MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

WEDNESDAY 12TH MARCH, 2014

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

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

Chairman: Councillor Alison Cornelius
Vice Chairman: Councillor Graham Old

Councillors

Maureen Braun	Arjun Mittra	Kate Salinger
Geof Cooke	Bridget Perry	Brian Schama
Julie Johnson	Barry Rawlings	

Substitute Members

John Hart	Kath McGuirk
Sury Khatri	Charlie O'Macauley

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

Andrew Nathan – Head of Governance

Governance Services contact: Andrew Charlwood 020 8359 2014
andrew.charlwood@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	1 - 10
2.	Absence of Members	
3.	Declaration of Members' Interests a) Disclosable Pecuniary Interests and Non Pecuniary Interests b) Whipping Arrangements (in accordance with Overview and Scrutiny Procedure Rule 17)	
4.	Public Question Time (If Any)	
5.	Members' Items (If Any)	
6.	GP Services at Finchley Memorial Hospital	11 - 20
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13.	Any Other Items that the Chairman Decides are Urgent	

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Decisions of the Health Overview and Scrutiny Committee

12 December 2013

Members Present:-

AGENDA ITEM 1

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

Councillor Maureen Braun	Councillor Barry Rawlings
Councillor Geof Cooke	Councillor Kate Salinger
Councillor Julie Johnson	Councillor Brian Schama
Councillor Arjun Mittra	Councillor Sury Khatri

Also in Attendance
Councillor Helena Hart – Cabinet Member for Public Health
Councillor Jim Tierney – West Finchley Ward Member

Apologies for Absence

Councillor Julie Johnson Councillor Bridget Perry

1. MINUTES (Agenda Item 1):

The Chairman updated the Committee in relation to minute items from the 3 October 2013 meeting as follows:

i) Item 6 (Transport Services – Finchley Memorial Hospital) – the Committee were informed that officers had confirmed that unspent section 106 contributions could not be used to fund the purchase of a shuttle vehicle for Finchley Memorial Hospital.

ii) Item 6 (Transport Services – Finchley Memorial Hospital) – the Committee noted that the Friends of Finchley Memorial Hospital had been given permission by the hospital to undertake a patient survey to gauge demand for additional on-site transport services. It was expected that this would take place in February or March 2014 unless new GP services were scheduled to come on site.

RESOLVED that the minutes of the meeting held on the 3 October 2013 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence had been received from Councillor Bridget Perry and Councillor Julie Johnson.

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

Member	Subject	Interest declared
Councillor Alison Cornelius	Agenda Item 7 (Barnet, Enfield and Haringey Clinical Strategy Update) and Item 8 (NHS Quality Accounts – Mid Year Update)	Non-pecuniary interest by nature of being on the chaplaincy team at Barnet Hospital
Cllr Kate Salinger	Agenda Item 8 (Maternity Services –Caesarean Births)	Non-pecuniary interest by nature of having two nieces who are midwives at Barnet Hospital

4. PUBLIC QUESTION TIME (Agenda Item 4):

None.

5. MEMBERS' ITEM - GP SERVICES AT FINCHLEY MEMORIAL HOSPITAL (Agenda Item 5):

The Committee considered a Members' Item in the name of Councillor Geof Cooke in relation to NHS England seeking to relocate local GP practices onto to the Finchley Memorial Hospital site.

Councillor Cooke informed the Committee that Dr Su Thwe (209 Ballards Lane, Finchley) was being forced by NHS England relocate her practice into the vacant GP spaces in Finchley Memorial Hospital as the current accommodation did not meet current NHS England accommodation standards.

At the invitation of the Chairman, Councillor Jim Tierney, Ward Member for West Finchley, addressed the Committee. Councillor Tierney considered that primary care services should be accessible within the community and questioned how moving an existing surgery from N3 to N12 would support this. The Committee were informed that Dr Thwe had 2,050 patients on her list and, when surveyed, 900 of these had indicated that they would not be prepared to travel to Finchley Memorial Hospital to access services.

Councillor Tierney advised the Committee that when Finchley Memorial Hospital was being redeveloped, there had been concern at the planning committee approval stage regarding the accessibility of the site and public transport links. He noted that at a previous meeting of the Committee, Transport for London had stated that they would not re-route local bus services into the hospital site as the cost would be prohibitive.

The Committee expressed disappointment that the Finchley Memorial Hospital Transport Plan submitted to the Council when the site was redeveloped had not been implemented and this was now causing on-going accessibility issues for patients.

A Member informed the Committee that NHS England were only able to require GP practices to move out of sub-standard premises when a GP retired.

Councillor Cooke noted that there was vacant space for GP premises on the Finchley Memorial Hospital site and there was a charge for the Barnet Clinical Commissioning Group for underutilised estates. Notwithstanding this, patients had indicated that they did not want the practice to move from its current high street location.

At the invitation of the Chairman, the Committee were addressed by Ms Soo Koh, Practice Manager at the surgery of Dr Thwe at 209 Ballards Lane, Finchley. She advised the Committee that the senior partner at Dr Thwe's practice had retired in March 2013 and that the surgery had been run on a caretaking basis since then. As such, NHS England had no obligation to retain the practice in its current location and could choose to advertise or disperse the list. The Committee noted that 209 Ballards Lane was currently below the CQC minimum premises standards and as a consequence the premises needed to be refurbished or move to an alternative site. Dr Thwe's preferred option was to move the practice from 209 Ballards Lane to 100 Ballards Lane and work was on-going to bring this site up to standard. However, NHS England's preference was for the practice to move into the Finchley Memorial Hospital site.

RESOLVED that:-

1. **the Committee invite NHS England to make a written submission and be invited to address the Committee at the March 2014 meeting on:**

   i) **the issues detailed above regarding the decision to move Dr Thwe's practice to Finchley Memorial Hospital; and**

   ii) **any progress made in relocating GP practices into the vacant GP space at Finchley Memorial Hospital.**

2. **the Committee receive a written submission in advance of the next meeting in relation to the impact of dispersing the patient list of two practices in the West Finchley area (Dr K Dodanwatawana, 110 – 112 Ballards Lane and Dr S S Thwe, 209 Ballards Lane).**

6. MEMBERS' ITEM - SITE ISSUES AT FINCHLEY MEMORIAL HOSPITAL (Agenda Item 6):

The Committee considered a Members' Item in the name of Councillor Kate Salinger in relation to site issues at Finchley Memorial Hospital site.

The Committee noted that Councillor Salinger had received responses to her queries from NHS Property Services and Community Health Partnerships and that these were detailed in the committee report. Councillor Salinger considered that the responses received did not address the issues raised particularly in relation to public transport, benches and the porter service.

RESOLVED that a NHS Property Services and Community Health Partnerships be requested to attend and present a full report at the next meeting of the Committee on 12 March 2014.

7. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY (Agenda Item 7):

The Committee welcomed Cathy Geddes (Barnet and Chase Farm Programme Director for the Barnet, Enfield and Haringey Clinical Strategy) and John Morton (Chief Operating Officer, Barnet Clinical Commissioning Group) who were in attendance to provide an update on the implementation of the Barnet, Enfield and Haringey Clinical Strategy.

Cathy Geddes outlined the principal reasons for the service changes. Members were informed that the Clinical Cabinet and Barnet, Enfield and Haringey Clinical Strategy Programme Office continued to meet whilst the Strategy was being implemented.

The Committee noted that the NHS had been working closely with Barnet Social Care Services on delayed transfer of care and PACE (Post Acute Care Enablement).

Members questioned how patients were triaged when they presented at urgent care. Cathy Geddes reported that patients would either be treated or referred back to their GP, or would be screened by the TREAT Service (Triage and Rapid Elderly Assessment Team) or RAID Service (Rapid, Assessment, Intervention and Discharge). She added that the RAID Service was not 24 hours, but hours would be increasing.

The Committee highlighted that Chase Farm Hospital would not increase their elective surgery capacity until 2014 and questioned whether there was currently capacity in the system to achieve the 18-week target. Cathy Geddes reported that the Highland Wing was already in place at Chase Farm. She acknowledged that there would be an issue with clearing the backlog to achieve the 18-week target and reported that Fiona Smith (Chief Operating Officer at Barnet and Chase Farm Hospitals NHS Trust) was dealing with this issue.

Cathy Geddes confirmed that the new 200 space car park on the Barnet Hospital site would be opening on 13 December 2013.

Members welcomed the improvements at Barnet Hospital Maternity and A&E.

A Member supported the investment in Alzheimer's care in the Larches Ward at Barnet Hospital, particularly the improvements to bed areas, the installation of a Tiptree Box and the refurbishment of the toilet.

A Member informed the Committee that he had visited North Middlesex Hospital and had been impressed at the changes to maternity services and the positive attitude of staff.

RESOLVED that:

1. **Committee Members be canvassed for availability to attend a site visit to A&E, Maternity Services, Alzheimer's/Dementia Services and the new car park at Barnet Hospital in February 2014.**

2. **the Barnet, Enfield and Haringey Programme Office be requested to provide the Committee with details of the number of Barnet patients currently scheduled for elective surgery.**

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8. NHS QUALITY ACCOUNTS - MID YEAR UPDATE (Agenda Item 8):

The Committee considered updates received from NHS health service providers on progress made in addressing the comments / recommendations made by when the 2012/13 Quality Accounts were reviewed on 9 May 2013.

NORTH LONDON HOSPICE

The Committee welcomed Pam McClinton, the Nursing Director at the North London Hospice. She made the following comments in addition to the update report set out in the committee report:

The Hospice had now achieved full compliance with Level 2 of the 2013/14 Information Governance Toolkit.

Whilst staffing ratios were currently good, recruitment could be an issue and the Hospice had been investigating ways to address this.

The Hospice Board had been undergoing a development programme facilitated by Help the Hospices. A new governance structure had been implemented which had delivered a more joined up approach. In addition, the Board of Trustees would be considering the implications of the Government's response to the Francis Report in early 2014.

The Committee noted that the table on pressure sore numbers should read 4 in 2012/13 and not 2 as per the published table.

Members were informed that Douglas Bennett would be stepping down as Chief Executive of the Hospice and would be replaced by Pam McClinton.

ROYAL FREE LONDON NHS FOUNDATION TRUST

The Committee welcomed Dr Steve Powis, Medical Director at the Royal Free London NHS Foundation Trust. He made the following comments in addition to the update report set out in the committee report:

Dr Powis reported that meeting the C. difficile target had been challenging and it was expected that the Trust would not meet the target in 2013/14. The Committee were advised that detailed root and branch reviews had been undertaken to investigate C. difficile cases. He added that a recent study by Oxford University had shown that reductions in the same of C. difficile cases could be attributed to reductions in the use of antibiotics rather than hospital cross-infection control measures.

Responding to a question, Dr Powis reported that patient-reported outcome or experience metrics were not related to satisfaction, but rather health improvements and pain management. He added that the system was currently being tested.

CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST

The Committee noted that Central London Community Healthcare (CLCH) had been unable to send a representative to the meeting

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Members commented that whilst PREMs (Patient Reported Experience Measures) responses from Barnet residents had increased to 20% of the total responses for CLCH, this was still represented poor performance from a borough with a population of 350,000.

BARNET AND CHASE FARM HOSPITALS NHS TRUST

The Committee welcomed Fiona Smith (Chief Operating Officer at Barnet and Chase Farm Hospitals NHS Trust) and Terina Riches (Director of Nursing at Barnet and Chase Farm Hospitals NHS Trust). They made the following comments in addition to the update report set out in the committee report:

In relation to MRSA, the Trust undertook a root and branch reviews to ascertain the reasons for these failures in care.

The Committee were informed that there had been one 'Never Event' where potassium had been given to a patient and it was reported that this had been referred to the serious incident panel.

A Member questioned whether the root cause analysis for specific incidents was shared across the NHS. Terina Riches reported that this did not happen routinely and at present, learning was shared with the Commissioning Support Unit.

BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

The Committee welcomed Clara Wessinger (Head of Clinical Audit and Effectiveness at Barnet, Enfield and Haringey Mental Health Trust).

At the invitation of the Chairman, Councillor Helena Hart (Cabinet Member for Public Health), addressed the Committee. She expressed serious concerns regarding the findings of recent Care Quality Commission (CQC) inspections of Barnet, Enfield and Haringey Mental Health Trust services. Members were informed that she had written to the Barnet Clinical Commissioning Group Chairman and that John Morton had written to the Trust regarding these issues. She reported that the recent CQC inspections were a follow-up from inspections undertaken in May 2013 which identified issues. Whilst there had been improvements in one ward, there had been no improvements in a number of other wards. Of the six basic quality and safety standards, four had been breached. She highlighted that there had been failures on medicines and oxygen management, patients had been forced to wear continence pads and that mealtime arrangements required improvements.

The Committee noted that the Cabinet Member for Public Health would be taking an urgent item to the next meeting of the Health and Well-Being Board on 23 January 2014. The Chairman suggested that a special meeting of the North Central London Sector Joint Health Overview and Scrutiny Committee be convened to consider the CQC inspection reports as soon as possible.

John Morton (Chief Officer at Barnet Clinical Commissioning Group) advised the Committee that Enfield Clinical Commissioning Group (CCG) were the lead commissioners for Barnet, Enfield and Haringey Mental Health Trust across the three boroughs. Members were informed that Mr Morton had been meeting regularly with Barnet, Enfield and Haringey Mental Health Trust. The Committee were informed that

the Mental Health Trust had a new medical director who had significant experience in the field.

In response to these concerns, Clara Wessinger reported that she was not able to respond to issues on the Quality and Safety Action Plan. She made the following comments in relation to the update report on NHS Quality Accounts set out in the committee report:

In relation to communications, process mapping work had been undertaken across services to identify gaps and as a result new protocols had been put in place.

A Member advised the Committee that that at a recent CCG meeting, GPs had commented that they had felt unsupported by the Mental Health Trust in relation to the GP Advice Line. It was highlighted that the number of calls to the GP Advice Line had been deteriorating. Clara Wessinger advised the Committee that there was no mechanism in place to capture feedback on the service. She added that the decline might be attributable to the recent Primary Care Academies which had introduced other systems to support GPs.

RESOVLED that:-

1. **The Committee note the updates on the NHS Quality Accounts 2012/13 as set out in the reports and above.**

2. **Barnet and Chase Farm Hospitals NHS Trust be requested to circulate the outcome of the Diabetes Audit to the Committee.**

3. **Barnet and Chase Farm Hospitals NHS Trust be requested to provide a written response to the Committee on the arrangements for sharing learning from "Never Events" across the NHS.**

4. **The Chairman of the North Central London Joint Health Overview and Scrutiny Committee be requested to set up a special meeting (of Barnet, Enfield and Haringey Members only) to consider the recent Care Quality Commissioning reports on Barnet, Enfield and Haringey Mental Health Trust, with representatives from Clinical Commissioning Groups, local Healthwatches and Cabinet Members for Health being invited to attend.**

9. MATERNITY SERVICES (CAESAREAN BIRTHS) (Agenda Item 9):

The Committee considered a report which outlined the performance of the Royal Free London NHS Foundation NHS Trust and Barnet & Chase Farm Hospitals NHS Trust in relation to maternity services and caesarean births.

The Committee welcomed Fiona Smith (Chief Operating Officer at Barnet & Chase Farm Hospitals NHS Trust) and Adam Rodin (Clinical Director of Women's Services at Barnet & Chase Farm Hospitals NHS Trust) for the item.

A Member expressed concern that caesarean rates seemed to be higher than the national average. Adam Rodin reported that the Trust were required to adhere to NICE guidelines which gave expectant mothers choice regarding delivery. He advised the Committee that there were multiple reasons for inductions and caesareans with the

numbers varying from month to month. Members were informed that the Trust had been working with University College Hospital to review practice in relation to inductions and caesareans.

RESOLVED that:

1. **The Committee note the updates set out in the report and above in relation to maternity services.**

2. **The Royal Free London NHS Foundation NHS Trust and Barnet & Chase Farm Hospitals NHS Trust be requested to provide an update on performance in relation to maternity services in their Quality Accounts submissions to the Committee in May 2014.**

10. GP SERVICES IN BARNET (Agenda Item 10):

The Committee welcomed Tony Westbrook (Head of Regeneration) to present a report on GP services in Barnet.

Mr Westbrook informed the Committee that some of the larger regeneration estates had been required to develop GP premises as a planning condition. However, GPs are self-employed and there is no requirement for them to operate their services from the premises provided as part of regeneration schemes.

The Committee noted that a Colindale focussed project group had been established with representation from the Barnet CCG, NHS England, NHS Property Services and the Council.

RESOLVED that:

1. **The Committee note the update on GP Services in Barnet as set out in the report and above**

2. **The Committee keep a watching brief on this issue**

3. **The Committee refer this issue to the Health and Well-Being Board to consider alongside the refresh of the Joint Strategic Needs Assessment**

11. BARNET HEALTHWATCH ENTER AND VIEW REPORTS (Agenda Item 11):

The Committee welcomed Julie Pal (Chief Executive at CommUNITY Barnet). In introducing the report, she advised the Committee that Healthwatch were disappointed at the response from Barnet, Enfield and Haringey Mental Health Trust to the issues raised in the Ken Porter Ward Enter and View report.

RESOLVED that:

1. **Officers be requested to liaise with support officers for the North Central London Joint Health Overview and Scrutiny Committee to investigate ways for the Healthwatch Enter and View reports be considered.**

2. **Committee Members be requested to identify potential mental health site for Barnet Healthwatch to consider for inclusion in the Enter and View programme of visits.**

12. BREAST SCREENING SERVICES - FINCHLEY MEMORIAL HOSPITAL (Agenda Item 12):

The Committee considered a submission from the North London Breast Screening Service and NHS England on the Breast Screening Service at Finchley Memorial Hospital.

The Chairman reported that she had been informed that breast screening mobile unit had been successfully connected and tested in readiness for services commencing on 2 December 2013.

RESOLVED that the update as set out in the report be noted.

13. NHS HEALTH CHECKS SCRUTINY REVIEW (Agenda Item 13):

The Committee considered a report which provided an update on the joint Barnet / Harrow NHS Health Checks Scrutiny Review.

RESOLVED that:-

1. **The Committee note the update on the joint Barnet / Harrow NHS Health Checks Scrutiny Review as set out in the report.**

2. **The Committee approve the final report of the joint Barnet / Harrow NHS Health Checks Scrutiny Review being approved by the Committee via e-mail to enable the report to be referred to Cabinet in February 2014.**

14. MINUTES OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 4 OCTOBER 2013 (Agenda Item 14):

The Committee considered the minutes of the North Central London Sector Joint Health Overview and Scrutiny Committee (JHOSC) which had taken place on 4 October 2013.

The Chairman advised the Committee that a visit to the 111 service was being arranged through the JHOSC.

The Overview & Scrutiny Manager informed the Committee that the Royal Free Hospital NHS Foundation Trust had submitted a request for the proposed merger of the Royal Free and Barnet & Chase Farm to be scrutinised through the JHOSC rather than individual Health Overview & Scrutiny Committees. The Committee were requested to consider whether they wished to retain the ability to scrutinise the merger or whether they were content for the issue to be scrutinised through the JHOSC only.

RESOLVED that the Committee note the minutes of the meeting of the North

Central London Sector Joint Health Overview and Scrutiny Committee held on 4 October 2013.

15. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME (Agenda Item 15):

RESOLVED that:

1. **The Health Overview and Scrutiny Committee Forward Work Programme be noted.**

2. **The Committee note that the Chairman would review the work programme and allocate items to committee meeting dates.**

16. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 16):

None.

The meeting finished at 10.00 pm

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AGENDA ITEM 6

Meeting	Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**GP Services at Finchley Memorial Hospital**
Report of	Scrutiny Office
Summary	This report provides the Committee with a submission from NHS England on GP Services at Finchley Memorial Hospital.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	West Finchley, Woodhouse, North Finchley
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	Appendix A – Submission from NHS England
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 The Committee considers information from NHS England on GP Services at Finchley Memorial Hospital as set out in Appendix A.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 12 December 2013, Agenda Item 5 – Members Item – GP Services at Finchley Memorial Hospital – the Committee considered a Members' Item in the names of Councillor Geof Cooke in relation to NHS England seeking to relocate local GP practices onto the Finchley Memorial Hospital site. The Committee received representations from Councillor Jim Tierney, Ward Member for West Finchley, and the Practice Manager at the surgery of Dr Thwe at 209 Ballards Lane. Following consideration of the item, the Committee resolved that NHS England be requested to make a submission to the next meeting on the issues raised.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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 have due regard to the equality duties when exercising a public function. The broad purpose of

this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.2 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of this report.

7. LEGAL ISSUES

7.1 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.

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 As set out in paragraph 2.1, the Committee considered an item on GP Service at Finchley Memorial Hospital at their 12 December 2013 meeting. An extract from the minutes is set out below:

9.2 "Councillor Cooke informed the Committee that Dr Su Thwe (209 Ballards Lane, Finchley) was being forced by NHS England relocate her practice into the vacant GP spaces in Finchley Memorial Hospital as the current accommodation did not meet current NHS England accommodation standards.

9.3 At the invitation of the Chairman, Councillor Jim Tierney, Ward Member for West Finchley, addressed the Committee. Councillor Tierney considered that primary care services should be accessible within the community and questioned how moving an existing surgery from N3 to N12 would support this. The Committee were informed that Dr Thwe had 2,050 patients on her list and, when surveyed, 900 of these had indicated that they would not be prepared to travel to Finchley Memorial Hospital to access services.

9.4 Councillor Tierney advised the Committee that when Finchley Memorial Hospital was being redeveloped, there had been concern at the planning committee approval stage regarding the accessibility of the site and public transport links. He noted that at a previous meeting of the Committee, Transport for London had stated that they would not re-route local bus services into the hospital site as the cost would be prohibitive.

9.5 The Committee expressed disappointment that the Finchley Memorial Hospital Transport Plan submitted to the Council when the site was redeveloped had not been implemented and this was now causing on-going accessibility issues for patients.

9.6 A Member informed the Committee that NHS England were only able to require GP practices to move out of sub-standard premises when a GP retired.

9.7 Councillor Cooke noted that there was vacant space for GP premises on the Finchley Memorial Hospital site and there was a charge for the Barnet Clinical Commissioning Group for underutilised estates. Notwithstanding this, patients had indicated that they did not want the practice to move from its current high street location.

9.8 At the invitation of the Chairman, the Committee were addressed by Ms Soo Koh, Practice Manager at the surgery of Dr Thwe at 209 Ballards Lane, Finchley. She advised the Committee that the senior partner at Dr Thwe's practice had retired in March 2013 and that the surgery had been run on a caretaking basis since then. As such, NHS England had no obligation to retain the practice in its current location and could choose to advertise or disperse the list. The Committee noted that 209 Ballards Lane was currently

below the CQC minimum premises standards and as a consequence the premises needed to be refurbished or move to an alternative site. Dr Thwe's preferred option was to move the practice from 209 Ballards Lane to 100 Ballards Lane and work was on-going to bring this site up to standard. However, NHS England's preference was for the practice to move into the Finchley Memorial Hospital site.

RESOLVED that:-

1. **the Committee invite NHS England to make a written submission and be invited to address the Committee at the March 2014 meeting on:**

   i) **the issues detailed above regarding the decision to move Dr Thwe's practice to Finchley Memorial Hospital; and**

   ii) **any progress made in relocating GP practices into the vacant GP space at Finchley Memorial Hospital.**

2. **the Committee receive a written submission in advance of the next meeting in relation to the impact of dispersing the patient list of two practices in the West Finchley area (Dr K Dodanwatawana, 110 – 112 Ballards Lane and Dr S S Thwe, 209 Ballards Lane)."**

9.9 The submission requested at 9.8 above has been received and is set out at **Appendix A**. Officers from NHS England will be in attendance to answer questions from the Committee.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Cleared by Finance (Officer's initials)	**JH**
Cleared by Legal (Officer's initials)	**SC**

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APPENDIX A

REPORT TO BARNET HEALTH OVERVIEW AND SCRUTINY COMMITTEE
12 MARCH 2014

This report provides information requested by the London Borough of Barnet's Health Scrutiny Committee following their meeting in December 2013 in relation to

i) the decision to relocate Dr Thwe's practice to Finchley Memorial Hospital;
ii) progress made in relocating GP practices into the vacant space at Finchley Memorial Hospital; and,
iii) the impact of dispersing the patient lists of two practices in the West Finchley area (Dr K Dodanwatawana, 110 – 112 Ballards Lane and Dr S S Thwe, 209 Ballards Lane)

NHS England's decision to relocate Dr Thwe's practice to Finchley Memorial Hospital (FMH)

It is important to note the following clarifications to the information provided by the practice to the Committee:

- NHS England has not made a decision to relocate Dr Thwe's Practice to FMH
- Dr Thwe, as the service provider, is responsible for finding and securing adequate premises for the delivery of her contract. These should be compliant with NHS and Care Quality Commission (CQC) standards.
- Dr Thwe is a GMS (General Medical Services) contractor and she holds the contract with NHS England in her own right after the retirement of her partner Dr Vyas. Her contract is substantive, not time limited and is not on a caretaking basis.
- NHS England cannot disperse a patient list unless the contract has ended in accordance with the provisions of the contract and a subsequent decision is taken that the future care of the patients of that practice is managed by asking the patients to register elsewhere (dispersal)

It may be helpful to explain that where NHS England establishes that a GP Provider is practising from premises that do not meet standards it must address this in the interests of patient quality and safety. In these circumstances if the provider does not take action, NHS England can issue a contract notice or request that they develop a plan that remedies the failure in standards. Providers would typically be allowed at least six months to develop their plans. The consequence of not submitting a plan is that NHS England can take formal action that may result in the removal (ultimately) of and/or contract sanctions.

Obviously in these circumstances the provider may need to consider relocation to new premises. These too must meet NHS standards and will be subject to NHS

England approval. NHS England would also provide feedback to contractors who are considering relocation when asked. This may include feedback that the premises they are considering would not meet standards, for example if they are too small. It is understood that Dr Thwe is currently reviewing options to relocate her practices and shall at some point submit these to NHS England for approval. In making any determination NSH England shall take into account the impact of void premises at Finchley Memorial Hospital on the health economy.

Progress on the relocation of GP practices into the vacant space at Finchley Memorial Hospital

NHS England is actively supporting two GP practices, Squires Lane and Cornwall House, in order to facilitate their move into Finchley Memorial Hospital. Meetings with the practices, the Clinical Commissioning Group and NHS England are held fortnightly to progress the move.

The landlord for the property, Community Health Partnerships (CHP), and the two GP practices are negotiating the lease arrangements to support the use of the premises. NHS England has worked with both of these parties to resolve issues where this was appropriate or requested. At the time of writing the report, the parties had advised that they had made good progress on resolving key issues.

Once the outstanding issues with the lease have been agreed between the two parties, the practices and NHS England will be in a position to consult with patients regarding their needs and preferences when accessing primary medical services at Finchley Memorial Hospital. This will determine the timing of any move of services into Finchley Memorial Hospital. The practices have also been mindful that the timing of any move should have minimal disruption to services and therefore should avoid periods of high activity.

The impact of dispersing the patients lists of two practices in the West Finchley area (Dr K Dodamwatawana, 110-112 Ballards Lane and Dr S S Thwe 209 Ballards Lane)

NHS England decided to disperse the patient list of The Finchley Practice, 110-112 Ballards Lane following consideration of the views of other stakeholders, the overall viability of the practice and the impact on patients and other services.

NHS England liaised with the patient group, the local MP, Mike Freer, and other stakeholders regarding the future plans for the patients on Dr Dodamwatawana's list. The plan to close the practice at 110-112 Ballards Lane took effect from 31 January 2014. Each adult patient has been written to regarding this and they have been

provided with details of all local GP practices in the area where they can register to receive GP services. The practice has provided NHS England with a list of vulnerable patients and in order to provide continuity for their care, these patients have been allocated to another practice. Patient choice is paramount and patients have been provided with details of how to access NHS Choices website where they can compare practices and a number to ring in Patient Support Services should they experience any difficulties registering with a new practice. To date NHS England is not aware of any patient concerns and has not received any correspondence from patients about the dispersal of the list and their requirement to register with another practice.

Prior to coming to the decision to disperse the patient list, NHS England had written to all GP practices within a 1.5 radius of the practice at ask whether they could register an influx of patients in their postcode area. NHS England is satisfied that there was capacity in excess of what is required within these practices to register all the patients, having been assured so by a sufficient number of local practices that confirmed that they did indeed have capacity.

It should be noted that improving quality and access can be cost effectively achieved by increasing the average list size of practices. As you will be aware practice patient list sizes in Barnet historically have been below average in London. As would be expected, smaller practices are less able to leverage economies of scale to develop and expand premises and workforce (key factors in improving access). For this reason, list dispersal is a strategic approach to improving quality and access as it encourages and supports practice expansion.

Post the closure of the practice, NHS England will review those patients that remain unregistered with a GP practice. Children under 5 and the elderly aged 75 and over will be referred to the Health Visiting and District Nurse teams in order that they can review these lists and follow up with the patient/parent/carers.

It is not unusual that when a patient list is dispersed that there will be some people who fail to register with another GP practice in the area. This may occur for a number of reasons – in London the main reason is often that the patient no longer lives in the area and has no need of local services.

Tessa Garvan
Assistant Head of Primary Care GP & Pharmacy North East and Central London
NHS England
February 2014

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AGENDA ITEM 7

Meeting	Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**Site Issues at Finchley Memorial Hospital**
Report of	Scrutiny Office
Summary	This report updates the Committee on site issues at Finchley Memorial Hospital

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	All
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	None
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Committee considers the update received from NHS Property Services and Community Health Partnerships in relation to site issues at Finchley Memorial Hospital and make appropriate comments and/or recommendations.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview & Scrutiny Committee, 12 December 2013, Minute Item 6, Members Item (Site Issues at Finchley Memorial Hospital) – the Committee considered a Members' Item in the name of Councillor Kate Salinger and the response of Community Health Partnerships / NHS Property Services to the issues raised. At the conclusion of the item, the Committee resolved that Community Health Partnerships / NHS Property Services be requested to attend and present a full report to the next meeting.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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 have due regard to the equality duties when exercising a public function. The broad purpose of

this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.2 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None.

7. LEGAL ISSUES

7.1 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.

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 At the meeting held on 12 December 2013, the Committee received a Members' Item in the name of Councillor Kate Salinger which set out a number of queries questions relating to site issues at Finchley Memorial Hospital. At the conclusion of the item, the Committee resolved that NHS Property Services and Community Health Partnerships be requested to submit a full report and attend the next meeting to respond to questions. Details of responses received at the 12 December 2013 meeting are set out in sections 9.1.1 to 9.1.6 below:-

9.1.1 "Why is there no bench or chair adjacent to the drop off point for patients who are brought by car and may need to sit down whilst waiting for their driver to accompany them into the hospital? There are two benches next to the garden by the main car park but they are no help to frail or disabled patients in that position."

There are permanently fixed benches in the memorial garden which are there for patients/the public to find some peace away from the building. We have previously trialled putting some free-standing benches outside the main building entrance but this was then used by smokers who created more problems by congregating in this area and leaving their litter behind (notwithstanding the hospital is a no-smoking site). We do not have enough security resource to continually keep moving smokers away from this area and/or cleaning staff to maintain the area and keep free from cigarette butts.

9.1.2 "Why are the disabled parking bays not close to the main entrance? Surely they should be on the same side as the hospital and shouldn't there be more of them?"

The disabled bays were located as close to the main entrance as possible without impeding the main carriageway that leads from the site entrance to the building entrance.

The nearest disabled bay is less than 10 metres from the entrance to the building which for a hospital is very good. The space in between and directly outside the main entrance is reserved for emergency ambulances only (e.g. collecting patients from site who attended the walk-in centre when the severity of their condition necessitated emergency admission to A&E).

The position of disabled bays was agreed with the local authority as part of the planning process and should reflect the needs of all users.

9.1.3 "Why are there no wheelchairs available at the entrance to the hospital to help transport disabled patients to their clinics?"

Porters are onsite who are available to transport anyone requiring their services to wherever they need to get to within the hospital grounds.

9.1.4 "Why are the podiatry and chiropody rooms so far from the main entrance? Most patients for these clinics have trouble walking and to position them so far away from the main entrance is ludicrous? Surely some of the consulting rooms which are nearer to the main entrance could be used for these purposes."

As mentioned above, porters and wheelchairs are available upon request. This is a multi-service building and moving one service closer to the main entrance would result in another service moving further away thereby inconveniencing the patients visiting that service instead.

9.1.5 "There are no chairs in the entrance hall either for people to sit on and wait for their accompanying drivers"

There are chairs in the main atrium inside the main entrance, next to the main reception. There are also some even closer in the pharmacy sub-wait area. I understand patients currently use these while waiting for their drivers/taxis etc. They can also wait in the café which is also close to the main entrance and has plenty of seating.

We will ask the Centre Manager to review the provision of chairs where possible but these should not block access for other people. In particular we are unable to allow seating to be placed in the draught lobby as this would block access to the building.

9.1.6 "It is ridiculous that no bus enters the hospital. Some patients have to take taxis as they cannot manage the walk from the gate to the main entrance of the hospital. Could we have a further update on this matter, please?"

Discussions have been held with TfL who are responsible for management of bus routes. They have they have no plans to route a service through the site but if that view changes then we will be pleased to work with them in that regard. I should add that a Travel Plan was agreed with the Local Authority as part of the planning process and the need for a bus service was not identified then.

9.2 As requested at the last meeting, NHS Property Services and Community Health Partnerships have provided a further update on the issues raised. Details are set out in sections 9.2.1 to 9.2.3 below:

9.2.1 **Public Transport**

As detailed in the original response, TfL are responsible for management of the bus route. The NHS has done what it could (and within its control), provisions were made by the NHS when the site was designed to accommodate a bus route (I believe the area outside the main entrance was

designed to accommodate a bus turning circle). The issue is that TfL will not fund a new route nor do they believe there is sufficient demand to do so. They will also not divert an existing route as that will only inconvenience other residents in the areas no longer served from where they diverted the route. Finally the new hospital is on the same site as the old hospital that has been here for 100+ years – there was no bus route serving the site prior to the new building, so it is not clear why there is an issue now? This issue is also not within the control of the NHS.

9.2.2 **Benches**

Since the last LBB HOSC, 2 benches have been installed at the main entrance to the hospital. This hopefully now addresses the issue raised, however please note that this is again on a trial basis as before and if the issue of smokers congregating in this location reoccurs, this will need to be reviewed. (as background, previously, the clinical services located close to the main entrance complained that the smoke was entering their consulting rooms via their open windows. If this occurs again, then benches will be removed once more. While the seating point is understood, the requirements of the clinical services and their patients must come first.)

9.2.3 **Porters**

We have nothing further to add. The response given previously details the service available onsite and directly addresses the issue raised of "why are there no wheelchairs available at the entrance to the hospital" – not only are there wheelchairs but there are also porters available to assist as has already been explained. The service provided is also consistent with the same service provided at other hospitals. Please also note that frequent visitors usually go directly to the wheelchair store located in the main entrance atrium and borrow a wheelchair themselves without requesting a porter to assist.

9.3 The Committee are requested to consider the update as set out in section 9.2 above and make appropriate comments and/or recommendations to Community Health Partnerships and NHS Property Services. Officers from Community Health Partnerships will be in attendance at the meeting to respond to questions from the Committee.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Cleared by Finance (Officer's initials)	**JH**
Cleared by Legal (Officer's initials)	**LC**

AGENDA ITEM 8

Meeting	Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**Healthwatch Barnet Enter and View Reports**
Report of	Healthwatch Barnet
Summary	Members are requested to consider the Enter and View report from Healthwatch Barnet as set out in Appendix A

Officer Contributors	Selina Rodrigues, Head of Healthwatch Barnet Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	West Hendon
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	Appendix A: Woodfield House, Enter and View Report
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Committee note the Enter and View Report for Woodfield House as set out in Appendix A and make appropriate comments and/or recommendations to Barnet Healthwatch or the service provider.

2. RELEVANT PREVIOUS DECISIONS

2.1 Safeguarding Overview and Scrutiny Committee, 27 November 2013, Barnet Healthwatch Enter and View Reports

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

3.4 Healthwatch will be the primary vehicle through which users of health and care in the Borough will have their say and recommend improvements. These should lead to improved, more customer focused outcomes and will assist in meeting the objectives in the Health and Well Being Strategy 2012-15.

4. RISK MANAGEMENT ISSUES

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

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

5. EQUALITIES AND DIVERSITY ISSUES

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 have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.2 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet. The Healthwatch contract value is £197,361 per annum. The contract commenced on 1 April 2013 and will expire on 31 March 2016; the contract sum received is £592,083. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

7. LEGAL ISSUES

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

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 Healthwatch Barnet delivers 'Enter and View' visits, which are review visits by lay-people of the quality, care and safety in residential and health care settings. The Healthwatch Enter and View team are given the legal right to do this and have all been well trained in their role. The most important aspect of Enter and View is that it is intended to add value by working in collaboration with service providers, residents, relatives, carers and those commissioning services.

9.2 The Enter and View reports are written by the Enter and View team and sent to the care provider to check for factual accuracy and to respond to the report recommendations. The Reports are reviewed and authorised at each stage by Healthwatch Barnet staff, and once finalised are uploaded to the Healthwatch Barnet website. The reports are then sent to the Care Quality Commission and the Head of Safeguarding, Adults and Communities at Barnet Council and either the Safeguarding Overview and Scrutiny Committee (for social care settings) or the Health Overview and Scrutiny Committee (for health care settings).

9.3 A report which provided a detailed analysis of the Barnet Healthwatch Enter and View programme was reported to the Safeguarding Overview and Scrutiny Committee on 9 September 2013.

9.4 The Committee are requested to consider the Enter and View report for the Woodfield House attached at **Appendix A** and consider whether they wish to make appropriate comments and/or recommendations to Barnet Healthwatch or the service providers.

10. LIST OF BACKGROUND PAPERS

10.1 Enter and View Reports considered by the Safeguarding Overview and Scrutiny Committee can be accessed here: http://barnet.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=196

10.2 Enter and View Reports considered by the Health Overview and Scrutiny Committee can be accessed here: http://barnet.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=179

Cleared by Finance (Officer's initials)	**JH**
Cleared by Legal (Officer's initials)	**LC**

healthwatch Barnet

Enter and View – Visit Report

Name of Establishment:	Woodfield House 63 Cool Oak Lane, West Hendon, London NW9 7NB
Staff Met During Visits:	Augustine Sahr Tutu (Manager) Care staff
Date of Visit:	9 July 2013 and 30 July 2013
Purpose of Visit:	A planned Enter & View Visit (E&V)
Healthwatch Authorised Representatives Involved:	Stewart Block Christina Meacham Nahida Syed Allan Jones Due to the indisposition of one of us on 9 July the visit was in two parts. The first to primarily talk to residents, staff and family/carers and the second on 30 July to review policies and procedures and to talk to the management.
Introduction and Methodology:	Our visit was part of a planned strategy in response to concerns Barnet LINk received, prior to Healthwatch, about the treatment of Mental Health patients in various locations in the borough. As a result, E&V decided to visit as many facilities as possible to understand the issues involved and this included visiting locations where no complaints had been made. Each Healthwatch has the statutory powers to enter health and social care premised to observe and assess the nature and quality of services and obtain the views of the people using those services. The principal role of Healthwatch is to consider the standard and provision of services, how they may be improved and how good practice can be disseminated. Subsequent to any visit a report is prepared, agreed for accuracy by the manager of the facility visited, and then made public via the website and made available to interested parties, such as the Safeguarding Overview and Scrutiny Committee.

Enter and View – Visit Report

	As part of our preparation for the visit we reviewed the Care Quality Commission (CQC) Report published on 1 May 2013 (http://www.cqc.org.uk/directory/1-141569038) This report relates only to the service viewed on the dates of the visits, and is representative of the views of the staff, visitors and residents who met members of the Enter and View team on those dates. Woodfield House is a privately owned Care Home providing Residential Care for 5 residents each in a single room. The home provides support and care as a precursor to returning to the community and sees itself as a Recovery House. Resident's length of stay is determined in consultation with the Springwell Unit and Barnet Social Services. The on-duty staff/resident ratio is 1:1. The owners told us that their objective is to create a supporting family relationship to help residents back into the community rather than a money-making venture. There are 9 staff, a staff list with detailed cv's was provided by Woodhouse. Each resident has key worker. Four of the staff are members of the owners' family. One staff member is on call over-night and sleeps on the premises. Staff overnight accommodation is adjacent to residents' rooms but up a flight of stairs – this may make communication between residents and staff difficult at night. There is facility for a second staff member if a future resident has need of over-night support. **DISCLAIMER:** ***This report relates only to the service viewed on the date of the visit, and is representative of the views of the staff, visitors and residents who met members of the Enter and View team on that date.***

Enter and View – Visit Report

General Impressions:	We were pleased to see that the "flyer" advertising our visit to residents/families was displayed, as was a staff list. Clean, bright and airy rooms with recreational facilities and access, under supervision, to a computer. Although we were told that none of the residents currently use the facility. A pleasant family atmosphere with residents welcome as part of our discussion with management. A very pleasant home with a beautiful garden. There was a pool table in the back garden and the cover was secured by four bricks – one in each corner. There is a computer room at the far end of the garden.
Policies & Procedures:	Comprehensive documentation was made available to us. We were free to review the documents, including Care Plans. Also able to discuss with two residents the extent to which they understood their Care Plans. Residents are weighed once a month and their eating is monitored. A local GP visits as required, residents are able to go to a dentist as necessary Regular fire drills are carried out including an evacuation. Medication is kept secure and delivered via a standard Boots MDS pack for each patient (Monitored Dosage System) Staff were asked what procedures they would follow in an emergency and clearly responded.
Staff:	Nine staff are employed and are supported with a regular training programme. We were provided with detailed staffing plans, covering day & night staff, for a three week Rota. Cover appeared adequate.
How the Home Gets Residents Views:	There is a Resident's Forum every two weeks.

Enter and View – Visit Report

How the Home Gets Relatives' / Carers' Views:	The Home is very small. The staff told us if there were difficulties these are discussed with the Manager and, if necessary, with the Barnet care coordinator.
Privacy and Dignity:	We saw evidence of residents being treated with respect as individuals. Only one resident is a smoker, there is a garden where he can go to smoke.
Environment:	Clean, pleasant, light and airy
Furniture:	Clean, in keeping with the surroundings
Food:	The staff told us that residents are encouraged to do their own cooking, whilst staff were present, with the aim of their being better prepared for, later, independent living.
Activities:	Residents are free to go on unescorted outings and family visits. In the case of the latter there is close communication between Woodfield and family on a residents journey and arrival/departure times. It is noted that there is a long walk to the nearest bus stop, and the nearest shop is approximately a mile away. There was someone who co-ordinated the home activities. Staff are aware of the need to meet the religious needs of residents; at the moment we were told that only one resident had religious needs and attended church. There are no local churches nearby.
Feedback from Residents and Relatives/Visitors:	At the second visit we were able to talk to two residents, without staff being present. Both seemed open. They were looking forward to moving to live independently. They said the staff had been very supportive. On the first visit, two of our authorised representatives had discussions which took place in the garden with some residents and relatives.

