delivered to the ward at around 10am and is heated on the ward. The amount delivered is a 'best guess' of the actual requests based on previous experience, and if this is not correct the staff team have to manage the situation. When ready to serve, the housekeeper plates up the meals which are delivered to the patients by the nursing staff. A record of the amounts eaten by the patients is made on their records. The housekeeper does not work at weekends so the tasks have to be covered by the nursing staff. On our Saturday visit the nurse in charge took this task and plated all of the meals for the patients.

Protected Meal Time A sign was displayed explaining that 'protected mealtime' was in place and asking visitors to avoid this time. However 10 North has all day visiting and we observed visitors (some of whom were carers) assisting patients to eat, and this did not seem to be a problem. We did not observe any medical interventions during the mealtimes.

Clearing Up after Meals Most patients finished a good proportion of their meal. We observed staff recording how much had been eaten. We also observed a tray being taken back with nothing eaten but the nurse explained that the patient needed to eat little and they are given some liquid food and hydrated on a regular basis.

Phase 2: Feedback from Patients

Cleanliness/Hygiene The ward appeared to be very clean. We only observed a couple of patients who were mobile and went to wash their hands before the meal. Patients were provided with wipes on the trays, but these were used inconsistently and they did not appear to be opened by staff if patients did not use them or understand what they were for.

Support with Eating We observed that patients who needed support into a comfortable position to eat, were supported by the staff member who brought their meal and not in advance. This meant that there was some delay in eating the meal so the food may have cooled by the time it was eaten. All food was placed within reach and where patients were clearly not able to open sachets etc. these were done for them.

Approximately 25% of meals were served on red trays and it was explained that patients were very much encouraged to be independent even if it meant it took a long time to eat the meal. Hence only those who really needed help were given red trays.

We observed one patient (not given a red tray) who was not able to feed himself and was not receiving support (this was identified to the nurse in charge).

Quality and Choice of Food and Drink Most patients were satisfied with the quality and quantity of food, and were generally positive about the nutrition and hydration.

We observed one patient asking for a sandwich from Marks and Spencers and a staff member went down to the M&S outlet to get one for them.

Ordering System As mentioned above the housekeeper talked the team through the process of taking orders and managing these against the food that is delivered.

Patients that we spoke to did not have any concerns about the ordering process and they told us that they saw the menu when the staff member took their orders in the morning.

Dietary/Cultural Requirements No particular issues were raised about these.

Portion Size People that we spoke to did not have any concerns about the portion size.

Availability of Additional Snacks We observed a fridge well stocked with snacks and supplements for patients.

Patients were aware that snacks were available.

Friends and Family to Bring in Food Some families/friends brought in food for patients but this did not appear to be as a replacement for meals.

Recommendations

To ensure that meals are served in the most efficient way at weekends, particularly making sure that the ward manager is able to have a good overview of the whole situation.

Conclusions

Most patients were satisfied with the food and service provided on this ward, and were very positive. The mealtimes appeared very well managed and the staff were very caring.

Report 2 – Ward 9 West – HPB/Liver/Blood, 28 Beds

Healthwatch Authorised Representatives: Tina Stanton and Margaret Peart

Date of Visit: 1 March 2017 - lunch

Patients spoken to:

Number of patients observed: 10

Number of patients spoken to: 12

Findings

Phase 1: General Observations

We noted that the menu for breakfast and a list of available snacks was pinned to the wall in the corridor. We were shown a list of food that patients had ordered for lunch; the food was heated on a trolley in the corridor which was timed to be ready at lunch time, and we observed individual servings being tested with a thermometer.

Initially when lunch was served each plate of prepared food was given to a waiting member of staff to take to patients, but once the first set of food was given out there were no staff ready to receive the second lot of plates which would not have then been at the same temperature as the earlier food. It seemed to be rather a laborious process. All of the plates appeared to contain the same amount of food, so that patients with smaller appetites were not catered for. When a meal was placed on a red tray, signifying that help would be needed by the patient, the person serving the food made a general request for someone to assist, rather than handing this to a designated member of staff.

Protected Meal Time We did not see a notice specifying a protected meal time, but there was a barrier in place around the food trolley. We noticed some medical staff on the wards during lunch time, but as many of the patients were not eating, they could have been seeing them.