Enter and View – Visit Report

	As the number of residents is very small we feel that it is impossible to relay their feedback without identifying individuals which would be counterproductive. Therefore we have identified the issues that were raised and need clarification, and we have done this on an anonymised basis.
Recommendations:	1. Woodfield is in a difficult location to find and is situated at a dangerous bend. We recommend that the owners look at some signage and safety measures to improve this. This may be of concern for visitors and emergency service vehicles. In view of the perceived isolation of Woodfield it is important to make it easy for visitors to find and access the house 2. Where possible residents should be able to visit the home prior to being placed there to ensure there are comfortable with its location and facilities. 3. Compliments as well as complaints should be recorded. 4. Although it is a small Home with staff and residents well known to one another, consideration should be given to the wearing of clear name badges by staff. 5. The use of staff vehicles for transporting residents needs clarification. This should also cover who plans and organizes outings, who/how they are paid for and any insurance issues concerning use of staff cars for outings. 6. We would like to see the planned programme of outings made more readily available. 7. It would be helpful to ensure that relatives and residents are fully aware of what planning is in place to assist their moving on safely into the community And that there is clear ongoing communication between Barnet

	Care Co-ordinator, residents and their families 8. Ensure that relatives and residents are clear about the role and responsibilities of the Barnet Care Co-ordinator. 9. Ensure that the Complaints Procedure documentation is clearly available to staff, residents, relatives and carers. 10. Confirmation that any pre-existing resident medical conditions are carefully recorded and monitored and that all staff are made aware of resident's condition and likely symptoms. 11. Ensure that the staff are aware of advocacy services for people with mental health conditions and that these are publicized within the home. 12. In view of poor mobile 'phone reception we recommend provision of a public fixed line in a location where residents can speak privately. 13. Key worker name and contact made available to all families. 14. Clarification on the Meals Policy should be provided making it clear what meals are provided by Woodfield and what meals residents have to prepare themselves, how are they supervised and nutritionally monitored. Also at what times the kitchen may be left available to residents to make food/snacks for themselves. 15. Provision of room or personal alarms be researched so that staff can be made immediately aware of any out-of-hours incidents.

Enter and View – Visit Report

	16. With only five residents there may be a degree of informality between residents and staff. Nevertheless, the Residents Forum meetings should be recorded and minutes made available to residents and their families/carers. 17. Suggest that the cover for the Pool Table in the garden should be secured in a different way rather than being held down with bricks.
Signed:	Stewart Block, Christina Meacham, Nahida Syed, Allan Jones
Date:	December 2013

Response received from Woodfield House:

Enter and View – Visit Report

Woodfield Homes
Woodfield House
63 Cool Oak Lane
West Hendon
London
NW9 7NB

Tel: 020 8 205 0257

Dear Lisa,
We will be grateful if you pass on to the group our profound gratitude for visiting Woodfield House on the 9th and 30th July 2013 respectively. Although your organisation's visit was in two stages, the interaction on each occasion was interesting; a new experience which came with valuable lessons for the entire staff at Woodfield House. We carried out every necessary preparation to ensure maximum attendance by all parents. Furthermore we gave appropriate and adequate information to our residents to be present at the meeting to enable the group to achieve its purpose. We will be always prepared to welcome the group if their visit becomes necessary in the near future. We were happy to acknowledge that the Barnet Healthwatch (Enter and View Team) felt welcome during their visit. We are committed to make continuous strive to uphold good practice and meet accepted standards. We largely agree with the content of the report but we will be providing necessary explanation for areas that require a bit of clarity for the benefit of the report's future readers and to ensure the accuracy of the factual information therein. The response to the draft report will be carried out chronologically.

Pages 1-2
Woodfield house agrees with the report contained in those two pages which was about the purpose for the visit, introductory and methodology.
Nonetheless I would like to give further information on the comments which

highlighted that four (4) members of the owners' family were included on the staff list of nine (9). The four members of the owners' family on the staff list are qualified Health and Social Care workers, founding members of staff, previously working for other reputable organisations. They have sacrificed as their individual contribution to take huge cuts on their incomes to promote Woodfield House still at its teething stages. Woodfield House is registered to provide accommodation for persons who require nursing or personal care. We have provision for five individuals. We are contracted to the London Borough of Barnet for charges considered to be one of the few lowest. Irrespective of the different needs of our resident, support fees allocated to them has remained the same during the three (3) consecutive years since we became operational on the 10th of August 2010. The four members of the family working at Woodfield House are University graduates with each of their qualifications intrinsically related to Health and Social Care. Each of these family members of staff have long standing experience working in residential care homes for individuals recovering from mental health problems. One is a Registered Nurse and has held a position of a deputy manager in two large Nursing homes for several years. The registered manager has a post graduate qualification in Health and Social care with core discipline in public sector management. The third member has a certificate in psychology and has a degree in Film Studies. In addition, she has been a manager of activities in a large residential setting for nine years and until recently she has been a deputy manager of a mental health residential setting for fifteen (15) individuals. The fourth member is a graduate with BSC (Hons) in Applied Science and Food Studies. The different skills and experience of the family members working at Woodfield House together with other staff members and our professional partners in the community have contributed immensely to the current stability of the mental health of all the residents we care for. Our residents have had no reason to be recalled in hospital over their years of stay.

Pages 3&4
Pages 3 and 4 represent accurate report however we will like to remind the team that there were some smokers amongst the residents at Woodfield House at the time of the visits. Four of the residents like the location of

Woodfield House and actually enjoy walking to and from the shopping areas at the South-North cardinal points. With the exception of one resident regular shopping trip is considered as some form of therapeutic walk. Some residents who frequently visit the shops are most of the time reluctant to accept a lift on their way to the shops.

Pages 5&6

It's extremely important that staff build a good working relationship with relatives to enable cooperation in implementing the individual care needs of residents. Woodfield House believes that working with residents would be difficult in the absence of this significant support from relatives. The phenomenon to work collaboratively with close family members is considered by Woodfield House management as integral if residents are to be appropriately supported to enhance recovery. We have enjoyed consistent support and working together in close consultation with nearly all relatives of our residents

(1) Woodfield House is situated in a quiet therapeutic residential area. Emergency service have never had problems accessing us and when their services are needed staff members are required to stand on the main Street to lead them to the building. Woodfield House is a semi-detached building. Our previous next door neighbour lived at (…. Cool Oak Lane) with his wife and two children for more than forty years without any incident whatsoever before selling the property in 2012. The two children grew up at (… Cool Oak Lane) until they fled the nest. The owners of Woodfield House have lived peacefully and brought up five children at that address since 1994. We agree about the need to make it easy for visitors to locate the facility. Consequently we will be writing the word Woodfield House conspicuously on the brick wall (part of a fence) adjacent the building. We will ensure that this is easily visible by all our future visitors.

(2) Every resident is encouraged to visit the facility prior to moving in. However, this is not always possible in cases of emergency placement.

Notwithstanding, placement is reviewed after six weeks stay and residents would be relocated by the multidisciplinary team in cases of dissatisfaction or if the placement does not meet the needs of the resident. Woodfield House has five residents and each of them have stayed for more than three years. Woodfield House makes complaint policy and procedure available to all residents during admission; a copy is left at the reception for relatives and visitors to access. We take complaints seriously and in case of one we are obliged to investigate and record appropriately. We have a clear procedure and we pass on information and give support to individuals to enable them forward complaints as a last resort to Care Quality Commission (CQC) when they fail to achieve satisfaction at all levels. We will continue to willingly advise relatives on how to make complaints.

(3) We recognise the relevance of wearing name badges by staff however we desire to provide a homely environment for our residents and avoid any practice that would not be somehow appropriate for them. Futhermore, we acknowledge that wearing name badges would be suitable for clients experiencing short-term memory lose; which does not describe any our residents. Our residents know every member of staff by their respective names and our members of staff are aware of introducing themselves to all visitors. If the needs of our residents require wearing badges we will be prepared to put in place this enabling concept.

(4) Woodfield House has a Freelander which is the only appropriately insured vehicle to support our residents to access facilities in the community. Management has made it known to staff that their vehicles should not be used to transport residents. We are currently looking for an opportunity to own a vehicle capable of taking residents and staff together for group activities including visiting seaside and other social

recreational facilities in the community. We have supported residents to acquire Freedom pass which is used in the absence of the Freelander. We also use mini-cab services.

(5) We will encourage as good practice, to continue to display planned programme of outings for easy access by everyone including visiting professionals and relatives.

(6) We work collaboratively with Care coordinators and families of our residents. Plans and assistance for safely moving on for individuals are agreed with care coordinators, Psychiatrist Consultants, residents and relatives.

(7) Woodfield House has continued to work closely with residents and families in supporting them to be fully aware of the responsibilities of the care coordinators. Stability in the mental health of our residents over the years could be attributed to the privilege of good team work and the relentless support received from the Rehabilitation Team at Springwell Centre in Barnet General Hospital.

(8) In addition to what we do in connection with complaints mentioned in paragraph marked (3), we will continue to make available to staff, relatives and carers, copies of complaints procedure documents.

(9) Prior to admission, Care Coordinators send care plan and risk assessment which would comprise of the individual's pre-existing medical condition/s. Informed by these documents and in consultation with residents, relatives and other professionals previously involved in the individuals' care, Woodfield House prepares a care plan and risk assessment to guide staff in meeting the needs of our residents. Care plans indicate the diagnosis of the residents and the known symptoms. We expect our staff to be aware of the residents' condition and how to

support them including moments when they show symptoms of been unwell.

(10) We will continue to support our staff to be aware of the advocacy services for people with mental health problems within our locality. A list of the facilities will be displayed at Woodfield House.

(11) The land line phone at Woodfield House has two cordless receivers. We have supported our residents to uphold confidentiality in making and receiving phone calls. Residents respond to their telephone calls in their respective rooms. For those who may choose to make use of the opportunity, each of the en suite facilities has provision for private telephone line. Residents and relatives have been informed about this facility. We will continue to encourage our residents to obtain mobile phones to facilitate confidentiality and promote safety.

(12) The team (Barnet Healthwatch) would attest that Woodfield House has a comprehensive key worker system in place; a list of which is displayed in the office area accessible by residents and relatives. Our residents know their key workers; which was demonstrated by them during the team's visit. Woodfield House provides all the meals in accordance with the agreed menu. Food is provided three times in a day and this includes breakfast, lunch and dinner. Residents will have to buy their own food items if they decide to cook outside the schedule of the daily meal preparation. We are supported by the Springwell Rehabilitation team who sends a support worker to support some of our residents to participate in activities including cooking. We are operating with very tight budget to provide the needs of our residents; therefore we emphasise that practice food preparation should take place at the times for the three meals meant for everyone. Cooking at Woodfield House will continue to be supervised by staff. The staff will at the same

time monitor the required nutritional level. Our residents are allowed in the kitchen to make drinks and snacks between meals and are supervised whenever they are involved in cooking. After 10pm snacks, tea, coffee and drinking water are left in the conservatory overnight for the use of our residents.

(13) Woodfield House has an underdeveloped provision for personal alarms in the individual rooms. We will be re-examining the possibility of making it functional.

(14) Residents at Woodfield House meet regularly to discuss issues of mutual interest. Woodfield House keeps record of residents' meeting copies of which we will continue to make available to families/carers.

(15) The table football has been removed because of the bad weather. In the near future, we will ensure that strings are used to hold together a cover for any recreational activity table left outside.

Augustine Tutu
(Registered Manager)

AGENDA ITEM 9

Meeting	Barnet Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**Barnet and Harrow on the Move: The Annual Report of the Director of Public Health, 2013**
Report of	Director of Public health
Summary of Report	The report is a call to action on physical activity across the Boroughs of Barnet and Harrow from the Director of Public Health. It looks at the levels of physical activity in different groups in the populations and considers the evidence of what works to get more people active. It then gives some ideas that individuals, groups and organisations might want to adopt to help us make Barnet and Harrow healthier and more active places.

Officer Contributors	Carole Furlong, Consultant in Public Health Leah Desouza-Thomas, Knowledge Manager Plus contributions from many others within and outside the Public Health team
Status (public or exempt)	Public
Wards Affected	All
Key Decision	N/A
Reason for urgency / exemption from call-in	NA
Function of	Committee
Enclosures	Annual Director of Public Health Report
Contact for Further Information:	Carole Furlong, Consultant in Public Health. 020 8420 9508, carole.furlong@harrow.gov.uk

1. RECOMMENDATIONS

1.1 The Committee consider the Annual Report of the Director of Public Health 2013 – Barnet and Harrow on the Move (Appendix A), the possible actions outlined in the report and support the Director of Public Health challenge

1.2 The Committee consider the prioritisation of the activities / actions outlined in Appendix A (on pages 29, 40, 54, 63, 71, 82 and 99) and make comments and/or recommendations to the Cabinet Member for Public Health and Health & Well-Being Board in this regard

2. RELEVANT PREVIOUS DECISIONS

2.1 Health and Wellbeing Board, 21st November 2013, Decision Items 5 (Barnet and Harrow on the Move – Annual Report of the Director of Public Health) and 6 (Joint Strategic Needs Assessment)

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The report supports the Health and Well-Being Strategy, particularly the 'How We Live' section as set out in Section 5 (Keeping Well – How we Live) which sets out the relevant findings from the Joint Strategic Needs Assessment, 'What needs to be done?' and 'Measuring progress'.

4. RISK MANAGEMENT ISSUES

4.1 None identified.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 The Equality Act 2010 places specific and general duties on service providers and public bodies. This includes, when carrying out a public body function, having due regard to the equality implications when making policy decisions around service provision. A report incorporates assessment of physical activity behaviours and barriers to activity amongst and beyond defined equalities groups.

5.2 The Annual Report of the Director of Public Health (ADPH) report is split into chapters focused on different age groups and also has sections considering the significance of physical activity for those with mental health problems and disabilities. The report highlights that in some age groups there are gender and ethnic group differences in the number of people undertaking physical activity. It also highlights the impact that physical activity can have on different groups e.g. for young adults, physical activity can improve self esteem, result in lower levels of anxiety and stress and have a positive impact on educational attainment; for older adults, physical activity can reduce the risk of heart disease, stroke, type 2 diabetes and cancer. In relation to mental health,

research shows that if people are more active, this may result in an improved ability to deal with stress, improved mood and mental wellbeing. For people with disability, physical activity can reduce social isolation and create a positive role model for disabled people.

5.3 The report contains steps which public bodies and individuals can take to increase the number of people who are undertaking physical activity. When public bodies are making relevant decisions on policies such as planning and infrastructure, funding of services and contractual arrangements with third party providers, the information contained in the ADPH report should be used to identify any impact of these decisions on specific protected groups under the Equality Act 2010.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 There are no financial implications from the recommendations of the ADPH report. The report is a call to action rather than a plan.

7. LEGAL ISSUES

7.1 The Health and Social Care Act 2012 added in a new s.73A to the National Health Service Act 2006 requiring the appointment of a Director of Public Health. Under subsection s.73B (5), the Director is required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority is required to publish this report.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 The first annual public health report (APHR) from Dr Andrew Howe, Director of Public Health for the London Boroughs of Barnet and Harrow, is a 'call to action' on physical activity. It details the best available evidence on the importance of physical activity across the life-course and in specific population groups.

9.2 The first chapter covers the importance of physical activity and how it relates to the Health and Well-Being Strategies in both Boroughs.

9.3 Chapters 2 to 5 focus on different age groups and the Chief Medical Officers recommendations for participation. They provide a better understanding of physical activity at the national, regional and local level and detail the services and projects that relate to physical activity, offered by both Councils.

9.4 There are a further two chapters dedicated to how levels of physical activity impact on mental health and wellbeing and a chapter on how the environment within which we work, live and play also impacts on one's ability to take physical activity. The evidence to support more active lifestyles for better mental health and wellbeing is outlined and recommendations are made for councils, employers and schools to encourage them to create environments that support physical activity.

9.5 This Annual DPH Report offers more than the usual Public Health rhetoric in a move that it is hoped will engage and motivate residents to become more physically active. Dr Howe has put forward the 'Director of Public Health's Challenge'. The Challenge encourages residents to see what they can do to become more physically active themselves as well as help family, friends or others in the community to do so. Helpful hints and tips are offered. These range from setting achievable goals to building preferred physical activity into daily life through to ways to get and maintain motivation.

9.6 Residents are being encouraged to share their successes using social media. The use of the stated hash-tags (#dphchallengeharrow or #dphchallengebarnet) should allow the Public Health team to gain insights into how successful the Challenge has been. In May 2014 the team intends to shortlist all Challenge entries and showcase the three most inspiring stories from Barnet and Harrow each of which will be awarded a prize. Prizes will also be awarded for one community group and one primary and secondary school in each Borough. All shortlisted entries will be invited to attend the first Public Health Awards ceremony in June 2014 to celebrate their success stories.

9.7 The intention of this report was to move beyond the more traditional recitation of data and knowledge of where the problems of the Boroughs lie. This 'call to action' is a more interactive, inclusive, solution-designed format that allows our residents to be a part of the positive changes the Public Health team is trying to achieve, rather than residents merely being talked at.

10. LIST OF BACKGROUND PAPERS

10.1 Keeping Well, Keeping Independent: A Health and Well-Being Strategy for Barnet 2012 – 2015: https://www.barnet.gov.uk/downloads/download/1056/barnet_health_and_well being_strategy

Cleared by Finance (Officer's initials)	**JH**
Cleared by Legal (Officer's initials)	**LC**

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Harrow & Barnet On The Move

The Annual Report of the Director of Public Health

of the London Boroughs of Barnet and Harrow

2013-14

Foreword

Welcome to what is my first report as Joint Director of Public Health for Harrow and Barnet Councils.

I have taken physical activity as the theme of the report for a number of reasons. Firstly, so many people have increasingly sedentary lives, driving short distances to save time; sitting on our sofas watching TV – often watching programmes about the sport we could be taking part in; obesity is on the increase in both children and adults and along with it increasing rates of diabetes; our children are the least physically active generation that we know of, preferring to play on their computers than go outside and play with friends.

In this report, I will look at physical activity from all angles and by all groups in our community. The report will present the best evidence about why we should be physically active, what works to get different groups in the community active and what the two councils are doing to help you make the change to become fitter and healthier or to help your family, friends and community become a more active place. I have made recommendations for future action for both councils as well as for other organisations including schools.

But that's not all, we all need to make a personal commitment to do more exercise and at the end of the report you will find my challenge – one I hope you will take up with enthusiasm.

Come on, let's get going!

Dr Andrew Howe

Director of Public Health

Barnet and Harrow

Contents

Chapter 1: The Importance of physical activity

Physical activity refers to any bodily movement that involves a raised heart rate and requires burning calories[1]. This can range from active play or occupational activity to dancing and organised and competitive sport.

Low levels of physical activity have high costs for the individual, families and wider society (figure 1). The level of physical activity we take is influenced by a range of factors including, age, gender, socio-economic status, occupation, our weight and where we live. In the UK, the Department of Health defines physical inactivity as less than 30 minutes of at least moderate intensity physical activity on five days per week. Only 34% of men and 25% of women in England manage this level of activity[2].

Being physically active goes far beyond merely balancing calories, for some time we have known about the benefits of physical activity[3]; the most physically active people have around a 30% reduction in the risk of death compared to those who are less active.

Background

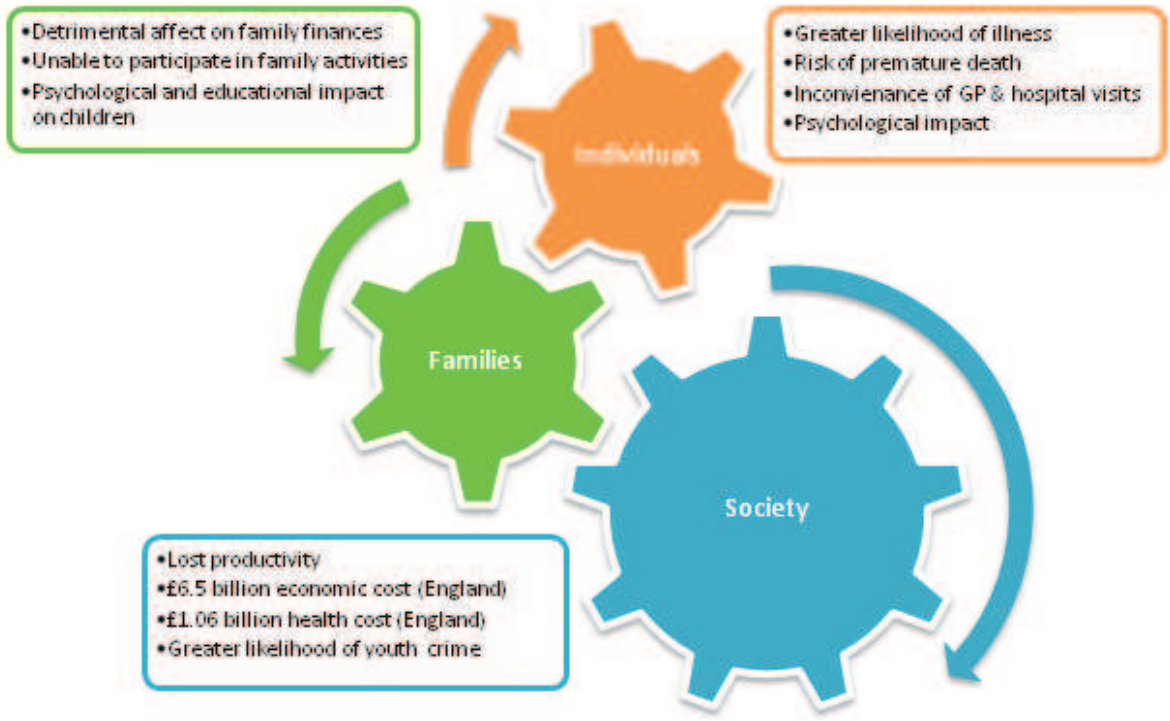
Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. This follows high blood pressure (13%), tobacco use (9%) and high blood glucose (6%)[1].

There is a clear relationship between the amount of physical activity people do and all-cause mortality. But physical activity is not just about preventing death, it can also help with a wide variety of health issues.

Bones, joints & muscles

Increasing physical activity can increase spine and hip bone density by 1% to 2%. Better bone density means a reduced risk of fractures due to osteoporosis. Physically active older people also have a 30% lower risk of falling and so are less likely to break their hip if they do fall.

Figure 1: Interlinking impacts of low levels of physical activity at individual, family and societal level [4,5]



People with osteoarthritis, fibromyalgia or rheumatoid arthritis may benefit from moderate intensity, low impact physical activity such as swimming and walking. This level of physical activity has been found to be an effective means of reducing pain and improving function, quality of life and mental health. Muscle strengthening (physical activity that involves the use of weights or body weight) has been found to enhance muscle mass, strength and power.

Middle aged and older adults who participate in regular physical activity have a 30% lower risk of experiencing some limiting physical factors that would for example prevent a person from completing a range of simple or complex tasks.

Heart health

Physically active people have a 20% to 35% lower risk of cardiovascular disease (heart disease and stroke). This is important because diseases of the cardiovascular system are the number one cause of death locally, regionally and nationally. Regular physical activity has been linked to increased levels of high-density lipoprotein (HDL) – also known as 'good' cholesterol.

Cancer

Adults participating in daily physical activity have a 30% lower risk of colon cancer and in women, a 20% lower risk of breast cancer. Experts think that physical activity could also help protect against other cancers including endometrial cancer (cancer of the lining of the womb).

Cancer Research UK estimates that 1% of all cancers in the UK may be related to inadequate levels of physical activity. One percent sounds low, but this could mean that among 40 to 79 year olds, 124 breast cancers in Harrow and 179 breast cancers in Barnet could be prevented each year if we increased our levels of physical activity.

Metabolic health

Moderately active adults have a 30% to 40% lower risk of developing type 2 diabetes and metabolic syndrome (a combination of factors that increase the risk of developing heart disease and diabetes) compared to their less active counterparts. For those already diagnosed with diabetes regular physical activity has been found to prevent long-term complications and help control blood sugar.

Mental health & wellbeing

Participation in regular physical activity has been shown to reduce the risk of depression in adults and memory loss and dementia in older adults by as much as 30%. Physical activity can also relieve the symptoms of depression and anxiety and improve mood and sleep quality. Feeling rested, contented and happier will in turn give an improved sense of wellbeing.

Healthy weight

Aerobic physical activity has been shown to have a favourable and consistent effect on achieving weight maintenance. Physical activity uses up calories and can help maintain a healthy energy balance. Combining physical activity, with a healthy balanced diet can increase energy expenditure.

How much should I be doing?

The government's recommendations for physical activity are based on the "lifecourse" approach, which reflects our different needs at different stages of life (Box 1). The guidelines have also shown that a shorter session of activity, from as little as 10 minutes of moderate to vigorous activity a day, can give the same benefits in terms of risk factors for heart disease and type 2 diabetes. This is a good starting point for those who might have been inactive for some time.

Box 1: Government guidelines for minimum amount of physical activity[6]

Under 5s

Children capable of walking unaided should be physically active for at least 180 minutes (3hours) daily.

Children & Young people (5-18 years)

Should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours daily

Adults (19-64 years)

Should aim to be active daily with moderate intensity activity adding up to 150 minutes (2.5 hours) per week or 75 minutes of vigorous activity per week.

Older adults (65+ years)

Should aim to be active daily, a week of moderate intensity activity should add up to 150 minutes (2.5 hours). Regular exercisers should aim for 75 minutes of vigorous activity per week

Images courtesy of depositphotos.com

Source: Start active, Stay active, Department of Heath

Although it isn't usually until adulthood and older age that most chronic conditions set in, the exposure to risk through inactivity begins in the early years. Habits are formed early in childhood and so it is important that physical activity is incorporated within family activities throughout childhood. Developing these habits early in life can have a positive effect since levels of physical activity are known to decline between childhood and adolescence. Higher levels of activity in childhood generally lead to sustained participation in physical activity in later years.

The prevention of different conditions may require different 'doses' or levels of activity. There is limted evidence to link specific levels of activity to different disease conditions and as such the guidelines offer recommendations for general health benefit.

Levels of physical activity can be classified as light, moderate and vigorous and table 1 show the range of activities which fall into these categories. Moderate physical activity is known to stimulate the cardiorespiratory, musculoskeletal, and metabolic systems over time allowing these systems to become more efficient. Moderate activity will also lead to faster breathing, an increase in the heart rate and a feeling of warmth. The bodily

response you experience from physical activity will depend on your level of fitness, although fitness will improve with increasing doses of physical activity.

Vigorous activity offers health benefits over and above that of moderate intensity; this level of activity will lead to heavy breathing, being short of breath, a rapid heartbeat and not be able to carry on a conversation comfortably.

Table 1: Intensities and energy expenditure for common types of physical activity

Activity	Intensity category	Intensity (METS*)	Energy expenditure†
Ironing	**Light**	**2.3**	**69**
Cleaning and dusting	**Light**	**2.5**	**75**
Walking-Strolling, 2mph	**Light**	**2.5**	**75**
Painting/decorating	**Moderate**	**3.0**	**90**
Walking – 3mph	**Moderate**	**3.3**	**99**
Hoovering	**Moderate**	**3.5**	**105**
Golf – walking, pulling clubs	**Moderate**	**4.3**	**129**
Badminton – social	**Moderate**	**4.5**	**135**
Tennis – doubles	**Moderate**	**5.0**	**150**
Walking – brisk, 4mph	**Moderate**	**5.0**	**150**
Mowing lawn – walking, using power-	**Moderate**	**5.5**	**165**
Cycling – 10-12 mph	**Moderate**	**6.0**	**180**
Aerobic dancing	**Vigorous**	**6.5**	**195**
Cycling – 12-14 mph	**Vigorous**	**8.0**	**240**
Swimming – slow crawl, 50 yards per	**Vigorous**	**8.0**	**240**
Tennis – singles	**Vigorous**	**8.0**	**240**
Running – 6mph (10 minutes/mile)	**Vigorous**	**10.0**	**300**
Running – 7mph (8.5 minutes/mile)	**Vigorous**	**11.5**	**345**
Running – 8mph (7.5 minutes/mile)	**Vigorous**	**13.5**	**405**

Source: Based on data from Ainsworth et al. 2000

* MET = Metabolic equivalent: 1MET = A person's metabolic rate (rate of energy expenditure) when at rest. 2 METS = A doubling of the resting metabolic rate

Kcal equivalent, for a person of 60kg doing the activity for 30 minutes)

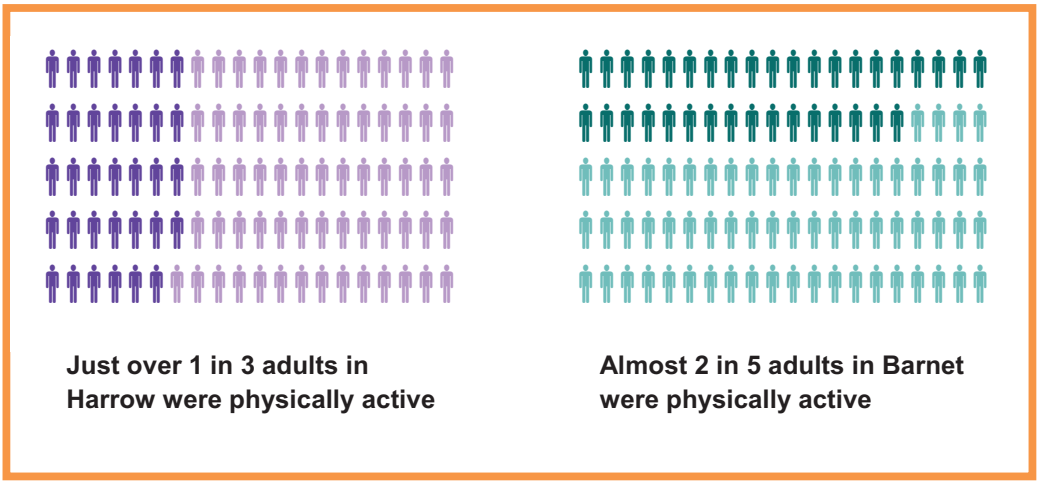
† Kcal equivalent, for a person of 60kg doing the activity for 30 minutes)

How active are we?

National data from Sport England shows that between 2005/06 and 2011/12, there was a statistically significant increase in the proportion of adults reporting that they had participated in at least four sessions of at least moderate intensity activity for at least 30 minutes in the previous 28 days[2]. During this period, there were also significant increases in the participation of both men and women although the participation of women was on average 10% less than that of men. There were also significant increases among those 26 years and over, adults across the disability spectrum, those of white and non-white ethnicities and individuals in higher social classes (National Statistics Socio-economic Classification (NS-SEC) 1 - 3).

However, no significant change was observed in those of lower socio-economic status (NS-SEC 4 – 8) and there was a statistically significant decrease in the level of participation among those aged 16 to 25 between 2005/06 and 2011/12.

Figure 2: Adult participation in one 30 minute moderate activity session, Barnet and Harrow 2011/12



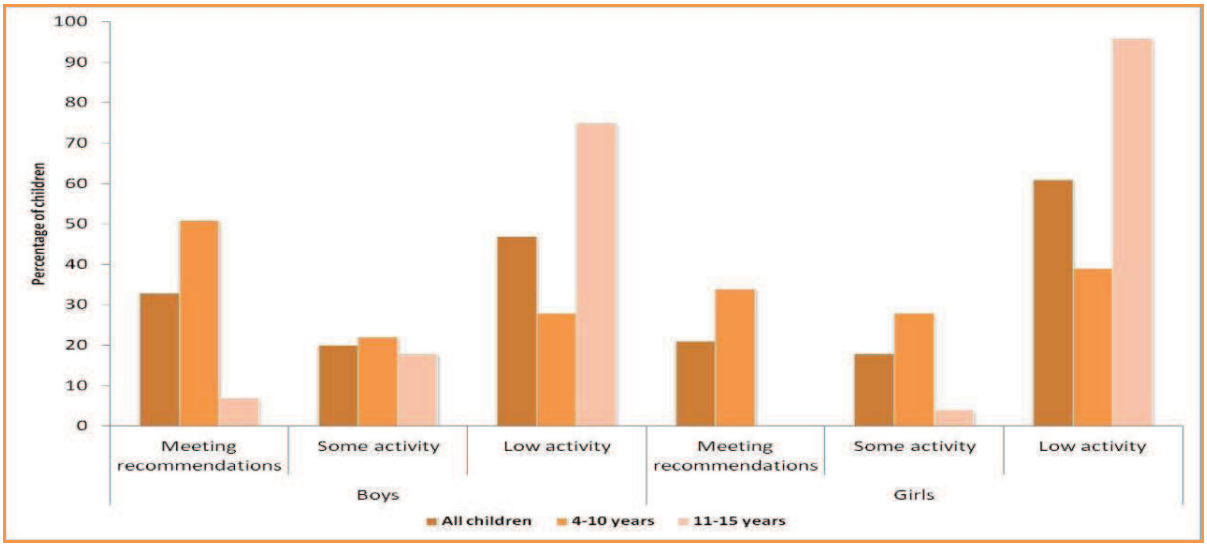
Source: Sport England, Active People Survey 6

During 2011/12, fewer than half of the population of England took part in some physical activity based on the previous guidelines of at least 30 minutes a day of at least moderate intensity physical activity on five or more days of the week. This was reflected locally where only 34% of Harrow residents and 36% of Barnet residents met the recommended physical activity (figure 2).

In much the same way that men tend to be more physically active then women, boys also tend to be more active than girls. Data from the 2008 Health survey for England shows that among children up to the age of 15, 33% of boys and 21% of girls met the previous recommendations of 60 minutes or more of at least moderate activity on all seven days. However, when the ages were split roughly into primary (4-10 years) and

secondary (11-15 years) school ages there was a marked decline in the proportion of boys and girls meeting the recommended levels of activity as children transitioned from primary to secondary school (figure 3).

Figure 3: Objectively measured physical activity levels in children, age and gender, England 2008



Source: Health Survey for England 2008

The National Institute for Health and Care Excellence (NICE) have commissioned the production of a Return on Investment (ROI) tool to help facilitate decision making at local level in physical activity policy. The tool allows users to assess the ROI of implementing a package of interventions, thus estimating the benefits that could be achieved through physical activity programmes.

The bigger picture

Physical inactivity is one of the major risk factors causing death and ill-health both globally and locally. Increasing physical activity has the potential to improve the physical and mental health of the population, reduce all cause mortality and improve life expectancy and quality of life. It can also save money by significantly easing the burden of chronic disease on health and social care services. Increasing cycling and walking will reduce transport costs, save money and help the environment. Fewer car journeys can reduce traffic, congestions and pollution, improving the health of communities[7]. Increasing physical activity in children and young people can help them in the acquisition of social skills through active play (leadership, teamwork and co-operation), better concentration in school and displacement of anti-social and criminal behaviour[8].

Physical activity, health and wellbeing are embedded within a range of policies, strategies and guidance publications across a wide range of sectors and service areas. The ***Health and Social Care Act***[9] set out that the old Primary Care Trust's public health responsibilities for local health improvement would transfer to councils. Councils now lead on promoting integration and partnership working between the NHS, social care, public health and other local services and strategies. Health and wellbeing boards are in place to ensure the integration of commissioning of local NHS services, social care and health improvement.

The Coalition Government's Healthy white Paper ***Healthy Lives, Healthy people: our strategy for public health in England***[10] sets out a new vision for public health emphasizing the importance of healthy lifestyles. Being physically active is a vital part of a healthy lifestyle.

The ***Public Health Outcomes Framework***[11], is intended to refocus the whole system around the achievement of positive health outcomes for the population and reducing health inequalities.

The indicators are grouped into four main domains: 'Improving the wider determinants of health'; 'Health Improvement'; 'Health Protection' and 'Healthcare public health and preventing premature mortality'. Physical Activity is mainly addressed within the Health Improvement domain, alongside other lifestyles factors. Indicators that are relevant to physical activity include:

Domain 2: Health Improvement

- Excess weight in adults
- Proportion of physically active and inactive adults
- Recorded diabetes

Domain 4: Healthcare public health and preventing premature mortality

- Mortality causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from respiratory diseases
- Health-related quality of life for older people
- Hip fractures in over 65s

The UK-wide physical activity guidelines issued by the four Chief Medical Officers (CMOs) of England, Scotland, Wales and Northern Ireland and detailed in ***Start Active, Stay Active***[6]. The guidelines offer recommendations for children, young people and adults and for the first time in the UK include guidelines for early years and older people.

The guidelines advise that physical activity is important for all age groups and that excessive sedentary behaviour is an independent risk to health at all ages.

The flexibility of the guidelines creates new ways to achieve the health benefits of an active lifestyle. These include:

- A lifecourse approach
- A stronger recognition of the role of vigorous intensity activity
- The flexibility to combine moderate and vigorous intensity activity
- Weekly target; daily activity
- New recommendations on sedentary behaviour

The ***NHS Health Check*** programme is an important national programme that relates to adult physical activity[12]. The programme aims to help prevent heart disease, stroke, diabetes and kidney disease. It is a national initiative that offers preventative checks to all those aged 40 –74 who have not already been diagnosed with one of these conditions, to assess their risk of vascular disease followed by appropriate support, advice and interventions to help them reduce or manage that risk. The NHS Health Check programme offers an ideal opportunity to identify and tackle modifiable factors that impact on vascular disease such as physical inactivity and managing those sedentary adults who are at risk of developing the above conditions.

Transport Planning and Policy Guidance[13] aims to integrate planning and transport at the national, regional and local level to:

- promote more sustainable transport choices for both people and freight;
- promote accessibility to jobs, shopping, leisure facilities and services by public transport, walking and cycling; and
- reduce the need to travel, especially by car.

The guidance set out strategies and measures for local authorities to promote walking and cycling as part of their local walking and cycling strategies.

Sport England Strategy: A Sporting Habit for Life 2012-2017[14] aims to create a meaningful and lasting community sport legacy by growing sports participation at the grassroots level. By offering long-term pathways that help young people continue playing sport into adulthood the strategy wants to create a lifelong habit, in particular, amongst 14 to 25 year-olds. National governing bodies will be supported by County

sports partnerships and continue to play a pivotal role in increasing participation, among young people.

The strategy will invest the funding in four main work areas: Whole Sport Plans, School Games, Facilities and Local Investment.

There are five London Pro-Active Partnerships covering the East, Central, North, South and West of London and they are part of the national County Sports Partnership network. Each Partnership consists of a network of organisations committed to working together to increase participation in physical activity and sport. ProActive London aims to improve the health and well being of Londoners, provide strategic co-ordination and contribute to the London 2012 legacy through sport and physical activity. The partnerships are responsible for the local roll out of the national strategy.

A Sporting Future for London[15]: The Mayor's sports strategy aims to deliver a grass-roots sporting legacy for Londoners from the 2012 Olympic and Paralympic Games by securing a sustained increase in participation in sport and physical activity amongst Londoners and using sport to assist in tackling social problems including ill health, crime, academic underachievement and lack of community cohesion. The Mayor is committed to using the Games to transform the sporting landscape by making sport and physical activity accessible to all. The Mayor is also aiming to strengthen the link between sport and physical activity.

NICE Physical Activity Briefing (PHB3)[16]: In addition, to guidance relating to physical activity (PH2, PH17, PH8, PH13) NICE have also developed public health briefings for local authorities and their partner organisation in the health and voluntary sectors, in particular those involved with health and wellbeing boards. The briefings cover a range of topics and in the case of physical activity offer assistance in the development and response to increasing physical activity for the local population.

Local Health and Wellbeing Strategies

Locally, there is a significant degree of overlap in the themes of the Health and Wellbeing strategies of the two councils, particularly in relation to increasing physical activity. Both strategies recognize the need to create a supportive environment to address the prevention agenda and that partnership working is key to identifying and addressing the factors underpinning health inequalities across Barnet and Harrow.

Figures 4 and 5 show how the high level strategic Health and Wellbeing aims are filtering down to concrete action in both boroughs.

Figure 4: Barnet's Health & wellbeing strategy as it relates to physical activity

Figure 5: Harrow's action plan as it relates to physical activity

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Chapter 2: Physically active children

As soon as they are able to walk, pre-school children need unstructured, active and energetic play to allow them to develop basic motor skills and balance. By school age however, young children are developmentally ready to benefit from more intense activity, over shorter periods. This is reflected in the government's physical activity guidance (figure 6).

Figure 6: CMO physical activity recommendations for children

Source: Start Active, Stay Active

While the evidence for physical activity among under 5s is limited it is fairly conclusive; being active at such a young age is the basis for creating an active adult and thereby reducing health risks associated with inactivity later in life. Playing or undertaking structured activities organised by adults combined with reduced time sitting or lying improves motor skills, promotes healthy weight, enhances bone and muscular development and helps children develop social skills.

As children get older the behaviour patterns that have important implications for their health and wellbeing - both short and long term are cemented and the health benefits from regularly activity become more pronounced. The evidence suggests that for older children, those participating in physical activity session of greater intensity and longer duration achieve greater health benefits, particularly for bone and metabolic health.

Background

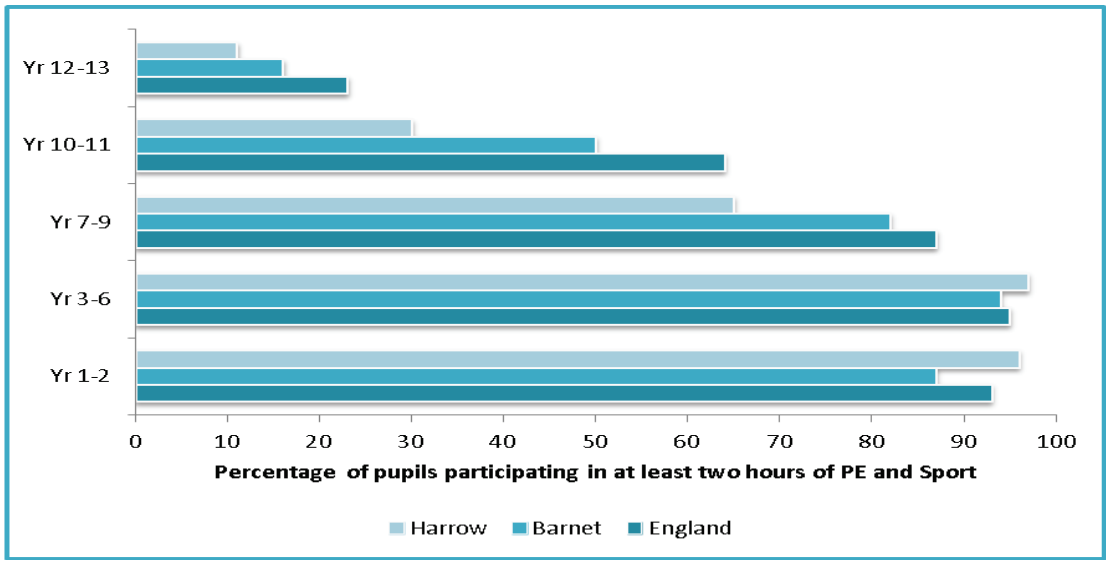
Across England the percentage of children who are physically active for 60 minutes every day rose from 66% to 68% between 2002 and 2008 across all children aged two to 15[1]. The same data showed an 8% difference in activity levels between boys and girls, with lower proportions of girls meeting recommendations in 2008. This percentage further decreased as girls got older; at two years 35% of girls met the recommendations compared with only 12% among those aged 14.

For the first time the latest government guidelines for physical activity incorporate recommendations regarding sedentary behaviour. Children in England spend on average 3.4 hours on weekdays and 4.1 hours on weekends in sedentary pursuits which include watching television, reading and other screen time activities such as playing computer games or with mobile devices[1] when they could be being physically active.

Sports and Physical Activity Participation

Physical education (PE) is a key element of physical activity and sport participation in young people of school age. The 2009/10 PE and Sport Survey found that not only were lower proportions of 5-16 year olds participating in at least two hours a week of high quality PE and sport during curriculum time in Barnet (81%) and Harrow (78%) when compared to the national average (86%) but also as children progressed through the school system the proportion of pupils participating in high quality PE declined markedly[2].

Figure 7: Children and young people's participation in school based PE & sporting opportunities



Source: PE and Sport Survey 2009/10

Figure 7 shows PE and sport participation by school year. In Harrow, almost a third of pupils stopped participating in PE and sport when they started secondary school followed by a further third stopping by Years 10 and 11. Only one pupil in 10 continues in years 12 and 13. In Barnet, the decline upon starting secondary school was lower than Harrow's but a further third stopped by Years 10 and11 and another third in Years 12 and 13, leaving only 3 in 20 participating by the time they leave school.

In terms of sport participation, the proportion of children aged 5-15 who 'participated in sport in the last week' significantly decreased from 81.4% in 2008/09 to 77.7% in 2011/12[3]. As with other physical activities, boys were more likely to have participated in sport than girls. Table 2 lists the ten most popular sports that children participated in in the last four weeks in England.

Table 2: The top ten most popular sports participated in by 5-10 year olds (in the last four weeks) in England 2011/12

Sport	%
Swimming, diving or lifesaving	45.3
Football (including five-a-side)	36.9
Cycling or riding a bike	29.6
Walking or hiking	19.5
Gym, gymnastics, trampolining or climbing frame	13.0
Tenpin bowling	9.2
Tennis	8.8
Cricket	6.9
Martial arts – Judo, Karate, Taekwondo and other martial arts	6.4
Roller skating/blading or skate boarding	5.9

Figure 8: National online news, July 2013

In addition to competitive sport, travelling to and from school is a prime opportunity for children to achieve part of their recommended daily physical activity. Recently there have been calls from health experts to reduce the numbers of parents who drop their children to school (figure 8).

The 2010 National Travel Survey suggested that for 41% of 5-16 year olds the main method of getting to and from school was by walking, second was 'being driven' (33%)[4]. The Harrow School Sport Survey 2012, found that 54% of 5-12 year olds surveyed reported that the main way they travelled to and from school is by foot[5].

Walking to school as a form of physical activity is one area where girls participate more, with 65% of girls compared to 63% of boys walking to or from school at least one day in the last week[1]. Data from the National Travel Survey found that 68% of children aged 2-16 reported walking (in general) for at least 20 minutes or

more, at least once a week.

The Olympic effect

Children's motivation to take part in sport increased as a result of the London 2012 Olympic and Paralympic Games. Data from the Taking Part Survey found that, in 2011/12 one quarter of 5 -10 year olds were encouraged to take part in sport as a result of the UK hosting the Olympic and Paralympic Games. Among 11-15 year olds, almost half were inspired to take part in a sport[3].

> ***"Watching great Olympians play sports that I have not tried yet makes me want to play them"***
>
> *Comment from the Harrow School Sport Survey 2012*

This observation is also reflected in data from the Harrow School Sports Survey, which suggests that 56% of those surveyed reported that the London 2012 Olympics inspired them to do more sport, compared to 34% who said it hadn't made any difference to them[5].

What works?

NICE guidelines provide a number of recommendations to increase the physical activity levels of those aged 18 years and under[6].

- Involve children and young people from the outset – find out what would encourage them to participate in more physical activity and which activities they would like to regularly participate in. Ensure this involves children from different socioeconomic and ethnic groups to get everyone's views. Also ensure those with a disability are involved.
- Support the delivery of national campaigns, such as Change4Life at a local level. Integrate such campaigns into local initiatives and requirements such as the National Child Measurement Programme.
- Ensure sustainability is a key element of all initiatives, for example utilising the free resources provided by Change4Life
- Educate children and parents/carers around the benefits of physical activity and the opportunities available locally, taking a whole family approach.
- Develop effective partnerships to deliver multi-component interventions (e.g. after school clubs) including schools, families and communities.
- Have a coordinated approach to the development of school travel plans to encourage more physical activity.

Services provided in both boroughs

Children's Centres

Children's centres have a pivotal role in supporting the physical development of babies and young children.

Harrow's children's centres provide services for babies, young children and young people to ensure the best possible start in life. The centres act as a central point where families can access information and services from a team of professionals. The early years curriculum includes a 'Physical Development Stage' which is delivered by children's centre staff.

In Barnet, the Eat Well Be Active programme currently operates in Sweets Way children's centre where a series of training sessions with staff and workshops with parents are held to ensure they have the confidence to create opportunities for physical activity and purposeful play. There is a Being Active Matters programme for Early Years settings delivered on behalf of the Early Years Advisory Team where, over a period of four to six months, staff are trained and work is carried out with children to help them to be more physically active.

> ***"The physical development of babies and young children must be encouraged through the provision of opportunities for them to be active and interactive and to improve their skills of coordination, control, manipulation and movement. They must be supported in using all of their senses to learn about the world around them and to make connections between new information and what they already know. They must be supported in developing an understanding of the importance of physical activity and making healthy choices in relation to food."***
>
> *The Early Years Foundation Stage Statutory Framework*

Primary School Sport Premium

The government is providing additional funding of £150 million per annum for academic years 2013/14 and 2014/15 to improve provision of PE and sport in primary schools. This funding, provided jointly by the Departments for Education, Health and Culture, Media and Sport, will be allocated to primary school head teachers.

Schools Sports Partnerships

Although Harrow no longer has a School Sports Partnership (SSP) several primary and secondary schools work together independently to promote PE and sport. The Harrow School Improvement Partnership (HSIP) provide the service, School Sport Harrow, to support schools aiming to increase the standards of teaching and provision of extra-curricular sporting opportunities and health outcomes through physical activity. This is achieved through teacher training, brokering and promoting good practice between schools, auditing current practice and running competitions and events.

Barnet has an equivalent Barnet Partnership for School Sport (BPSS). The BPSS is a "not for profit" organisation that has been established as a mechanism to maintain the outcomes achieved by the School Sport Partnerships, including the organisation of events, competitions, festivals and leadership opportunities. The overall outcome is to increase participation at all levels. Ninety percent of Barnet Schools have subscribed to be a part of the BPSS.

Healthy Schools London

Healthy Schools London is an award scheme sponsored by the Mayor of London in recognition of schools helping children lead a healthy lifestyle. Schools in Barnet and Harrow are already doing great work to support their pupils to be more active but Healthy Schools London will document this and help schools to go further.

To fulfill the criteria for a bronze award schools have to name a member of the senior leadership team responsible for physical activity, have an up to date policy for increasing physical activity and provide a minimum of 90 minutes to two hours of PE a week. The criteria also requires schools to provide evidence regarding their playground provision and active travel.

At the time of print, Healthy Schools London is in the early stages but already 21 Schools from Harrow and 23 Schools from Barnet have registered with the programme and are working towards the bronze award.

Change4Life Clubs

The national Change4Life School Sport Clubs programme launched in March 2012 and currently runs in 12 primary schools in Harrow. One member of staff per school runs lunch time or after school clubs which encourage young people to have fun while being physically active and learn about how to eat

healthily and live a healthy life-style. The hours of activity are recorded on wrist bands and in log books which encourage parents to get involved in their child's progress.

Further investment from the Department of Health, has allowed 22 more clubs to be established in Harrow's primary schools over the next two years. This has also been delivered by the BPSS in Barnet and is expanding in 2013-14.

School Games Organiser (SGO)

The school sport coordinator (SSCO)and teacher release programmes have ended due to the termination of the funding which enabled secondary school PE teachers to be seconded for one day per week to local primary schools. Two academies in Harrow, however, are continuing with this initiative independently and will focus on running sports activities on their school site for children from local primary schools. There is one school games organiser (SGO) in Harrow who has overall responsibility for the national school games programme in the borough. The SGO's remit covers objectives previously governed by SSCO's (table 3)

In Barnet, there are four SGOs based in four schools across the locality. They make up part of BPSS.

Participation in the London Youth Games in Harrow and Barnet

The Games are a unique season of events at the heart of youth sport in the capital involving all 33 London Boroughs and 26 Sporting National Governing Bodies. The Games are free of charge and open to all young people, aged between 7 and 18 living in or going to school in London. Encouraged by Harrow Sports Development Team and BPSS, Harrow and Barnet children regularly participate in the London Youth Games.

Table 3: School Sport Coordinators objectives

Strategic planning:	To enhance PE and sports development for the school through the school development plan.
Primary liaison:	To establish and develop linked PE and sports development programmes for local schools, particularly targeting the KS2/3 interface.
School to community:	To build and support school/club links.
Out-of-school-hours activities:	To develop and support out-of-school-hours sport programmes with local clubs, NGBs, school sport associations and sports development officers.
Coaching and leadership:	To develop leadership, coaching and officiating programmes for senior students to gain appropriate skills and qualifications to enhance their future role within the sporting community.
Raising standards:	To support schools in reviewing current PE and sport programmes and the role they play in raising standards across the school.

The Games offer competitive opportunities for participants of varying abilities and experience and has been a stepping stone in the careers of international Olympic and Paralympic athletes. Each year approximately 200 young people aged 11 to17 represent 'Team Barnet' at various competitions and the finals weekend in July at the Crystal Palace National Sports Centre. 'Team Harrow' is represented by over 300 young people, in 2013, 314 young people participated in the Games.

Volunteering and Sports Clubs

The Community Sport and Physical Activity Network's (CSPAN) 2012/13 Delivery Plan aims to enable young people in schools to volunteer their time, access local sports clubs and to increase membership levels. The CSPAN plans to meet this objective by using the SSP to undertake an audit of local sports clubs identifying coach education, volunteering & placement opportunities. They also want to deliver a coach education programme at Stanmore College to build capacity amongst sports clubs and improve the skills of 142 local coaches. Finally, they plan to deliver a sport maker volunteering convention for young people in Harrow schools and colleges (similar to the adult version currently running).

Both boroughs also deliver Sports Makers, a volunteer programme, accredited through ASDAN, a curriculum development organisation and awarding body, involving local sporting organisations offering 12-hour work placements. The programme targets young people aged between 14 and 17 and provides a high-quality learning experience that increases skills and knowledge that will support young people to develop themselves and improve their employment prospects.

Harrow Programmes

London Youth Mini Games

The Mini Games is a scaled down version of the main games for younger athletes. The Mini Games cover eight events designed for young people aged 9 to11. In 2013, 53 children represented Harrow.

2012 School Games

'School Games' is an umbrella term for all school sport competition. Sixty one percent of Harrow schools participate in the school games, compared to 57% of schools signed up nationally.

The school games ensure all competition takes place according to national governing bodies (NGBs) frameworks for each sport. Every school competes to the same standards and so when one team wins the league in one borough they will be of the same standard as a team winning in another borough. Both teams can then competently compete in the next level; ensuring young people have a clear route to better quality sport in higher level competitions.

Football Development Programme on the Rayners Lane Estate

The Rayners Lane Estate in Roxbourne, is one of two areas in the borough which falls into England's 20% most deprived lower super output areas. This area is a key focus for many interventions. Harrow council's sports development team plan to create a weekly futsal session at the Beacon Community Centre with exit routes to local football clubs. They also plan to train local coaches to ensure sustainability of the project.

Cedars Youth and Community Centre

Cedars YCC provide a number of activities aimed at younger children.

Tots and Mini Tots Football sessions are growing in popularity with up to 30 children attending each of the Saturday morning sessions.

Tots and Mini Tots Tennis are Saturday morning tennis coaching sessions for children 4-8 years old. Around 25 children attend each session.

Barnet Programmes

Ambassador Programme

The young ambassador programme in Barnet seeks to develop young leaders and volunteers by providing them with the responsibility of being an ambassador for PE and school sport. The individual forms a vital link between the students, teachers and SGOs. Barnet partnership for school sport has platinum ambassadors (working with the BPSS) and gold ambassadors (working across the borough). Each secondary school has two sliver ambassadors (working within their school and attached primaries). The ambassadors act as a role model throughout Barnet and strive to promote the benefits of sport through assemblies, workshops and events.

Barnet Energy Clubs

Energy Club is a fun, free physical activity club for children aged 4-11, delivered by trained volunteers (primarily parents and friends) the clubs run 30 minute sessions outside of school hours at primary schools across the borough.

Barnet Healthy Lifestyle Coaches

Twelve primary schools have been selected using the London Borough of Barnet 's (LBB) 2012 National Child Measurement Programme (NCMP) data to receive the Healthy Lifestyle Coach (HLC) Project which is designed to support schools to inspire children who are less active to choose and enjoy new sporting activities and healthy choices.

The project aims to:

- Increase the number of children participating in school sport and motivate them to continue making healthy lifestyle choices
- Help schools to maximise their involvement in health-focused initiatives such as Change4Life
- Recruit and develop young people to take on roles as HLC champions.

Barnet Healthy Families Programme

BPSS run a series of 10 week programmes which bring families closer together through the development of active lifestyles. The sessions are held at three local locations offering a range of classes on different days. Activities range from fitness testing, archery and badminton to trampolining, circuits and gym sessions. Incentives and rewards are offered and there is also an end of programme celebratory event.

Alternative Education (Barnet)

Targeting young people at risk of exclusion from school, these day a week courses provide a high-quality, accredited learning experience for students. Alongside music production, catering, gardening and motorbike mechanics – a sport, health & wellbeing course will begin in the autumn term that will provide learners with a range of skills, qualifications and experiences.

Mini London Marathon

The mini London marathon involves a road race taking place over the final three miles of the main London Marathon route. Young people from all 33 London Boroughs and regions around the country compete in the under 13, under 15 and under 17 age groups.

At the 2013 event, a young Barnet boy successful won the under 13 category.

What could we consider doing?

The Councils

- Maximise the use of the Change4life brand within school and community groups.
- Ensure that messages and events are promoted widely and to the right groups and areas of the borough.
- Encourage more after school clubs within schools. These act as a feeder into community based clubs and so inspire the next generation
- Work with HSIP and BPSS
- Take the example of the school sports partnerships and extend the good practice into the community.
- Create environments that encourage activity
- Any emphasis on physical activity or sport should also be accompanied by healthy lifestyle messages to ensure a healthy weight is maintained
- Reduce barriers to popular sports such as swimming and football

Communities

- Encourage outdoor play
- Get children to join in with local community activities – community gardens or environmental projects
- Have a community fun day with lots of activities that children can take part in.

Schools

- Encourage more after school clubs within schools. These act as a feeder into community based clubs and so inspire the next generation

- Make play areas stimulating, fun and safe and give children the opportunity to create their own active play

The Health Sector

- Ensure parents know about developmental stages and how to encourage their children's movement skills
- Promote physical activity in children

Parents and Carers

- Encourage structured play either by providing a stimulating environment or an imaginative game. For example, a safe play area with equipment or a treasure hunt
- Be a role model, for example, walk your children to school instead of driving; walk or cycle to work or to the local shop.
- Young infants should be able to kick, crawl and pull themselves up without being restrained by carriers or clothing. Objects placed out of reach will encourage infants to move towards them.
- Tailor activities according to the child's developmental age and physical ability. Ensure they are inclusive, progressive and enjoyable. The activities should develop the child's movement skills (such as crawling, running, hopping, skipping, climbing, throwing, catching and kicking a ball). Children should also experience more advanced activities such as swimming, cycling, playing football and dancing.

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Chapter 3: Physically Active Teenagers and Young Adults

The transition from childhood to adulthood can be fraught with difficulties for many young people; adolescence is generally thought of as an emotionally difficult time to navigate. These are the years when children who were once full of energy may lose interest in physical activities as they enter young adulthood.

Between school, college or university, studying, socialising and part-time jobs young people have a lot of interests vying for their time and attention. However, young people who have enjoyed sports and physical activity as children often remain active throughout their lives all they need is a little encouragement to get them through the teenage years.

The harms from physical activity are minimal for most teenagers and young adults; but the risks of poor health from inactivity are far greater.

Background

All young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Vigorous intensity activities including those that strengthen muscle and bone should be incorporated at least three times a week, and young people, including teenagers should minimise the amount of time spent in sedentary activities[1].

Young people who have a physically active lifestyle have improved self-concept and self-esteem, and lower levels of anxiety and perceived stress[2]. It is also widely documented that young people's quality of life is also likely to be improved through elevated levels of physical fitness associated with high levels of physical activity.

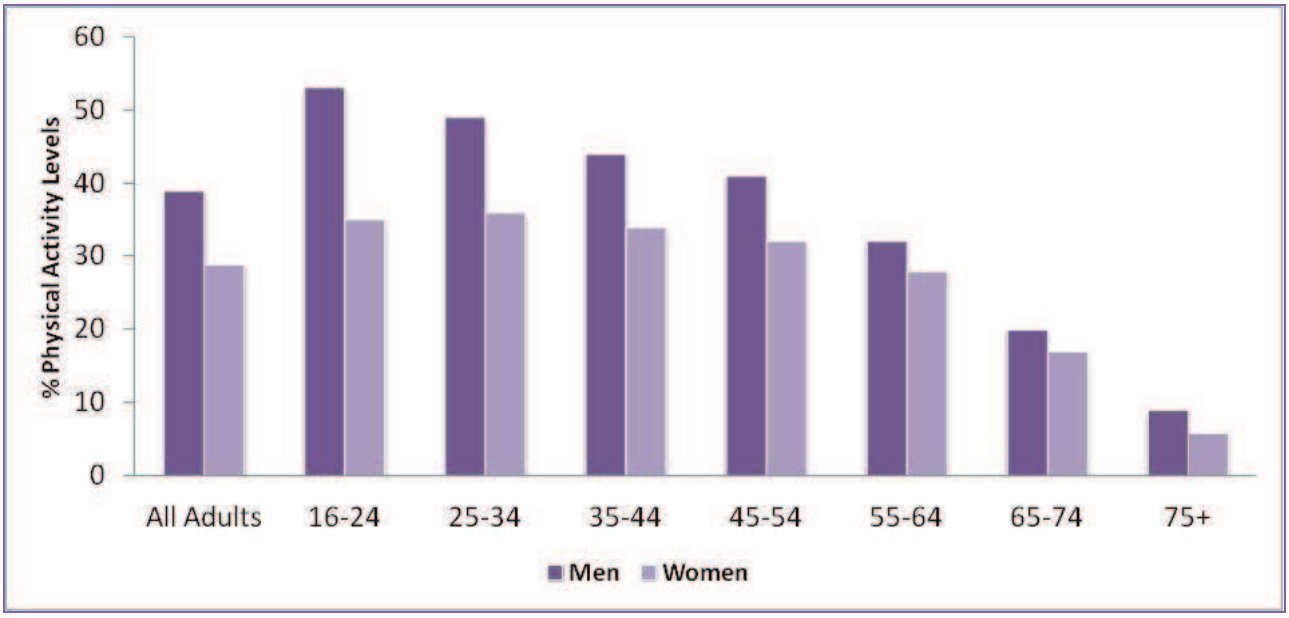
While the physical benefits of participation in sport are well known and supported by large volumes of empirical evidence, sport and physical activity can also have positive benefits on education. There is evidence to demonstrate that involvement in physical activity and sports has a positive impact on educational attainment especially in young

people[3]. Studies based on survey data show robust associations between sport participation (in school and non-school settings) and educational attainment, regardless of socio-demographic factors[4,5] . In addition, sport also helps by giving young people the opportunity to develop new skills, as well as the confidence and motivation to gain qualifications that can ultimately lead to employment and career development.

Furthermore, sport and physical activity projects can make a significant contribution to the reduction in crime rates and anti-social behaviour. It has become increasingly apparent in recent years that physical activity and sport can act as a diversionary activity in reducing the levels of crime and disorder, especially among young people who are recognised as the most significant group in terms of offending. Early involvement in sport and physical activities by young people can help in preventing a life of crime or diverting others away from re-offending.

Sport and physical activity can also be combined with other interventions to reduce crime in particular groups and communities[6]. And research has shown that young people who participate in organised sports at school or in their communities are less likely to engage in negative health behaviours, such as cigarette smoking and drug use, than those non-sports participants.

Figure 9: Self-reported physical activity by age and gender



Source: Townsend et al, 2012

Among 16 to 24 year olds in England, 53% of men and only 35% of women reported that they met the CMO's recommendations[7], this is the age group when self reported physical activity is at its peak among men (figure 9).

The British Heart Foundation report highlights three self-reported categories relating to the physical activity guidelines; meeting recommendations, some activity, and low activity. The report shows the need for the majority of young women and a smaller proportion of young men to increase their activity levels to meet the recommendations.

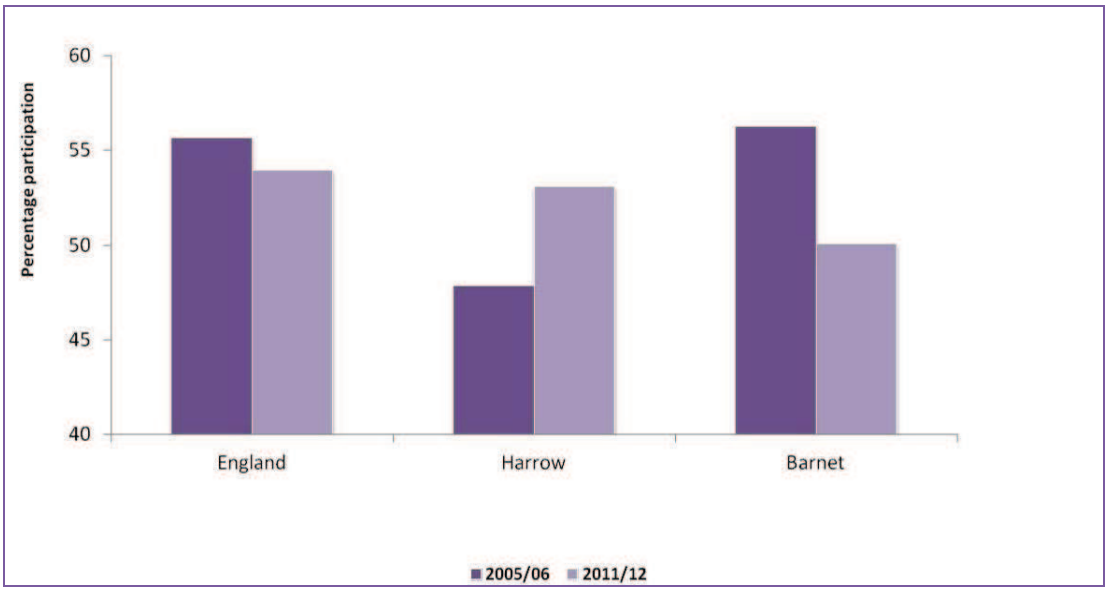
"who could I play with if I really wanted to ……."

''….or where could I play if I really wanted to"

A Harrow resident

Sports England's Active Peoples Survey provides the largest sample for a sport and recreation survey in England. The survey found that between 2005/06 and 2011/12 there was a 5% increase in participation in at least 30 minutes of moderate intensity physical activity among 16 to 25 year olds in Harrow. In contrast there was a 6% decrease in participation in Barnet, a less marked decline was observed across the rest of England (figure 10).

Figure 10: Participation in 30 minute sport among 16-25 year olds, 2005/06 - 2011/12



Source: Sport England

So why do our levels of physical activity decline from early adulthood[8]? Research has shown there are a number of reasons why young people in the UK give up on participating in physical activity. These reasons include negative PE experiences at school, perceived lack of ability, lack of money or equipment and competing interests such as social activities, hobbies, time-consuming work or further study and self-esteem issues. Moreover, young adults are less likely to participate in sports and physical activity if they did not participate in them in the past[9].

These reasons are corroborated by evidence commissioned by Sports England.[10] The framework devised by researchers, links together the factors that are likely to influence participation in sport and physical activity (figure 11). They concluded that irrespective of young women's level of participation in physical activity, life transitions, such as moving from school to college or education to employment, generally have a negative impact upon sports participation. This was principally due to decrease in levels of spare time, money and energy. In addition, family and friends were considered to be the most important factors influencing participation in sport, and complex psychological issues such as self-confidence, and perception of personal ability, were also found to play a significant role in the decision to participate in sport.

What works?

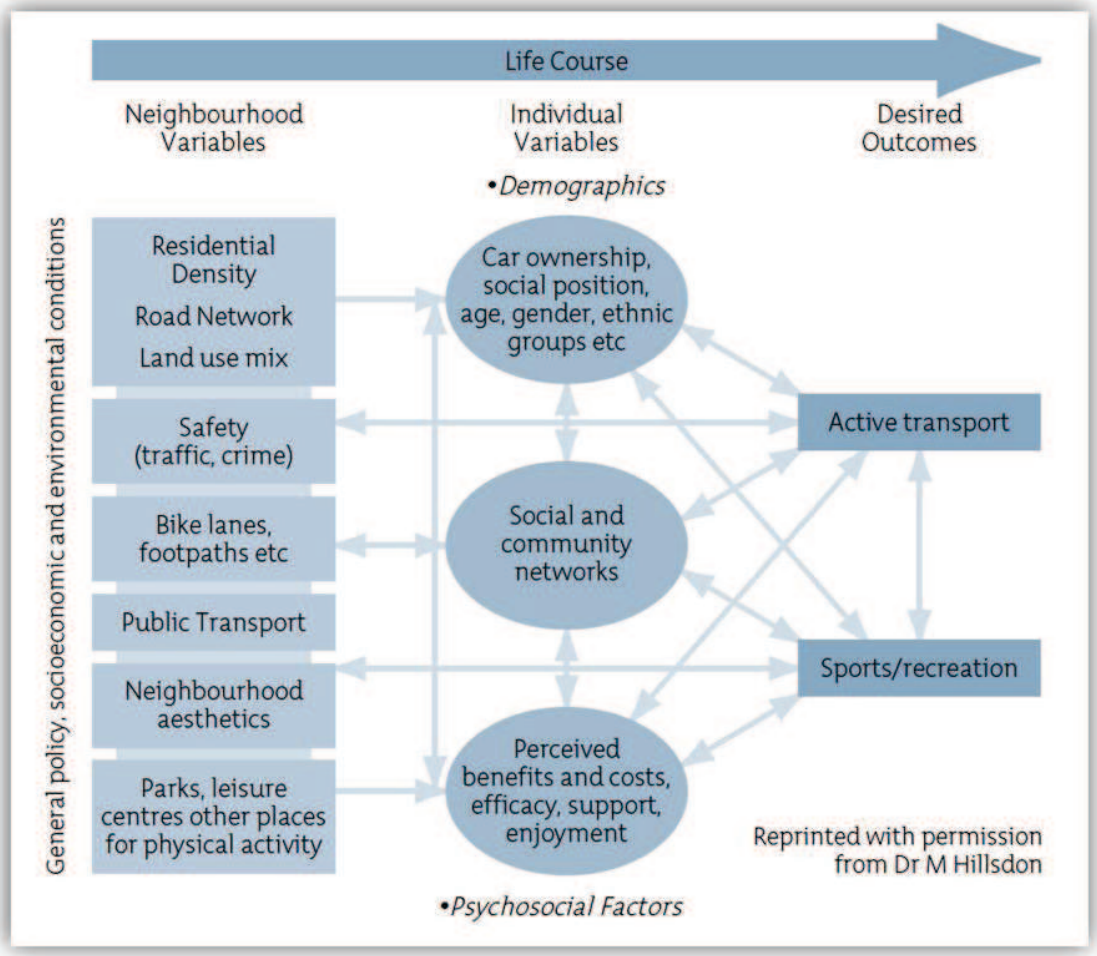
When considering how to increase participation levels, it is easy to concentrate on supply; merely increasing opportunities to be active. While this is important we also need to take action to increase demand for such opportunities. This means increasing the number of teenagers and young people in the borough wanting to be more active and then providing the support to them to make this a viable option.

Given that the evidence that life transitions can negatively impact on physical activity interventions to increase participation should focus on these transition events and provide support to young people.

NICE guidance[11] provides recommendations on a range of actions to help promote physical activity in children and young people.

- Identify local factors that may affect whether or not children and young people are physically active by regularly consulting with them, their parents and carers
- Find out what type of physical activities children and young people enjoy, based on existing research or local consultation (for example, some might prefer non-competitive or single- gender activities). Actively involve them in planning the resulting physical activities.
- Remove locally identified barriers to participation, such as lack of privacy in changing facilities, inadequate lighting, poorly maintained facilities and lack of access for children and young people with disability. Any dress policy should be practical, affordable and acceptable to participants without compromising their safety or restricting participation.
- Provide regular local programmes and other opportunities for children and young people to be physically active in a challenging environment where they feel safe (both indoors and outdoors). Ensure these programmes and opportunities are well publicised through appropriate channels.
- Ensure physical activity programmes are run by people with the relevant training or experience.

Figure 11: Framework of the factors determining sports participation



Source: Sports England

Programmes in both boroughs

Mini London Marathon

Taking place over the final 3 miles of the main London Marathon route (on the same day as the main event), approximately 70 young people aged 11-17 from the London Borough of Barnet can compete against the other 32 London boroughs as well as regions from across the UK. Athletes are selected through an open session held on the Copthall site. Runners not selected to represent the borough are encouraged to join a local athletics club that support the planning and delivery of the programme.

In 2013, 53 young people represented Harrow in the mini London marathon.

Programmes in Barnet

In addition to the plethora of activities provided by sport and physical activity services commissioned by Barnet Council, those provided by community and voluntary sector and those of the private sector, there are some specific programmes aimed at young people.

Barnet Leadership Academy

The BPSS develops and coordinates the borough's leadership academy. The academy provides official training opportunities to young people through Middlesex University; young people can then volunteer at local sporting events.

Positive Activities (Holiday Provision in Barnet)

Barnet sports development team coordinate a range of high-quality and challenging activities (many of which are accredited or provide qualifications) including sport and physical activities. These are offered to young people aged 8 to 19 or up to 25 for those with learning difficulties. Examples of the activities on offer include: multi-sports; martial arts, football, tennis, badminton, basketball, volleyball, gym, dance, boxing, athletics and trampolining. In 2012/13, 1500 young people took part in 100 holiday programmes around the borough.

London Youth Games

Europe's largest youth sports event, the London Youth Games incorporates all of London's 33 boroughs competing across 30 different sports. Athletes are selected through a number of methods including open sessions, school competitions and local sports clubs.

Term-time Physical Activity

As well as a number of short-term programmes designed to generate interest in physical activities and highlight pathways into local, accessible provision, the Barnet youth & community service also directly co-ordinate:

- Boxing & Circuits at Grahame Park Youth Centre, Colindale, NW9 – Monday's 5-6.30pm – 11-17 year olds
- GymFit – Canada Villa Youth Centre, NW7 - Wednesday's 5.30-7pm – 11-17 year olds
- Football – Grahame Park All Weather Pitch, NW9 – Wednesday's 5.30-8pm – 11+
- Dance (various styles) – Finchley Youth Centre, N2 – Various evenings

Duke of Edinburgh Award Scheme

The Barnet youth & community service co-ordinate this programme for the borough – liaising closely with secondary schools. A key element of completing the award involves physical activity.

Alternative Education – Health, Wellbeing and Sport

The Barnet youth & community service co-ordinate a selection of alternative education programmes to engage young people aged 14 to16. Referred from local schools, the young people are considered 'at risk' and would benefit from other forms of learning outside of mainstream education settings. A new course starting in September 2013 revolves around health, wellbeing and sport and will incorporate a significant amount of physical activity.

Young Sportz Maker Programme

The young sportz maker programme offers 12-hour volunteer placements to young people aged 14 to 17 from a selection of local sporting providers. The programme is currently accredited through ASDAN and involves a number of skills development opportunities with many providers incorporating physical activity into their placement.

Doorstep Sports Club' (DSC)

The Barnet youth & community service will be coordinating the delivery of a project in the Grahame Park area that will target local young people aged 14 to 25. The DSC will increase publicity of and access to existing provision, as well as deliver a selection of new, fun and challenging physical activities. This will be combined with opportunities for young people to develop wider life skills, and acquire qualifications and leadership awards.

Services in Harrow

As in Barnet, there are a range of sports activities and opportunities across Harrow that young people can access.

Harrow Sportivate

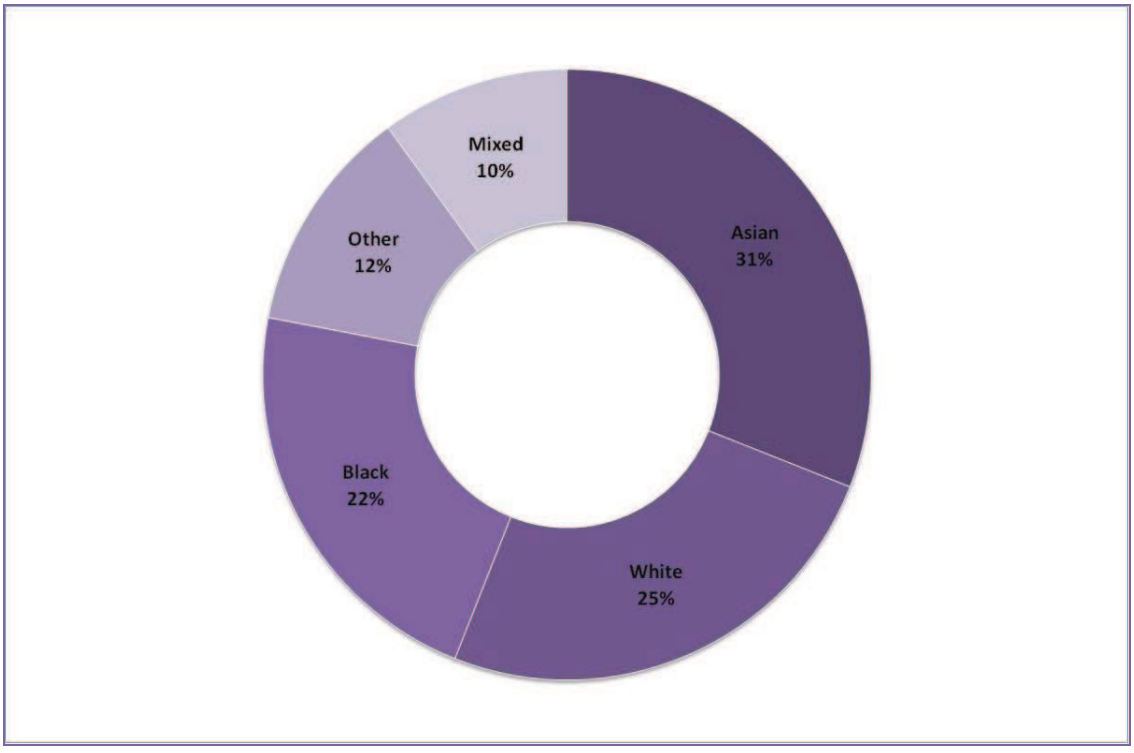
Sportivate is a government funded programme that gives 11 to 25 year olds access to coaching courses in a range of sports and activities. It is part of 'Places People Play', the government's mass participation legacy plans. The programme is aimed at those not currently choosing to take part in sport in their own time and will provide 6 to 8 week coaching courses in a wide range of sports and physical activities, as well as support to continue playing in local community clubs.

Harrow Council's sports development team were successfully awarded £27,000 to fund Sportivate which forms part of the 2012 mass participation legacy plan. Sportivate captures the excitement of sport and London 2012 by providing attractive and

sustainable community opportunities in sport. Sportivate is aimed at young people in the borough who have an interest in sport, but may not be participating on a regular basis. Twelve new sports clubs were lauched in 2012 as a result of the funding.

The first year Sportivate results in Harrow have shown that out of the 265 participants, 135 (51%) were retained. The male to female mix was reported to be 55% and 45% respectively and 6% of participants had a disability. The highest level of participation in the programme was among young people of Asian backgrounds (figure 12). The second year had a retention target of 328 but actually retained 521young people. Successful project included basketball, netball, table tennis and the Whitmore programme. The funding is now in year three and the sports development team have confirmed and started sports which are aimed at the upper ages, these include badminton, hockey, tennis, volleyball and judo. The team continue to fund the Black Hawks basketball club for 5 to 18year olds, the Allstars Netball Club for 8 to 16 year olds and table tennis sessions 10 to 18 year olds.

Figure 12: Level of Sportivate participation by ethnic group in Harrow, 2011



Source: Sports Development, London Borough of Harrow

Cedars Youth Community Centre

The Cedars YCC opened in 2012 and is a partnership between Harrow council and Watford FC's Community Sports and Education Trust. Since it opened, over 1,200 young people have joined the centre and on average there are 1,000 visits per week,

with over 75% of these being in the 11 to 18 age group. The Cedars YCC offer the following youth activities:

- Kickz: Free football for 11-19 year olds on Mondays & Fridays nights. Over 50 young people attend each session.
- FA Mash Up: Football provision for young people 14-17 years on Friday afternoons with a coach from Watford FC's Community Sports and Education Trust. Around 25 young people attend these sessions.
- Youth Gym: Each week a specific session is held in the gym for young people 14-16 years old. This session attracts around 10 young people per week.
- School Holiday Activities: Easter, half term and summer holiday camps were held for 5 to 13 year olds. Over 200 children attended activities during the waster and half term activities.
- Youth Club: On Mondays, Thursdays & Fridays a free youth club for 11-19 year olds provides activities including table tennis, pool, table football, x-box, and various sporting activities. The youth club currently attracts 15-20 young people per session.

When the centre was established, the main aims were to help children become more active. However, there have been additional benefits. In the area surrounding the centre, there have been other noticeable changes. Overall crime was down 25% compared to the previous year. Anti-social behaviour dropped by 37.5% and there was a reduction in street litter of 33.6% per cent in the surrounding area

"There are definitely fewer young people hanging around the area now that there is much more to do … There appears to be a greater respect for property in the surrounding roads now, and the centre's staff have done their bit by keeping the immediate grounds clean and litter-free."

Lisa Golding, Cedars receptionist & has lived in the neighbourhood for 15 years

On Your Marks

'*On Your Marks*' is a Sport England funded programme for over 16s who have a disability. This programme runs in partnership with Brentford Football Club Community Trust and the sessions include short mat bowls, table tennis and swimming.

Back to Netball

Harrow hosts a netball development officer funded by England Netball. 'Back to Netball' sessions are run for the over 16's. Sessions provide a gentle re-introduction to the game and are led by qualified coaches

What could we consider doing?

The Councils

- Develop multi-component school and community programmes.
- Promote awareness of the benefits of physical activity and give children and young people the confidence and motivation to get involved
- Encourage a culture of physically active travel (such as walking or cycling)
- Encourage children and young people, especially those who live within a two-mile radius of their school or other community facilities, to walk, cycle or use another mode of physically active travel to get to their destination
- Map safe routes to school and to local play and leisure facilities.
- Identify and use appropriate role models
- Take into account the views of pupils, parents and carers and consult with the local community.
- Consider how to overcome any barriers to physical activities that are identified by local people, (for example, a lack of secure cycle parking, safety fears in parks, street lighting to encourage walking and cycling in evenings)
- Set performance targets for school travel plans and audit them annually. Take remedial action when agreed targets are not reached

The Community

- Encourage outdoor activities and sports
- Set up family fun days and schemes such as 'Play in the park'.
- Start a local team – football, netball, cricket or other sports and challenge other community groups.
- Provide opportunities for young people to be active during leisure time (including weekends and holidays) in wider community settings and the private sector. These should consider activities aimed at young women and non-sport activities.

Leisure services

- Consult girls and young women to find out what type of physical activities they prefer and actively involve them in the provision of a range of options in

response. This may include formal and informal, competitive and non-competitive activities such as football, wheelchair basketball, dance, aerobics and the gym.

- Consider barriers to participation by girls and women including the need for women only sessions or groups, changing facilities offering privacy, dress policy.

The Health Sector

- Promote physical activity to parents and to young people as part of consultations

Schools and Colleges

- Create a supportive school environment and new opportunities for physical activity during breaks and after school
- Develop a school travel plan which has physical activity as a key aim. Integrate it with the travel plans of other local schools and the local community so that children and young people choose physically active modes of travel throughout their school career.
- Provide suitable cycle and road safety training for all pupils
- Provide opportunities for physical activity at intervals throughout the day in pre-school establishments; during playtimes and lunch breaks at school; as part of extra-curricular and extended school provision
- Offer school-based physical activities, including extra-curricular ones. Provide advice on self-monitoring and individually tailored feedback and advice
- Develop family activity days

Parents and Carers

- Be aware of the government advice that children and young people should undertake a minimum of 60 minutes moderate to vigorous physical activity a day and at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.
- Plan a range of indoor and outdoor physical activities for children on a daily basis, including opportunities for unstructured, spontaneous play.
- Join in with the activities
- Be a role model – make walking and cycling be your own and your family's usual mode of transport
- Allow children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances

Individuals

- Get involved. If there's a barrier to participating find out who can help you overcome it.
- Find an activity that you like – the gym isn't everyone's taste
- Keep a diary of your activity and see how you improve over time

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Chapter 4: Physically Active Adults

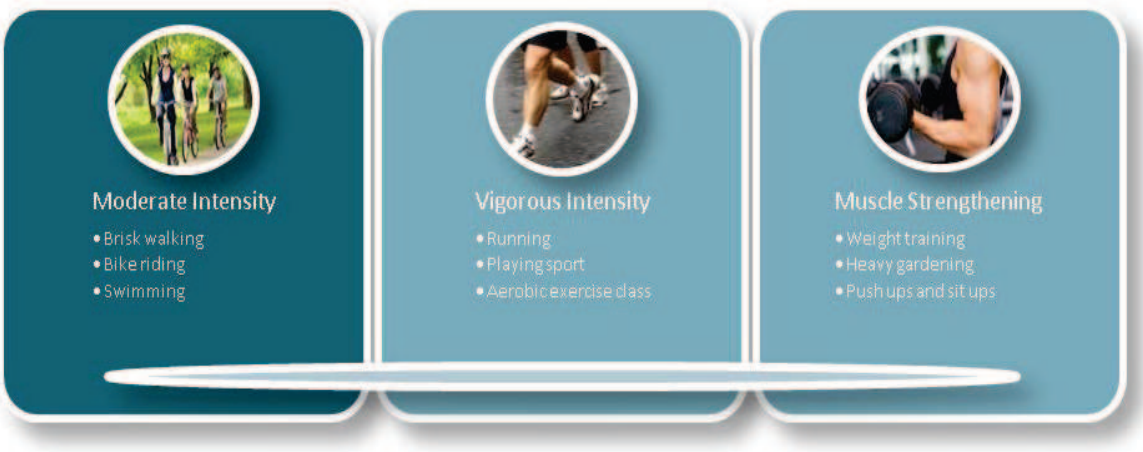
The opportunities for physical activity in the 21st Century have become limited as we have engineered agricultural and technological solutions that have progressively removed the need for any activity in our daily lives.

Recent research using data from the Active People Survey showed that almost one in 10 adults have not walked (with the exception of shopping) continuously for five minutes in the past four weeks and nearly 80% of the population fails to achieve the recommended level of physical activity[1]. Inadequate levels of physical activity and excessive sedentary behaviour are critical public health issues.

One way to approach meeting the recommendations is to do 30 minutes of moderate intensity activity on at least five days a week and incorporate muscle strengthening activities on at least two days a week. The overall volume of physical activity, however, is more important than the specific type of activity, intensity or frequency of sessions, since a larger quantity of activity at higher intensity can bring further benefits (figure 13).[2]

For most people, the simplest and easiest forms of physical activity that are most acceptable are those that can be incorporated into everyday life, such as walking or cycling instead of travelling by car.

Figure 13: Types of activity



Sport and recreational activity included alongside everyday physical activity can also provide important social benefits that help to sustain participation. For adults the key issue is maintaining activity levels particularly through key life transitions such as marriage, parenthood and retirement[2].

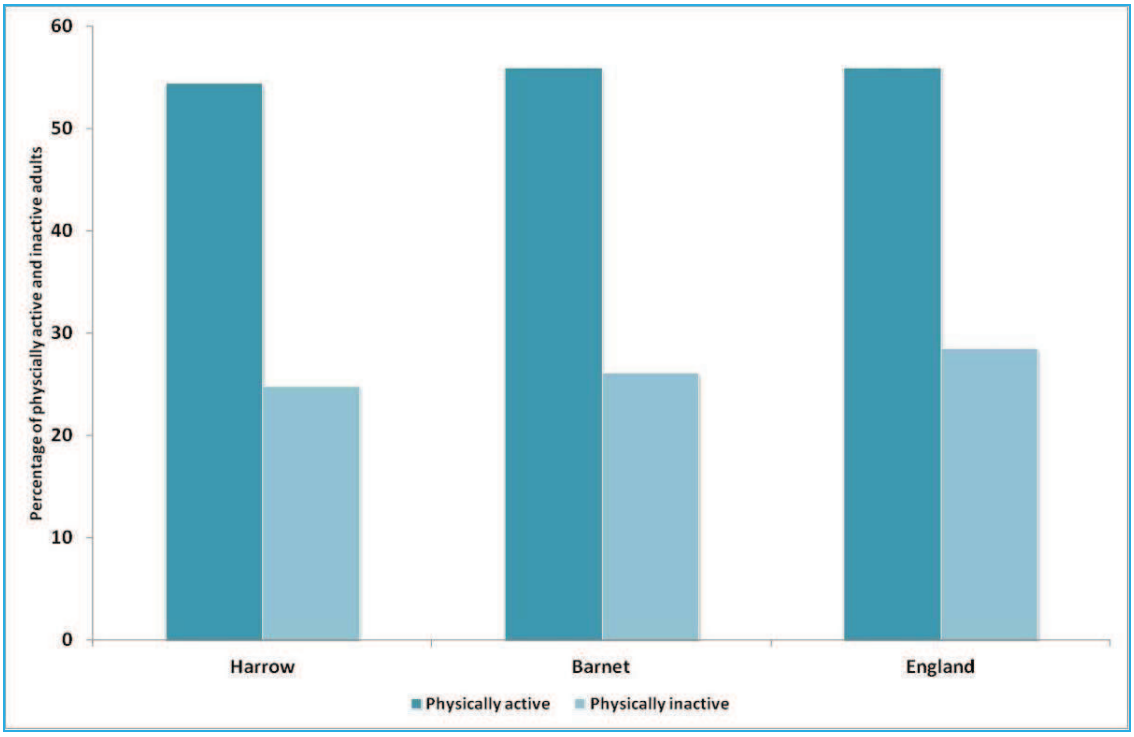
How active people are is influenced by a wide range of factors, from the advice or encouragement of friends, through programmes at work or in local communities, to the influence of the built and natural environment and general socio-economic conditions. All activities qualify as long as they are of sufficient intensity and duration, including occupational activities and active travel[2].