Clearing Up after Meals The food we saw being cleared away on the whole, was collected in a timely way, we did not see any records being kept whether patients had eaten the food or not.

Phase 2: Feedback from Patients

Length of Stay This varied between one day to several months for some patients.

Support with Eating We observed two or three patients who needed assistance and they were made comfortable and helped to eat their lunch. We observed one patient struggling to remove the cellophane from their plate. On the day of our visit when a meal was prepared on a red tray, staff were heard to call for someone to assist the patient with their meal, rather than a designated member of staff being responsible for this task.

Cleanliness/Hygiene The ward appeared to be very clean, all patients were provided with wipes on a tray with their food. One patient told us that they could not use the wipes as it upset their eczema, and another patient told us that they preferred to use their own wipes.

Quality and Choice of Food and Drink One patient told us that the food was all ok and the staff were very nice, but on the whole people did not find the choice of food to their taste. Most of the patients were seriously ill, with poor appetites and often missed meals because they were not hungry, or 'nil by mouth'. One patient who had been in for several weeks said the menu was the same every week and there was little variety, another told us it was repetitive and bland. Another patient told us that on one day the choice was cottage pie for lunch and shepherd's pie for dinner, virtually the same meal.

One vegetarian told us there was very little choice for them. The choice at lunch time was for a cooked meal, with no sandwiches on the menu, patients told us that if they asked for a sandwich there was little choice, several patients told us that they did not know that they could order sandwiches at lunch time.

One patient told us the food was not to their taste as it was too spicy. A couple of patients told us that the vegetables were too watery. Patients told us there was no fresh fruit on the menu, if they asked, sometimes they would be offered a banana. Little pots of tinned fruit were available but one patient said it was either peaches or pineapple, they didn't eat pineapple but were often given that as the peaches had run out; another patient told us that they frequently asked for fruit juice, this was rarely available as it had run out.

We observed the tea trolley arriving at different stages of the meal to the bays; patients told us that the tea trolley often arrived before or with the main meal, rather than after the meal when they would like it.

Several patients told us that the water jugs were only changed once a day unless they asked for this to happen more frequently, and they were not filled up to the top.

Ordering System Most patients told us the ordering was quite straightforward, they were not all given a menu, some just had it read out to them. One person told us they felt rushed when ordering their food.

Dietary/Cultural Requirements One patient told us that he had to take medication with his food, and that breakfast was served at 8.30am and the evening meal at 6pm, so no food was served for the 14 hours in between, this patient had to ask for a sandwich before breakfast so that he could take his medication.

Three patients on the same ward told us that the dietician had told them they needed a protein rich diet, but this was not served to them. Lunch that day had been a pasta dish with tuna, which was mainly pasta with very little tuna. One had asked for additional cheese, which again had been a tiny portion. The dietician had told one patient they could ask for a glass of milk whenever they wanted, this patient only found this out weeks after they had been in hospital.

One patient with diabetes said that the food was not really suitable for his diet. We asked if he had seen a specialist doctor or dietician who could advise on a suitable diet to adjust his insulin to cope with additional food, as he wanted to put some of the weight back he had lost, but he said not.

Portion Size Many patients on this ward complained that the portions were too big, and we observed the same amounts of food being given to everyone. One patient told us that on the whole they ate one third of the meal. It would be beneficial for patients if their individual requirements could be taken into account when serving food.

Availability of Additional Snacks There was a list in the corridor showing additional snacks that were available, but only one patient of the 12 that we spoke to, who had been told this on the day we visited, knew about this. One patient told us they had been in for 19 days and had found out that day that they could ask for additional snacks – she had asked for cheese and biscuits, but they had run out and more would be obtained later that day. One patient told us that if they asked for an additional sandwich 'some staff were not pleased'.

Need for Friends and Family to Bring in Food Several patients told us that they had food brought in for them, as they could not eat the meals provided. Some patients had fruit brought in for them.

Any Occasions When Meals Have Been Missed Patients who missed meals were generally offered a sandwich on returning to the ward.

General Comments

Patients told us that the food did not look appetizing which would not tempt the palate of people with poor appetites. Several patients told us that food they had received in other hospitals, had been much better with much more choice. One patient complained that the cutlery was ineffective and the knives did not cut.