Background

The benefits of physical activity are clear in terms of promoting health and preventing disease.

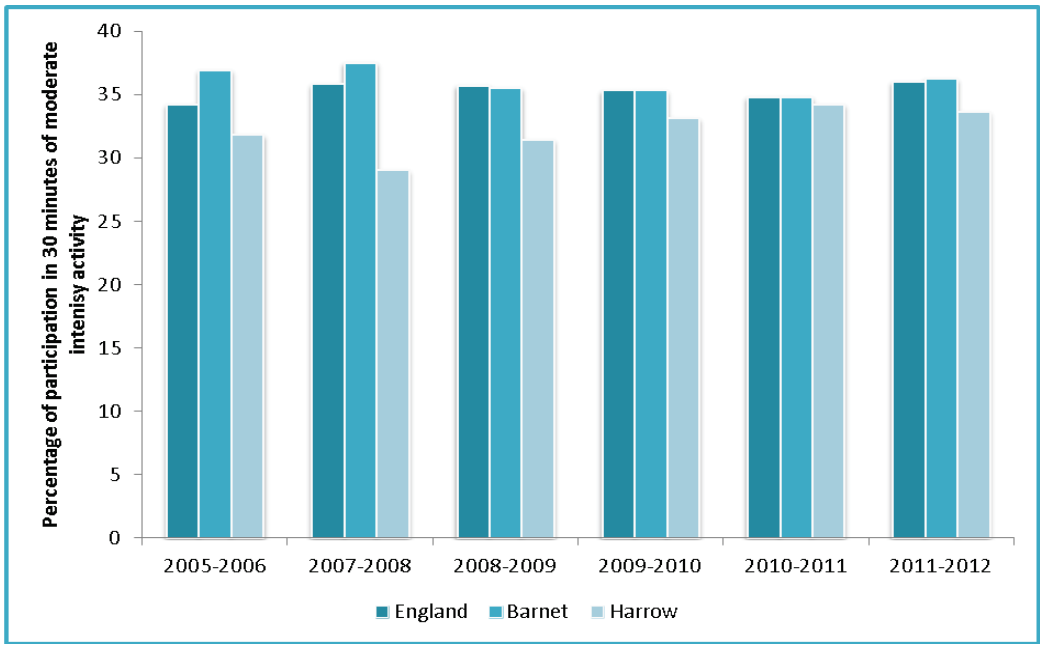
Adult participation in physical activity in Barnet and Harrow does not differ significantly from the rest of England (figure 14). In 2012, 56% of adults in Barnet and 54% of adults in Harrow did at least 150 minutes of physical activity per week in accordance with the UK Chief Medical Officer's guidelines on physical activity. As in England, a quarter of adults in Barnet and Harrow were classified as physically inactive[3] (i.e. they did exercise for 30 minutes or less per week).

Figure 14: Percentage of physically active and inactive adults, 2012



Source: Public Health Outcomes Framework Data Tool

Figure 15: Adult participation in one 30 minute session per week of at least moderate intensity activity, 2005/06 to 2011/12



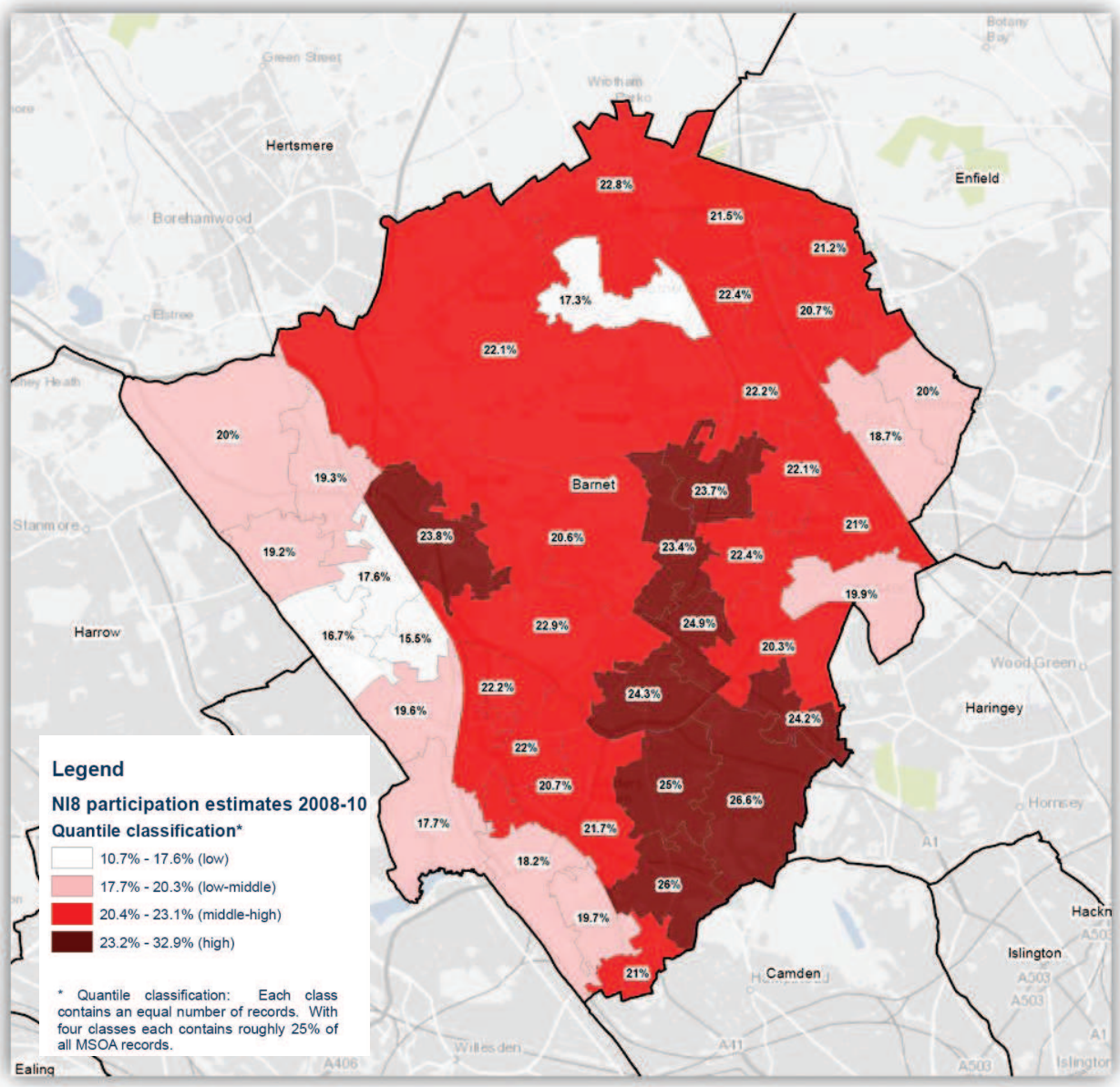
Source: Sport England, Active People Survey 6

There was little change in adult participation in moderate intensity activity among Barnet residents between 2005/06 and 2011/12, while in Harrow the proportion of adults participating in one session of moderate intensity activity during this period increased although this level of participation has always been less than England as a whole (figure 15).

Sport England's local sport profile found that the most popular sports for adults in Harrow to take part in are swimming, gym activities, football, athletics and cycling. More than half of all adults wanted to do more sport (62%), namely swimming and cycling. In Barnet, the most popular sports were gym activities, football, swimming, athletics and cycling. Sixty-three percent of adults reported wanting to do more sports, specifically swimming and cycling.

The maps below show areas of low physical activity and sport participation in Harrow and Barnet. In Barnet, parts of the Colindale, Burnt Oak and Underhill wards have low participation estimates (map 1). In Harrow, participation in physical activity is low in the south and east of the borough (map 2).

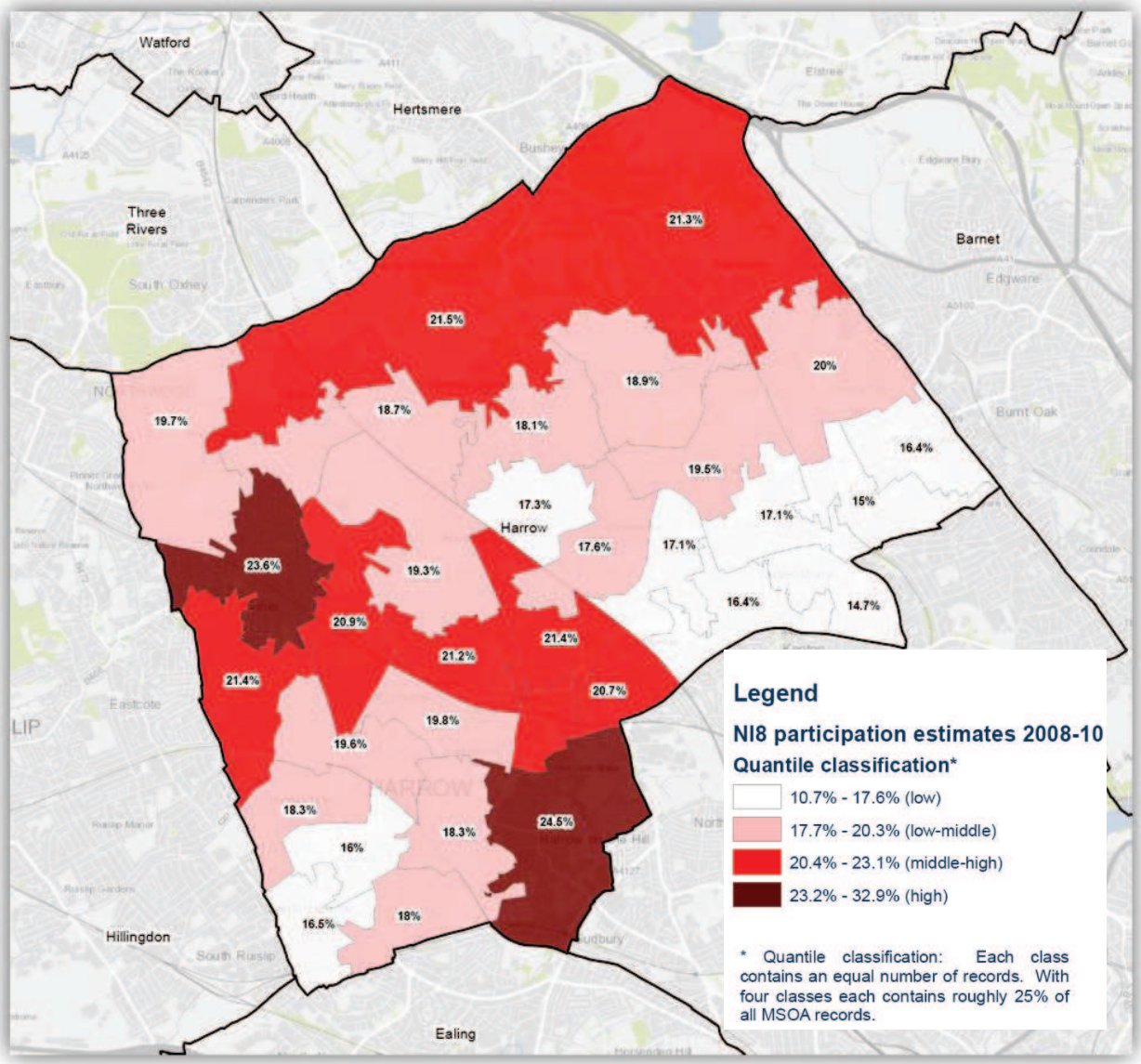
Map 1: Adult participation‡ in sport and active recreation, by Medium Super Output Area in Barnet (2008/10)



Source: Sport England

‡ Participation is defined as the percent of the adult population (age 16 and over) participating in at least 30 minutes of sport and active recreation (including walking and cycling) of at least moderate intensity on at least three days a week (formally National Indicator 8, N18).

Map 2: Adult participation[§] in sport and active recreation, by Medium Super Output Area in Harrow (2008/10)



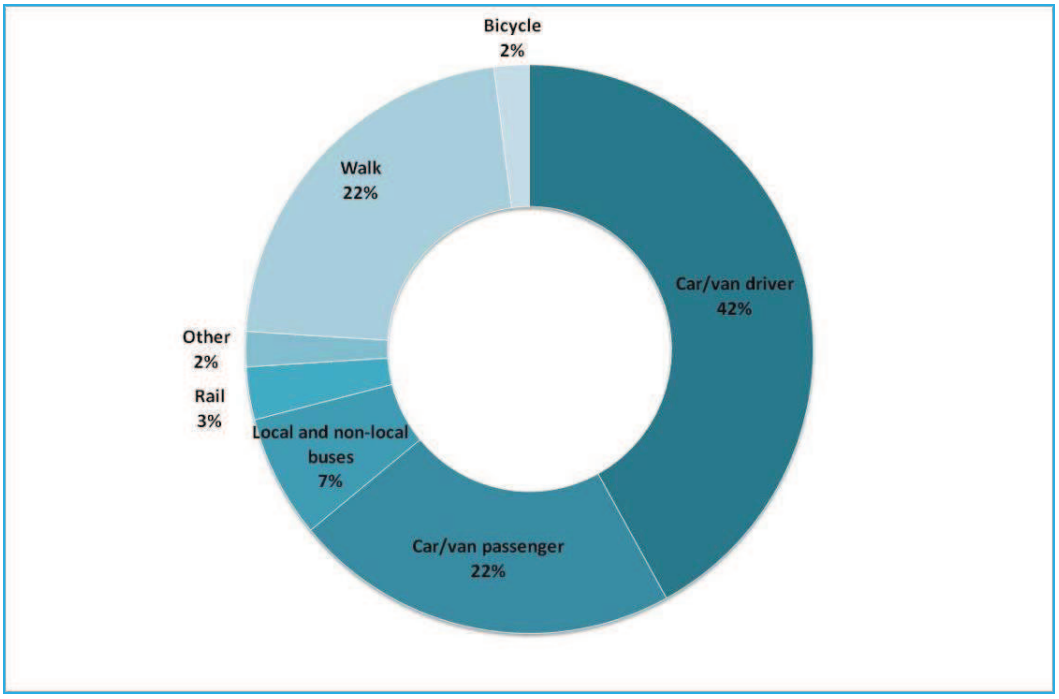
Source: Sport England

Another key opportunity for being active within the community can be incorporated into how we travel. The 2010 National Travel Survey (NTS) is the latest in an established

[§] Participation is defined as the percent of the adult population (age 16 and over) participating in at least 30 minutes of sport and active recreation (including walking and cycling) of at least moderate intensity on at least three days a week (formally National Indicator 8, N18).

series of household surveys of personal travel in Great Britain. In 2010, 64% of all trips were made by car (as a driver or passenger) compared to 23% by walking or cycling. Car travel accounted for 78% of the total distance travelled (figure 16).

Figure 16: Average number of trips made in Great Britain



Source: National Travel Surey, 2010

The Health Survey for England questioned adults about their perceptions and attitudes to physical activity and barriers to taking part. Some key findings from this research showed that women were slightly more likely than men to want to be more physically active than they currently were (69% and 66% respectively). Men and women were found to have different barriers to increasing activity. Men were most likely to cite work commitments as a barrier to increasing their physical activity (45%), while lack of leisure time was the barrier most cited by women (37%). The result highlights the need for effective workplace health programmes[4].

What works?

NICE have provided guidance on four common methods used to increase the population's physical activity levels[5]. These methods are brief interventions in primary care, exercise referral schemes, pedometers and community-based walking and cycling programmes.

Brief interventions in primary care

Brief interventions involve opportunistic advice, discussion, negotiation or encouragement. They are commonly used in many areas of health promotion, and are

delivered by a range of primary and community care professionals. The interventions vary from basic advice to more extended individually–focused attempts to identify and change factors that influence activity levels. Brief interventions involve:

- Identifying adults who are not currently meeting the UK physical activity guidelines
- Advising adults who are inactive to do more physical activity with the aim of meeting the guidelines by providing information about local opportunities to be physically active for people with a range of abilities, preferences and needs. There should also be a follow-up appointment or opportunity to assess progress towards personal goals or meeting the guidelines

Exercise referral schemes

An exercise referral scheme directs someone to a service offering an assessment of need and development of a tailored physical activity programme, monitoring of progress and a follow-up. The fitness industry association estimates that there are around 600 schemes in England. They involve participation by a number of professionals and may require the individual to go to an exercise facility such as a leisure centre.

Pedometers, walking and cycling schemes

Pedometers are a common aid to increasing physical activity through walking. Much of the research about pedometers has involved comparing the validity and reliability of different models.

Walking and cycling schemes are defined as organised walks or rides in national sports reports.

Services in Harrow

Exercise on Referral

Exercise on referral is a programme of tailored exercise sessions offered to meet a person's need. The programme introduces people to the benefits of physical activity. Individuals are referred onto the programme by their health professional (GP, practice nurse, physiotherapist etc.). The programme is open to adults aged 16 years and over

who have an existing health condition, meeting the referral criteria and are considered inactive (not currently participating in at least 30 minutes of moderate intensity activity on three or more days a week). Participants must be Harrow residents or registered with a Harrow GP to access the scheme. In 2010/11, 599 people accessed the Harrow Exercise on Referral programme.

Health Checks

NHS Health Checks are for 40-74 year olds who presently do not have an existing cardiovascular risk factor. Invites are sent out to eligible individuals from their GP surgeries. Follow-up programmes have been put in place to support those who have been identified as needing to increase their physical activity levels. These include HealthWise (gym based exercise programme), weight management programme (gym and dietary advice), Let's Get Moving (motivational interviewing and signposting programme) and resources highlighting local opportunities.

Work Place Health

NHS Harrow have supported 10 local companies to adopt a healthier workplace and have provided them with the tools and resources necessary to implement initiatives. Health champions were identified and trained within the workplaces and sustainability packs produced specific to their workforce. These include resources such as physical activity opportunities across the borough, physical activity challenges, and posters (such as, use the stairs not the lift).

Harrow Community Sport and Physical Activity Network (CSPAN)

The Harrow CSPAN is made up of individuals from key organisations involved in the provision of sport and physical activity across Harrow. It forms one of six CSPANs across the Pro-Active West London sub-region and provides the critical linkage between sub-regional co-ordination and local planning and delivery.

Walk Your Way to Health

Walk Your Way to Health provides an opportunity for individuals to walk regularly in a relaxed and friendly environment and also to enjoy some beautiful green spaces. Walk Your Way to Health in Harrow is free and is open to anyone. The walks are led by qualified leaders, who encourage you to walk at your own pace. Everyone is welcome, regardless of age and fitness level. Currently there are seven regular walks all year and

an additional three run over the summer months. In 2010/11, over 300 new people accessed the programme. Expansion of the walk scheme has been provided recently through a growing number of Nordic walks that are incorporated within the health walks programme. Nordic walks are held once weekly and beginners courses once a month. All Nordic walks are volunteer led and so far over 50 people have accessed a course.

> "I heard about the walks from Sunrise Radio. I love the walk, it is very good and I have made many friends. The leaders are excellent and it helps your health!"
>
> Niranjana Rupandia, South Harrow and Rayners Lane walker

Physical Activity Directory

A comprehensive list of physical activity and exercise opportunities within the borough has been compiled for adults aged 18 years and over. The directory includes activities at local leisure centres as well as those delivered within community based facilities such as churches and schools. All the information is also available electronically through www.getactivelondon.com

Harrow Outdoor Gym- Activators Programme

Volunteer peer activators are being put in place to encourage and support users of the outdoor health and fitness gyms. Outdoor gyms are unique in that they are free and suitable for all to use. There are presently four outdoor gyms in local parks across Harrow. The project builds on this original opportunity by providing a sustainable model by using and building strong relationships with volunteers in Harrow.

The Cedars Youth and Community Centre

In addition to the activities for children and young people, the Cedars YCC also provides opportunities for adults to do physical activities. There is a gym which has low membership fees and has, in the first year, got over 200 members. They also run a weekly session where women get exclusive use of the gym, badminton, table tennis and any other applicable sporting activity.

Services in Barnet

Outdoor gyms and marked and measured routes

LBB is proposing to install five to six outdoor gyms and marked and measured routes in parks in Barnet. This is in addition to the outdoor gym in Oak Hill Park. The all weather outdoor gyms are expected to be installed by April 2014 and will be open to the public at anytime.

Activator scheme

To encourage more people to use the outdoor gym and marked and measured routes, and support them to use it effectively, volunteer activators will be recruited from the community and trained to Level 2 fitness instructor. These volunteers will complete their nationally accredited training and be in place by April 2014.

Barnet Walks scheme

LBB provides a walk scheme from 4 sites (Woodside Park, Friary Park, Orange Tree and Hampstead Heath) every day of the week. It offers a range of difficulty levels to suit people of different ages and abilities. Participants receive a discount if they pay for 10 walks or if they are over 60 years old. In 2012/13, 5,063 people participated in 252 walks. There is a plan to expand this scheme to more sites in the borough.

Barnet Sport and Physical Activity Services and Parks

Barnet council works in partnership with Greenwich Leisure Limited (GLL) in the management and development of seven Barnet sports facilities. There are also a number of parks and outdoor sport and recreation facilities which are free and open to all users. In some instances participants are required to pay a fee to use the facilities.

Sports clubs

There is a wide range of regular sports clubs that offer a variety of regulated, regular and structured physical activity for residents. They are promoted on the London active website www.getactivelondon.com. The clubs are open to residents and are run from different locations in the borough.

Barnet Skyride

British cycling runs Skyride in partnership with the London Borough of Barnet. This programme is providing regular cycling opportunities for residents of different ages and cycling ability.

Barnet Half Marathon

The London borough of Barnet are currently working with partners to hold a half marathon in Barnet in 2014/15.

Saracens Community Dance programmes

The dance programme offers a range of dance styles and forms which appeal to different ages and abilities including cheerleading, street dance and hip hop.

National Programmes

There are a number of national programmes that Harrow have been involved with, these include:

My Best Move

Part of the NHS London 2012 legacy is to get patients more active. At least two practices in every London borough have been identified through the Clinical Transition Group (CTG) to take part in My Best Move. This short training programme is currently being delivered to GP practices across London, to encourage patients to become more physically active.

Let's Get Moving

Delivered by health trainers and launched in 2009, Let's Get Moving is a behaviour change intervention based on NICE guidance. It endorses the delivery of brief interventions for physical activity in primary care as both clinically and cost effective in the long term. The programme is currently being rolled out across Harrow in conjunction with NHS Health Checks.

Volunteers

Sports Makers is a volunteering project that is funded by the National Lottery and supported by Sport England. Sport makers are the people who make sport happen locally whether it be volunteering in a sports club, or getting their friends or colleagues to participate in regular activities such as five-a-side football. Sports development and the Harrow CSPAN agreed to take a lead role in delivering sport makers in Harrow by supporting the promotion and recruitment of local sports makers, organising a convention and producing an ongoing list of placement opportunities in the borough. To date over 100 local sport makers have registered for volunteering opportunities within the borough.

Change4Life

Change4 life has now expanded to focus on adults and families, with the ‘Get Going Everyday’ campaign.

The campaign aims to encourage adults to increase their physical activity levels by fitting in more activities into our everyday lives. Simple ideas and tips are provided to help achieve the physical activity recommendations.

What could we consider doing?

The councils

- Expand the walk schemes to encompass GP practice walking routes, children centre 'buggy walks', and shorter workplace lunch time walks
- Promote active travel and support businesses and schools to develop active transport plans
- Support the health service to be able to signpost people to physical activity opportunities by providing education sessions to equip people with the tools and resources to confidently discuss physical activity with patients and to know where and what they can signpost them to.
- Increase awareness of existing programmes and initiatives open to individuals to allow people to take a more proactive approach to increasing their physical activity levels
- Targeting areas with low physical activity levels and putting population specific initiatives in place.
- Utilise the green spaces as centres for promoting and engaging in physical activity
- Join in with existing national initiatives to increase awareness of local programmes such as www.getactivelondon.com and Change4Life
- Continue to develop strong and meaningful partnerships with other organisations in relation to physical activity through networks such as CSPAN and BPSS
- Undertake a robust evaluation of current services such as exercise on referral to see if there has been sustained participation in physical activity. More evidence to show those interventions that have proved most successful will help provide best practice for the future

Health Services

- Attend educations sessions to build skills and knowledge
- Increase the number of people who are signposted to physical activity opportunities
- Promote active travel by staff and patients

Workplaces

- Develop active travel plans that include how your staff can get to work using active transport such as walking and cycling
- Encourage staff games - inter-departmental or between businesses

Individuals and Communities

- Take part in physical activities by joining in some of the wide range of opportunities available
- Organise local activity events for communities
- Encourage your families, friends, workmates and neighbours to join in
- Travel on foot where possible and cycle for further differences. Use the car as little as possible
- Limit the amount of TV you watch and do something active instead – even if it's just dancing to your favourite music in the living room!

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Chapter 5: Physically active older people

Older people, those 65 years and over, have greater health needs than younger adults as certain conditions are more likely to occur with advancing age as one's muscle strength, flexibility and mobility diminish[1], limiting the ability of the person to self care. These changes make an older person more prone to falls[2].

Image courtesy of kootation.com

Older people often have to cope with a vicious cycle where a greater burden of poorer health and inability to cope with self-care leads to progressively worsening health. In addition, falls are the largest cause of emergency hospital admissions for older people and are a major reason why people in this age group move from their own home to long term nursing or residential care.

Physical activity can act as a cost effective measure to reduce the risk and incidence of worsening health for older people. This can pay huge dividends by reducing illnesses such as coronary heart disease, stroke, type 2 diabetes, cancer and obesity, and saving health care costs[3].

Many health benefits of physical activity relate to health conditions that older people are more likely to experience (table 4). Older people have much to gain from adopting an active lifestyle on a regular basis.

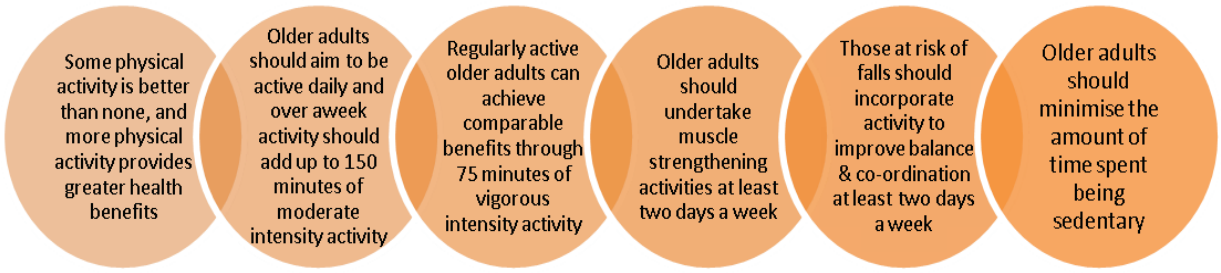
Table 4: Health conditions affecting older people and the health benefits of physical activity

Health Condition	Health Benefits of Physical Activity
Hypertension, Coronary Heart Disease, Stroke	Better blood pressure control; Improved cardiac function; Improved recovery from stroke
Diabetes	Better control of blood glucose levels
Cancers: Breast, Colon, Prostate	Reduced numbers of new cases of breast and colorectal cancers
Osteoporosis	Better bone strength
Falls and Injuries	Better body balance
Musculoskeletal disorders: Arthritis, Spinal deformities	Improved balance; flexibility and mobility of joints
Mental Health: Depression, Dementia, Memory loss	Reduced depression
Poor nutrition and weight problems	Better body weight maintenance
Respiratory conditions: Pneumonia, COPD, Flu	Better aerobic fitness
Gastrointestinal & Urinary Disorders (incontinence)	Improved pelvic tone that assists with urinary incontinence
Sensory impairments - sight, hearing, balance	Improved body balance

Source: WHO 2003 and 2010

For the first time physical activity guidelines from the Department of Health include recommendations for the amount of activity older adults should be doing. This population covers a wide range of ages and physical function from the athletic to the frail and immobile and these guidelines also take into account the variation in the population (figure 17)[4].

Figure 17: CMO's recommendations for older adults



Background

Older people in Harrow and Barnet carry most of the burden of the illnesses that are strategic health priorities for the boroughs: heart disease, stroke and diabetes. Many of these conditions can be prevented or improved with physical activity.

"Exercise of some kind or other is almost essential to the preservation of health in persons of all ages – but in none more so than in the old"

Daniel Maclachlan, 1863
A Practical Treatise on the Diseases and Infirmities of Advanced Life

In Barnet, 13.3% of the population (almost 48,000 people) are aged over 65 years. This is a lower proportion than the national average (16.4%) but higher than the London average (11.1%). A significantly higher proportion of older people in Barnet are from an ethnic minority group (17.1%) compared with the rest of England (4.4%). This is important because, diabetes and cardiovascular related conditions are more prevalent as we age and some ethnic groups have higher rates. Older people in Barnet are also slightly more likely to be income deprived (18.6%) compared to the rest of the country (18.1%).

In Harrow, people aged 65 years and over make up 14.1% of the population (almost 34,000 people). As in Barnet, there are significantly high proportions of older people from ethnic minority groups living in Harrow (24.9%) and the level of income deprivation among older Harrow residents (20.7%) is significantly worse than in England.

The rate of emergency hospital admissions due to falls in this age group, particularly in women is significantly worse in both Barnet (2,212 per 100,000 people over 65) and Harrow (2,249 per 100, 000 people over 65) when compared with England (2,028 per 100,000 people over 65). Fewer older women in both Harrow(211.3 per 100,000) and Barnet (207.5 per 100,000) were able to return to their usual place of residence following a hip fracture compared to their peers in England (294.4 per 100,000).

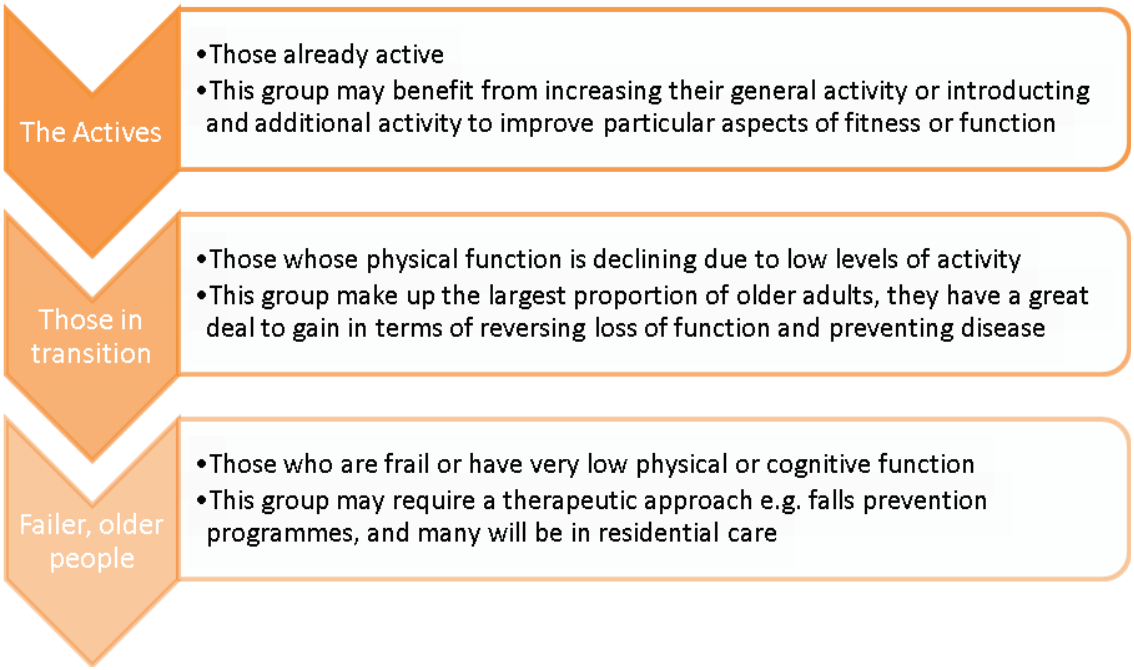
Among older adults living in England, 14% of men and 25% of women were classified as 'walking impaired', i.e., walking at speeds of less than 0.5 metres per second. Walking ability further declined with age as 36% of men and 56% of women aged 85 years and over noted walking difficulties[5]. Forty-one percent of adults in Great Britain over the age of 70 take a 20 minute walk (for transport purposes) less than once a year[6].

In 2005/06, 18.5% of Barnet adults aged 55 years participated in at least 4 sessions of at least moderate intensity physical activity for at least 30 minutes in the previous 28 days. By 2011/12 this had increased to 22.9%. In Harrow, there was no change in the proportion of this age group participating in this level of activity over the same period (18.4%).

We are aware that sedentary behaviour increases with age and evidence from self-reports and accelerometry indicates that sedentary time rises sharply from age 70 onwards[7]. Many older adults spend ten hours or more each day sitting or lying down, making them the most sedentary population group[8].

Three groups of older adults have been identified each with different functional status and differing physical activity needs (figure 18).

Figure 18: Three groups of older adults by physical activity status



Source: British Heart Foundation National Centre

What works?

There is growing evidence on ways to increase physical activity and decrease the risk and likelihood of older people developing the conditions mentioned above although, more research is still needed. It is important that those working to engage and encourage the participation of older adults in physical activity offer tailored programmes that reflect the preferences of older people themselves[9]. Common features found in successful physical activity programmes for older people include:

- Information and counselling from health professionals on physical activity and health and older people encouraged to engage in regular physical activity[10].
- Continuous reviews of each person's progress towards their goals throughout the programme and providing on-going support and encouragement[11].

- The use of a behaviour change model and intrinsic motivation[11], cognitive behavioural strategies (such as self monitoring and goal setting), assessment and negotiation of social and environmental barriers to physical activity[12] and the use of support strategies (such as telephone, home visits and peer support)[11].

In the short term (12 months), the participation of older people in group-based physical activity appears to be effective, although longer term adherence to physical activity programmes is superior in home-based programmes[13].

Physical activity programmes designed to improve balance and decrease falls should include activities specifically designed with the purpose of improving balance rather than simply increasing physical activity levels[2]. The exercises found to be most effective in reducing the incidence of falls are those:

- aimed at improving postural stability through strength, balance, flexibility and coordination training[14]. This includes aspects of bone loading, postural and gait training and support endurance work and tasks to improve visual vestibular and sensory input[15].
- tailored specifically to the individuals and progressive[14].
- delivered by a specialist trained professional in either a home or group-based setting[15].

Older people's motivation to participate in physical activity depends on a variety of personal attitudes, appropriate opportunities and broader environmental factors. Older people will undertake activities if they know they will help maintain their independence and allow them to remain engaged in activities that are integral to an active later life.

A range of factors that would enable older people, of varying functionality, to increase their physical activity levels include:

- A positive attitude towards physical activity
- A belief in the benefits of physical activity
- A belief in one's ability to be active
- Feelings of confidence, success and achievement
- Activities available that are consistent with personal goals, identity and lifestyle
- Social support from friends, peers and family

- Education on the way the body feels when activity is having a training effect

> **"I fell in love with running, I started forgetting my grief and traumas"**
>
> Fauja Singh
> 101 year old marathon runner

Motivation is one part of the solution; with appropriate support and help, older people can make small and significant changes in their physical activity levels. In order to achieve this, older people need accurate information about how much and what type of physical activity they should be doing. Community based programmes should be developed to meet the needs of participating older people and their impact should be evaluated using relevant outcomes measuring physical function and quality of life[16].

Services in Barnet

Seed funding is planned for a range of physical activity interventions delivered by community organisations and charities which focus on older adults in the community from November 2013. The programmes aim to increase opportunities for older people to engage in physical activity by expanding ongoing sessions or setting up new ones if there is significant community interest.

Exercise DVD in Care Homes

Older adults who live in care homes are less likely to engage in physical activity. There is evidence that exercise DVDs are effective in improving levels of physical activity among older adults. The public health team has provided exercise DVDs to care homes in Barnet who have indicated interest in using them to improve the level of physical activity of their residents.

Dance programme

AgeUK Barnet runs a dance programme in various community centres in the borough for residents 65 years and over. This intervention is part of a falls prevention pathway and is aimed at people who have had a falls incident or are at risk of having a fall. Saracens, part of the community dance programme, run a dance programme targeted at over 50s called Love to dance.

AgeUK Tai Chi programme

AgeUK Barnet also runs a number of tai chi sessions in community centres. Tai chi is a great activity to improve balance, strength and gait in older adults and helps in falls prevention.

Services in Harrow

Although not specifically for older people the Harrow Health Walks, Outdoor gyms and exercise on referral programmes are available to and used by older adults.

AgeUK Harrow

Age UK Harrow offers a range of leisure opportunities in Harrow some of which are specifically for older people. They are provided through leisure centres, resource centres, community centres and educational establishments, many of which cater for specific ethnic groups.

There is a weekly class every Tuesday morning from 10:30-12:00 (£2.50 for members and £3.50 for non members) with highly trained tutors that are able to meet the needs of older people. Age UK have said “The class is a good way to meet new friends and improve your health at the same time.”

The Cedars Youth and Community Centre

Despite it’s name, the Cedars also has weekly sessions for the over 55s. “Extra Time” sessions run every Tuesday from 11am to 12.30pm and involves social and light sporting activities. The session currently attracts 8-10 people.

Harrow leisure centre

Harrow leisure centre offers users over 60 years two swim school classes on Tuesday (9:30 – 12:00) and Friday (10:30 – 11:00) mornings and an aerobics class on Wednesday (9:30 -10:30am) morning.

Annie’s Place

Annie’s Place is a new council run drop-in service for people who have been diagnosed with dementia, their carers and family. The drop-in provides a focus on early information and prevention. Exercise, memory training and reminiscence are core elements of this service, which offers support to the person with dementia and all generations of the family on understanding and living healthily with dementia.

Dementia walking groups are being organised to link people with dementia and their carers to the Age UK memory cafes being developed across Harrow and Annie’s place drop in for people with dementia and their carers. The walking groups will provide physical activity for people with dementia leading to improved well-being and potentially reducing wandering for some service users.

What could we consider doing?

The councils

- Create safe, age-friendly neighborhoods and communities
- Ensure there are convenient and attractive walking and cycling opportunities and access to natural environment

Health Services

- Identify physically inactive older people and encourage them to take exercise – offering referrals to free programmes if appropriate
- Focus on ability rather than limitations

Leisure services

- Ensure there are experienced and qualified leaders, instructors and teachers who understand how to work with older people
- Create opportunities for people to try out and experience new activities as well as continuing with those they enjoy
- Provide accessible groups or classes and opportunities for social interaction

Communities

- Develop age-appropriate community-based activity programmes

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Chapter 6: Physical Activity and Mental Health & Wellbeing

Modern life can be fraught with angst and worry about a range of things which for the most part are beyond our control. Welfare reform, terrorist threats, the impact of the financial crisis and public health scares may leave many people feeling impotent and stressed. Unsure of the best way to cope with these feelings, some people use food, alcohol, cigarettes or drugs. This can often make you feel worse and you can get caught in a vicious cycle.

Mental wellbeing includes a person's ability to develop their potential, build positive, strong relationships, work productively and creatively and contribute to their community. It also includes some of the emotional aspects of life such as self-esteem, optimism, having control over your life and a sense of purpose. While it is natural not to have positive feelings all the time, frequent, sustained or intense negative emotions can play havoc with a person's ability to function in their daily life[1].

Becoming more active is a good way to deal with the stress, improve your mood and your mental wellbeing. So how does it work? Being active seems to have an affect on certain chemicals in the brain, such as dopamine and serotonin. The cells in the brain use these chemical to communicate with one another and so they affect your mood, thoughts and feelings. Physical activity also seems to reduce the harmful changes in the brain caused by stress[2].

Good mental health is important for good physical health, but it also works the other way your mind can't function unless your body is working properly.

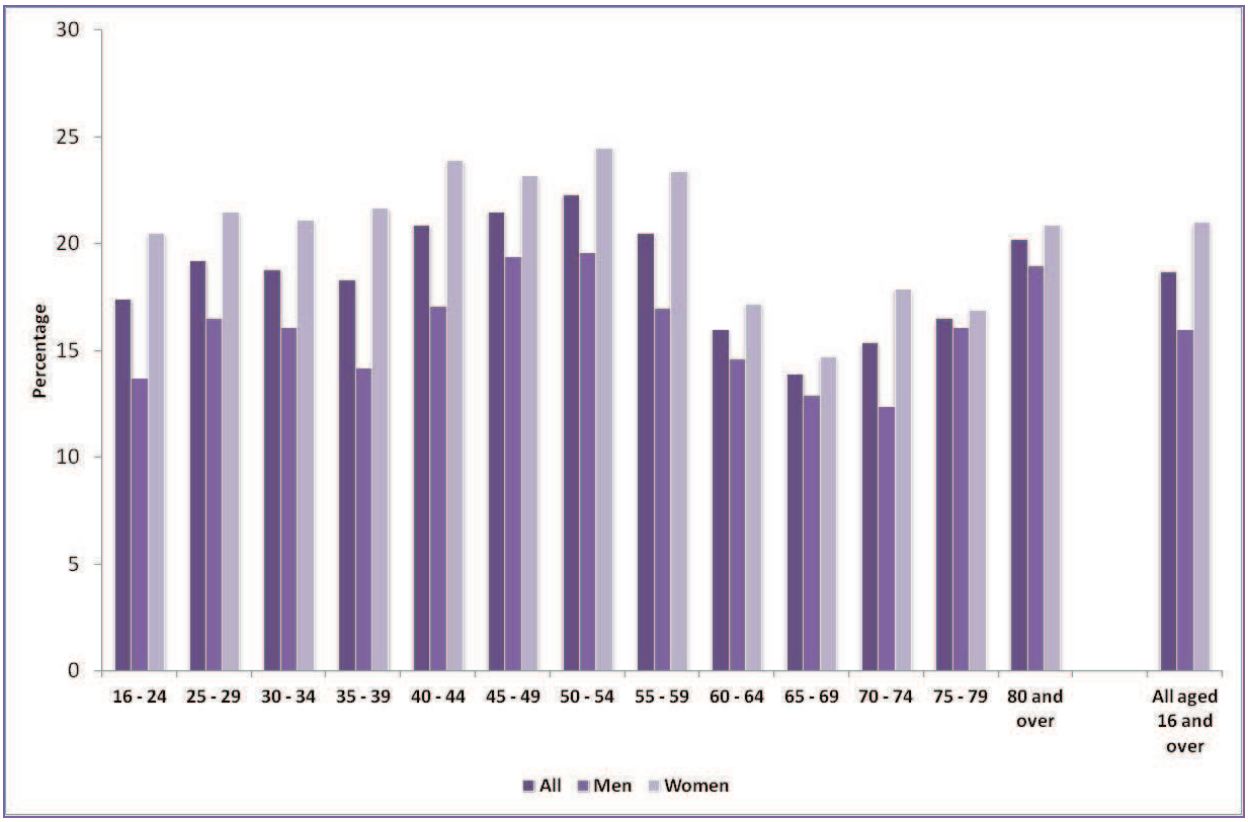
Background

At least one in four of us will experience a mental health problem at some point in our life[3].

In 2010/11, nearly one in five (19%) of adults over 16 years in the UK had some indication of anxiety or depression with a higher proportion of women (21%) than men.

There was variation in the level of anxiety or depression by age; the lowest levels were in the youngest age groups and the highest in those aged 50 to 54. This then reduces from the age of 55 with the lowest level in older people among the 65 to 69 age group, the levels of depression or anxiety then increase after the age of 70. Irrespective of age, more women than men have indications of anxiety and depression (figure 19).

Figure 19: UK respondents with some indication of anxiety and depression, 2010/2011



Source: Understanding Society, Wave 2, 2010/11

In addition to age and gender, there are other variations in the proportion of people who have some indication of mild to moderate anxiety and depression. It varies according to:

- Marital status: 27% of divorced people compared to 16% of people who were either single, cohabiting, widowed or married / in a civil partnership had some indication of mild to moderate anxiety and depression.
- Employment status: 23% of those not in paid work compared to 15% in paid employment.
- Perceived health status: Almost four in ten people who reported relative dissatisfaction with their health compared to only one in ten who were relatively satisfied with their health.
- Carer status: 25% of those who were classed as a carer for someone else in their household compared to 17% those who did not provide such care[4].

The employment rate in Barnet has fluctuated over the past two years but in March 2013, it had recovered and was higher than the national rate and only slightly lower than that of London as a whole. In 2011/12, the percentage of adults diagnosed with dementia (0.61%) was significantly higher than England (0.53%). However, the percentage of adults with depression in Barnet (8%) was significantly lower than the rest of the country (12%)[5].

Harrow has had better employment rates than the national and London averages. In the past three years, employment peaked at almost 75% in March 2012 but has since dropped to 71.6% which is only slightly higher than London (70.8%) . If we look at the ratio of recorded to expected cases of dementia, we can assess the variation of diagnosed to underdiagnosed patients. The ratio in Harrow (0.31) is significantly worse when compared to the rest of England (0.42).
In 2011/12, the proportion of adults with depression was significantly lower in Harrow (7%) than in England (12%)[6].

"Exercise gives you a natural high and is a great way to boost your mood."

Paul Farmer
Chief Executive, Mind

What works?

Physical activity has been used to treat depression and has been shown to be as effective as medication[7]. However, a recent study demonstrated that there is no additional benefit to be gained from physical activity alongside medication[8].

Physical activity has modest beneficial effects for other mental disorders including anxiety disorders, phobias and stress disorders[9]. It has also been shown to improve wellbeing in some patients with schizophrenia[10]. Physically active adults have a lower risk of depression and cognitive decline and may have improved quality of sleep.

Mental health benefits have been found in people who do aerobic or a combination of aerobic exercise and muscle-strengthening activities three to five days a week for 30 to 60 minutes at a time. Some research has shown that even lower levels of physical activity may also provide some benefits[11].

There is evidence to show that compared with exercising indoors, exercising in natural environments is associated with greater feelings of revitalization and positive engagement, decreases in tension, confusion, anger and depression and increased energy. People who exercised in the natural environment reported greater enjoyment and satisfaction with outdoor activity and declared a greater intent to repeat the activity at a later date[12].

In addition, regular physical activity appears to reduce symptoms of anxiety and depression for children and adolescents. Improving self-esteem may help to prevent the development of psychological and behavioural problems which are common in children and adolescents. Whether physical activity improves self-esteem is not clear[11] since evidence for the effects of physical activity on mental health is scarce. The available evidence suggests that physical activity has positive short-term effects on self-esteem in children and young people, and concludes that exercise may be an important measure in improving children's self-esteem[13].

Services in Barnet

Eclipse is an evolving and organic mental health and wellbeing service. It is delivered across the borough of Barnet in various community venues by the Richmond Fellowship in Barnet working in partnership with Mind Barnet, the Barnet Centre for Independent Living and people who have or had mental health problems. At the heart of the service is peer involvement, where people use their own experience and skills to support others. Eclipse work towards raising awareness and understanding of mental health in the community and inspire and support people to live a rich, healthy and fulfilling life by:

- Promoting recovery, health and wellbeing
- Increasing community participation and inclusion
- Reducing social isolation
- Providing peer support and co-production
- Allowing choice and control support
- Increasing awareness and understanding of mental health
- Challenging stigma and discrimination

Eclipse services are funded by LBB and are free of charge and open to everyone in the borough. Services are delivered in the community at libraries, church halls, community halls, cafes, public houses and rooms in the premises of other organisations.

Eclipse provides a range of opportunities for people to gain skills which help to improve and manage their health and wellbeing. Participating actively in the community also helps people get ready for volunteering or paid employment. The

service also offers additional benefits:

- Signposting people via the Eclipse advice line to physical activities including the Barnet outdoor gym
- Promoting the existing women's peer group that have chosen to access local exercise classes together
- Setting up a Peer Wellbeing Group to support Community Development and Community Wellbeing Activities.
- Delivering information, advice and workshops on the five ways to wellbeing which incorporates activities like yoga and the benefits of an active lifestyle
- Exploring the potential of Eclipse to join up with the Challenge Network to facilitate sponsored walks
- Offering Mental Health First Aid and Mental Health Awareness to sports organisations and facilities. Creating opportunities for community link advisors to ensure activities are 'mental health friendly'.
- Recovery Action & Support Planning is helping connect people to mainstream physical activities
- Running a Healthy lifestyle course for people registered with the service which includes:
    - Introduction to a healthy lifestyle
    - Physical health & mental wellbeing
    - Food, mood and wellbeing
    - Looking at what we eat and don't eat
    - Benefits and overcoming barriers
    - Exercise and linking with local groups

Services in Harrow

People with mental health problems in Harrow can participate in a scheme to help them to become more physically active.

The Harrow mental health physical activity programme

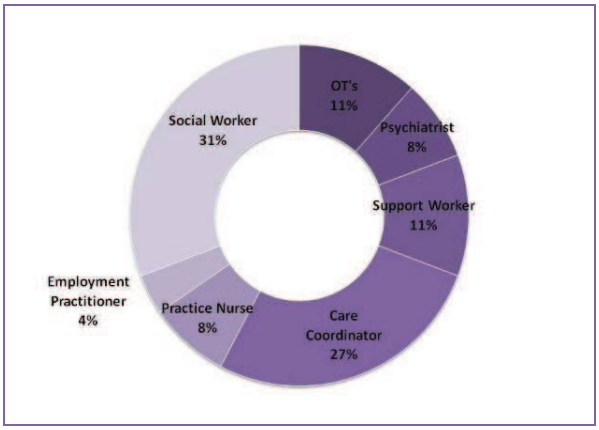
A mental health personal trainer's project was piloted in 2010/11. The project was established to address a gap in services and reduce the

"One of my clients, Mr X, has so far lost over 20kg since he started. He still attends EOR classes and goes to a local football group. He is no longer considered pre-diabetic and his blood pressure has returned to normal. His transformation has been one of many success stories of the project."

Harrow Mental Health Personal Trainer

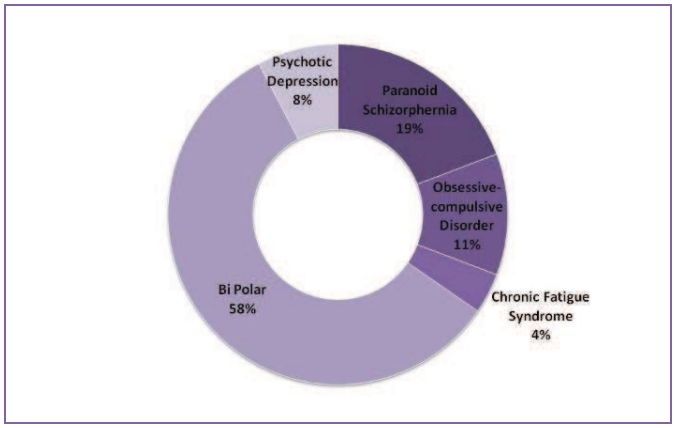
risks of real or perceived discrimination faced by clients with severe and enduring mental health problems if they took part in mainstream community sessions. The project received referrals from a number of health and social care professionals (figure 20) with the largest proportion coming from social workers. A wide range of people took part in the pilot with diagnoses of varying severity (figure 21). More than half of the people attending the pilot sessions had bi-polar disorder.

Figure 20: Professionals referring people to the mental health personal trainer project



Source: Mental Health Personal Trainers Project

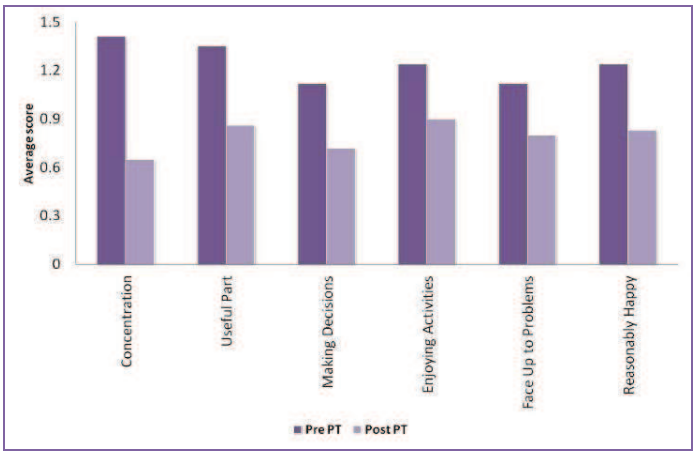
Figure 21: Diagnoses of clients referred to the mental health personal trainer project



Source: Harrow Mental Health Personal Trainers Project

The pilot successfully increased physical activity levels, increased the frequency of engagement in structured physical activity and perceived improvement in wellbeing amongst participants (figure 22).

Figure 22: Improved mental wellbeing before and after contact with mental health personal trainers



Source: Harrow Mental Health Personal Trainers Project

Following evaluation of the pilot, changes were made to the programme. Although the pilot was successful, service users, carers and mental health professionals felt that the programme did not address the integration of service users into the mainstream community-based physical activity opportunities. The new programme aims to improve opportunities for sustainable physical activity for mental health clients accessing community based mental health services in Harrow. Two personal trainers now work with 110 mental health service users, particularly those with additional health problems such as heart disease, obesity, diabetes and respiratory disease. All clients referred are risk assessed before starting the programme. Those clients that wish to make a commitment to increase their physical activity levels are accepted on the programme. The client can decide to take an unsupported route where they are given information to help increase their physical activity and are followed up by telephone over the following six months. However, if the client decides that they need more support, then they are 'buddied up' to access community based programmes supported by a personal trainer and followed up by telephone for six months.

"All truly great thoughts are conceived while walking."

Friedrich Nietzsche
Twilight of the Idols

Personalisation

CNWL administer personal social care budgets to people with critical or substantial social care needs, as part of the personalisation of social care. Many people are choosing to use gyms as part of their access to community resources, either independently or supported by a PA, as an alternative to using traditional day centres User and practitioners are reporting good outcomes.

Rethink Mental Illness now operate the Bridge Day Centre and facilitate, run or host a range of activity-based groups including yoga, horse-riding and therapeutic dance targeted at people living with mental illness.

What could we consider doing?

The Councils

- Current mental health physical activity projects should be fully evaluated and extended if found to be effective.
- Active travel should be supported by making changes to infrastructure such as cycle racks and the promotion of using stairs instead of an elevator or escalator. These small changes could make a difference to the levels of activity in the population and aid the prevention of mental illness.

- Consider programmes that focus on tackling the stigma associated with mental illness. This will help break down barriers to participation in community physical activity initiatives
- Promote good mental wellbeing and physical activity in schools

Health Service

- Ensure that every contact counts; each time a person makes contact with health services should be viewed as an opportunity to discuss health behaviours such as smoking and exercise.
- Health professionals in mental health services are in an ideal position to help signpost clients to physical activity opportunities, whether this is by referral to personal trainers, exercise on referral or simply telling someone about a sports class nearby.

Communities

- Tackle the stigma associated with mental illness, this will help break down barriers to participation in community physical activity initiatives

Schools

- Use PSHE lessons as an opportunity to discuss mental health and wellbeing and the importance of physical activity in good mental health.
- Promote active transport and other opportunities for physical activity in the school day – for both pupils and staff.

Workplaces

- Promote the use of counselling services and mental health charities in employee assistance programmes.
- Promote active transport and other opportunities for physical activity in the workplace.

Parents and Carers

- Where appropriate use family physical activities as an opportunity to open discussions with children and young people about things that are important to them

Individuals with metal health problems

- Look after your physical health by being active as this has an impact on your mental health too
- Find a buddy who will encourage you to be active

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Chapter 7: Physical Activity in People with a Disability

The risk of developing long-standing health problems is higher in people with a disability compared with those without a disability. People with a disability experience restrictions in everyday life that can prevent them fully accessing services including public transport, education, employment, and health care and leisure facilities.

Background

The Disability Discrimination Act (DDA) defines a disabled person as anyone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

There are over 11 million people with a limiting long-term illness, impairment or disability in Great Britain. The most commonly reported impairments are those that affect mobility, lifting or carrying[1]. It is predicted that in the next decade the number of people with a disability will increase due to advances in medicine and longer life expectation. Four in five people with a disability acquire their disability during their working lives. Only 17% of people with a disability were born with their disability[2].

Disability is strongly related to age. Nearly one third of 50 to 59 year olds have a disability. The highest disability rate is among older people with 78% of people aged 85 or over having a disability.

There is variation in the rates of disability related to deprivation and poverty and to ethnicity. Deprived and poorer areas of the country have higher numbers of people with a disability than areas that are more affluent. Some of this may be due to past employment history, e.g. rates are higher in past mining areas due to the higher incidence of lung disease. Some ethnic groups have been found to have higher rates of disability. Bangladeshi and Pakistani communities have the highest disability rates of all ethnic groups.

Learning Disability in Harrow & Barnet

There are 4,532 adults aged 18 to 64 with a learning disability (LD) in Harrow, 800 of whom have a moderate to severe learning disability. Barnet has around 14,400 adult residents with moderate to severe learning disabilities.

Harrow council's learning disability register has 595 clients[3]. The community health care register has 774 people with LD including 37% who are in residential and nursing care. Around 14% of people with LD have profound or complex needs[4].

Physical disability in Harrow & Barnet

The majority of people with a physical disability acquire impairment during their working lives. People become disabled because of illnesses such as stroke, bronchial asthma, emphysema, heart failure, respiratory problems, accidents or falls.

In Harrow the council has 10,108 people aged 18-64 with a physical disability registered. Six hundred and eighty four clients have severe and profound disability. The physical disability register has the highest number of clients among all disability registers.

It was estimated that approximately 9% of the population of Barnet aged 18 to 64 have a moderate or serious physical disability.

"I am registered blind and have very little vision, but it's easy to walk because people help me. Whenever I have been, I enjoy it very much. We go to a lovely little park in South Harrow and I enjoy taking it all in – we're usually walking for about 40 minutes."

Sarita Shah, South Harrow walker

Sensory Disability in Harrow

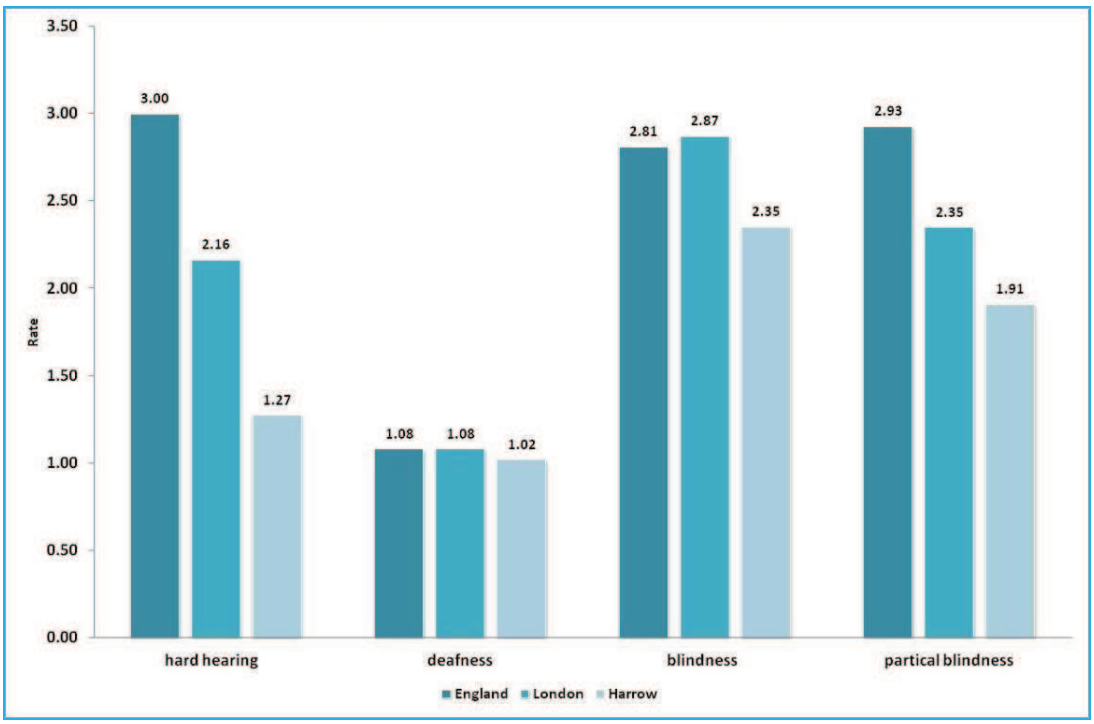
There are 225 people who are deaf or have a hearing impairment, 530 people who are blind and a further 430 people registered as partially blind on the Harrow Social Services register[5]. Four hundred and fifty of the people who have a visual impairment have an additional disability with 415 of them having a physical disability[6].

Compared with London and England, the rate of people registered with a sensory disability in Harrow is low (figure 23). The reasons for this difference are unknown. As well as the possibility that this difference is a true difference in the rate of sensory disability, a number of possible reasons have been suggested:

- firstly, that people with a mild or moderate level of disability are not registered due to cultural and social acceptability reasons;

- secondly that people with a sensory impairment are able to support themselves without applying for a disability allowance; or
- a discrepancy in recording people with multiple disabilities.

Figure 23: Sensory disability rates based on disability registers in Harrow (2010/11)



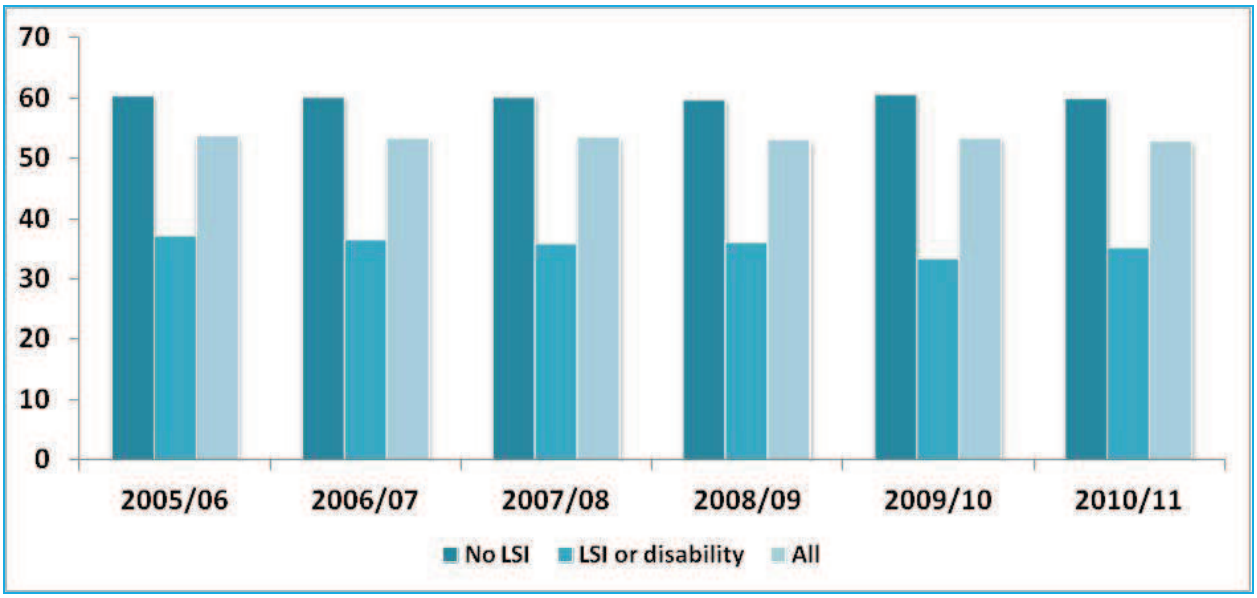
Source: The NHS Information centre

Physical Activity in people with a disability

Physical activity improves balance, muscle strength and quality of life in individuals with a disability. Participation of people with a disability in sporting activities reduces social isolation and creates positive role models for other disabled people.

Nationally physically active people with a limiting longstanding illness or disability participated in sport much less than people who did not have a limiting illness or disability. Just 35% percent of adults with a disability currently play sport every week compared to 60% of adults without a disability[7] (figure 24).

Figure 24: Percentage of people with or without a long standing illness (LSI) or disability who participated in sport once in the last four weeks (England)



Source: Sport England

Over 80% of adults with learning disabilities have a level of physical activity below the minimum level recommended by the Department of Health, and this is lower than the level observed in the general population (53% to 64%). Older age, immobility, epilepsy, no daytime opportunities, incontinence and living in restrictive environments are reasons for low physical activity[8].

A local survey conducted in 2012 shows that, in common with the rest of the population of Harrow there is a wide variation in the amount of sport and physical activity undertaken by people with a disability[9]. The survey showed that:

- Only 1 in 5 people with a disability had at least 30 minutes of physical activity once or twice per week.
- Twenty eight percent of participants were reported to undertake 30 minutes of physical activities more than three times a week.

"It's been double celebration time for Harrow Mencap's Football team 'Harrow Stone Stars' as they won both the County Cup and came top of the Middlesex FA Pan-Disability County League 2012. "

However, clients with hearing impairments, learning disabilities, physical and multiple impairments are among the regular users of local leisure facilities. Swimming sessions were the most popular activities among people with a disability in the survey. This was

followed by MENCAP football clubs, the swimming club and sports such as badminton, table tennis, squash, tennis and football.

What works?

To encourage inclusion and maximize the benefits from physical activity, programmes should be adapted to the needs of disabled individuals[10].

The factors that encourage disabled people to participate in sport include:

- sessions led by disabled instructors;
- specific impairment - tailored programmes;
- access to inclusive club sessions (disabled and non-disabled together);
- a buddy scheme;
- transport support; and
- single gender sessions

In addition, one to one support and building self-confidence helps clients to achieve their goals[11].

"On 19th July HAC had their very own Olympic Games at Bannisters athletics track to celebrate the Olympics coming to London. The rain held off and we had a fantastic time doing individual and team races!"

Doreen Luff, Harrow Mencap

Paralympic Legacy

London's Olympics and Paralympics in 2012 were unique for many reasons. For people with a disability, they were important because for the first time an Olympics and Paralympics were planned and delivered as one event. London 2012 had the largest number of paralympic participants and they proved inspirational for disabled people and the general public.

With the 'Inspire a Generation' programme a wide range of initiatives have started that will integrate mainstream sport and physical activity for people with a disability. In schools, the legacy aims for every single school to offer disabled children sport within a rounded PE curriculum. In community sport, new and important initiatives have been implemented such as targets aimed to raising participation rates among disabled people and the new payment-by-results model. Sport England is investing £8 million to help overcome some of the barriers that make it harder for disabled people to participate in sport.

Services in Harrow

Harrow Council has recently renewed its contract with DisabledGo for a further three years. DisabledGo provides an exciting web based access guide which contains details of accessibility for disabled people in shops, restaurants, cinemas, libraries, leisure and sports centres. The service helps people with a disability who live or work in, and visit Harrow to make informed choices about facilities and amenities they wish to use.

Disabled people in Harrow can also access Harrow health walks, outdoor gyms the mental health personal trainers project and exercise on referral programmes where appropriate.

The Larches Trust growing project

The Trusts Horticultural Programme aims to improve and secure employment opportunities for people with learning disabilities through a social enterprise initiative focusing on practical training in horticulture and employment skills. Integral to the programmes aims is the production, promotion and sale of non-chemically grown plants, seasonal vegetables and compost to the community.

Shaw Trust Horticulture Programme

Provides work opportunities and training in horticulture, retail and life skills to people with learning disabilities. The project supports around 50 people at any one time with 10 staff and four volunteers. Our supported work opportunities help vulnerable adults build confidence in a real working environment with an appropriate level of support from trained Shaw Trust staff. Service users participate in a range of horticultural activities and can work towards a course called ‘Skills for Working Life’ which is a City and Guilds qualification, at entry level 3.

Walk 4 Life for People with Learning Disabilities

A group of service users at Vaughan Neighbourhood Resource Centre are part of a weekly walking group established under the Walk 4 Life initiative in 2009. This group has clocked up over a 100 miles with regular walks.

Independent Travel Project

A programme is running in Harrow to support service users travel to their Neighbourhood Resource Centres by public transport and walking. Travel training and travel buddies have been made available to support this programme, which is focused on independence and healthier lifestyles.

Tizard Research Programme- Tackling Obesity and Diabetes

Following the success of a dance, musical-theatre and singing master class for users of Harrow Neighbourhood Resource Centres, the department have organised a series of classes. The Tizard Centre (University of Kent) funded by the Kings Fund have expressed interest in developing a research programme around the outcomes of the classes run by Harrow. The academic work would investigate the benefits for people with learning disabilities and specifically the positive impacts on obesity and diabetes.

Services in Barnet

Interactive, formerly London Sports Forum for Disabled People, is the lead strategic development agency for sport and physical activity for disabled people in London. Their aim is to ensure equality and inclusion are at the heart of grassroots sport in London. They influence and support mainstream sport providers and policy makers to ensure they create, deliver and sustain inclusive opportunities for disabled people. They use expertise and influence across London to advocate inclusive sport. They also inform and advise disabled people on how they can get involved at all levels in sport and physical activity in London.

In partnership with other London agencies they delivered ‘Inclusive and Active’ – a sport and physical activity action plan for disabled people in London undertaken from 2007 to 2012. This action plan had a vision of getting more active disabled Londoners achieving their full sporting potential. They seek to change the way that sport for disabled people

is viewed, to break down the perceptions. They want a world where disabled people can access sport of their choice, at the venues of their choice and at the level of their choice.

The School Games

The new Sport England strategy aims to enable every school and child to participate in competitive sport, including meaningful opportunities for disabled youngsters.

Sports M.A.T.E.

Sports M.A.T.E (Mentoring, Access, Training, Equality) supports young disabled people into participating in mainstream sport clubs/opportunities through provision of a personalised mentoring and referral scheme. Individuals are referred on to the project through disability services, disabled people organisations, local education establishments, families and support workers. Once the individual has been referred on to the project, the Sports M.A.T.E mentors provide up to 6 hours of support. The Sports M.A.T.E Project was authored by Tottenham Hotspur Foundation and successfully piloted and developed in partnership with the PRO-ACTIVE North London Partnership, Help a London Child and Interactive across North London including Barnet. Additional funding has been secured to continue the project in Barnet.

GLL Inclusive Membership

This inclusive membership allows disabled people to take advantage of full anytime access to gyms, pools and group exercise classes. An inclusive member enjoys benefits such as:

- No Joining fee, and no minimum contract
- Access to over 100 Better sport and physical activity services
- Free entry for an accompanying carer
- Anytime access
- Free fitness induction
- Telephone and online bookings made up to 6 days in advance for group exercise classes, squash and badminton.
- Up to 30% discount off the price of other non-member activities

This inclusive membership costs £19.95 per month and is available to those aged 16 years and over and entitled to any of the following:

- Severe Disablement Allowance
- Mobility Allowance
- Disability Living Allowance
- Disablement Benefit
- Attendance Allowance
- Employment and Support Allowance

What could we consider doing?

People with a disability

- Find out what's available in your area
- If you aren't very active, talk to your local sport and physical activity service provider to see what they can do to support you.
- If you are active, tell others about it and get them to join you.

The Councils

- Promote Disable Go website to improve knowledge of both providers and participants
- Ensure that contracts with providers require them to have suitably adapted/ accessible facilities that cover a range of disabilities

Communities

- Providers should obtain specialist advice in order to create tailored programmes for a variety of people with disabilities with focus on specific mobility, stretching and strengthening exercises, postural awareness, balance and co-ordination
- Improve access to services by using local trained buddies or volunteers to provide one to one support to people with disabilities to become more physically active

Schools and workplaces

- Schools should adjust PE and other physical activities in order to accommodate disabled children and young people
- Showers and changing facilities should be able to accommodate wheelchairs etc.

Parent and Carers

- Children with a disability should be actively encouraged to participate in family activities and sports and other physical activities outside the home where appropriate.
- Parents and carers should obtain specialist advice on the best activities for their child

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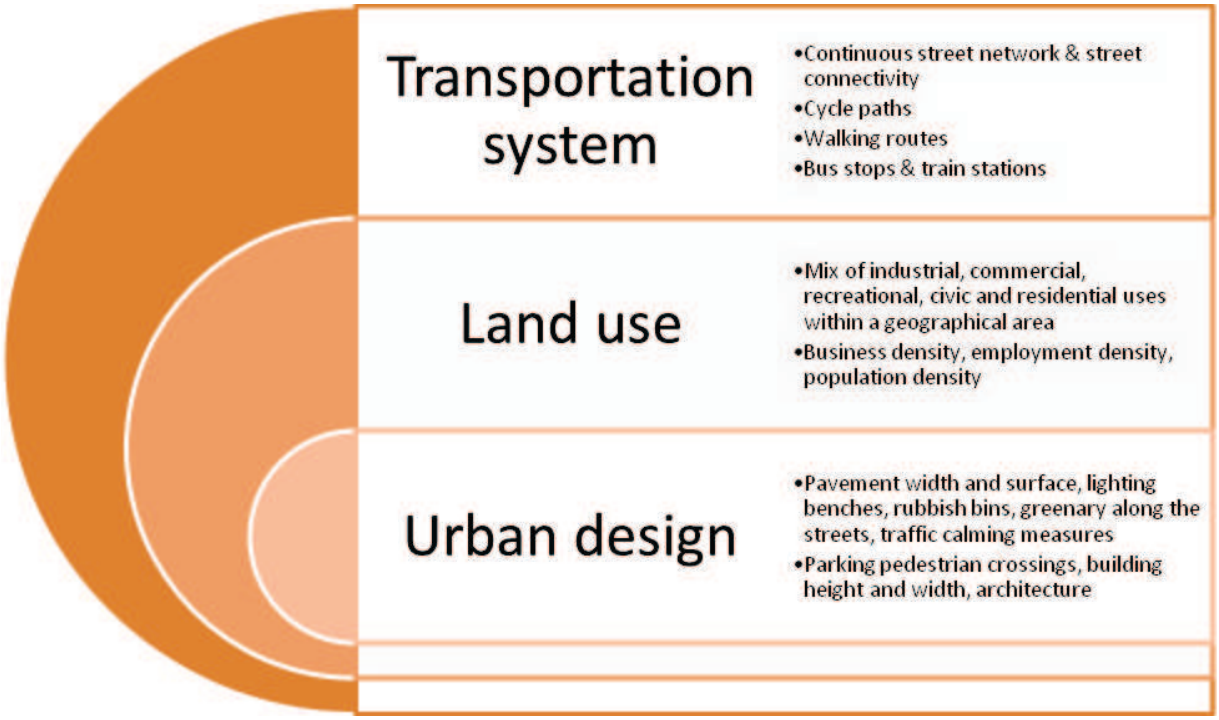
Chapter 8: Physical Activity and where we live

The places and spaces in which we live, learn, work and play throughout our daily lives have a significant impact on our overall health. These constitute the built environment which is broadly defined as including urban design, land use, and the transportation system and encompassing patterns of human activity within these physical environments[1]. Scientific evidence tells us that the built environment varies across settings and can work to facilitate or act as a barrier to opportunities for physical activity. Figure 25 shows how the three major domains of the built environment are associated with physical activity.

Figure 25: The three domains of the built environment



Source: Adapted from Institut National de Sante Publique du Quebec

Background

The built environment impacts upon physical activity through a number of mechanisms. These include accessibility as it relates to social economic and geographic factors, attractiveness of the environment and safety through perceptions of and actual road traffic and crime. Statistically significant associations have been demonstrated between the presence of non-motorised transportation infrastructure, access to recreational and sports infrastructure and urban form in terms of density, mixed land use and street

connectivity and physical activity. These features will in turn have an impact on active travel and active leisure time.

The design of some communities has potential to contribute to increased physical activity. There is evidence to suggest that people who live in communities characterised by mixed land use such as shops in walking distance of homes, well-connected street networks and high residential density are more active, than those who live in communities that are designed for dependence on cars.

In both Barnet and Harrow, where planning applications for developments meet certain criteria, developers are required to produce a Travel Plan (TP) that aims to reduce vehicle use and promote walking, cycling and public transport use. Across Barnet, there are over 120 sites at residential developments, religious buildings, shops, offices, hospitals, sports grounds etc that have or are required to have in the future a TP. It is expected that within their TPs they will commit to a range of measures to reach targets for vehicle reduction and increase more sustainable travel. The council tries to ensure that all TPs have an objective and measures that promote active travel as part of a healthy lifestyle. Examples of the measures are:

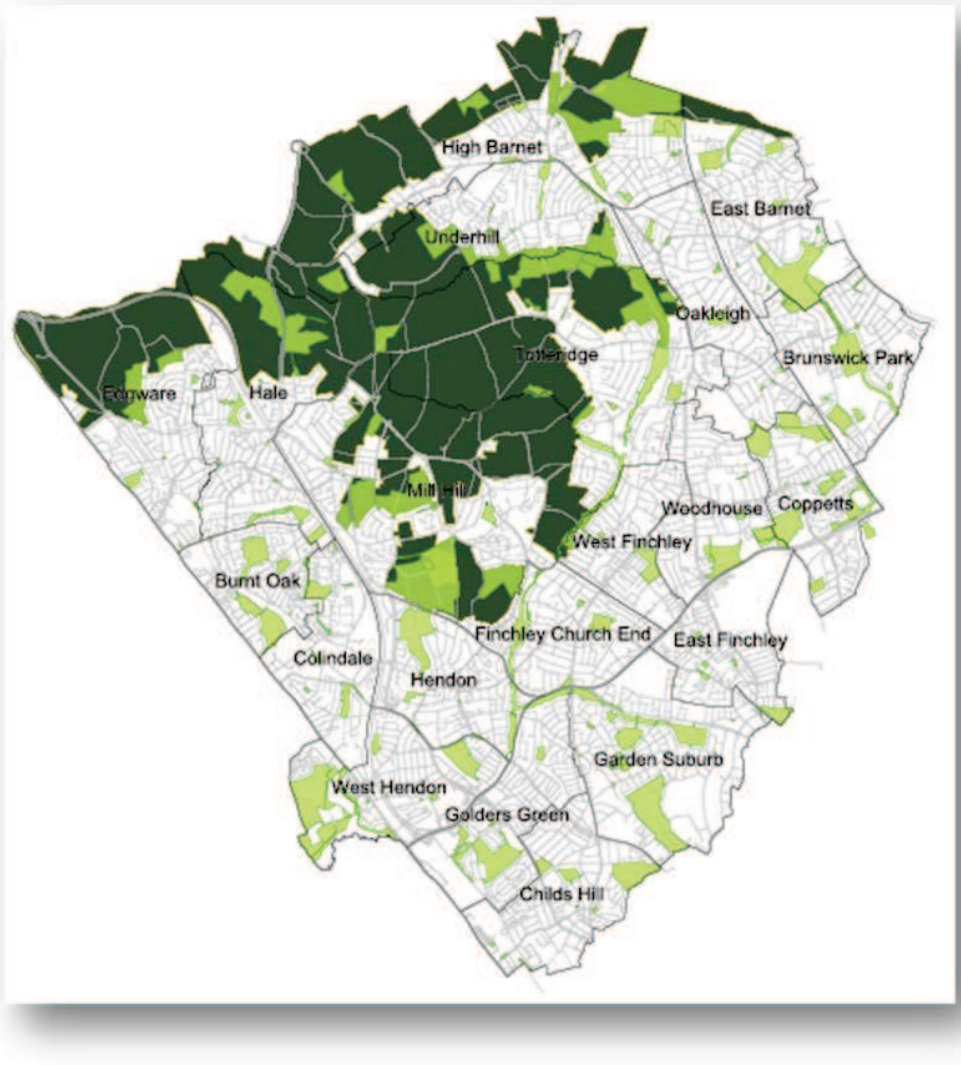
- Infrastructure improvements – such as new walking and cycling routes, public open space
- Cycle storage (In 2012/13, 497 cycle parking spaces installed and a further 3,532 required as part of planning permissions across the borough)
- Dr Bike maintenance sessions
- Welcome packs to include walking and cycling routes and distances to local facilities, benefits of active travel
- Bicycle user groups
- Cycle vouchers and agreements for discounts at cycle shops
- Funding towards public transport use
- Walking groups
- Events and competitions – virtual cycle rides, logging walking distances completed, stall at residents events
- Provision of a car club – demonstrated to reduce number of miles travelled by a member of a car club by car and increase walking, cycling and public transport use.

Green space in Barnet

Barnet benefits from a large number of parks and open spaces, a consequence of its location where rural and urban landscapes overlap. A large proportion of land is designated as green belt land, setting it apart from other London boroughs (map 3). With many attractions, features and attributes such as play areas, sports pitches, cafés, water and wildlife features, there is a park within one mile of the majority of homes in the borough which ensures that whether you're walking the dog, taking a morning stroll,

playing with your children or relaxing with a good book, there's a park within easy distance for you to enjoy.

Map 3: Greenbelt and parks across wards in Barnet



Source: Policy Unit, Barnet

The parks currently offer:

- an outdoor gym at Oak Hill Park
- a number of led and general walks available throughout the borough
- Seven beautiful Local Nature Reserves (LNR) throughout the borough and a Site of Special Scientific Importance (SSSI) at Welsh Harp reservoir
- multisport facilities across the borough providing access to basketball, football and tennis courts

- Over 40 play areas with new exciting equipment installed at Brookside Walk, Lyttelton Playing Fields, Mill Hill Park and Friary Park.
- The Dollis Valley Green Walk which is over seven miles of parks and open space with areas of conservation, woodland and play that can be enjoyed by everyone.

Green Space in Harrow

Harrow offers over 50 parks, open spaces, and recreation grounds (map 4). Centenary Park is located in Stanmore with entrances from Culver Grove and Crowshott Avenue. The park provides 9.41 hectares of open space. It includes a bowling green, children's pay area, two tennis courts, a nine hole pitch and putt and five-a-side football pitches.

Map 4: Parks and open space across wards in Harrow

Pinner Memorial Park, close to the centre of Pinner, was once part of the West House Estate, the home of Lady Hamilton. The park provides over five hectares for peaceful recreation, as well as a bowling green there is a pond with a ducks and geese and a small aviary of budgerigars. An ornamental 'Peace Garden' provides a quiet place to sit.

Roxeth recreation ground, south of Northolt road in South Harrow, provides nearly seven hectares of open space with football, bowls and cricket facilities. The bowls green

is home to Roxeth Bowling Club. Roxeth recreation ground contains two senior football pitches, a junior football pitch, a cricket square, a tennis court, a multi use court, a basketball practice goal, children's play area and changing facilities.

Alexandra park, also located in South Harrow, provides eight hectares of green space for residents in the surrounding area. The park's facilities include basketball practice goals, Millennium garden, children's play area and fitness area.

Bentley Priory Nature Reserve in Stanmore provides 66 hectares of countryside open space. It is a Site of Special Scientific Interest (SSSI) for its meadow areas. As well as the meadows the site includes extensive woodlands and two ponds. In the summer cattle graze the meadows. The site is a haven for bird life and a wide range of plant life. Adjoining the open space is a private Deer Park with a herd of approximately 24 Fallow Deer and to the north is Bentley Priory RAF base from which the Battle of Britain was commanded during World War II.

Other parks in Harrow include,

- Bernays Gardens,
- Bryon Recreation Gound,
- Chandos Recreation Gound,
- Grimsdyke Open Space,
- Govefields
- Harrow Recreation Ground,
- Harrow Weald Recreation Ground,
- Heasdstone Manor Recreation Ground,
- Litle Common Pinner,
- Montesoles Recreation Ground,
- Pinner Village Gardens,
- Priestmead Recreation Ground,
- Queensbury Park,
- Rayners Mead,
- Roxbourne Park,
- Saddlers Mead Recreation Ground,
- Shaftesbury Recreation Ground,
- Stanmore Common,
- Stanmore Country Park,
- Stanmore Recreation Ground,
- Steamside Reservation,
- The Cedars,
- The Crofts,
- The Viewpoint,
- Weald Village Open Space,
- West Harrow Recreation Ground,
- Whitefriars Open Space,
- Woodlands Open Space
- Yeading Walk

.

Allotment plots are also available at various locations across both boroughs. Allotment gardening offers a huge range of benefits including producing cheap homegrown organic food, physical activity and the satisfaction of knowing that you were responsible for producing something fresher than anything you can buy in the shops.

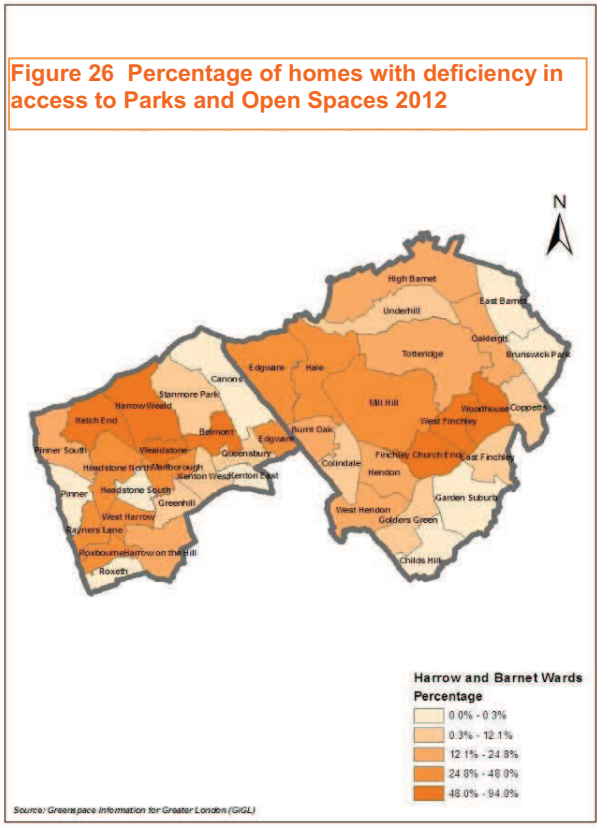
The London Plan sets out a maximum distance which London residents should have to travel to access a Public Open Space (POS). Areas outside of these distances are classified as areas of deficiency. By mapping these areas of deficiency, the provision of POS across Greater London can be analysed and open spaces planned and managed accordingly.

Previously, areas of deficiency have been based on distance as the crow flies. Greenspace Information for Greater London (GIGL) has developed a new method of accurately mapping areas of deficiency based on actual walking distances along roads and paths, pedestrian streets and alleys. The new model gives a more accurate idea of where areas of deficiency lie because it uses London-wide data rather than using data from within a single borough. However, the analysis of public open space is based on access to designated green/public open space and therefore excludes farmland, and other types of green space outside of the public open space category definitions within the London Plan and no POS outside of the London boundary is included.

Homes further away than the maximum recommended distance are considered to be deficient in access to that type of public open space. The recommended distances for each type, as per the London Plan, are:

- Regional Parks = 8km max
- Metropolitan Parks = 3.2km max
- District = 1.2km max
- Local, Small and Pocket parks = 400 metres max.

Figure 26 Percentage of homes with deficiency in access to Parks and Open Spaces 2012



Although both Barnet and Harrow have a large number of parks and open spaces, using this definition, there are areas where access to POS is poor (figure26).

Active Travel

This approach to travel and transport focuses on increasing physical activity of the individual rather than the use of motorised and carbon-dependent modes of transport.