Recommendations

- To allocate a member of staff to assist patients using red trays
- To consider the needs of the patients with poor appetites, and provide them with smaller portions, and see if food could be made to look more appetising.
- To consider the needs of patients requiring specialist diets, for example protein rich or low sugar, to coordinate menus with a dietician, or specialist to ensure optimum nutrition is provided to aid recovery. Also to provide more variety for vegetarians.
- To provide more choice including sandwiches at lunch time, and ensure that food (such as cottage pie and shepherd's pie) is not served on the same day.
- To consider providing water based hand wipes suitable for all patients.
- To ensure that the tea trolley arrives after the main meal is served.
- To provide fresh fruit.
- To change water in jugs more than once a day and to ensure they are properly filled up.

Conclusions

Generally speaking we found the staff helpful, and the system of heating the food on the ward good, as it ensured that food was hot, as long as it was served promptly.

The patients on this ward were quite poorly, often with poor appetites and many would miss meals because they were not hungry. Some patients said that the food was satisfactory, but the majority did not find the choice of food to their taste. This could be improved significantly by adding sandwiches and fresh fruit at lunchtime, and ensuring that people with poor appetites were given smaller portions. It would

also be beneficial to review the menus to include more variety between the lunch and evening meals. Also to coordinate menus for patients who require specialist diets to ensure they received optimum nutrition to aid their recoveries.

Report 3 - Ward: 7 West – Surgical, 28 Beds

Healthwatch Authorised Representatives: Tina Stanton and Margaret Peart

Date of Visit: 28 February 2017 – evening meal

Patients spoken to:

Number of patients observed: 16

Number of patients spoken to: 10

Findings

Phase 1: General Observations

The food was heated on a trolley in the corridor which was timed to be ready at the specified time. Staff were lined up in aprons ready to distribute food to the patients in an orderly and efficient fashion.

Protected Meal Time There was a barrier in place and a notice stating the start and finish of the protected meal time which appeared to be strictly adhered to.

Clearing Up after Meals The food we saw being cleared away on the whole, was collected in a timely way, we did not see any records being kept whether patients had eaten the food or not.

Phase 2: Feedback from Patients

Length of Stay This varied, some patients had only arrived that day, but one patient had been there for 50 days.

Cleanliness/Hygiene The ward appeared to be very clean, all patients were provided with wipes on a tray with their food.

Support with Eating We observed two or three patients who needed assistance and they were made comfortable and assisted to eat.

Quality and Choice of Food and Drink Most patients were satisfied with the food, saying it was acceptable for hospital food. One patient said 'beggars can't be choosers'; two commented that the vegetables were watery, and one said the butter was melted; one said that the soup was always cold.

Patients told us there was no fresh fruit on the menu, when one asked they were given an apple. Little pots of tinned fruit were available. We observed the tea trolley arriving at different stages of the meal to the bays; patients told us that the tea trolley often arrived before or with the main meal, rather than after the meal when they would like it.

Ordering System Most patients told us the ordering was quite straightforward, some were given a menu, while others had the menu read out to them.

Dietary/Cultural Requirements One patient told us that they had ordered the meatballs from the menu, but when they arrived this contained pork which she did not eat.

Two patients, both Greek Cypriots told me that the food was not to their taste at all and they found it difficult to eat anything so relatives brought food in for them

Portion Size Some patients told us that the portions were too big, but one patient told us they were always hungry and there was not enough. They had been given fish and chips on Sunday and counted 8 chips in their portion.

Availability of Additional Snacks Only about half of the patients that we spoke to were aware that they could ask for additional snacks.

Need for Friends and Family to Bring in Food Some patients told us that they had food brought in for them, as they could not eat the meals provided. Some patients had fruit brought in for them.

Any Occasions When Meals Have Been Missed Patients who missed meals were generally offered a sandwich on returning to the ward.

Recommendations

- To specify on the menus and tell patients if food contains pork.
- To ensure that the tea trolley arrives after the main meal is served
- To consider the portion size in relation to each patient to reduce wastage and cater for those with bigger appetites.
- To provide fresh fruit

Conclusions

Most patients were satisfied with the food and service provided on this ward, the few recommendations that we have made would improve things for all patients.