Participating in more active forms of transport has a dual purpose of increasing levels and frequency of physical activity in addition to being of benefit to the wider environment.

"It is unreasonable to expect people to change their behaviours when the environment discourages change"

Schmid *et al*. 1995

Data from the National Travel Survey found that in 2011 the majority (64%) of all trips were made by car as a driver or a passenger; only one in four households did not have access to a car. In 2011, the average number of walking trip[5] was 222 trips per person per year compared with 292 trips in 1995/97, a decrease of 24%.

Sixty-nine percent of all commuting or business trips were made by car (driver or passenger) in 2011, only 10% of these trips were made on foot. Car or van journeys accounted for 43% of all trips to educational establishments while almost two fifths walked.

The concept of active travel recognises the potential contribution of personal movement to the increasing levels of physical activity and health improvement and is an important area for joint working between public health experts and transport planners.

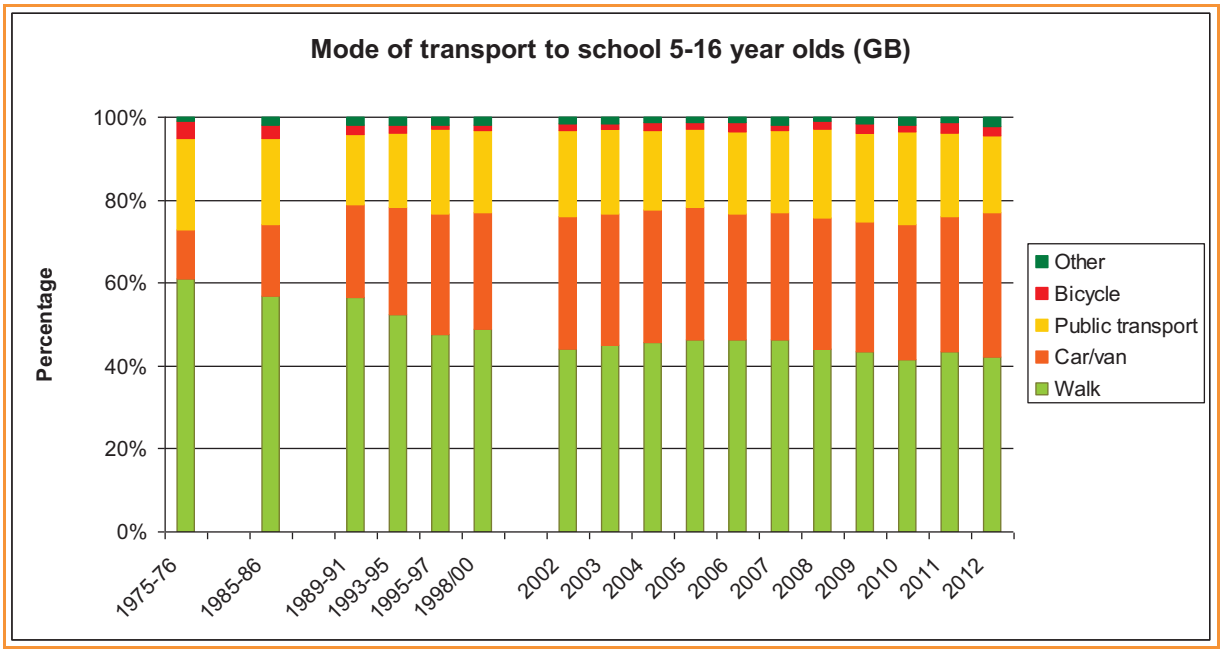
Walkable communities are areas that are densely populated, where businesses and services are available and where streets are connected for ease of access for pedestrians. Areas like this are positively associated with active travel.

Residential areas with pavements and cycle paths are associated with greater opportunities for physical activity. Individuals are most likely to participate in active travel in areas that offer several destinations, such as schools, shops and businesses, in close proximity to their home especially when linked to these destinations by routes that promote cycling or walking.

Safety is also an important feature of active travel. Fear of accidents and crime mean that far fewer children walk or cycle to school than would have done in previous years. In 2011, only 42% of all school trips were on foot and 35% were by car

[5] A trip is defined as a one-way course of travel with a single main purpose

Figure 27: Transport to school 5-16 year olds (GB data)



Source: National Travel Survey

Schools in Barnet are encouraged to involve parents, carers and staff in promoting more active and sustainable forms of travel as part of their school travel plans, including the benefits of active travel as part of a healthy lifestyle. Activities to engage parents, carers and staff in active travel include; parent/carer coffee mornings, displays and activities at open evenings and fetes, parent volunteers supporting walking buses and Walk on Wednesday schemes, staff walking groups.

Active Recreation

Active recreation refers to physical activity that is voluntarily undertaken during an individual's leisure time for their mental or physical satisfaction.

The proximity to and presence of recreational and sports facilities such as leisure centres, playgrounds, parks and pools in addition to pleasing aesthetics is associated with more recreational physical activity among residents[2]. This is particularly relevant for children and adolescents.

Children and adults need places where they can be physically active

on a regular basis. The accessibility of these spaces depends not only on the proximity to one's home but also how costly they are to use, how easily they can be reached and how safe they are. Disadvantaged areas tend to offer fewer opportunities for active recreation than more affluent areas. This may be because there are fewer parks or green spaces, leisure centres and cycle paths or it may be the perception of risk of crime which ensures that residents of these areas face barriers to active recreation.

What works?

Alongside the evidence for the benefits of physical activity, there is growing evidence base for interventions to encourage and help individuals to achieve healthy, active lifestyles. The CMO's report[3] described four effective ways to tackle attitudes, perceptions and improve environments for increasing participation rates in physical activity. Interventions should focus on:

Environmental Action: By investing in infrastructure for cycling and adopting strong pro-bike policies. Central to this is the need for cycling to be prioritised as part of local authority transport plans.

Organisational Action: Employers' health promotion policies can help people to be more active and less sedentary as part of their working lives. The ways in which employers' can help include providing showers for cyclists and walkers, prioritising stairs over lifts and encouraging active commuting.

Community Action: Whole community approaches where people live, work and play have the opportunity to mobilise large numbers of people. Investments in community level programmes such as parks, playgrounds, walking clubs can help to influence social norms around activity.

Interpersonal Action: Primary care professionals and or other allied staff can conduct simple and quick patient assessment of their level of physical activity using tools such as the GP Physical Activity Questionnaire (GPPAQ) and provide advice and guidance on the amount and type of activity and where to get further support.

Services in Barnet and Harrow

RE:LEAF

RE:Leaf is a partnership campaign led by the Mayor of London to protect the capital's trees and encourage individual Londoners, businesses and organisation to plant more trees. The Mayor also wants to protect London's woodlands and associated wildlife and make London a greener, more attractive city.

So far the campaign has:

- Planted 10,000 street trees;
- Planted two new woodlands in the boroughs of Croydon and Barking and Dagenham.
- Held a number of tree planting events across London, including planting 20,000 trees across seven London boroughs in January 2011;
- Planted a new orchard and three woodlands in Redbridge, Greenwich and Bexley;
- Distributed 11,000 trees to over 50 communities across London through the Woodland Trust community tree packs programme.
- Held seed gathering events to encourage Londoners to grow their own trees from seed;
- Established London's first ever 'London Tree Week' to celebrate London's trees and woodlands.

Urban greening

There are parts of London where green space is at a premium; in these areas there is both an opportunity and an imperative to increase the amount of green cover. Urban greening describes the parts of green infrastructure that are most applicable in the most urbanised parts of the city. These include green roofs, street trees, and soft landscaping designed to contribute to sustainable drainage systems.

A few simple measures, such as planting climbers and wall shrubs, growing plants for wildlife, using permeable paving and installing green roofs, can ensure gardens are contributing to urban greening. You can also help reduce stormwater flows into drains (and thereby help in reducing flooding and improving water quality) by installing simple rain gardens.

The Mayor has a target to increase green cover across central London by 5% by 2030. In this respect urban greening is a key element of the much broader Climate Change Adaptation Strategy, which encourages the use of planting, green roofs and walls and soft landscaping.

Pocket Parks Programme

Pocket parks are part of the Mayor's London's Great Outdoors - the programme to improve streets, squares, parks, and canal and riverside spaces across London. The Pocket Parks initiative aims to deliver 100 new or enhanced pocket parks.

Pocket parks are small areas of attractive public space for all people to enjoy, providing relief from the hustle and bustle of the city. These spaces should have trees and greenery; they should be open to all; they should have places to sit and relax and for people to come together; and they should contribute to making the city friendlier, greener and more resilient.

The Mayor of London is directly supporting the creation and enhancement of 100 pocket parks through a funding programme launched in November 2012. These 100 new and improved spaces across London will be delivered by March 2015.

Harrow is bidding to be part of the Pocket Parks programme.

Active Travel- Bikeability

The Bikeability training scheme was introduced by the Department for Transport through Cycling England in 2007 as cycling proficiency for the 21st century. Both Barnet and Harrow Councils have been delivering the scheme for five years. The training follows the national standards/Bikeability syllabus and follows an agreed programme designed to give young cyclists the necessary skills to be safe road users. There are levels of training which are arranged for pupils of different age groups and ability:

Level 1: For children age eight or nine years - A two hour session of playground training covering basic cycle control. Pupils need their own cycle, and should have the ability to ride a short distance without assistance.

Level 2: Children over 10 years - Four sessions of two hours. Sessions are held in the playground and on local roads around the school site. Pupils should have reasonable balance and control of their bicycles, which should be suitable for riding on the road.

The London borough of Barnet are now working with Transport For London to establish new cycling routes

Active Travel- Walking

Walk on Wednesday (WoW) rewards students who regularly Walk on Wednesday or Walk once a Week. It aims to maintain year round enthusiasm for walking to school. In Barnet grants were paid to 11 schools to pay for them to purchase Walk on Wednesday resources.

Each year schools can take part in the National Walk to School Week campaigns that occur in May. Schools are supplied with resources for the week to encourage children to walk every day. In Barnet, at least 46 schools took part in May 2012.

Harrow schools also take part in the International October Walk to School Month. In Harrow online resources are provided to all primary schools to take part in a themed walk. A run of Theatre in Education shows with a sustainable transport message are available to schools during Walk to School Month.

Barnet also provide Theatre in Education to deliver an active travel message with eight secondary schools and 30 primary schools receiving this intervention last year.

Other Barnet based work includes cycle route maps created specifically for 21 schools, sustainable transport and active travel materials, practical pedestrian training for Year 4 in 43 schools and at Foundation and KS1 for a further 54 schools and installation of cycle storage for 51 schools up to July 2012.

Services in Barnet

Fit and Active Barnet Campaign

Barnet's Sports and Physical Activity Needs Assessment identifies that levels of physical activity are lower in Barnet in comparison to London and England average. The needs assessment also found that cost and access to facilities are the two main barriers for people being active. Enabling increased levels of activity requires these barriers to be addressed.

This campaign aims to provide a co-ordinated physical activity and healthy weight programme in Barnet. Outdoor Gyms and Activator programme will be conducted under this campaign alongside many other activities such as healthy walks.

Outdoor Gym

LBB plans to install five to six outdoor gyms in which are free to use, suitable for varying fitness levels, can be used in all weather conditions, do not require any specialist equipment or clothing and suitable for people of all ages and abilities. Outdoor gyms are similar to conventional indoor gyms but use equipment specially designed for outdoor use.

This programme also aims to provide a more local and sustainable form of physical activity which encourages people to be outdoors and use their local open and green spaces.

Currently in Barnet there is one Outdoor Gym located in Oak Hill Park, EN4. The project plan is to provide additional five to six outdoor gyms initially. The proposed locations will be in support of Barnet Council's priority of targeting areas of low participation in sports

and physical activity and deprivation. The priority areas will be the wards with the lowest rates of physical activity.

In addition to the health benefits the outdoor gym:

- Provides a fitness facility for those who can't afford a gym
- Creates a facility of benefit to a very broad section of the community
- Encourages inter generational activity
- Provides opportunities for mums and adults visiting playgrounds
- Encourages the use of parks and public spaces
- Creates a community facility that encourages social interaction
- Increases walking as many people walk to parks to use the outdoors gym equipments
- In children and young people, encourages better concentration in school and displacement of anti-social and criminal behaviour.
- Save money by significantly easing the burden of chronic disease on the health and social care services.

It is expected that the outdoor gym installation will be completed by March 2014, and it will be formally launched by April, 2014.

The Activator Programme

The Outdoor Gym Activator programme will train and use volunteers to increase participation levels through:

- Encouraging use of the outdoor gyms, highlighting availability for all residents
- Encourage the correct use and technique of the Outdoor Gym equipment
- Signposting local people to active health (exercise) possibilities

Identifying and targeting groups in the community that are the hardest to reach – peer activators will be encouraged and supported to use their local contacts to engage peers in their own communities. This will include local community groups, community centres, leisure centres and GP surgeries

We aim to provide a minimum team of six highly qualified volunteer "Activators" to encourage participation amongst most at risk local residents in the borough, and to support the ongoing usage of existing and any new outdoor health and fitness gyms.

The volunteers will be trained and receive Fitness Instructor Level 2 NVQ qualification which is the current industry standard. The training will give them the skills, knowledge and confidence to create an informal environment where their peers can learn how to exercise safely, effectively and independently to achieve health improvements. The volunteers will sign a pledge to commit to dedicating time each month to the project. An accredited training institution will be commissioned to provide the training to the

volunteers. The volunteer activators will carry out their Level 2 Fitness Instructor training from October, 2013 to March 2014.

The scheme is a means of promoting the outdoor gyms to the local population. It also helps to ensure that people are using the gym equipment properly and acts as a means of evaluating the effectiveness of the programme.

Services in Harrow

Active travel (adults)

Various initiatives have been developed to support people to consider and undertake more active means of travel, many in conjunction with the Local Authority. Cycle training is available to all residents of Harrow free of charge, walking maps are available to show what is within a five, 10 and 20 minute walk of the centre of Harrow, which is aimed at businesses who regularly travel throughout Harrow to meetings enabling them to encourage employees to walk rather than drive. Dr Bike sessions are held periodically in Harrow to encourage people to come along and give their bike a quick MOT. Regular events are held throughout the year to support national campaigns such as walk to work week.

Outdoor Gym Activators project

According to Sport England, "cost" and "access to quality facilities" are the two main barriers for people to overcome to increase levels of participation amongst non users and in later life to return as physical activity participators. Sport England's market segmentation research for Harrow, identifies key areas that have a low participation levels as in the East and South of the Borough.

Outdoor gyms are unique in that they are free and suitable for all to use, you don't need experience to use them and no special training or "kit" is required. The project builds on this original opportunity by providing a sustainable model by using and building strong relationships with volunteers. Other areas such as Camden have recognised that having fitness instructors would support and motivate people to use the gyms in their parks and Harrow council have used research to develop a programme of 'Outdoor gym activators'.

Harrow council, in partnership with Stanmore College, have supported 12 volunteers, recruited through the job centre, to receive a Fitness Instructor Level 2 NVQ qualification which is the current industry standard. The training gives them the skills, knowledge and confidence to create an informal environment where their peers can learn how to exercise safely, effectively and independently to achieve health improvements.

Six of the local parks in Harrow are now equipped with outdoor gym facilities. This has created a great opportunity for local people at their doorsteps. They can experience FREE fitness exercise outdoor among trees and whenever it is convenient for them. It removes the barriers of costs and access which are the two key factors impacting on the low levels of physical activity especially among disadvantaged sections of the population.

After going through CRB checks and completing the training 12 volunteers will be on placement for six months to provide two hours a week to help local communities use the gyms. Along the way they will be adding new skills and experience to their CVs and improve their confidence for further employment. Volunteer activators will be promoting the facilities within their local community as well as helping with the correct use of equipment. They will be providing advice and support for a healthier lifestyle and refer members of the public to other services.

The following six parks have the outdoor gym equipment in Harrow:

- Harrow Recreation Ground
- Kenton Recreation Ground
- Byron Recreation Ground
- Saddlers Mead Recreation Ground
- Alexandra Park
- Chandos Recreation Ground

An evaluation framework has been designed to help measure the difference made by the volunteer activators. Baseline information on how much the outdoor gyms are used was collected in June and this will be compared with three months after the activators are in place. Also a user questionnaire will be collected between July and October to assess the types of people using the service and their physical activity before and after the session.

A promotion campaign with press releases, posters, leaflets and through e-magazines, websites, email networks, local newspapers have been used to increase local people's awareness of the facilities and the sessions with trained volunteer activators. The project was launched on 30th June, at Under One Sky festival and a local promotion

campaign will target schools, children centres, community centres, libraries, leisure centres, GP Practices, pharmacies to increase usage.

Community growing

The aim of this project is to develop a community growing initiative that builds upon current community assets such as under utilized green space, community organisations and skills within the area. The project aims to build community cohesion and inclusion in the neighbouring areas; improve the physical and emotional wellbeing of participants as well as utilising green spaces and promote biodiversity

Local communities will be involved in the design of the project and in setting the outcomes they want to achieve. The pilot projects will ensure the project model is built to achieve sustainability within the community

It is anticipated that the project will start in October 2013.

What could we consider doing?

The Councils

- Provide leadership across the local partnerships to promote physical activity and a process of continuous evaluation to understand whether the changes made lead to the expected outcomes
- Make increased physical activity a priority in the planning of new development and transportation projects, by incorporating Health Impact Assessments
- Adopt and develop policies that promote active transport and make it easier to access physical activity and recreation areas, e.g. by allowing for residential and commercial use near each other (mixed-use development)
- Create policies that encourage new schools to be sited in locations that allow children to cycle and walk to school
- Ensure that the distribution of facilities is equitable and offers opportunities to encourage physical activity in disadvantaged areas
- Incorporate safe routes to schools and workplaces in transport planning to encourage cycling and walking to school and work
- Improve the infrastructure for walking and cycling to promote active transport
- Adopt “traffic calming” street design standards and elements to reduce vehicle speed and promote safe cycling and walking, for all ages

Communities

- Look at how to maximize use of school and community spaces for physical activity during and outside school hours.
- Develop your own local environmental greening project or bid for a pocket park.

Schools

- Monitor physical activity space and equipment for safety
- Offer staff opportunities for physical activity – and act as role models for children
- Develop active transport plans (bike, walk to school), working with local government and community groups

Workplaces

- Allow flexible work time or breaks to allow participation in physical activity
- Promote the use of stairs, such as by using signs or by making stairwells safe and attractive
- Have an active transport supported by provision of bicycle storage, showers and/or changing facilities
- Implement formal policies that promote physical activity in the workplace, such as polices for exercise breaks or bicycle parking
- Larger employers should look at the provision on-site gyms or other physical activity facilities, such as walking paths

Parents and carers

- Be active as a family, choosing activities that family members of all ages and abilities can enjoy such as walking in one of the many parks and open spaces in the boroughs.
- Be a role model for children by becoming more physically active and by limiting sedentary activities, such as television watching
- Promote safe physical activity, such as having children wear bicycle helmets
- Walk or cycle to school with children
- Encourage children to play outside

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The Director of Public Health Challenge

At the start of this report, I said we would look at physical activity from all angles and by all groups in our community and I think we've done that.

We've shown you how physical activity is good for you both physically and mentally, we've told you about what we've done to help you become more active and what's available out in the community.

So now I'd like to challenge you to see what you can do to become more physically active or to help your family, friends or neighbours do so.

Tips to start getting fit

Ready, set, goal!

Set one easy, specific, measurable goal at a time – make your first one really easy to achieve and you'll feel great that you achieved it and then you can build on it from there.

Don't say "I'm going to exercise", say "I'm going to walk for 15 minutes during my lunch break on a Wednesday and then walk back again"

Then write it down and put it where you can see it – it will remind you each time you look at it.

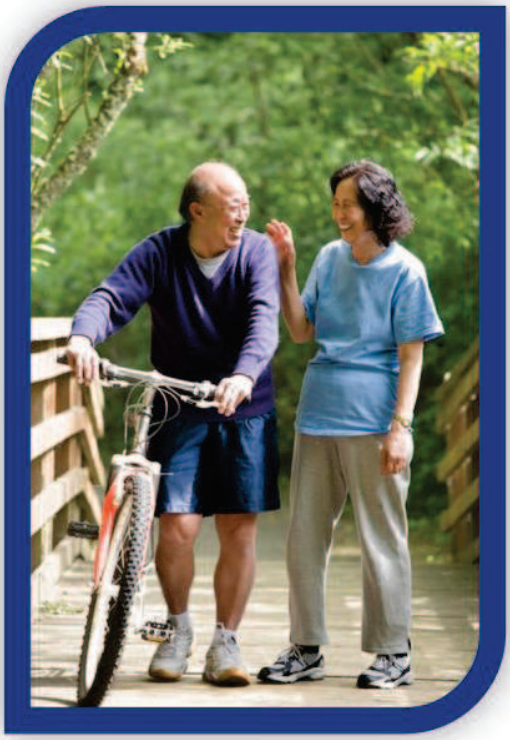
Do what's right for you

Going to the gym is some people's ideal place to exercise but it isn't everyone's cup of tea. Think about what you like doing, and build your activity around it. Alternatively, think of things that seem more like a fun or productive activity than like work. Anything that gets you moving around for at least 20 minutes will work. You might like team games, a kick about with the kids in the park, a walk with friends, gardening, dancing or washing the car. There's something for everyone and it doesn't have to cost a fortune – and sometimes it's completely free.

Having loose-fitting comfortable clothing and supportive shoes will ensure that you don't over heat or feel uncomfortable because they don't move with you and that you don't damage your feet or ankles when exercising. Your trainers should have good cushioning and arch supports.

Warm Up - Cool Down – Stretch

Of all the exercise tips, this is the one that is critical and very often ignored. Before starting any exercise, whether it's walking, dancing to your favourite fitness DVD or working out at the gym, make sure to warm up and stretch your muscles. You want to ensure you don't tear any muscle tissue during your workout.



Your warm up should be approximately five minutes. Simply walk or march in place for a few minutes to warm your muscles. Next, take some time to stretch your muscles to ensure proper flexibility and range of motion for your exercise routine.

And when you've finished, don't just stop suddenly, you need to cool down. The main purpose of cooling down is to bring your breathing, body temperature and heart rate back to normal slowly. Your cool down should also be five minutes to 10 minutes. Your muscles will now be nice and warm and you should get a deeper and more beneficial stretch to all your major muscles and any muscles you used during your exercise or sport. This will stop them becoming too achy later on. Each stretch should be held for 30 seconds.

Start Slowly

Most people try to do too much when they start exercising. It's important to start out slowly especially if you have been inactive for a long period of time. The speed and amount of your exercise or the length of your walk should match your level of fitness. It's fine to break up your exercise into chunks throughout the day. Even little bits of regular exercise and activity add up to big benefits. It may be necessary for you to start with just 10 or 15 minutes and increase as you feel able.

Get motivated

Writing down your goal and logging your success is a good way of remaining motivated.

Telling people about your goal is another way. It can encourage them to join you, so you can encourage each other, and they will act as a reminder when you're not feeling self motivated and they can celebrate your successes with you.

Plan a non-edible reward when you reach your goal, as a motivation to keep you going.

Let us celebrate with you

Of course, you can keep your successes to yourself or you can celebrate them with us. Let everyone know what you've done, how you feel and how they can join in with the challenge.

You can do this in a number of ways:

- Tweet using the one of the hashtags #DPHchallengeHarrow or #DPHchallengeBarnet depending on borough where you live..
- Put a message on one of either the Barnet Council or Harrow Council Facebook pages or mention us on your Facebook page using #DPHchallengeHarrow or #DPHchallengeBarnet
- Follow our blog - http://dphchallenge.blogspot.co.uk/ and comment on our regular posts which will give tips and advice on becoming more active
- Mention us on your blog using #DPHchallengeHarrow or #DPHchallengeBarnet
- Send us an email to publichealth@harrow.gov.uk with the subject line My DPH Challenge

In May 2014, my team and I will shortlist all entries and I choose the most inspiring stories from Harrow and from Barnet who will receive an award.

In addition, we will have an award for one primary and one secondary school in each borough and one community award from each borough.

All of the shortlisted entries will be invited to come to the first Public Health awards ceremony in summer 2014 to celebrate your success stories.

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AGENDA ITEM 10

Meeting	Barnet Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**Public Health Commissioning Intentions 2014-15**
Report of	Director of Public Health Barnet and Harrow
Summary of Report	The paper contains the commissioning intentions for Public Health in Barnet for 2014-15. The intentions will support the delivery of statutory requirements and the provision of discretionary services within the Local Government Public Health remit. The intentions align with the priorities in the Barnet Health and Well Being strategy and represent the Council's Public Health contribution to delivery of the strategy.
Officer Contributors	Brian Jones, Barnet and Harrow Public Health Service
Status (public or exempt)	Public
Wards Affected	All
Key Decision	No
Reason for urgency / exemption from call-in	N/A
Function of	Committee
Enclosures	None
Contact for Further Information:	Brian Jones, Public Health Service, Harrow Council Brian.Jones@Harrow.gov.uk 020 8966 5542

1. RECOMMENDATION

1.1 The Committee consider the Public Health Commissioning intentions for 2014-15 and make appropriate comments and/or recommendations to the Cabinet Member for Public Health.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health and Wellbeing Board, 23rd January 2014, Agenda Item 11, Public Health Commissioning Intentions

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The proposed commissioning intentions align with, and support delivery of, the Health and Well-Being Strategy 2012-15 and the commitments outlined in the first annual performance report of the Strategy, presented at the Health and Wellbeing Board in November 2013.

3.2 Specifically the four themes of the Health and Well-Being Strategy are supported by various Public Health programmes and initiatives as summarised in the table below:

	Preparation for Healthy Life	Well-Being in the Community	How we Live	Care when Needed
Sexual Health	✓		✓	
School Nursing including NCMP	✓	✓		
Drugs	✓	✓	✓	✓
Alcohol	✓	✓	✓	✓
Health Checks		✓	✓	✓
Smoking cessation	✓	✓	✓	✓
Healthy weight and healthy eating	✓	✓	✓	
Lifestyle Interventions	✓	✓	✓	✓
Employment		✓	✓	
Self Care		✓	✓	✓
Active Leisure (Centres)	✓	✓	✓	

4. RISK MANAGEMENT ISSUES

4.1 Final values for some contracts are subject to agreement. Work is in hand to contain spending on those contracts for open access services.

4.2 Externally provided services are subject to contract management and performance scrutiny to ensure effective and appropriate delivery of service.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 The commissioning intentions align with the Barnet Health and Well-being Strategy which is based on the population health needs identified in the Joint Strategic Needs Assessment (JSNA). The Joint Strategic Needs Assessment considers health and social care outcomes across all of Barnet's population groups and pays particular attention to the different health inequalities that exist in the Borough.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 The Public Health commissioning intentions will be entirely financed by the ring fence Public Health allocation to Barnet Council from central government as announced on 10 January 2013 for the financial years 2013-14 and 2014-15.

6.2 The Department of Health (DH) allocated £14,335,000 to Barnet Council for financial year 2014-15. This figure includes the previous separate allocation of the Drug Intervention Programme (DIP) but not the Mayor's Office for Policing and Crime (MOPAC) element which, it is expected, will be paid separately to the Council. This budget will allow mandatory requirements to be met, core services to continue and the introduction of new services.

7. LEGAL ISSUES

7.1 The 2012 Health and Social Care Act confers duties on councils to deliver a number of public health functions.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 The major services commissioned by the Public Health team to meet mandatory duties are: increasing access to NHS Health Checks; sexual health and family planning; and the national child measurement programme (delivered as part of the school nursing service).

Other services commissioned include: improving recovery outcomes for drug and alcohol users (building on year on year improvement in outcomes in Barnet); reducing the number of people who smoke (and targeting the single biggest preventable killer); healthy weight initiatives for children and adults; and community wellbeing.

Areas of new investment in 2013-14 will continue to be funded in 2014-15. These are: Children's Centre investments; parenting support; support for first time mothers; breastfeeding; children's oral health; Barnet Healthy Schools Programme (physical activity, emotional wellbeing, nutrition, sexual health, substance misuse and discouraging smoking), workplace health promotion and employment support; outdoor gyms; older people's physical activity opportunities; and the winter well programme.

9.2 The prevention of ill health investments are based on three principles:

Primary prevention extends disease free life and supports the compression of morbidity (i.e. people will be supported to live healthy lives for longer)

Life expectancy has increased significantly in recent years but so has the prevalence of chronic degenerative disease. If life expectancy increases at a faster rate than increase to disability-free life expectancy (i.e. later onset of chronic disease), the period that people live with chronic disease and their demands on services will increase. To avoid this there needs to be substantial delays in the onset of disability in later life. This is achieved through primary prevention that promotes the widespread adoption of healthier lifestyles, coupled with social changes that support these lifestyles. Investment in secondary prevention (i.e. preventing illness becoming more severe), aims to prevent deteriorating health and escalating need for services.

Investing early in the life course will deliver greatest returns

Whilst the public health investments cover the whole life course it is recognised that the greatest cumulative returns are achieved from intervention in early years and childhood (Marmot Review, 2010),

Supporting elderly people to improve their ability to look after themselves will improve their health and minimise their need for care outcomes, and allow funding to be re-invested in prevention rather than cure

As set out in the Health and Wellbeing Strategy, "In both the NHS and Adult Social Care, the spending profile is skewed towards acute hospital and residential based care. Better care and support can be delivered in people's own homes avoiding admissions to hospital, promoting choice in end of life care through integrated working across health and social care, joining up services around the individual and providing good support to family carers to sustain them in their caring role."

9.3 The following table gives concrete examples of what these principles mean in practice and what is intended in Barnet.

Public Health area	**Services expanding/ increasing primary prevention**
Early years	Development of single children's health offer (with transition of health visiting from the NHS to local authorities in 2015): investing in pre- and post- natal support and develop parenting skills programmes and tackling obesity in early years
Mental health	Investment to build emotional resilience and wellbeing in schools and Ageing Well community networks.
Physical activity	Environmental improvements and behavioural interventions building on existing investment (outdoor gyms and marked routes, Healthy Weight initiative in Children's Centres) with appropriate links to primary care
Employment	Public health work includes development of targeted services to help people into work with a particular lead on addressing health related concerns e.g. drugs and alcohol
Older people	Contributing investment to delay onset of ill health, supporting expansion of self-care, maintaining mobility and tackling social isolation

10 Commissioning Intentions

10.1 In 2014 – 15 new areas for investment are:

Return to work/ Unemployment and health
Building on experiences of commissioning employment support for residents affected by welfare reform, a broader programme of support into work will be developed in conjunction with other Council initiatives. The protective health benefits of employment and the detrimental consequences of unemployment

are well recognised and these investments have the potential to deliver health benefits whilst containing costs to the Council and its partners.

Supporting people with long term health conditions – self care
This investment will be used to develop a programme to support self care for people living with long term conditions in the community. It will align with and enhance the self care and prevention components of the integrated care programme.

Alcohol Intervention
This will be used to support the Alcohol Strategy and fund a range of initiatives including health information and awareness raising campaigns, licensing, brief intervention and additional alcohol treatment services.

Ageing well
The ageing well investment will continue and extend supporting the neighbourhood projects in East Finchley and Burnt Oak. These are projects which connect with local older people in those areas and support them in identifying local issues and developing local responses to address them. These include tackling isolation, mental health, and physical activity.

Further investment in Outdoor Gyms
Subject to satisfactory evaluation of the first tranche of outdoor gyms and marked and measured routes which should be operational in early 2014, it is intended that further infrastructure investment will follow in the financial year 2014-15.

Public Health promotion and campaigns
A programme of pro active press releases will be conducted. Physical activity promotion will be a particular focus in 2014-15 with a Fit and Active Barnet (FAB) campaign launching in the New Year and running alongside the Director of Public Health Physical Activity Challenge.

10.2 The budget for 2014-15 is:

Health Checks	**573,425**	
Sexual Health	**4,368,461**	
National Child Measurement and other Schools work	**1,083,508**	
Drug Misuse	**1,091,933**	
Alcohol Misuse	**1,637,899**	
Tobacco control	**688,249**	
Physical Activity	**680,000**	
Barnet Public Health	**2,304,056**	**Includes continued funding of new investment from 2013_14, new investment in 2014_15, and contingency funds**
Non Payroll	**569,265**	**Includes PH Service infrastructure costs payable to Harrow council**
Payroll	**1,426,610**	**Includes funding contribution to the Barnet Council graduate placement scheme**
Budget	**14,423,406**	

11. LIST OF BACKGROUND PAPERS

11.1 Health and Wellbeing Board, 23rd January 2014, Agenda Item 11, Public Health Commissioning Intentions: http://barnet.moderngov.co.uk/documents/s12657/Public%20Health%20Commissioning%20Intentions%202014-15.pdf

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AGENDA ITEM 11

Meeting	Health Overview and Scrutiny Committee
Date	12 March 2014
Subject	**NHS Health Checks Scrutiny Review – Final Report**
Report of	**Scrutiny Office**
Summary of Report	This report at Annex 1 details the findings and recommendations of the NHS Health Checks Scrutiny Review.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	All
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	Annex 1 – Report of the NHS Health Checks Scrutiny Review
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATION

1.1 The Committee note the findings and recommendations of the NHS Health Checks Scrutiny Review, as set out in the report attached at Appendix 1.

1.2 The Committee note that the report will be referred on to the Barnet Cabinet and Harrow Cabinet for consideration.

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 3 October 2013, Minute Item 12, NHS Health Checks Scrutiny Review – the Committee received an update on the progress of the joint Barnet / Harrow NHS Health Checks Scrutiny Review.

2.2 Health Overview and Scrutiny Committee, 12 December 2013, Minute Item 13, NHS Health Checks Scrutiny Review – the Committee received an update on the joint Barnet / Harrow NHS Health Checks Scrutiny Review and agreed that the final report could be approved by the Committee via e-mail to enable the report to be referred to Cabinet in February 2014. *(Note: Item has subsequently been deferred for consideration at Cabinet on 2 April 2014)*

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 In relation to the **NHS Health Checks Task and Finish Group**, the following outcomes and targets are relevant to the work of the Group:

"To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and

"We will work with the local NHS to encourage people to keep well by increasing the availability of health and lifestyle checks for those aged between 40 and 74, and promoting better use of green space and leisure facilities to increase physical activity."

"Increase the number of eligible people who receive an NHS Health Check to 7,200"

4. RISK MANAGEMENT ISSUES

4.1 None.

5. EQUALITIES AND DIVERSITY ISSUES

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 have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.2 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 Scrutiny reviews have the scope to consider value for money issues which identify how well the Council is managing and using its resources to deliver value for money and better and more sustainable outcomes for local people. Reviews must take into consideration the costs and benefits (both financial and non-financial) of any recommendations which they propose. In relation to the NHS Health Checks Scrutiny Review, all recommendations are expected to be delivered within the proposed 2014/15 budget of £573,425 allocated to deliver Health Checks in Barnet.

6.2 The costs associated with administering the NHS Health Checks Scrutiny Review have been met from existing resources within the Governance Service budget. Administrative support for the review has also been supported by the Scrutiny Office at the London Borough of Harrow and from an Expert Advisor from the Centre for Public Scrutiny.

6.3 The Community Engagement workstream was commissioned by the Scrutiny Review and funded from the London Borough of Harrow Public Health budget.

7. LEGAL ISSUES

7.1 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.

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take

such steps as it considers appropriate for improving the health of people in its area.

7.3 Under Section 9F of the Local Government Act 2000, the Council's executive arrangements are required to include provision for appointment of an Overview and Scrutiny Committee with specified powers, including the power to make reports or recommendations to the authority or the executive with respect to the discharge of any functions which are the responsibility of the executive.

8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 In April 2013, the Centre for Public Scrutiny (CfPS) launched a programme to support local authority scrutiny functions to review their local approach to NHS Health Check and improve take up. A bid for support was made by the London Boroughs of Barnet and Harrow (who have a shared Public Health function) and the bid was successful. Work on this project was undertaken between June and December 2013. This project has been be managed jointly by Scrutiny Officers from Barnet and Harrow and links directly to each council's overview and scrutiny committees; in the case of Barnet this is the Health Overview and Scrutiny Committee. As part of the offer from CfPS, the review has received support from a CfPS Expert Adviser (5 days total). In addition, the Joint Director for Public Health has been supporting the review.

9.2 In accepting the CfPS support offer, Barnet and Harrow committed to the following:

- Completing the review by the end of November 2013
- Using the CfPS Return on Investment (ROI) model
- Participating in Knowledge Hub online discussions
- Keeping an Action Log which will be utilised to co-produce a case study
- Participate in Action Learning Events

9.3 Barnet Members appointed to the Group were Councillors Alison Cornelius, Graham Old and Barry Rawlings. The Chairman of the Group was Councillor Vina Mithani from London Borough of Harrow.

9.4 The Scrutiny Review held meetings on the following occasions:

9.4.1 **25 July 2013**

- Approved of the Project Briefing to enable the review work to commence in advance of formal committee approvals
- Approved the composition of the Task and Finish Group (3 Harrow Members and 3 Barnet Members (Councillors A Cornelius, Old and Rawlings))
- Approved the consultation / engagement approach
- Noted resourcing arrangements
- Agreed an outline plan for the utilisation of the CfPS Expert Advisor support available

9.4.2 **18 September 2013**

- Received a summary of activity to date
- Reviewed and agree the Project Plan
- Received the results of a data mapping exercise undertaken by the public health team (including trend analysis)
- Agreed the approach to engaging with key stakeholders and residents / patients

9.4.3 **2 October 2013**

- Received a presentation from the CfPS Expert Adviser on the ROI approach
- Agreed the format of the Stakeholder Workshop

9.4.4 **1 November 2013**

- Stakeholder Workshop attended by Public Health England (London), GPs, Practice Managers, Healthwatch, Diabetes UK, Cabinet Members, Barnet / Harrow Public Health and Barnet Clinical Commissioning Group.

9.4.5 **4 December 2013**

- Considered results of an online questionnaire on Health Checks (promoted via Engage Space, Twitter / Facebook, Older Adults Partnership Boards and Members)
- Received results of community engagement exercise which included focus groups (generic, men and deprived areas) and 1:1 interviews

9.5 A detailed update was reported to the Health Overview and Scrutiny Committee on 12 December 2013 where the Committee agreed that the sign-off of the report could take place via e-mail. The final report agreed by the Committee is set out **Annex 1**. As this report has already been formally signed off by the Committee, the final version of the report is being reported to the Committee for information only.

9.6 The final report of the NHS Health Checks Scrutiny Review will be reported to the London Borough of Barnet Cabinet on 2 April 2014. The report was approved by the London Borough of Harrow Health & Social Care Scrutiny Sub-Committee on 11 February 2014, and will be reported to the Harrow Cabinet on 13 March 2014 for initial consideration and again on 10 April 2014 for formal response.

9.7 The work undertaken during this review forms part of a wider body of work on NHS Health Checks funded by Public Health England and supported by the Centre for Public Scrutiny. Barnet and Harrow are one of five NHS Health Check Scrutiny Development Areas nationally. Further details can be found via the link at item 10 below.

10. LIST OF BACKGROUND PAPERS

10.1 Centre for Public Scrutiny NHS Health Check Programme: http://www.cfps.org.uk/health-check

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NHS Health Checks Scrutiny Review

Final Report

January 2014

Index

1. Executive Summary

1.1 Aim of Review

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

1.2 Background to NHS Health Checks

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

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

1.3 Summary of Services / Existing Contracts

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

1.4 Activity Levels and Current Performance

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

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

1.5 Strategic Direction and Policy Drivers

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

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

1.6 Best Practice

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

1.7 Evidence

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

1.8 Return on Investment

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

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

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

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

1.9 Recommendations

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

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

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

2. Scope

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

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

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

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

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

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

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

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

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

- Identify ways in which NHS Health Checks can be promoted within each borough under the leadership of the Joint Director of Public Health;
- Explore the extent to which NHS services promote the NHS Health Checks to eligible residents;
- Consider the capacity of GPs, local pharmacies or other suitable settings to undertake Health Checks;
- Determine the extent to which secondary services are available to those who have been identified as having undetected health conditions or identified as being at risk of developing conditions without lifestyle changes;
- Identify examples of best practice from across England to inform the approach of Barnet and Harrow to commissioning and monitoring the NHS Health Checks Programme;
- Explore whether GPs could be organised on a cluster basis to deliver NHS Health Checks in each borough; and
- Utilise the CfPS Return on Investment model to undertake an analysis of the cost/benefit of developing the NHS Health Checks Programme. The outcomes from this will influence the recommendations

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

3. Background

3.1 NHS Health Checks

3.1.1 The NHS Health Check is a health screening programme which aims to help prevent heart disease, kidney disease, stroke, diabetes and certain types of dementia. Everyone between the age of 40 and 74 who has not already been diagnosed with one of these conditions or have certain risk factors will be invited (once every five years) to have a check to assess their risk. Once the risk assessment is complete, those receiving the check should be given feedback on their results and advice on achieving and maintaining a healthy lifestyle. If necessary individuals should then be directed to either council-commissioned public health services such as weight management services, or be referred to their GP for clinical follow up to the NHS Health Check including additional testing, diagnosis, or referral to secondary care.

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

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

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

3.1.4 The Health Checks programme requires collaborative planning and management across both health and social care. Health and Well Being Boards are therefore vitally important in the local oversight of this mandated public health programme[3].

3.1.5 As part of the Health Checks programme, local authorities will invite eligible residents for a health check every five years on a rolling cycle. Health Checks can be delivered by GPs, local pharmacies or other suitable settings. In Harrow and Barnet Health Checks are currently delivered exclusively at GP surgeries.

3.1.6 The tests comprise a blood pressure test, cholesterol test and Body Mass Index Measurement. Following the test, patients will be placed into one of three categories of risk: low, medium or high. Patients are offered personalised advice based on the outcome of their check.

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

3.2 Funding

3.2.1 The public health funding allocation is ring-fenced, to be spent only on public health functions. In Barnet, the current contractual liabilities do not cover all of the mandatory functions for councils in respect of public health. Historically in Barnet there has been no permanent budget line to cover NHS Health Checks. In Barnet and Harrow the 2013/14 commissioning plans allocate approximately £0.5m towards the provision of NHS Health Checks in each borough.

3.2.2 LB Barnet and LB Harrow Health Check Budget:

Barnet

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

Harrow

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

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

3.3 Commissioning

3.3.1 Year 1 – the joint Public Health team have been limited during year 1 (2013/14) due to the transfer of existing contracts from primary care trusts to the local authorities. Whilst this has constrained the service delivery options, this has enabled the Public Health team to carry out a data base-lining exercise which will be used to support de-commissioning or re-commissioning decisions.

3.3.2 Year 2 – the joint Public Health team have an opportunity from year 2 (2014/15) onwards to develop a commissioning strategy for NHS Health Checks in Barnet and Harrow based on findings of this scrutiny review.

3.3.3 At present, Barnet and Harrow have different payment mechanisms. Barnet GPs are paid for both offers and completions, whilst Harrow GPs are paid on completion only. At present, Barnet GPs may be incentivised to make offers only as they will receive payment for this element of the check. The Scrutiny Review are recommending that the financial incentives be restructured to maximise the impact of the programme locally (see recommendation 5).

3.4 Link to Corporate Priorities and Health & Well Being Strategies

3.4.1 In Barnet, the Corporate Plan 2013 – 2016 has a corporate priority "To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health" and priority outcome of working with the local NHS to encourage people to keep well by increasing the availability of health and lifestyle checks for those aged between 40 and 74, and promoting better use of green space and leisure facilities to increase physical activity.

3.4.2 The Barnet Health and Well-Being Strategy (Keeping Well, Keeping Independent) 2012 – 2015 identifies that, in relation to lifestyle factors, that statutory agencies need to "Increase both the offer and take-up of health and lifestyle checks in primary care to all people aged between 40 and 74 years to help reduce risk factors associated with long term conditions." A target of delivering a "Year on year increase based on the 2009/10 baseline of people aged between 40 and 74 who have received an NHS Health Check. In five years our coverage should be 80%."

3.4.3 In Harrow, the Corporate Plan 2013 – 2015 has a corporate priority of "Supporting residents most in need, in particular, by helping them find work and reducing poverty" and a outcome of delivering "…an efficient public health service with the resources available, to positively influence residents' health and wellbeing."

3.4.4 The Harrow Health and Well-Being Action Plan 2013 – 2016 has under the objective of "Early identification of cardiovascular disease and diabetes though the health checks programme" the following targets:

1. Promote uptake of health checks including use of social marketing (June 2013)
2. Evaluate outcomes and referrals onto other services as a result of health checks programme (March 2014)
3. Implement a programme of activity to provide health checks to Harrow residents who are not yet registered with GPs (September 2013)

3.5 Marmot Review

3.5.1 Sir Michael Marmot was commissioned by the Government to review what would best reduce health inequalities in England[4]. The review proposed that health interventions should be offered to everyone (and not just the most deprived) but that it must be 'proportionate to the level of disadvantage' – the principle of 'proportionate universalism.'

[4] http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

4. Context

National Context

4.1 Purpose and Rationale

4.1.1 The purpose of the NHS Health Check has been outlined in sections 1 and 3 above.

4.1.2 The rationale for the NHS Health Check programme is to identify those who are at a higher risk of developing certain illnesses at a stage where the illness may still be prevented and/or future complications of an illness could still be avoided. The NHS Health Checks screening programme is expected to have beneficial effects on people's health, as well as saving money in the health and social care economy in the future as costly interventions will be prevented. Public Health England recommends that 20% of the eligible population should be invited each year and that councils should aim for 75% of those offers to be taken-up.

4.1.3 Local authorities took over responsibility for the NHS Health Check from 1 April 2013. Nationally, the check is most likely to be offered in GP surgeries and local pharmacies. However, a number of areas have offered and/or delivered health checks via different providers and in other suitable and accessible locations in the community. Examples of alternative delivery models are explored in section 5 of this report.

4.2 Responsibilities

4.2.1 Local authorities are responsible for commissioning the Health Checks programme and have a statutory obligation to provide the patients GP with the outcomes and data of an individual's Health Check. Local authorities are responsible for commissioning the checks and for monitoring the amount of invitations and take-up. Clinical Commissioning Groups (CCGs) are responsible for ensuring that there is appropriate clinical follow-up such as additional testing, referral to secondary care and on-going treatment. The connection between these two aspects of the programme is essential in making it successful.

4.3 Budget, Potential Savings and Take-Up

4.3.1 The Department of Health (DoH) has estimated that the NHS Health Check programme is likely to be cost effective in the long-term. The programme is underpinned by cost-benefit modelling which considers cost in relation to quality adjusted life years (QALY – the number of years added by the intervention) which shows that it is extremely cost effective. The programme is also likely to generate significant social care savings as a result of a reduction of people accessing care through ill health. The cost calculations include two components:

- The cost of the check itself plus any follow-on tests or monitoring; and
- The cost impact of the interventions that are provided as a result of the NHS Health Checks.

Modelling conducted by the Department for Health when the programme began in 2008/09 proposed that a basic NHS Health Check would cost in the region of £23.70. This does not include the cost of lifestyle and other follow-up services provided by local authorities and health to reduce the health risks identified by the check.

4.3.2 The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health and well-being benefits[5].

4.3.3 A substantial number of people will need to receive the NHS Health Check and subsequent support for the programme is necessary in order to achieve its estimated savings. Current data shows that this expected to be a significant challenge. A study analysing data from the NHS Health Checks programme in 2011/12, published in the Journal of Public Health[6] in August 2013, concluded that coverage was too low currently to make the programme pay for itself. An article in PulseToday found that national figures for 2012/13 showed that overall uptake (the proportion of people invited who received the check) was 49%, having fallen back from 51% the previous year[7]. This data indicates that significant steps will need to be taken at a local and national level to improve take-up. Local authorities have a legal duty to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check as part of their statutory duties. The higher the take up rates for the programme, the greater the reach and impact of the programme and the more likely the programme is to tackle health inequalities.

4.3.4 The NHS Health Checks website offers a 'Ready Reckoner' tool which can be used to identify the potential service implications, health benefits and cost savings of NHS Health Checks per local authority. The tool uses 2010 population data from Office for National Statistics to base its estimates on and presumes that 20% of the eligible population is invited to a health check each year, and that the 75% of these people will take up the offer of a health check[8]. The extent to which Barnet and Harrow are achieving this performance will be explored in detail in section 6

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

[6] http://jpubhealth.oxfordjournals.org/content/early/2013/07/22/pubmed.fdt069.abstract?sid=0cf9fa5e-eb55-4946-8f48-0d696fbd20e2

[7] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/less-than-half-of-patients-attend-nhs-health-checks-show-official-figures/20003835.article#.UI_vX9K-qK4

[8] http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/ready_reckoner_tools

Indicative Costs and Savings for Barnet

4.3.5 Applying the Ready Reckoner Tool[9] for Barnet, it is estimated that the total cost of providing NHS Health Check for one year based on national estimates would be £673,408 (against an approved budget of £500,000 for 2013/14). The workforce requirements to undertake NHS Health Check in this year would be 4,243 hours of time to invite people to Health Check and arrange appointments, 5,039 hours of contact time for the Health Check tests and 3,536 hours of contact time for feedback on the results.

4.3.6 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 673,408	£ 107,397	£ (566,011)
5th year after checks	£ 1,373,409	£ 705,042	£ (668,367)
10th year after checks	£ 1,679,593	£ 1,475,877	£ (203,716)
15th year after checks	£ 2,056,281	£ 2,014,528	£ (41,753)
20th year after checks	£ 2,367,931	£ 2,419,419	£ 51,487

Indicative Costs and Savings for Harrow

4.3.7 Applying the Ready Reckoner Tool estimation for Harrow is that the total cost of providing NHS Health Check for one year based on national estimates would be £458,726 (against an approved budget of £456,000). The workforce requirements to undertake NHS Health Checks in this year would be 2,874 hours of time to invite people to Health Check and arrange appointments, 3,424 hours of contact time for the Health Check tests and 2,395 hours of contact time for feedback on the results.

4.3.8 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 458,726	£ 73,347	£ (385,380)
5th year after checks	£ 936,550	£ 481,750	£ (454,800)
10th year after checks	£ 1,141,916	£ 1,005,487	£ (136,429)
15th year after checks	£ 1,396,064	£ 1,369,713	£ (26,352)
20th year after checks	£ 1,604,439	£ 1,642,587	£ 38,147

4.3.9 The Ready Reckoner tool provides some indicative data on the potential costs and savings in each borough. Whilst the tool highlights that the NHS Health Checks programme will take 20 years to provide net savings, these savings will be across the whole health economy and will result in improved health and well-being for people more generally.

[9] Total costs and savings will vary across Local Authorities, depending on demographic factors. More detailed information about the health benefits can be found when using the Ready Reckoner Excel tool.

4.4 Approaches to Implementation

4.4.1 The NHS Health Check Programme is most beneficial when it reaches people that would not otherwise be identified as being at risk, for example people who are unlikely to visit their GP's regularly now. Reaching these groups is difficult, but will be an essential aspect of successfully implementing the NHS Health Checks programme in Barnet and Harrow.

4.4.2 The health and financial benefits associated with the programme will not accrue until people's risk of diseases has been reduced. This reduction can be achieved by medication, but also by changes in lifestyle such as increasing exercise, following a healthy diet and giving-up smoking. These changes in lifestyle are often difficult to achieve for people, even when they are provided with support services. There is, therefore, a balance to be achieved between medical interventions and encouraging people to take ownership of their own health and well-being. In line with other public health programmes (such as the Smoke Free initiative), the NHS Health Checks programme commissioned in Barnet and Harrow should seek to achieve a balance between intervention and individual responsibility for healthy lifestyle choices. Measuring the impact of the programme should have a medium to long-term perspective to ensure that lifestyle changes are maintained by individuals on an on-going basis.

4.4.3 The NHS Health Check Implementation Review and Action Plan describes commissioners' and providers' experiences with implementing the NHS Health Checks Programme. The review identifies that several commissioners considered that successful implementation had been driven by a 'mixed model' for delivery. GP's were central to the successful delivery of the Programme as they hold patients records and are a trusted source of care for most patients. However, GP services can be supplemented by a variety of other providers as follows:

- Community Teams – commissioned to make contact with those who are typically resistant to presenting in a doctor's surgery by visiting community centres, shopping centres, leisure centres, church groups, markets, football clubs and work spaces.

- Health Buses – used in supermarket car parks and other public spaces, both for walk-ups and by people notified by their GP's that the service would be available at that time and place.

- Private Providers – commissioned to provide Health Checks in collaboration with GP's who are sometimes able to provide a room in their surgeries.

- Pharmacies – used with mixed success, as they sometimes lack private space to perform the checks and can have difficulties in targeting the right audiences.

4.4.4 Public Health England is currently working on providing a repository of local case studies to support local implementation which will be published on the NHS Health Checks website.

4.5 Experts Views on NHS Health Checks Screening Programme

4.5.1 Whilst it is anticipated that there will be significant potential health and financial benefits as a result of the NHS Health Checks programme, there is a limited amount of peer reviewed evidence to support the success of mass screening programmes. Whilst PHE and DoH advocate the programme and are promoting and investing in it, a number of health care professionals have expressed concern regarding the effectiveness of the programme.

4.5.2 Dr Richard Vautrey, Deputy Chairman of the British Medical Association's GPs Committee, has said that "Last year they were talking about taking money from disease prevention, now they want to do this. We are very suspicious. Previous screening programmes have been introduced after much consideration and analysis of evidence. It doesn't seem like this is." [10]

4.5.3 Professor Nick Wareham, Director of the Medical Research Council Epidemiology Unit, has said that the current programme may not represent the best use of resources. Instead, the advisor to Public Health England urged public health leaders to target high-risk individuals as the evidence suggested this was likely be cost-effective.[11]

4.5.4 A study by NHS Heart of Birmingham, published in BMJ Open in March 2013[12] suggested that the NHS Health Checks Scheme programme overlooks a third of patients at high risk of having or developing diabetes, as patients with high HbA1c levels, but with normal or low body weight were not identified for further tests.[13]

4.5.6 The Chair of the Royal College of General Practitioners, Professor Clare Gerada, has backed a call from Danish researchers for the NHS Health Checks programme to be scrapped.[14] [15] The Danish research evaluated screening programmes run in a number of countries and concluded that general health checks failed to benefit patients and could instead cause them unnecessary worry and treatment.

4.5.7 Barbara Young, Chief Exec of Diabetes UK, expresses support for the programme by stating that "…while the £300 million it costs to run might sound like a lot of money, diabetes and other chronic conditions are expensive to treat. This means that once you factor in the savings in

[10] http://news.bbc.co.uk/1/hi/health/7174763.stm
[11] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/reconsider-age-based-approach-to-health-checks-urges-public-health-england-adviser/20004268.article#.UlPsGtK-qK4
[12] http://bmjopen.bmj.com/content/3/3/e002219.long
[13] http://www.pulsetoday.co.uk/clinical/therapy-areas/diabetes/health-checks-scheme-fails-to-identify-a-third-of-patients-at-risk-of-diabetes/20002241.article#.UmAebdK-qK4
[14] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/gerada-scrap-health-checks-programme/20004025.article#.UlPjQNK-qK4
[15] http://www.bbc.co.uk/news/health-23765083

healthcare costs, the NHS Health Check is actually expected to save the NHS about £132 million per year." [16]

4.5.8 Despite the concerns outlined above, the NHS Health Checks programme has been identified by the Secretary of State as an important vehicle for improving prevention and early diagnosis and the initiative is supported nationally by, PHE, DoH and the LGA. In addition, Health Checks are corporate priorities for both Barnet and Harrow councils and there is a significant opportunity for both authorities to utilise the data from this review to inform their commissioning strategies to deliver best value for money.

[16] http://www.bbc.co.uk/news/health-23765083

5. Performance

5.1 Targets

5.1.1 There are no nationally prescribed targets in relation to NHS Health Checks. However, PHE suggest that health and well-being boards should aim to offer checks to 20% of their eligible population every year and for 75% of those offered checks to take them up. NHS Health Checks is a rolling five-year programme meaning that 100% of the eligible population should have been offered a check at the end of the period. In relation to quarterly performance, a local authority that has offered the Check to 5% of the population in quarter 1 and sustain that over the following three quarters will have offered a check to 20% of the eligible population at the end of the year.

5.1.2 High performing areas are those that both **offer** to a high proportion of the eligible population cohort and then achieve a high **transfer rate** (i.e. converting the Health Checks offered into Health Checks received).

5.2 Performance Data

Outcomes – 2012/13

5.2.1 NHS England data[17] identifies that Health Checks in Barnet and Harrow in 2012/13 scored slightly lower than the London average, but close to the national average. Data for all London boroughs has been included in Table 1 for comparison purposes:

[17] http://www.england.nhs.uk/statistics/statistical-work-areas/integrated-performance-measures-monitoring/nhs-health-checks-data/

Table 1 – Number of eligible people that have been offered and received NHS Health Checks (April 2012 – March 2013) (England and London)

Name	Number of people eligible for a NHS Health Check	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that were offered a NHS Health Check
England	**15,609,981**	**2,572,471**	**1,262,618**	**16.5%**
London	**2,082,748**	**429,027**	**194,035**	**20.6%**
Havering PCT	69,304	6,529	4,771	9.4%
Kingston PCT	53,678	7,661	5,668	14.3%
Bromley PCT	100,037	23,117	9,042	23.1%
Greenwich Teaching PCT	63,098	15,137	6,511	24.0%
Barnet PCT	**114,883**	**18,357**	**4,758**	**16.0%**
Hillingdon PCT	72,886	6,742	3,783	9.3%
Enfield PCT	79,400	12,746	5,503	16.1%
Barking and Dagenham PCT	41,328	12,821	4,152	31.0%
City and Hackney Teaching PCT	55,561	11,483	6,775	20.7%
Tower Hamlets PCT	48,778	9,365	7,242	19.2%
Newham PCT	40,000	9,500	5,369	23.8%
Haringey Teaching PCT	55,476	12,523	6,461	22.6%
Hammersmith and Fulham PCT	40,050	6,568	4,276	16.4%
Ealing PCT	70,881	15,789	9,931	22.3%
Hounslow PCT	55,297	6,997	4,501	12.7%
Brent Teaching PCT	76,444	15,410	9,505	20.2%
Harrow PCT	**76,840**	**12,477**	**5,827**	**16.2%**
Camden PCT	49,685	14,761	4,378	29.7%
Islington PCT	42,650	10,167	7,142	23.8%
Croydon PCT	100,197	20,047	2,512	20.0%
Kensington and Chelsea PCT	50,475	7,651	590	15.2%
Westminster PCT	61,800	13,307	7,119	21.5%
Lambeth PCT	92,171	26,592	6,382	28.9%
Southwark PCT	79,294	21,145	6,524	26.7%
Lewisham PCT	72,646	19,279	6,622	26.5%
Wandsworth PCT	57,000	15,984	12,766	28.0%
Richmond and Twickenham PCT	49,856	14,305	4,857	28.7%
Sutton and Merton PCT	113,300	24,184	13,364	21.3%
Redbridge PCT	72,000	12,015	6,286	16.7%
Waltham Forest PCT	62,932	8,301	3,388	13.2%
Bexley Care Trust	64,801	18,067	8,030	27.9%

5.2.2 However, the statistics in Table 1 above should be treated with caution. There is a significant variation in the national statistics relating to the number of people eligible for an NHS Health Check (114,883 in 2012/13) and locally derived statistics provided by Public Health (91,139 in 2013/14 (see 5.2.3 below)).

Outcomes – Quarter 1 2013/14

5.2.3 The table below summarises the performance information regarding the NHS Health Check Programme for Quarter 1 of 2013/14:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that were offered a NHS Health Check of those offered
Barnet	91,139	4,911 (5.4%)	1,520 (1.7%)	31%
Harrow	63,879	1,093 (1.7%)	582 (0.9%)	53.2%
London	1,967,213	94,245 (4.8%)	41,517 (2.1%)	44.1%
England	15,323,148	598,867 (3.9%)	286,717 (1.9%)	47.9%

5.3 Comparative Performance

5.3.1 London Boroughs where a higher percentage of people are offered the health check tend to have a lower percentage of health checks received. At the same time, boroughs where a high percentage of the people received a health check tend to have offered health checks to a relatively low percentage of the population. Boroughs with the highest overall performance are those that both offer checks to a high percentage of their population as well as have a high percentage of checks delivered.

5.3.2 The London Borough of Wandsworth has been identified as an example of a local authority where both the percentage of offers made and the percentage of checks received have been on target.

5.3.3 In quarter 1 2013/14, the top five London Boroughs for **offering** the highest percentage of their eligible population a NHS Health Checks are:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of those offered
Camden	50,399	4,925 (9.8%)	924 (1.8%)	18.8%
Greenwich	60,012	5,605 (9.3%)	1,981 (3.3%)	35.3%
Lambeth	65,181	5,870 (9%)	2,013 (3.1%)	34.3%
Islington	44,687	3,429 (7.7%)	1,840 (4.1%)	53.7%
Westminster	52,589	3,971 (7.6%)	1,479 (2.8%)	37.2%

5.3.4 In quarter 1 2013/14, the top five London Boroughs for highest percentage of people that have **received** the health check after being offered it are:

Q1 2013-14	Total eligible population 2013-2014	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of those offered
Hounslow	61,153	664 (1.1%)	664 (1.1%)	100.0%
City of London	2,266	72 (3.2%)	72 (3.2%)	100.0%
Havering	70,211	1,507 (2.1%)	1417 (2%)	94.0%
Newham	59,455	1,720 (2.9%)	1376 (2.3%)	80.0%
Wandsworth	64,128	3,203 (5%)	2419 (3.8%)	75.5%

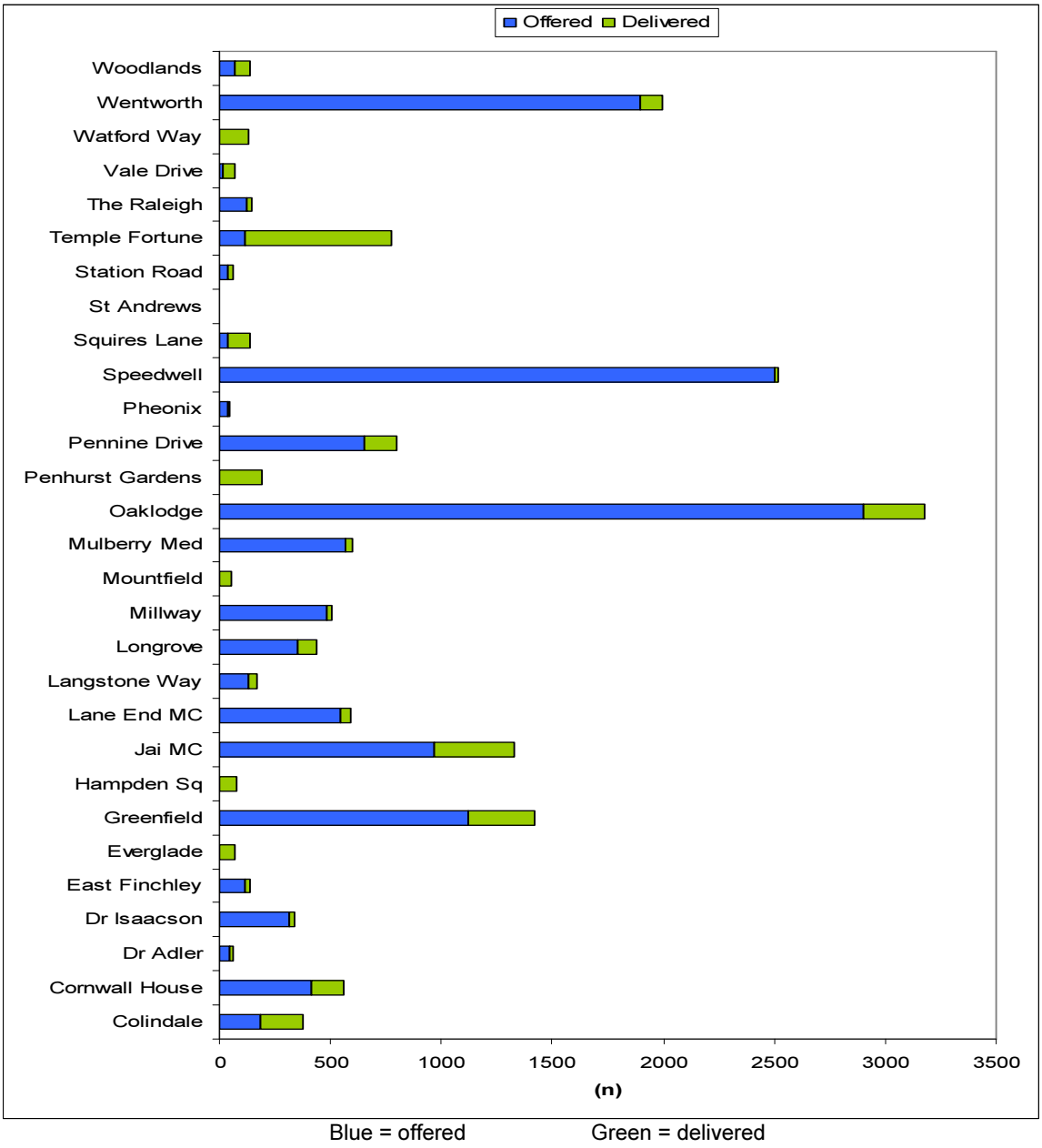
5.3.5 For the NHS Health Checks programme to be successful, commissioners should be seeking to meeting or exceeding both targets to ensure that the reach of the programme is as wide as possible.

5.4 Local GP Practice Performance

5.4.1 As part of the review, the Public Health team provided a breakdown of the performance of individual GP practices in Barnet and Harrow during 2012/13.

5.4.2 Table 1 provides relevant statistics for Barnet. Due to issues with the data transferred to the council, performance information for Barnet was only available for the period November 2012 to March 2013. Barnet achieved a 19% conversion rate from 'offered' status to 'delivered'. The table shows that larger GP surgeries tended to be the worst performing.

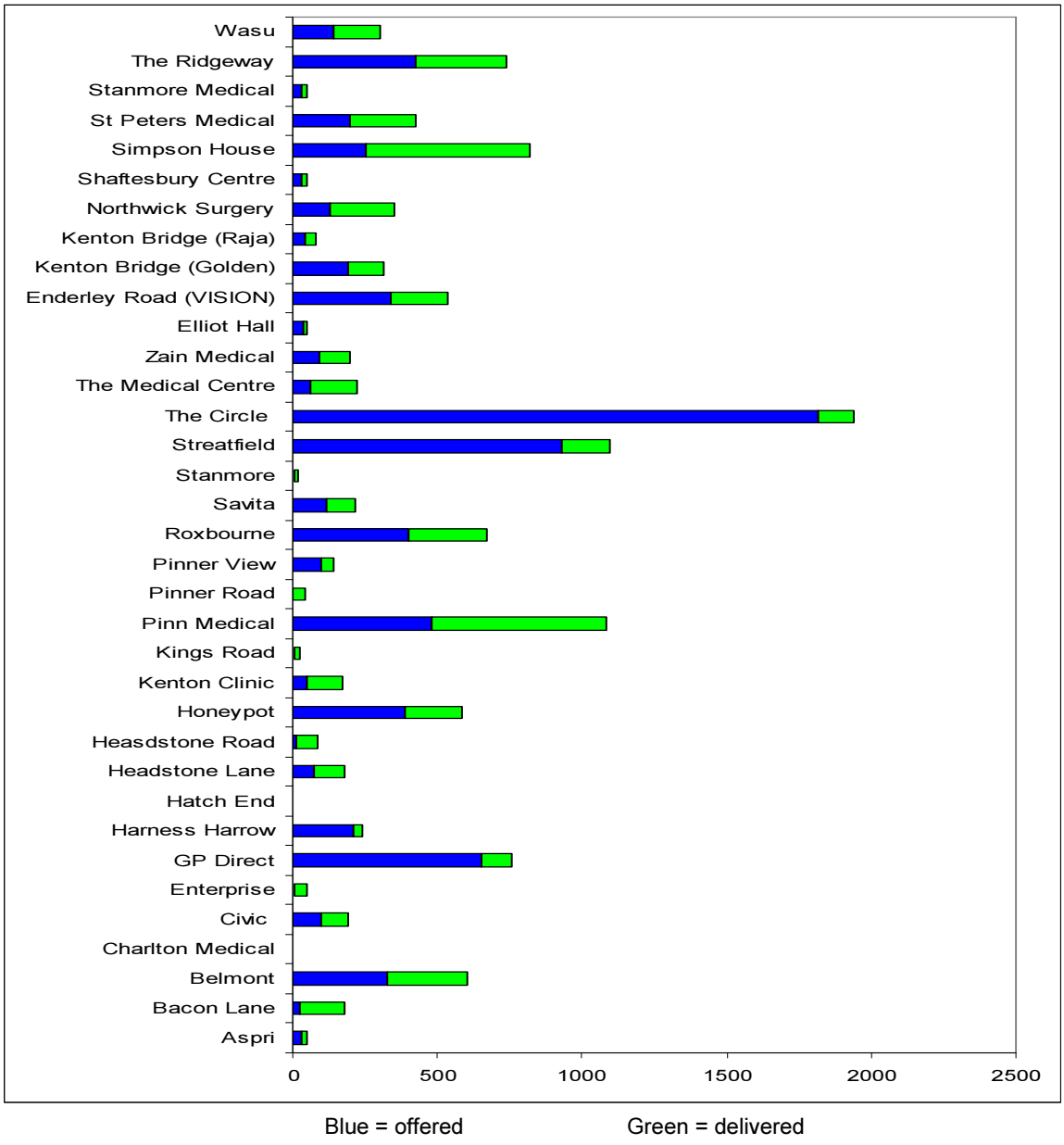
Table 1 – GP surgeries in Barnet performance, Nov 2012 – March 2013



Blue = offered Green = delivered

5.4.3 Table 2 shows the statistics for Harrow. Members were advised that Harrow has a 38% conversion rate. As with Barnet, the larger surgeries had the lowest performing rates.

Table 2 – GP surgeries in Harrow performance between April 2012 – March 2013



6. Best Practice

6.1 In conducting the review, Members have explored best practice examples to identify the principal differences between the approach taken in Barnet and Harrow and the approach in high performing areas.

6.2 Haringey

6.2.1 In 2012/13 the activity for NHS Health Check offers in Haringey was 12,523 and 6,461 checks were delivered. This translates to a 52% uptake rate, which is better than the uptake rate for 2011/12 (which stood at 35%).

6.2.2 Haringey's programme is targeted at areas of highest deprivation and CVD mortality: East, Central and part of West Haringey (Stroud Green and Hornsey wards). Over 70% of the Health Checks Programme is delivered by GPs in Haringey. The programme is being supported by behavioural support programmes (e.g. Health Trainers) and these arrangements have been strengthened during 2013/14. Community programmes that ran in 2012/13 included a focus on mental health users and a focus on men.

6.2.3 Haringey identified that to improve uptake they had to:

- increase coverage across eligible practices;
- reduce variation in activity;
- target high risk groups;
- target men;
- improve data quality; and
- improve onward referral mechanisms.

6.2.4 Haringey consider that one of the main reasons for success is that alcohol misuse screening delivered as part of NHS Health Checks programme has encouraged people to take part. They are also planning to deliver some Health Checks at community events in order to expand the reach of the programme.

6.3 Teesside

6.3.1 Teesside have used several techniques to achieve success with delivering NHS Health Checks. Firstly they have invested in a rolling training budget that can be allocated to external providers to help extend the availability of the service. Secondly they have used social marketing techniques to help inform the development of a communications and marketing strategy. By doing this they have made the service more visible. They have delivered Health Checks under the local identity of 'Healthy Heart Check' which has further helped to make the service more accessible and embedded in local culture.

6.3.2 Teesside have targeted certain groups and have created a prioritisation list of certain groups to help tailor the service and to increase take up. They have also invested directly in dedicated primary care informatics (or information management systems), a nurse facilitation team and project management as a way of extending the reach of the service. It is worth noting that death rates from heart disease have reduced at a faster rate in Teesside than England as a whole since the implementation of the Health Checks programme. Health Checks in Teesside have also been provided at particular work places in an effort to make the take-up more substantial.

6.4 County Durham

6.4.1 In comparison to national performance, County Durham has been very successful in delivering NHS Health Checks. They promoted Health Checks via a 'Check4Life', campaign which is based on the 'Change4Life' national health and well-being programme. They have utilised the same branding as the Change4Life campaign which has improved recognition locally.

6.4.2 County Durham have carried out the service with 'opportunistic screening' (when someone requests that their doctor or health professional undertakes a check, or a check or test is offered by a doctor or health professional) with a focus on predicting and preventing vascular disease risk. Health Checks have been conducted on a 'one-stop-shop' approach in order to make the delivery of these checks more accessible, attractive and patient focussed. They have also promoted the service at road shows, such as 'Health@Work', where Health Checks have been offered in certain work places.

6.4.3 In addition to this, County Durham has focussed on the notion of 'Mini Health MOTs', which are targeted at certain groups. This has helped to broaden the scope of the service and has helped to promote the service across the area. In analysing the success of the campaign, County Durham found that 91.3% were very satisfied with the Mini Health MOT, whilst 99.1% would recommend it to others. Intertwined with the NHS Health Checks, it was also reported that 82.2% were very satisfied with the NHS Health Check and that 99.6% would recommend an NHS Health Check to other people. During 2011/12 73.5% of those offered a Health Check in County Durham took the offer. To date 2013/14, 8,509 people have been offered a Health Check and 3,936 people have received one from an eligible population cohort of 164,760.

6.5 Richmond upon Thames

6.5.1 The London Borough of Richmond upon Thames has been successful in delivering NHS Health Checks. They have adopted an approach that relies on a strong advertising premise supported by a strong database to record the number of checks offered and delivered. As a result, Richmond is one of the leading boroughs in London in delivering NHS Health Checks.

6.5.2 Richmond works with more than 40 different partners including GPs, pharmacies, outreach and external providers to deliver Health Checks. Lifestyle programmes such as weight management, diabetes prevention and a health trainer service have been specifically commissioned for patients to be referred to.

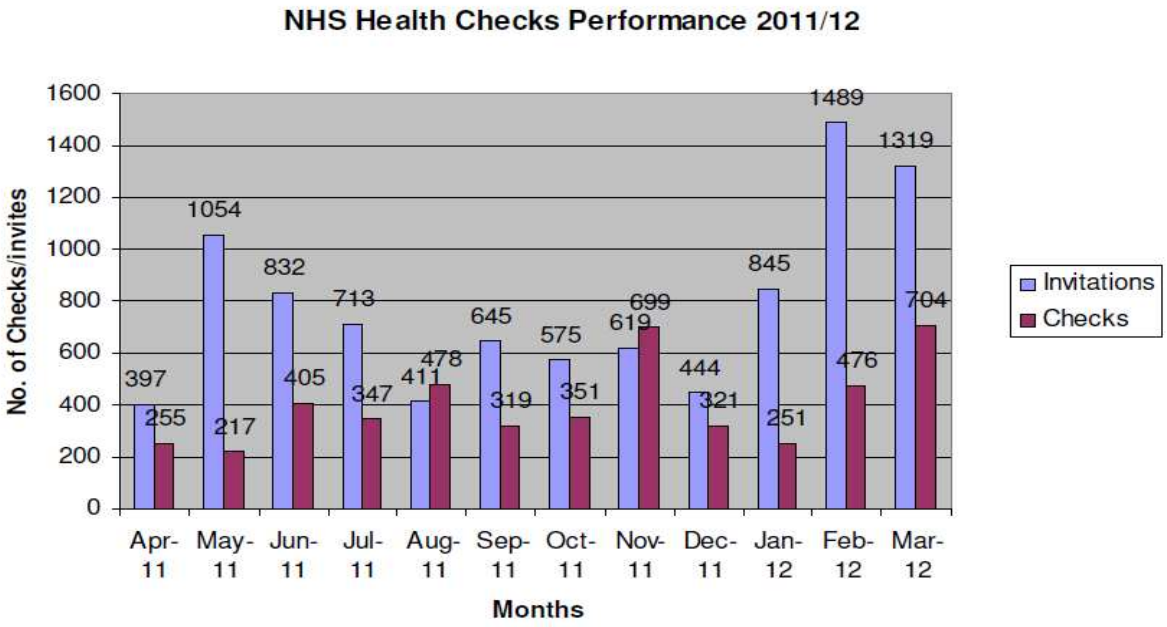
6.5.3 Richmond launched a pilot programme in 2009 in line with the national launch of the NHS Health Checks programme which focussed on delivering Health Checks in the most deprived wards in a pharmacy setting. This helped to make the service accessible both in terms of timing and capacity. The Public Health team also carried out a Health Needs Assessment and selected the top three deprived wards and the six pharmacies which were best suited to run the pilot. Health Checks have been delivered by the *Live Well Richmond* service which also provides an exercise referral scheme in addition to other lifestyle services. This has helped the Health Checks delivery model to become locally known. GPs have been commissioned to deliver targeted invitations based on factors such as age, gender, body mass index, ethnicity, blood pressure/cholesterol levels, physical activity and smoking status.

6.5.4 More than 50% of the eligible population have been invited and more than 20% have received a check. More than 200 people have been newly diagnosed with various cardiovascular diseases such as hypertension, diabetes, chronic kidney disease and coronary heart diseases as a result of a health check. In 2011/12, 5,700 health checks were completed in general practice, pharmacy and at community outreach events which exceeded DoH targets.

6.5.6 Richmond have delivered a marketing programme which comprises newspaper adverts, a dedicated webpage[18], letters, posters, leaflets and press releases to attract people for a health check. They also emphasised selling through personal sales (pharmacists, GPs and outreach), incentivising GPs, through focus groups and direct invitations.

6.5.7 Richmond use iCap, an IT system, to keep track of their Health Check performance. This system has enabled them to target checks where necessary and assists in provide statistical analysis as follows:

[18] https://www.live-well.org.uk/richmond/



6.6 Enfield – Innovision Health and Well-being Limited

6.6.1 In November 2012, Enfield Council awarded a contract for Community Health Checks to Innovision Health and Well-being Limited. This was done in an effort to allow targeting of health checks to communities that do not traditionally access primary care or who do not respond to invitations from primary care, which should improve the number of health checks being completed.

6.6.2 Innovision deliver health checks in both primary care and community settings. They perform health checks on behalf of GPs in communities and make a focussed effort to understand communities. By doing so, they are able to deliver health checks regularly. In Enfield, for instance, Innovision have noted that there is a large Turkish and Kurdish population and they have targeted Health Checks in those communities' first languages.

6.6.3 In Enfield, Innovision has established relationships with organisations such as ASDA, Tesco, various health centres and sports centres to enable delivery in these settings to encourage those who would not otherwise go to their GP. In an ASDA in Enfield, there is a weekly footfall of around 55,000; Innovision deliver checks in this ASDA on a daily basis. They determined that this was a good site after surveying the local area both in terms of weekly footfall and the regular attendance from specific communities. Innovision are also aiming to deliver Health Checks in all Boots stores in every London Borough that they are operating within (currently Brent, Haringey, Enfield and Islington). In addition, they deliver checks at community events, particularly in deprived areas in order to achieve their commitment of working with deprived communities.

6.6.4 Innovision have an on-line system where Health Check data is inputted to. This enables Public Health to be provided with non-identifiable data and has subsequently helped with reporting. This system has been used with Enfield and previously Haringey. The Innovision Health Check comprises the follows:

- BMI, weight and blood pressure checks are undertaken immediately
- The check takes 15-20 minutes
- Results of the above are given straight away
- If the patient falls out of the appropriate health range then they are signposted to their GP. GPs receive this information which they can then use as data in the future; the onus is on the GP to contact any patient who has risk factors or is in need of treatment.
- Innovision stress that primary care settings are the only places where advice can be given; those performing checks for Innovision are directly instructed not to give advice
- Checks are tailored to communities and are performed in appropriate settings (such as mosques, restaurants and wherever is possible)

7. Evidence

7.1 The Scrutiny Review recognised the importance of considering quantitative and qualitative evidence from a variety of sources. On that basis, the Group undertook three separate and distinct elements of engagement with key stakeholders as detailed below.

7.2 Community Engagement

7.2.1 The review commissioned a Community Engagement work stream to identify barriers to take-up across both boroughs. The full findings from the Community Engagement element of this project are attached at **Appendix A**. However, a summary of the key recommendations emerging are detailed below:-

i. Marketing and promotion – people are not familiar with the Health Checks brand and individuals would like to know more about the objectives of the programme. GPs need to be convinced of the value of the programme at a national level.

ii. Value for money – the economic case for Health Checks needs to be developed in greater detail by Public Health England. In addition, residents were concerned about the overlap with other screening programmes and wanted to see a more joined up approach to supporting wellness. The value of investing in Health Checks over other initiatives was questioned. Residents felt that support to make lifestyle changes should be free and have a long-term focus.

iii. Innovative approaches to delivery – residents considered that commissioners should take a more flexible approach to delivery (e.g. community teams, a health bus, clinics at flexible times)

iv. Effective IT – effective and joined up IT systems (across health and social care) would be essential for identifying the target population, collating data and information about individual risks, ensuring that follow-ups timely and evaluating the Health Checks programme. Residents wanted IT systems to provide a joined up and holistic view of their health.

v. Competency of providers – residents considered that the Health Check should be provided by a registered professional to ensure that advice and support started seamlessly in the context of the discussions relating to risk factors.

7.3 Questionnaire

7.3.1 To support the review, Scrutiny Officers conducted a snap survey of Barnet and Harrow residents to gauge awareness and take-up of NHS Health Checks. The survey was promoted locally by both councils communications

teams and via local networks, such as Healthwatch. The survey received 47 responses and the detailed findings are detailed in the sections below. Responses to the questions relating to the residents' experience of the checks should be treated with caution due to the relatively small sample size. They do, however, provide some insight into the views of people who have experienced an NHS Health Check:

7.3.2 85.7% of respondents were from Barnet and 14.3% of respondents were from Harrow.

7.3.3 In response to the question 'Have you ever been offered a Health Check from your GP?' 80.9% stated 'no' and 19.1% stated 'yes'. This highlights that the vast majority of respondents had not been offered a check, despite the Health Check programme having been in place in both boroughs since 2009.

7.3.4 Respondents were asked to provide the name of their registered GP surgery. 17 different practices in Barnet and three different practices in Harrow were identified as not offering Health Checks to participants.

7.3.5 Of those respondents that had been offered a Health Check, 100% had taken up the offer. Respondents were asked to identify the reasons why they had accepted the offer and their responses are summarised below:

- General health and well-being check
- Aware of the Health Check programme and wanted to see how it worked in practice.
- Multiple health issues
- Precautionary measure
- Family history of high cholesterol, cardiovascular disease or diabetes

7.3.6 When questioned how important they considered regular health checks to be, 71.4% considered that it was very important and 28.6% considered that it was neither important or unimportant.

7.3.7 When questioned how beneficial they considered the Health Check that they had received to be, 66.7% considered it was beneficial or very beneficial and 33.3% considered it was not very beneficial or not beneficial at all. Respondents were asked to give reasons for their answer. One respondent stated that they were dissatisfied as they were still waiting for their blood test results following a check completed over a week ago.

7.3.8 Respondents were asked whether they considered that there were any areas of the Health Checks process that could be improved. 57.1% answered yes and 42.9% answered no. Respondents were asked to identify specific areas for improvements and the responses are summarised below:

- Consider the option of Integrated Medicine (homeopathy or other natural medicine choices)
- Scans for aneurysm
- Prompt results and more screening around breast cancer, etc.

- Health Checks should consider an individual's mental health too

7.3.9 When respondents were questioned whether they would recommend the Health Check to other people, 85.7% said yes and 14.3% said no. Respondents were asked to give reasons for their answers which are summarised below:

- Early detection of diseases
- Encourage people to make healthy lifestyle choices for them and their families
- Concern for the health and wellbeing of others
- Useful especially for men as they tend not to visit their GPs
- Early detection of health issues and an opportunity to discuss these with health professionals

7.4 Stakeholder Workshop

7.4.1 It was agreed at the outset of the project that engagement with stakeholders was key to understanding the overarching issues. In November 2013, Barnet and Harrow held a Stakeholder Workshop, facilitated by the CfPS Expert Advisor and supported by Scrutiny Officers from Barnet and Harrow. The aim of the workshop was to provide Members of the Scrutiny Working Group and key external stakeholders with the opportunity to:

- Understand the external factors that currently influence the commissioning and delivery of the Health Check in the Barnet and Harrow
- Identify the barriers to delivering the Health Check
- Identify opportunities for effective delivery in the future
- Discuss the improvements in services that could be achieved by change
- Identify and prioritise issues to be considered in the commissioning of the Health Check

7.4.2 The workshop was a deliberative forum which enabled participants to consider relevant information, discuss the issues and options and develop their thinking together before coming to a consensus view. The facilitators used the CfPS Stakeholder Wheel (as shown in Table 3 below) to structure the discussion throughout the workshop and to address the return on investment question of:

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

7.4.3 Based on the discussions that took place, the following recommendations emerged from the Stakeholder Workshop:

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

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

7.4.4 Although listed as separate elements above, the Public Health team are recommended to undertake a **whole system review** (offer, appointment, results, advice etc.) to inform the future Health Checks commissioning strategy.

7.4.5 The recommendations at 7.4.3 have been endorsed and adopted by the Scrutiny Review Group.

7.4.5 In addition to the recommendations outlined above, the following have been identified as priority areas for Public Health to consider when commissioning Health Checks in the future:

1. Improve take-up across the board

2. Engage with local Healthwatch to promote

3. Communication – liaise with community leaders

4. Communication – develop and embed a local message articulating the offer

5. Providers and incentives need to be realigned

6. Target Health Checks locally to specific communities

7. Understanding barriers to take up in areas offered

8. Examine the whole system from offer to follow on

9. Communicate the advantages

10. Extent that service providers can encourage take-up (e.g. weekend availability)

11. Follow up with personalised letters and phone calls; state the advantages

12. Improve access based on research

13. Initiate follow-up programmes

8. Return on Investment

8.1 When applying to become a CfPS NHS Health Check Scrutiny Development Area, Barnet and Harrow committed to using the CfPS Return on Investment Model (RoI) to conduct the review.

8.2 The RoI model seeks to quantify what the return on investment would be for a specific course of action being taken as a consequence of the scrutiny review. As identified in the Stakeholder Workshop section, the RoI question that this review has been seeking to address is

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

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

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

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

8.4 Public Health England has estimated that over the next four years around £57 million will be saved through Health Checks and that over a 15 year period £176 million will be saved. After 20 years the NHS Health Checks programme is expected to have paid for itself and deliver improvements to the general health and well-being of the population.

8.5 The RoI modelling below will seek to analyse cost of this review against the potential financial benefits of implementing the recommendations arising. It is acknowledged that the RoI modelling could be open to challenge as it is based in a number of assumptions. Notwithstanding this, the model does provide a platform to demonstrate the potential financial and social benefits that implementing scrutiny recommendations could deliver if implemented; the model should therefore be considered on that basis.

Return on Investment – Cost of Scrutiny Review vs. Potential Savings

Table 2 (Input Costs)

Input	Scrutiny Officer Review	Public Health	External Engagement	**Total**
	2 x Scrutiny Officers for 1 day per week for 24 weeks (mid-July to mid-December) = 168 hours Plus 5 days of graduate trainee support = 37 hours Total hours 373 hours x £25 per hour = **£9,325**	Public Health Officers (including involvement in planning meetings, providing data and attending) Total hours = 10 days or 74 hours x £25 per hour = **£1,850**	22 days = **£13,370**	**£24,545**

Table 3 (NHS Health Checks – Newly Diagnosed Conditions)

	Number of people eligible for a Health Check	Number of Health Checks offered to the eligible population	Number of Health Checks performed	Transfer rate (take up of those offered)	Number of cases of Hypertension diagnosed as a result of a Health Check	Number of cases of Diabetes diagnosed as a result of a Health Check	Number of cases of High Cholesterol diagnosed as a result of a Health Check
Harrow (2012/13)	62,892	12,680 (20.16%)	3,729 (5.93%)	34%	65	32	815
Barnet (2012/13)	69,904	16,820 (24.06%)	3,263 (4.67%)	19%	146	65	750
Richmond (2011/12)	Approximately 19,000	9343 (c. 50+%)	4823 (c. 25%)	51%	152	19	Data not available

8.6 In considering the financial implications of not treating risk factors or diagnosed conditions early, a review of information available on the cost of treating chronic conditions was undertaken. The result of the modelling below should be treated with caution as the financial assumptions have not been fully tested. The findings do however provide an estimation of the potential savings across health and social care following the roll out of a successful NHS Health Checks programme in Barnet and Harrow.