Report 4 - 6 South (Stroke Ward)

This visit was planned to observe breakfast on Sunday 19 March 2017

The two Enter and View volunteers arrived at the ward at 7.15am and presented themselves to the ward manager at this time to introduce themselves and to start the visit. Unfortunately, the ward manager had not been briefed by the hospital management team that a visit by Healthwatch Barnet may have been taking place that day, and did not allow the volunteers to start the visit. The volunteers had photo identity badges with them and introductory letters as agreed with the Head of Facilities at Royal Free Trust, but were still not allowed to enter. They spoke with one of the nurses for some time while waiting for the ward to contact the site managers. They were again informed that they could not undertake the observations or talk to patients, but were asked to wait to speak to the site manager. By this point the breakfast service which they had come to observe was completed. They waited for 20

minutes further for this to happen but when the site manager had not arrived they left, only to be called back as they reached the lift that the Site Manager was on his way up to meet with them. They returned but when the Manager had not arrived after a further 15 minutes they insisted on leaving.

Healthwatch have a statutory right to undertake Enter and View visits and this visit and date had been pre-arranged with the Head of Facilities/ Director of Nursing/Director of Facilities at the Trust, so it was frustrating and disappointing that entry was refused.

We have received an apology from the Divisional Nurse Director- Urgent Care/ Deputy Director of Nursing, who explained that the information about the visits had not been communicated due to a misunderstanding.

Report 5 - Ward 11 South – Haematology & Oncology, 19 single rooms

Healthwatch Authorised Representatives: Janice Tausig and Jeremy Gold

Date of Visit: Monday 20th March 2017 – Evening Meal 6 to 7pm

Patients spoken to:

The team specifically observed 8 rooms and talked to 8 patients and 5 relatives.

Findings

Phase 1: Our Observations

General This ward comprised 19 single rooms, each with a large lobby (thus two doors) between the corridor and the bed. This arrangement made it difficult to view what was happening without being intrusive. This limited our observations compared with what is possible when beds are arranged in bays, and we were as sensitive as possible to ensure that we did not disturb patients who did not wish to talk and waited until they had finished eating unless invited in by relatives.

The ward notice board showed that four nurses were rostered for this shift, but only three were on duty on this evening.

Most lobby and room doors were left partially open, and staff took no particular hygiene precautions before entering patients' rooms. The use of such rooms makes it more difficult for staff to observe and interact with patients, and more difficult for patients to attract attention if their call bell is not answered promptly.

Protected Meal Time We did not see any notice placed at the ward door explaining Protected Mealtime was in place. On further examination when leaving the ward the team did see a general notice on the wall inside a window casement in the ward explaining Protected Mealtimes but it was surrounded by other notices and was not prominent so the public would easily have missed it. Some relatives were sitting with patients.

During the mealtime two doctors visited a patient who had been admitted during the morning – on being asked about this the patient said they had finished eating when they visited and they had no complaint about it.

Clearing Up after Meals Although meals were finished, trays had not been cleared at 7pm – an hour after start of service.

The volunteers were told that the 'Green Tick' system was usually in use on the ward but was not being done that day as the cards had not been received. The green tick system is a process where when the meal is finished, the plastic card on which is a green tick, was placed on the tray to let the Nurse know the tray could be removed. We were unclear how these cards were cleaned and kept hygienic.

Phase 2: Feedback from Patients

Length of Stay Patients had been in the ward for a variety of timescales from that day arrivals to someone who had been there for more than 2 weeks.

Cleanliness/Hygiene The team asked patients if they had the opportunity to clean their hands before eating. Two hand wipes were provided on each tray and all patients were aware of these and where necessary they were used.

Support and Assistance with Eating and Drinking Staff placed meals on the patients' mobile tables and ensured that both food and water were within reach, except for one observed case where the table was full so the meal tray was placed on the bed. We did not observe staff helping patients to sit up and most appeared to be eating their meal from a semi-prone position. However when we asked patients, all except one stated that they felt they had been helped into a suitable position. None of the patients spoken to complained about this. One patient commented that if meals or drinks were not left within reach and ready for eating they would call for a nurse who would come quickly.

In all but one case, water was at the bedside and easily within reach of the patient.