8.7 The British Heart Foundation reports that 103,000 heart attacks occur every year, costing around £2 billion per year to treat or £19,417 per case. Diagnosing conditions such as Hypertension can be argued to prevent heart attacks from occurring later on therefore meaning that for every case diagnosed £19,417 is potentially saved. On this premise, the following amount of money will be saved as a result of Health Checks:

8.7.1 LB Harrow

In 2012-13, 3,729 had health checks (5.93% of the eligible population). This led to 65 cases of hypertension being diagnosed, saving a potential of £1,262,105.

If the uptake was improved to 11.86%, then it is possible that around 130 cases of hypertension could be diagnosed, saving a potential £2,524,210.

8.7.2 LB Barnet

In 2012-13, 3,263 had health checks (4.67% of the eligible population). This led to 146 cases of hypertension being diagnosed, saving a potential of £2,384,882.

If the uptake was improved to 9.34%, then it is possible that around 292 cases of hypertension could be diagnosed, saving a potential £5,669,764.

8.8 If the recommendations arising from this review (as set out in the following section) are agreed and implemented, it is anticipated that there will be a significant increase in the uptake of NHS Health Checks in both boroughs, particularly if roll-out of the checks is prioritised based on demographic risk factors.

8.9 **Social Return on Investment**

8.9.1 The Scrutiny Review Group wish to emphasise that the implementation of the recommendations made will deliver social as well and financial benefits. Encouraging people to adopt healthy lifestyles and managing pre-existing conditions before they become chronic will deliver health and well-being benefits in addition to the potential financial savings.

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9. Summary Findings and Recommendations

Summary Findings

9.1 Following consideration of all the evidence received during the review, Members questioned whether GPs were the correct vehicle for delivering NHS Health Checks. Whilst performance in Barnet and Harrow had been around the national average, there was a lack of awareness of the checks in both boroughs. Best practice examples demonstrated that alternative delivery models could improve up-take by targeting to specific groups and making the checks more accessible.

9.2 Data supplied by the Public Health team had indicated that the cohort of patients presenting for health checks were not reflective of the demographics in each borough (e.g. there were a disproportionate number of women from more affluent areas). As such, presentations were not linking with communities identified as being at risk. There should therefore be a focus on hard to reach groups including specific ethnic communities with high risk factors, mental health patients, the homeless and men.

9.3 The Group recognised that there should be a balance between interventions and individuals managing their own risk factors. A communications campaign should therefore seek to strike a balance between promoting the checks locally and encouraging people to adopt healthier lifestyles.

9.4 Members recognised the importance of ensuring that there was a clearly defined pathway for those identified as being most at risk. Medical interventions should be supported later in the pathway by risk management and reduction elements and a joined up approach would be required to achieve this.

9.5 Contracts transferred from primary care trusts were inconsistent and in Barnet did not incentivise completion of the check. The Group considered that when the commissioning strategy was defined, there should be consistent payment by results contracts across both boroughs. Members were supportive of the work being undertaken within the West London Alliance to regularise NHS Health Checks contracts on a sub-regional level.

9.5 The Group recognised that greater work was required to understand the whole costs of the NHS Health Check process. Local authorities are responsible for commissioning the check and CCGs are responsible for ensuring an appropriate clinical follow-up. Further evaluation of the post-check care costs is required to provide an accurate cost benefit analysis.

9.6 The Group were supportive of the recommendation in the PHE / LGA paper titled *NHS Health Check: Frequently asked questions* (September 2013) that "Health and Wellbeing Boards (HWBs) should ensure that NHS Health Check is reflected in the commissioning plans stemming from locally agreed Joint Health and Wellbeing Strategies (JHWSs) and that it is resourced to operate

effectively. Coordinating the programme with wider strategic decision making by the whole council will avoid duplication, and can help maximise the programme's impact and value for money. It is important to ensure that the risk management and reduction elements of the NHS Health Check (lifestyle interventions such as stop smoking services, weight management courses and drug and alcohol advice) are properly linked to other council services like education, housing and family support."

Recommendations

9.7 The Group agreed that the recommendations arising from the Stakeholder Workshop, as detailed in **section 7.4.3** should form the basis of the recommendations to each council's Cabinet and Health & Well-being Board as recommendations were supported by all of the quantitative and qualitative research undertaken as part of this review.

10. Project Activity

A summary of the meetings in carrying out this scrutiny review is provided below:

Date	Activity
25 July 2013	Approved the Project Briefing to enable the review work to commence in advance of formal committee approvals Approved the composition of the Task and Finish Group (3 Harrow Members and 3 Barnet Members Approved the consultation / engagement approach Agreed an outline plan for the utilisation of the CfPS Expert Advisor support available
18 September 2013	Received a summary of activity to date Reviewed and agree the Project Plan Received the results of a data mapping exercise undertaken by the public health team (including trend analysis) Agreed the approach to engaging with key stakeholders and residents / patients
2 October 2013	Received a presentation from the CfPS Expert Adviser on the ROI approach Agreed the format of the Stakeholder Workshop
1 November 2013	Stakeholder Workshop attended by Public Health England (London), GPs, Practice Managers, Healthwatch, Diabetes UK, Cabinet Members, Barnet / Harrow Public Health and Barnet CCG
4 December 2013	Results of an online questionnaire on Health Checks (promoted via Engage Space, Twitter / Facebook, Older Adults Partnership Boards and Members) Results of community engagement exercise which includes focus groups (generic, men and deprived areas) and 1:1 interviews Outline report, co-authored by LB Barnet and Harrow Scrutiny Officers

11. Acknowledgements

The Scrutiny Review Group wishes to thank those attendees and witnesses outlined below in addition the officers in the joint public health team who supported them during their work.

Councillors	
Councillor Vina Mithani	Harrow Council
Councillor Alison Cornelius	Barnet Council
Councillor Graham Old	Barnet Council
Councillor Helena Hart	Barnet Council
Councillor Barry Rawlings	Barnet Council
Councillor Ben Wealthy	Harrow Council
Councillor Simon Williams	Harrow Council
Council Officers	
Dr Andrew Howe	Joint Director of Public Health, Barnet and Harrow
Mary Cleary	Interim Senior Public Health Commissioning Manager
Rosanna Cowan	Public Health Commissioner
Dr Matteo Bernardotto	GP VTS Trainee at North West London NHS Trust, Public Health
Andrew Charlwood	Overview and Scrutiny Manager, Barnet Council
Felicity Page	Senior Professional Scrutiny, Harrow Council
Edward Gilbert	Graduate Trainee / Assurance Officer, Barnet Council
Hannah Gordon	Graduate Trainee, Barnet Council
Witnesses	
Brenda Cook	Expert Advisor, Centre for Public Scrutiny
Stephanie Fade	Managing Director, What Matters Cubed
Paul Plant	Deputy Regional Director – London, Public Health England
Christine Gale	Pinner Road Surgery, Harrow
Smita Mody	Pinner View Medical Centre, Harrow
Dr Sue Sumners	Barnet Clinical Commissioning Group Chairman
Councillor Helena Hart	Cabinet Member for Public Health, Barnet Council
Cllr Simon Williams	Health and Wellbeing Portfolio Holder, Harrow Council
Dr Pandya	Savita Medical Centre, Harrow
Roz Rosenblatt	London Regional Manager, Diabetes UK
Rhona Denness	Healthwatch Harrow
Selina Rodrigues	Healthwatch Barnet

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2013

Health Checks: Community Engagement Report

Summary

This work was commissioned by the Overview and Scrutiny teams from the London Boroughs of Barnet and Harrow. Focus groups and one to one interviews with residents of both Boroughs were carried out to explore public views about NHS Health Checks. This community engagement work showed that whilst residents supported the concept of Health Checks they wanted a more person-centred approach. Two over-arching themes emerged; the need for a more coherent wellness strategy pulling together all the current checks and screening initiatives and a greater focus on quality over targets in relation to access, delivery and follow-up. This paper describes these two themes setting out residents' views for consideration in the context of the wider local review of the Health Checks programme, which explored commissioner and provider perspectives. The report concludes with some considerations for the local development of the Health Checks programme linking with ongoing national work being led by Public Health England.

Stephanie Fade PhD RD, Director
What Matters Cubed
11/29/2013

Background

The Overview and Scrutiny Teams at Harrow and Barnet Councils commissioned this in-depth, yet fast-paced community engagement work to explore public views on NHS Health Checks.

The NHS Health Check is a health screening programme which aims to help prevent heart disease, kidney disease, stroke and diabetes and identify certain types of dementia. Everyone between the ages of forty and seventy-four, who has not already been diagnosed with one of these conditions or have certain risk factors should be invited (once every five years) to have a check to assess their risk and provide advice/signpost services to help them reduce or manage that risk. Health Checks may be delivered by GPs, local pharmacies or other suitable settings.

Both Councils ran an online survey on the topic and consulted with commissioners and providers in parallel with this community engagement work.

The community engagement work started on 22nd October 2103 and completed on 30th November 2013.

Approach

The engagement sought to access views from different cultural perspectives, different socioeconomic groups, men and women, people across the eligible age range as well as groups that might face specific challenges accessing health services such as carers, people with disabilities, people with learning difficulties and other mental health diagnoses. A list of groups engaged is shown in appendix one.

Engagement via General Practice Patient Participation Groups

All GP Practice Managers across Barnet and Harrow were contacted by e-mail to identify Patient Participation Groups (PPGs) meeting during the time frame of the engagement work. Only four replies were received and three of these reported that the Practice's PPG was not due to meet until after the conclusion of the work. However one meeting was arranged with a PPG Executive group in Harrow. In order to ensure that PPG members had the opportunity to get involved with the work despite this constraint, two focus groups were arranged at the Harrow Council offices and Hendon Town Hall respectively. An invitation was sent to Practice Managers and PPG Chairs via the respective Healthwatch Directors, using the fliers in appendix two.

Engagement with Local Voluntary and Community Groups

Participants were identified from a number of sources:

1. Groups that represented the harder to reach communities in Harrow
2. Barnet CommUNITY website
3. Yell.com

Groups were contacted by phone call and e-mail in order to identify pre-existing meetings that were taking place during the timeframe available for data collection (28th October-26th November), where it would be possible to talk to small groups of residents about Health Checks.

Hard to Reach Groups

Following earlier analysis provided by the Harrow and Barnet Public Health teams, Overview and Scrutiny [Councillor Vina Mithani (Chairman of the NHS Health Checks Scrutiny Review), Councillor Alison Cornelius (Barnet), Councillor Graham Old

(Barnet), Councillor Barry Rawlings (Barnet), Councillor Ben Wealthy (Harrow)] had identified three groups of residents that were particularly under-represented in terms of taking up Health Checks, these were:

1. Men
2. Residents from deprived areas as indicated by the Index of Multiple Deprivation (IMD)
3. Overweight and obese residents

Men's groups or groups with strong male representation and groups meeting in deprived areas were targeted to ensure that the engagement took views from these groups into account.

The researcher (a registered Dietitian) sensitively identified overweight and obese people at the focus groups and arranged follow up phone calls with residents from this group to discuss relevant issues. Two interviews were carried out.

Engagement Tools

At each Focus Group the researcher used the survey questions shown in appendix three, to acquire quantitative data including demographic information from each respondent. Demographic data was used to report on the extent to which the engagement reached different ethnic and socioeconomic groups rather than to report differences between groups.

Group discussions were initially organised around the following themes developed in discussion with the Scrutiny Teams:

- Views about the general concept of Health Checks
- Awareness of Health Checks prior to the focus group and views on enhancing awareness

- Motivators and inhibitors for having a Health Check
- Experiences of booking or having a Health Check
- Experiences of the benefits of Health Checks or thoughts about the potential benefits
- Ideas about other potential ways to achieve the aims of Health Checks

Each session concluded with the question "Please tell me about anything that seems important to you about the subject of Health Checks that we have not already covered." This question sometimes highlighted new themes that were then explored further in later focus groups and interviews. Supplementary questions under each theme were designed to increase the depth and breadth of the data. For example to provide depth the researcher asked "Can you tell me a bit more about that?" or "Do you have any thoughts or sense of why ....happens or the circumstances around your experience." To increase the breadth of information the researcher asked: "Has anyone got a different view/had a different experience?"

As the meetings were relaxed and informal a decision was made not to tape record responses but simply to make notes during and after the session. Despite this an attempt was made to record quotes verbatim where key points were being made.

Data Analysis

Analysis began as soon as the first focus group session was completed enabling the identification of emerging concepts and where necessary relevant groups to engage with, in order to develop understanding around strong concepts in the data. A concept was considered strong if it occurred many times within or across groups or if cues indicated strength of feeling (e.g. making a statement such as "what makes me really angry is...." or shouting or becoming animated) even if the

view was only expressed by a few residents. This was considered important to ensure that the views of minority groups were reflected appropriately in the report. When new concepts emerged, data from previous groups were reviewed to check for examples that might have been missed on first analysis. As the work progressed concepts were organised under category headings and gaps in understanding were identified for exploration in future focus groups. A specific attempt was made to identify links between issues seen in the data in order to facilitate the development of a narrative describing the findings rather than a simple list of themes. This was done to make the findings more meaningful and user friendly particularly to the residents who had supported the work.

Findings

Survey Findings

Forty-one residents were involved in this work. 44% were from the Borough of Barnet and 56% were from the Borough of Harrow. 44% were male and 49% were identified as being from deprived wards (IMD score of 15.00 or more) based on data from the London Health Observatories (London Health Observatories 2010.) Before participating 51% reported that they were aware of the Health Checks programme. However the researcher noted significant confusion about the title "Health Check." Many residents reported that they had their health checked regularly and on discussion this seemed sometimes to be linked to checks relating to a pre-existing non cardiovascular health condition or routine checks carried out for older people by GPs. The researcher took care to specifically note residents who had been given a "Health Check" as part of the formal programme being investigated rather than all those who had experienced some form of check up in another context; however it must be accepted that there may have been some over-reporting. Of those who

had an awareness of Health Checks 29% (n=6) reported taking one up. In addition one resident said she would have to simply say that she was not sure if she had taken up a Health Check specifically but she had received a check up from her GP. 57% of all residents who had not had a health check (n=35) reported that based on the information provided by the researcher, they would like to have one. Reasons for not wanting to take up a Health Check are summarised in table one. The most common reason for not wanting to have a Health Check was the resident's perception that they already knew enough about their health. In many cases this was because the residents were already visiting their GP or another health professional regularly.

Reason for not wanting to take up a Health Check	**Number of residents (total who did not want to take up a check =15)**
Already know enough about my health	11
Don't think the service will be very good	2
Embarrassed to talk about my health	1
Don't have time	1

Table one: Reasons for not wanting to take up a Health Check

Of the very small number (n=6) of residents who had accessed a Health Check, all but one said that they would recommend the check to others, essentially because they believed that "prevention is better than cure." However the one respondent who stated that they would not recommend a Health Check felt strongly that the check was process-driven, inadequately individualised, delivered by someone who did not have the capability to respond to patient questions and who gave advice she found condescending.

Qualitative Findings

Based on the qualitative data the central theme identified by this work was that residents desire a more **"person centred approach"** to the promotion of wellness in the community than is currently reflected in the Health Checks programme. Figure 1 below summarises the findings.

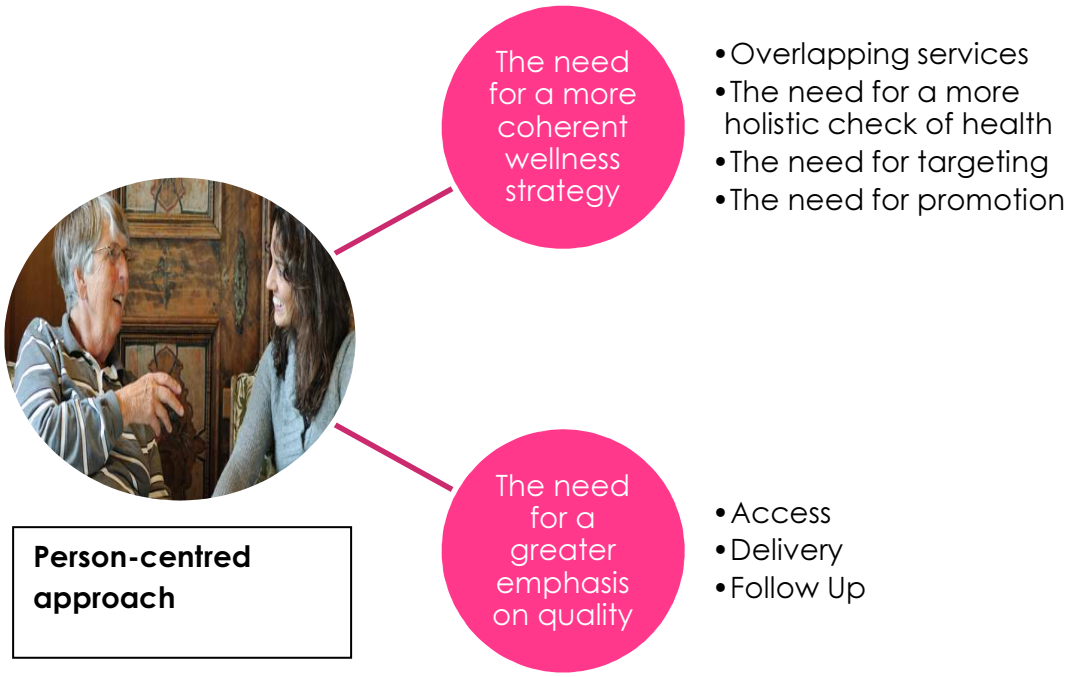

Figure 1: Summary of Residents' Views of the Health Checks Programme

What follows is a narrative describing the findings and summarising the sub-themes using quotes from the interviews and focus groups.

The need for a More Coherent Wellness Strategy

Residents were supportive of the concept of Health Checks but had questions and concerns about the programme's place in wider wellness strategy. Four sub-themes emerged:

1. Overlapping services

2. The need for a more holistic check of health
3. The need for targeting
4. The need for promotion

Overlapping Services

Residents expressed some confusion about the specific role of Health Checks. People at the older end of the eligible age range often reported that they believed that their GP already had good oversight of their general health. These residents reported that they were offered the same checks included in the Health Check already, often on an annual basis.

> "You get that anyway with your older person check....My GP is always saying: 'You haven't had your blood pressure taken for a while let's do it now or it's time for another blood test.' I don't understand what this Health Check adds."

By contrast other older people were concerned to ensure that they had access to more frequent checks as they got older and were concerned that they were often dismissed by the health system. This seemed to be more about the lack of intervention they were offered rather than lack of access to checks.

> "They don't' want to know you once you get older.....they say oh don't worry that's just old age. But we do worry and we want to be well."

Other residents with pre-existing non-cardiovascular conditions also commented that the blood pressure and height and weight check elements of the Health Check were already carried out as part of their routine reviews. Community groups such as the Barnet Asian Old People's Association already had a nurse doing weekly visits who checked blood pressure, height and weight and provided advice and support to members.

People were not only confused about the purpose of the Health Check in this context but also concerned about value for money.

> "Do they know the people they need to target? It doesn't seem like they do. If the Dr doesn't know the person has already had these checks then money is being wasted."

<u>The Need for a More Holistic Check of Health</u>

People felt that the term "Health Check" was very misleading in relation to this specific programme. Residents were disappointed that the check did not look at health more holistically.

Some people felt that more wide-ranging blood tests would be useful as a general indicator of health. The following were mentioned specifically; full blood count, urea and electrolytes, liver function tests and thyroid function tests. People acknowledged that this would make the Health Check much more expensive but argued that targeting the checks at a smaller group of at risk people whilst making the check more wide-ranging might be preferable and this will be explored further in the next section.

Specific concerns were raised about the missed opportunity to identify mental health problems:

> "It could be a way to reduce stigma about mental health. You come and have your health checked and of course that includes mental health. It shows people that professionals think it's important."

> "What about depression? It can be very black for some people and they probably don't feel like they can bother their GP with that. Professionals should check and make people feel like they can talk about it; you know it's ok to ask for help."

> "You withdraw, you don't tell anyone and then it's too late. If it was normal to be asked, people might feel..... you know like they're not a burden."

Another specific area of concern was musculoskeletal health particularly amongst those with very physical jobs or caring responsibilities:

> "How much do back problems cost this country? If you could get quick access to massage or physio from a routine check it could save pain and money."

> "What about bone health and the huge problems we now have with vitamin D?"

Residents also talked about joining Health Check results up with findings from all the other screening and checks they experienced to give them an overall picture of their health. Some residents linked this with concerns around lack of effective investment in NHS IT systems.

> "It's not joined up; the parts of the system don't talk to each other. You need a computer programme that takes all the test results and creates a picture of your health so your GP can see straight away how it all links up."

The Need for Targeting

Residents felt that the eligible age-range seemed somewhat arbitrary. They were also interested in research to explore population groups that would benefit most from a Health Check and felt intuitively that children and younger people ought to know about risk and be supported to manage their personal risk factors.

> "Why is it everyone 40-74? Don't you need to catch these things younger?"

> "You could argue you should be at mums and toddlers and in the schools with all this. Especially about food and activity."

> "They need a better idea which groups would benefit most.....I mean these diseases aren't they more common in some groups."

People were concerned about the burden that the scheme was placing on the healthcare system and furthermore the additional burden associated with carrying out the more holistic, person centred Health Checks that they felt were necessary to be of real benefit.

> "There is an issue about targeting.....If we really cannot afford to do it properly then maybe a scaled down version is needed."

Some people felt that there was already enough information about priority health problems in the community and that funding should be targeted on known problems. For example one resident with experience of healthcare delivery said:

> "For me the most important thing is obesity....regular weight checks....support groups....partnerships with organisations like Weight Watchers."

Other residents agreed:

> "Weight is at the centre of it all. If you're overweight you're more at risk of heart disease, diabetes, cancer, back and knee problems. Regular weight checks and advice when you need it, plus support over time might be a better way to spend our money."

The Need for Promotion

As previously discussed there was poor awareness of Health Checks as a brand and people were not clear about whether they had received a "Health Check" or just some other routine check carried out at their GP surgery. Residents made some interesting suggestions about how the scheme could be publicised and these are summarised in table two.

Potential approaches to promoting Health Checks suggested by residents
Topic on local "talk radio" or national television "magazine" shows
Article in local newspapers and magazines
Fliers in public places such as supermarket community notice boards, libraries, pharmacies, places of worship.
Information for Pharmacists to handout to customers

Table Two: Suggested Approaches to Promoting Health Checks

People also took the view that the name did not really reflect the aims of the check.

> "It's not a **health** check, it's a heart, diabetes and kidney check with dementia tacked on....it just doesn't make sense."

> "The real question is, what is the objective of Health Checks?"

Furthermore some people felt that screening was much more compelling as a concept than a check, although they also felt that it was not currently clear to them what was being screened as part of the Health Checks programme. This meant that people could not make a judgement about the potential benefits for them so felt this would be likely to reduce the take up.

"I just get this thing through the post and I think what's this about and why is it important for me?"

The Need for a Better Quality Service

Residents were concerned that the focus seemed to be on the number of checks offered and the number taken up. They were more concerned about the quality of the check and 3 sub-themes were evident from the data:

1. Access
2. Delivery
3. Follow Up

Access

Residents talked about needing access to Health Checks at convenient times and in convenient locations. Younger resident stated a preference for evening and weekend appointments or the opportunity to have a Health Check at their place of work or at job clubs and job centres. This was a particular concern for people who had experienced unemployment or feared being made unemployed:

"If you're looking for a job or trying to keep a job. It's hard to take time out; your boss is just not going to allow it. Going to the doctors when you're well, they would laugh and think you're lazy."

Some people recognised the funding challenges associated with offering health checks at work, given that workplaces include people from a variety of Local Authority areas. However they wondered if a funding model could be designed that

would make the change possible, for example, top-slicing or giving the budget to individuals. This latter point was also made in relation to the option for self-assessment using calibrated blood pressure monitors and home blood sugar and cholesterol testing kits available at pharmacies.

> "Why not pay the patient and give them options where to get their check. They can then pay the provider or buy stuff to check themselves."

Residents who regularly attended local community groups wondered if checks could be offered at their routine meetings.

> "If you're a carer you can't get out so much, we need things like this at our meetings."

Some community groups already had visits from a nurse who carried out height, weight and blood pressure checks and let people know what they should do if there was a problem. This service did not seem to be part of the "Health Checks" scheme. People also commented that GP surgeries did not seem to be the right vehicle for Health Checks as the system was already over-burdened.

> "If your GP is doing all these Health Checks it's going to be even more impossible to get help when you're sick."

Older people were concerned about their ability to attend yet another appointment and again wanted the service at groups they already attended or in libraries, supermarkets and even pubs. The benefits of mobile units were frequently

mentioned in relation to providing Health Checks at all the venues discussed in this section.

> "What about mobile units like they use for blood donation...with a clear NHS logo so you know it's NHS Health Checks."

Residents were also concerned about the difficulties they might experience accessing a Health Check and talked about times when they had tried to get health services that they were entitled to but met with administrative barriers, which they found very distressing. Examples included trying to get breast cancer screening when they'd had a lump previously and having to fight for several years to get access, requesting a blood pressure check and being given a six week wait, requesting a cholesterol check because of concerns associated with family history of heart disease and getting "lost in the system." People were clear that the system needed to be ready to deliver before Health Checks were more widely publicised or there was a risk of unnecessary stress and worry for those struggling to get a Health Check in a timely way. One resident reflected on previous difficulties with breast screening and all the distress that caused and there was a clear view that action should be taken to minimise the chance of missing people or miss-reporting risks.

Delivery

Residents talked about who should deliver the Health Check and the need for an individualised approach.

People who had experienced a Health Check described a standardised computer-based approach. Most residents did not see any risks associated with this but one

respondent was very concerned that the Healthcare Assistant who delivered her check was not able to answer her questions and seemed to be using a "script." This respondent reported finding the advice given as "condescending" and "not at all personalised." Other residents at this focus group agreed that this approach seemed concerning and talked about the need for the check to be conducted by a "registered professional." Doctors, Nurses, Pharmacists and Dietitians were mentioned as suitable staff to carry out the check. People talked about the need for a "one stop shop" where you could get the results of the check and then immediate access to professional advice and support. There was concern that knowing the results of the check without swift access to credible, professional advice and support risked causing people unnecessary stress and worry.

Another resident talked about the need for the check to be collaborative, involving the person having the check in working out a plan of action with a professional. This was also a theme at a group for older people.

> "Whose health is it? It's mine not theirs, I know what works for me. Is this really about me or ticking a box for politicians. I feel very sceptical"

People were concerned that Healthcare Assistants who often deliver the checks would not have the knowledge or skills to work collaboratively with individuals as they believed they were trained to follow a process and give standard answers.

> "I want to be able to ask questions about what matters to me and know the person has the knowledge to answer. I can read words on the computer screen myself... that's not it for me."

At one focus group this thinking triggered further discussion about the benefits of doing the actual assessment part of the Health Check online with the option to then click to see a list of local advice and support sessions. Some residents thought this support could be provided partly in groups based on individual risks.

> "I've had some experience of cardiac support groups.....it was very good and could be pushed out."

Follow Up

Residents believed that any interventions stemming from Health Checks needed to be free, implemented quickly and be reasonably long-term.

The cost and long term nature of support was a particular issue in relation to weight management and exercise on referral. People talked about these areas requiring initial and then intermittent, ongoing professional advice supported in between by people who would "walk alongside" them in order to help them stick with the changes they needed to make. For example one resident was shocked at the cost and short-term nature of the exercise on referral programme.

> "It's still £12.95 a month and it goes up after a few months...how can you do that when you are on benefits? You need someone to help you stick to it and that needs to be available to everyone."

Other residents had enjoyed being part of walking groups but expressed concern that these were not supported long term and relied on the good will of residents.

"I used to lead a walking group and the council said you know you take it over. But I can't do that I've got my own health problems and stress I need to think about me."

Residents who were part of community groups thought that long term funding for exercise classes at their regular meetings might deliver better value for money and would allow the sessions to be tailored to the needs of the group:

"You may have had an accident and people don't realise you need to build up your muscle strength....Lots of us here have had accidents if we could have supervised exercise it would help us get fit and prevent us having more falls."

People were very clear that these interventions needed to have strong professional oversight to ensure that the advice was correct and useful.

"Your needs must be followed up by the relevant professional so that you get appropriate information and accurate answers to your questions."

People were also very keen to ensure that GPs remained at the fulcrum so they could provide oversight for all the interventions.

"Your GP is the central point and has a duty of care."

Good IT support was highlighted as being essential to successful delivery.

> "If this was being done properly the computer would note the results and automatically refer for the right follow up."

Summary

This work has shown that the residents of Harrow and Barnet have a strong interest in taking care of their health and some insight into the funding constraints of current times. People were keen to capitalise on all the screening and routine checks that were already taking place by pulling together the findings to give people and their GPs a clear picture of their health from a broad perspective. People clearly needed screening and checks to be provided at convenient times and in convenient places and the GP surgery was seen as only one potential venue, with mobile units offering benefits to working people, older people, carers and those with existing health problems.

Residents made a distinction between the assessment part of the health check and the ongoing advice and support. There was a strong view that advice and support must have relevant professional oversight whilst some of the long-term motivational elements could be supported by peers, who were in turn well supported financially and administratively.

These findings provide important information for Public Health and wider wellness strategy development as well as information to help shape the Health Checks programme specifically.

Discussion and Areas for Further Work

The findings from this community engagement work in Barnet and Harrow reflect and further illuminate some of the key themes in recent publications about the ongoing development of Health Checks (Department of Health and Public Health England 2013, Public Health England 2013 a and b, Public Health England and Research Works 2013) as follows:

1. Marketing and promotion
2. Value for money
3. Innovative approaches to delivery
4. The need for effective IT
5. Competency of providers

This next section reflects on these themes in the light of the findings of this work and makes suggestions for local consideration.

Marketing and Promotion

Public Health England (PHE) has developed an action plan for ongoing implementation of NHS Health Checks (Public Health England 2013 b.) Action two states:

> "PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the NHS Health Check brand, establishing the effectiveness of different approaches to

recruitment and testing marketing campaigns to support uptake locally and nationally."

This community engagement work showed that people were not familiar with Health Checks as a brand but also that they wanted to understand more about the objectives of the Health Checks programme from their perspective as individuals. For the Health Checks programme to be successful, GPs will need to be convinced of the value at a population level and the public will need to understand the benefits for them personally. There is a danger that promotional work might focus too much on health benefits for the nation and too little on health benefits for individuals, families and communities.

Value for Money

PHE intend to carry out further work to refresh the economic case for Health Checks (Public Health England 2013 a and b.) Residents from Barnet and Harrow were particularly concerned about overlap with other screening services and checks and will want to see that this has been taken into account. Furthermore residents highlighted the potential benefits of a more joined up approach to supporting wellness, capturing all the checks and screening already taking place, allowing Health Checks to be individualised to fill in any gaps.

PHE acknowledge the need to consider indirect harm from generating an increased workload in primary care and the cost of investing in Health Checks at the expense of other Public Health initiatives (Public Health England 2013 a.) These were both issues raised by residents in this study who for example questioned the benefits of a

Health Check programme targeted at those aged 40-74 compared to the benefits of investing more in diet and lifestyle initiatives with children and younger people.

Furthermore residents highlighted concerns about the need for greater investment in lifestyle initiatives to support people identified as being at risk to make long term lifestyle changes. In particular residents felt it was important that interventions were free of charge to ensure that everyone could benefit and also that support to help people change their lifestyles was available on a more long-term basis. This will require innovation in delivery to develop schemes that are both affordable and effective. Residents would have much to offer in the co-development of such schemes and longitudinal exploration of the benefits.

Innovative Approaches to Delivery

A recent report (Public Health England and Research Works 2013) highlighted that in some areas, good uptake of Health Checks was thought by commissioners to be associated with the following:

1. Commissioning of community teams to go to community centres, shopping centres, leisure centres, church groups, farmers' markets, football clubs and workplaces to deliver Health Checks.
2. Taking a Health Bus to supermarket car parks and other public places to deliver Health Checks to passing members of the public and others who had been given the Health Bus itinery by their GP surgery.
3. Offering early morning or evening clinics to enable working people to access a check.

All these points were highlighted by residents in this study and it would be interesting for local commissioners to explore areas where these approaches to delivery have been effective and consider the implications locally. Public Health England is also exploring approaches to commissioning and delivery (Public Health England 2013b) and it will be interesting to participate in this work and consider the findings as they evolve.

The Need for Effective IT

Effective IT will be important for identifying people in the target population, collating data and information about individual risks, ensuring that individuals get access to all the relevant follow up in a timely way, evaluating the benefits of the programme and aggregating information from individual to population level. PHE talk about exploring:

> "....the use of innovation and IT technologies to allow the seamless flow of NHS Health Check data across the health and social care system." Public Health England 2013 b

This study showed that residents wanted IT solutions to go further than this joining up data and information from other checks and screening initiatives in order to provide a more holistic view of their health. Whilst it is likely that the technology exists to achieve this, the health and social care system has experienced significant challenges in joining up IT across provider organisations. Despite the challenges the findings of this work indicate that achieving a more joined up approach should remain an aim.

Competency of Providers

Whilst this work only reflects the views of a very small number of people who have actually had an NHS Health Check it is interesting that the issue of competence was raised by residents. One respondent in particular was very keen to raise this issue and their views do mirror a key statement in PHEs Implementation Review and Action Plan (Public Health England 2013 b.) PHE state that:

> "NHS Health Checks can and have been provided by a range of health professionals (GPs, nurses, healthcare assistants, volunteers etc). Further work needs to be undertaken to understand the value of using different types of professionals for different populations.....Some practitioners have suggested that they do not feel qualified to undertake lifestyle assessment discussions"

Several residents who had not had a Health Check felt that delivery of the advice and support element of the check had to be managed by a registered professional. Residents also talked about the potential for using Dietitians and Pharmacists to support Health Check delivery. Residents felt that it was important for advice and support to start seamlessly in the context of the discussion of risk and so stressed that registered professionals needed to have responsibility for this. Implementing this type of approach needs to be considered in discussion with Professional Regulatory Bodies such as the General Medical Council, the Health and Care Professions Council, the Nursing and Midwifery Council and the General Pharmaceutical Council as well as Health Education England and the local LETB, Health Education North West London and education providers.

Conclusion

There is currently a ground-swell of activity around Health Checks both nationally and locally and this presents an opportunity for debate and action to make improvements to the programme. Residents are the people this initiative seeks to benefit at individual, local and Borough-wide population levels. There are great opportunities for collaborations across local Borough boundaries and for strong and meaningful community engagement to develop the programme and design ways for it to link up with other wellness initiatives both in terms of assessing risk and implementing lifestyle change.

The researcher would like to thank local residents involved in this work for their time, honesty and innovative ideas which can now help shape the future of Health Checks across the Boroughs of Barnet and Harrow.

Appendix One: Groups that Participated in the Engagement

Harrow Carers

Harrow Healthwatch

Beacon Community Centre on the Rayner's Lane Estate

Pinn Medical Centre PPG Executive

Harrow Mencap

Barnet Asian Old People's Association

Barnet Voice for Mental Health

Barnet Centre for Independent Living

Barnet Healthwatch

Grahame Park Estate Work Club

GP Patient Participation Groups across Harrow and Barnet via Practice Managers and PPG Chairs.

Appendix Two: Fliers for Focus Groups

Are you aged 40-74? Are you interested in keeping Barnet healthy?

Everyone aged 40-74 is entitled to a Free Health Check to help prevent heart disease, kidney disease and diabetes.

- What do you think about this idea?
- How could we let people know about Health Checks?
- Do you have experiences to share about trying to book a Health Check or having a Health Check?
- Perhaps you think there are better ways to keep Barnet Healthy?

Come and share your views

On: 12th November 2013 at 11-12 noon
In: Committee Room 1, Hendon Town Hall, The Burroughs, NW4 4AX

To book a place or for more information please contact:
stephanie.fade@whatmatterscubed.com

Are you aged 40-74? Are you interested in keeping Harrow healthy?

Everyone aged 40-74 is entitled to a Free Health Check to help prevent heart disease, kidney disease and diabetes.

- What do you think about this idea?
- How could we let people know about Health Checks?
- Do you have experiences to share about trying to book a Health Check or having a Health Check?
- Perhaps you think there are better ways to keep Harrow Healthy?

Come and share your views
On: Tuesday 19th November 12.30-13.30
At: Committee Room 5, Harrow Council, Station Road, Harrow, HA1 2XY

Travel costs and parking will be reimbursed

To book a place or for more information please contact:
stephanie.fade@whatmatterscubed.com

Appendix Three: Survey Questions

Health Checks Community Engagement Survey

1. Male ❑ Female ❑
2. If you are happy to give it, we would like to know your postcode. We would like this information to ensure that we consider views from across the Borough.

Postcode	

3. If you are happy to tell us, we would like to get an idea of your age

We would like this information so that we consider views from all ages of people entitled to a Health Check in the next 5 years	
35-40	❑
40-50	❑
50-60	❑
60-70	❑
70-74	❑

4. If you are happy to share your ethnicity/heritage with us, please let me know which statement best describes you

White		**Black or Black British**	
British	❑	Caribbean	❑
Irish	❑	African	❑
Any other White background (✓ AND WRITE BELOW)	❑	Any other Black background (✓ AND WRITE BELOW)	❑
Mixed		**Asian or Asian British**	
White & Black Caribbean	❑	Indian	❑
White & Black African	❑	Pakistani	❑
White & Asian	❑	Bangladeshi	❑
Any other Mixed background (✓ AND WRITE BELOW)	❑	Any other Asian background (✓ AND WRITE BELOW)	❑
Chinese and Other ethnic groups			
Chinese	❑	Other ethnic group (✓ AND WRITE BELOW)	❑

5. Have you heard of NHS Health Checks?

   Yes ❑ **Go to Q6** No ❑ **Go to Q7**

6. Have you had a Health Check?

   Yes ❑ ***Go to Q9*** No ❑ ***Go to Q7***

7. Would you like a Health Check (An explanation of the check will be given first as required.)

   Yes ❑ ***Please contact your GP and thanks for your time*** No ❑ ***Go to Q8***

8. Please help us understand why you think the Health Check is not right for you

   a) I don't have time ❑
   b) I already know enough about my health ❑
   c) I don't think the service will be very good ❑
   d) It might make me worry about my health ❑
   e) I find it embarrassing to talk about my health ❑
   f) Other (please describe) ❑

Thank you for your time.

9. Would you recommend a health check to other people?

   Yes ❑ ***Go to Q10*** No ❑ ***Go to Q11***

10. Please help us understand why you would recommend Health Checks

11. Please help us understand why you would not recommend Health Checks.

References

Department of Health and Public Health England (2013) NHS Health Checks Programme: Draft Best Practice Guidance. Department of Health.

London Health Observatories (2010) Index of Multiple Deprivation Scores by Ward. http://www.apho.org.uk/resource/item.aspx?RID=111280 London Health Observatories.

Public Health England (2013a) NHS Health Check: Our Approach to the Evidence. Public Health England.

Public Health England (2013b) NHS Health Checks: Implementation review and action plan, Public Health England.

Public Health England and Research Works (2013) Understanding the implementation of NHS Health Checks: Research Report. Public Health England.

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AGENDA ITEM 12

Meeting	Health Overview & Scrutiny Committee
Date	12 March 2014
Subject	**Health Overview and Scrutiny Committee Forward Work Programme**
Report of	Overview and Scrutiny Office
Summary	This report provides Members with the Health Overview and Scrutiny Committee Forward Work Programme.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards affected	All
Enclosures	Appendix A – Health OSC Forward Work Programme
Reason for urgency / exemption from call-in	Not applicable
Key decision	N/A

Contact for further information: Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014

1. RECOMMENDATION

1.1 That the Committee consider and agree the Health Overview and Scrutiny Committee Forward Work Programme attached at Appendix A.

2. RELEVANT PREVIOUS DECISIONS

2.1 None.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

5.2 The Council is required to give due regard to its public sector equality duties as set out in the Equality Act 2010 and, as public bodies, health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.

6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of the report.

7. LEGAL ISSUES

7.1 None in the context of the report.

8. CONSTITUTIONAL POWERS

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) 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.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

9. BACKGROUND INFORMATION

9.1 Under the current overview and scrutiny arrangements, the Health Overview & Scrutiny Committee are required to ensure that the work of Scrutiny is reflective of Council priorities, as evidenced by the Corporate Plan and the programme being followed by the Executive. The Committee are requested to consider and agree the items contained within the work programme.

9.4 Future meeting dates for 2013/14 are:

12th May 2014

10. LIST OF BACKGROUND PAPERS

10.1 None.

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London Borough of Barnet

Health Overview and Scrutiny Committee

May 2013 – May 2014

Contact: Andrew Charlwood Tel: 020 8359 2014 email: andrew.charlwood@barnet.gov.uk

Subject	Decision requested	Cabinet Member	Author
12 March 2014			
GP Services at Finchley Memorial Hospital	NHS England have been requested to make a written submission to the Committee on: i) the decision to relocate Dr Thwe's practice to Finchley Memorial Hospital; ii) progress made in relocating GP practices into the vacant space at Finchley Memorial Hospital; and iii) the impact of dispersing the patient lists of two practices in the West Finchley area	N/A	NHS England
Site Issues at Finchley Memorial Hospital	NHS Property Services and Community Health Partnerships have been requested to make a written submission to the Committee on site issues at Finchley Memorial Hospital	N/A	NHS Property Services and Community Health Partnerships
Barnet Healthwatch Enter and View Reports	To consider enter and view reports from Barnet Healthwatch	N/A	Barnet Healthwatch
Annual Report of the Director for Public Health	To consider the 2013 Annual Report of the Director of Public Health: Barnet and Harrow on the Move	Cabinet Member for Public Health	Director of Public Health
Public Health Commissioning Intentions	To consider the commissioning intentions for Public Health in Barnet for 2014/15	Cabinet Member for Public Health	Director of Public Health
NHS Health Checks Scrutiny Review	To receive the final report of the joint Barnet / Harrow NHS Health Checks Scrutiny Review	N/A	Scrutiny Office

Subject	Decision requested	Cabinet Member	Author
12 May 2014 (NHS Quality Accounts)			
Barnet and Chase Farm Hospitals NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Barnet and Chase Farm Hospitals NHS Trust for 2013/14	N/A	NHS
Barnet, Enfield and Haringey Mental Health NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Barnet, Enfield and Haringey Mental Health NHS Trust for 2013/14	N/A	NHS
Central London Community Healthcare NHS Trust Quality Accounts	To receive and comment upon the Quality Accounts from Central London Community Healthcare NHS Trust for 2013/14	N/A	NHS
North London Hospice Quality Accounts	To receive and comment upon the Quality Accounts from North London Hospice for 2013/14	N/A	North London Hospice
Royal Free Hospital NHS Foundation Trust Quality Accounts	To receive and comment upon the Quality Accounts from Royal Free Hospital NHS Foundation Trust for 2013/14	N/A	NHS
Foundation Trust Status Updates	To receive updates on the attainment of Foundation Trust status from NHS partners at: • Barnet and Chase Farm Hospitals NHS Trust • Barnet, Enfield and Haringey Mental Health Trust • Central London Community Healthcare NHS Trust	N/A	NHS Trusts

Subject	Decision requested	Cabinet Member	Author
Unallocated Items			
NHS Trusts Performance	To receive a report on the performance of NHS Trusts providing services to Barnet residents against the NHS Outcomes Framework	N/A	Scrutiny Office / NHS Trusts
Health and Wellbeing Strategy	TBC	Cabinet Member for Public Health	Director for Public Health