We observed that puddings were not covered when the trays were delivered, though the main course is. As patients often eat slowly the hot puddings were cold by the time the patients got to eat them.

Nursing staff were seen to assist two patients to eat. We also observed some relatives sitting with a patient, and they had stopped the Staff assisting the patient as they said the patient was able to eat by themselves.

Only one red tray was observed and this patient had relatives with them at the time, so Staff were not supporting them.

Quality and Choice of Food and Drink We received mixed feedback about this. One patient who had been in hospital for a week said they felt the choice was limited and repetitious. They felt the food was sometimes served up congealed. They had been asking for ice in drinks as they were dehydrated and trying to increase liquid intake, but it had taken a week for this to happen.

Another patient told us soups and puddings are OK, but main courses are not appetising. "This is a problem as I have loss of appetite and need to 'feed up' prior to chemotherapy. Have mentioned this to doctor, who replied that that's what hospital food is like."

Two/three people said that regularly the meal that is ordered is not what is received.

Another patient's relatives said that the patient did not eat or drink for the first one to two days. The family then intervened and pointed out what the patient did and did not

like. Food presented is now quite acceptable – despite the fact puddings are served lukewarm to cold.

Another patient said the food was not always acceptable as he found it too spicy.

Ordering Some patients told us that they did not always see the menu or that it was quite confusing and difficult to use. Some others told us that the menu was read out to them and they were helped to choose and they were happy with that. One felt that the ordering process put them under pressure and was too rushed.

Portion Size Three patients told us the portions were too large, and that they found this off-putting. "It's too much for people after a major operation. Would much prefer smaller portions."

Availability of Snacks One patient had read about snacks being available but the rest were not aware and had not been told, though some commented that biscuits were sometimes brought round with the tea trolley.

Need for Friends and Family to Bring in Food Several friends and family brought food in for patients – sometimes to try and boost the amount being eaten and sometimes as the patient was not keen on the food served.

Any occasions when meals have been missed One person told us they had missed a meal as they had to go for some treatment, but it was kept and warmed up for them on return to the ward. Another said when they had missed meals an alternative was found for them.

Recommendations

1. Staffing levels should be maintained at the level specified. Staff appeared rushed in coping with the needs of patients.
2. It was not clear that the patients in this ward clinically needed single rooms and we wondered if a ward with single rooms is regularly used for patients who do not clinically require them, consideration should be given to re-allocation of bed space or re-configuration of the wards.
3. Explore improving the choice and quality of particularly the main courses.
4. Explore covering puddings when they are taken to patients to ensure they stay hot until they are eaten.
5. Staff to encourage patients to use hand wipes before eating – perhaps by opening them for patients.
6. To review the meal ordering process and ensure where appropriate menus are given to patients in font/print that is clear, and the information is easily understood. The use of pictures may also be beneficial, and some note about portion size be taken.
7. Ensure that all patients are advised that snacks are available, and how to access them.
8. Ensure that if the Trust feels that the 'green tick' system is effective, it is used consistently in all of the wards.

Conclusions

The meal service on this ward was technically efficient, but we felt that the staff were under a lot of pressure and were therefore rushed in the care that they were giving. Some patients were very positive about the senior staff on the ward and most felt that the care and support was fine.

Report 6 - 10 East (Renal Ward), 4 bays + 10 beds
and 10 South (Renal Ward), 30 beds in bays and single rooms

Healthwatch Authorised Representatives: Derrick Edgerton and Ellen Collins

Dates of Visits: 14th April Evening meal (10E) and 23rd April Lunch (10S)

Our views and observations were similar on both visits and hence are recorded together. As these wards care for patients with renal issues the food offered is from a specialised renal menu.

Findings

Phase 1: Our Observations

General The food is delivered from the central source and heated (regenerated) on the ward. The timing is automatically controlled. When ready a member of the nursing staff (assisted at lunchtime by ward orderly) takes the food out of the oven. Before opening those containers, the temperature is checked (no recording of temperatures is noted).

Available nursing staff came to assist (putting on plastic disposable aprons).

Trays of food were made up according to list of orders and taken to the patients.

On 10E the food serving trolley was located adjacent to the servery, on 10S the servery was in a different corridor. Hot food was served from the serving trolley and if a cold item (e.g. yoghurt) required, this was got from the fridge in the servery.

Each tray had on it cutlery, napkin and two wipes in foil. We did not observe many wipes being used but saw some staff members opening them for patients who were not able to open them.

Protected Meal Time On both occasions there was no signage at the entrances to the wards to indicate that a meal was being served. Whilst both wards did have a "Protected Mealtime" sign, this was used internally. Some clinical work (examinations, dialysis) was observed to be going on.

Clearing Up after Meals Once meals were finished, trays were cleared away by Healthcare Assistants in a suitable timeframe.

Phase 2: Feedback from Patients

Length of Stay Length of stay varied from 2 days to several weeks. One individual had at one stage been an inpatient for 7 months.

Support with Eating Staff were seen to be assisting individuals to eat, but only one red tray was observed to be given out on either visit.

Quality and Choice of Food and Drink The majority of individuals we spoke to on each occasion stated that the food quality was adequate, although some comments were passed over the state of the vegetables (cabbage hard, green beans tough). The food we saw looked and smelt appetizing. A few individuals said that after a while the food got monotonous.

These wards were renal wards so the food was tailored somewhat to that.

Ordering System The ordering system was confusing. It appeared to work as follows: The kitchen sends up the relevant number of meals (say 24) comprising 3 choices (e.g. 8 x A, 8 x B, 8 x C). A nurse goes around asking each patient what they would like. So the first patient gets a choice of A, B or C, but when all of A has gone the choice is B or C. We were also told that occasionally, the list of contents in the ovens, is not the same as what actually it is. So instead of 8 x A, B & C one might find 10 A & B and only 4 C.

This ordering system has apparently been in use for many years.

We were told by patients that they did not necessarily see a menu, but that a member of staff came round and told them what meals were going to be available and they made a choice on this basis. On occasion they were not offered what they had ordered, due to the system used as described above.

Dietary/Cultural Requirements One individual stated that the Halal food was particularly good.

Portion Size General portion size appeared variable. There were some comments that the portion size was too small, other comments that they were too large. On both occasions, there appeared to be a lot of food left over although some components (particularly deserts) were insufficient. There appeared to be confusion about the supply of gravy and custard, whether it was supplied centrally or produced on the ward.

Availability of Additional Snacks There appeared to be little knowledge that snacks were available (one diabetic patient stating that the period between dinner (6pm) and breakfast (9am) was too long).

Need for Friends and Family to Bring in Food We did not hear of any relatives bringing in food (apart from snack items).

Any Occasions When Meals Have Been Missed A new arrival was offered a meal within 30mins of being on the ward, choice being limited to what was available.

General Comments The overall impression was that the ward staff knew their patients and their likes and dislikes (comments like “they need lots of gravy”, “likes a small piece of sponge but lots of custard”).

Recommendations

1. Consider reviewing the ordering system to be able to more accurately reflect the patient’s requests in more cases.
2. Consider reviewing portion control to reduce wastage, and encourage all patients to eat well.

Conclusions

We were welcomed on both wards by staff who were happy to talk to us, and who knew and cared for their patients.

Overall, the patients appeared to be content with the food. The recommendations we are making are there to make things even better.

These reports relate only to the service viewed on the dates of the visit, and are representative of the views of the staff, visitors and patients who met members of the Enter and View team on those dates.

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London Borough of Barnet Health Overview and Scrutiny Forward Work Programme September 2017 - December 2017

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AGENDA ITEM 12

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
February 2018			
Suicide Prevention in Barnet	Committee to receive a report from Public Health on Suicide Prevention in Barnet	Public Health Team	**Non-key**
Healthwatch Barnet Update	Healthwatch Barnet to provide Committee with an update on Patient Participation Groups and Mealtimes and Royal Free Hospital.	Healthwatch Barnet	**Non-Key**
STP Update	Committee to receive an update report on the STP (sustainability and Transformation Plan)	North Central London CCGs	**Non-key**
To be allocated			
Enter and Revisit reports	Report on the enter and revisit reviews by Healthwatch.	Healthwatch Barnet	**Non-key**
Update Report: Finchley Memorial Hospital	Committee to receive an update report as a standing item on Finchley Memorial Hospital	Barnet CCG	**Non-Key**