MEETING HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME MONDAY 28TH OCTOBER, 2019 AT 7.00 PM
VENUE HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

Chairman: Councillor Alison Cornelius
Vice Chairman: Councillor Linda Freedman

Councillors

Golna Bokaei
Geof Cooke
Saira Don
Barry Rawlings
Lisa Rutter
Alison Moore
Anne Hutton

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore the deadline for public questions or comments is **Weds 23 October**. Requests must be submitted to tracy.scollin@barnet.gov.uk.

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

Andrew Charlwood – Head of Governance

Governance Services contact: Tracy Scollin, 020 8359 2315

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ASSURANCE GROUP

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10.	Alternative Personal Medical Services (APMS) APMS GP Practice in Cricklewood Kay Matthews, Chief Operating Officer, Barnet CCG	
11.	Ravenscroft Medical Centre Kay Matthews, Chief Operating Officer, Barnet CCG	
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Decisions of the Health Overview and Scrutiny Committee

11 July 2019

Members Present:-

AGENDA ITEM 1

Cllr Alison Cornelius (Chairman)
Cllr Linda Freedman (Vice Chairman)
Cllr Golnar Bokaei
Cllr Felix Byers (Substitute)
Cllr Alison Moore
Cllr Anne Hutton
Cllr Barry Rawlings
Cllr Geof Cooke
Cllr Saira Don

Apologies for Absence

Cllr Lisa Rutter

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

The Committee **RESOLVED** to **AGREE** the minutes as an accurate record.

Matters arising from the minutes:

The Governance Officer would contact Kate Wilkins of Central London Community Healthcare (CLCH) to request the outstanding information on the Quality Account.
Action: Governance Officer

The Governance Officer would follow up an action required of the North London Hospice (NLH). Note: following the meeting Fran Deane, Director of Clinical Services at NLH, confirmed that the two services that are fully funded are the Palliative Care Support Service and the Haringey Community Team. The North London Hospice had contacted Homeless Action in Barnet regarding the referral process to the Hospice.

A Member referred to the HOSC's feedback to CLCH (detailed on Page 9 of the Minutes of the HOSC meeting held in May 2019):

The Committee noted that the Trust had received a CQC rating of 'Requires Improvement' in the 'Safe' domain in Community Health Services for Children and Young People, which was due mainly to higher-than-recommended caseloads within the Health Visiting Service.

Given the higher than average caseload how could it be ensured that families at risk are prioritised? The Chairman asked Cllr Hutton, as a Member of the Children, Education

and Safeguarding Committee, to note this. The Chairman would also email Cllr Longstaff about this.
Action: Chairman

2 **ABSENCE OF MEMBERS (Agenda Item 2):**

Apologies were received from Cllr Lisa Rutter, who was substituted by Cllr Felix Byers.

The Chairman welcomed Cllr Barry Rawlings as a new Member of the HOSC Committee.

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

None.

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

None.

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

None.

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

None.

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

Minutes of the meeting on 21 June were not published at the time of the meeting but would be circulated to the HOSC as soon as they were available and also would be included with the 28 October Agenda.

8 **ROYAL FREE LONDON NHS FOUNDATION TRUST (Agenda Item 8):**

- **CQC Report**
- **Quality Account 2018-19 update**

The Chairman invited the following to the table:

- Dr Chris Streather - Chief Medical Officer and Deputy Chief Executive, Royal Free London NHS Foundation Trust

Dr Streather reported that the final version of the RFH Quality Account was on the Trust's website with both Barnet and Camden HOSCs' comments incorporated. He presented his Briefing Paper on the CQC Inspection Report and referred to the HOSC's comments on their Quality Account.

Dr Streather noted that the Trust has a one-year contract with the Community Care Foundation which is working to help to formally engage patients in its improvement work.

The Chairman noted that it was helpful to see the actions outstanding but that some of the issues raised by the CQC were avoidable as they had already been noted as requiring action. Dr Streather agreed that some of the criticisms were ‘own goals’. The ‘must do’s’ from the recent CQC inspection were all complete – this included mandatory training and medicines management issues. Each of the three Trust’s sites had developed an improvement plan following the report as detailed on his Briefing Paper.

At a meeting with the CQC following the publication of its Report, ‘should do’s’ had also been discussed by the Trust. These were good practice but not compulsory; Trusts not doing the actions had to give reasons for not doing them. Unfortunately, the Trust had failed to provide these explanations in some areas.

The CQC had noted that staff were adequately trained and safeguarding was good.

The Chairman asked about actions and how the public would be notified, for example in an online report? Dr Streather reported that an Action Plan would be circulated to commissioners and this was discussed with the CCG monthly. He would respond following the meeting on what might be the best public forum for sharing the information.
Action: Dr Streather

A Member asked about the Trust’s position on Never Events and equipment maintenance. Dr Streather responded that the CQC had fed back in its Report that the Trust did well in investigating serious incidents and this was an example of ‘very good practice’. The Trust had had two Never Events in the past eight months and had previously gone a whole year without one Never Event, which was good for a large complex site. Previously there had been a cluster of Never Events so this demonstrated that the learning is embedded.

Dr Streather reported that money had been spent on equipment to ensure that patients could not be given air instead of oxygen, as this had previously been raised as a concern. As Chairman of the Medical Equipment Board, Dr Streather had secured a small increase in the budget for medical equipment. In addition, the Trust’s Lead for Clinical Governance, who was in contact with the CQC, had been invited to sit on the Medical Equipment Board. New criteria for prioritising medical equipment had been adopted so that the ‘should do’s’ could be prioritised. A Member asked about testing equipment and whether an Action Plan was in place. Dr Streather did not have details at the meeting but offered to respond afterwards.
Action: Dr Streather

A Member enquired about the impact that high staff turnover has on mandatory training. Dr Streather noted that the pressures were greatest in nursing and this could be difficult. The Trust was looking creatively at recruitment, but he said it did not have problems attracting staff. Due to the competitive market, retention of staff was a problem particularly in the first year of employment, whereas longer term staff tended to be loyal. The Trust had begun some initiatives to welcome staff and to provide some subsidised accommodation. It was working in partnership with the Institute for Health Improvement on improving staff morale and retention.

Dr Streather reported that the Trust had had discussions with the CQC about the behaviour of surgeons in operating theatres at the Royal Free Hospital. The Trust had

taken action regarding unacceptable behaviour. The Staff Survey had shown an improvement over the last year, with staff reporting improvements in how they felt they were being treated. A review of the behaviour of surgeons had also formed part of the response to the Never Events and none of the recent Never Events had taken place in operating theatres. The Trust has a comprehensive program of training videos showing scenarios where behaviour might cross a line and the CEO had attended meetings with over 30 staff groups to show the videos and discuss these. It was too early to see their impact on the reporting of bullying and harassment but early indications showed improvements.

A Member asked what the reasons were for the failure of all staff to complete mandatory training and was concerned about the impact on patient care. Dr Streather noted that the CQC report showed that staff were aware of the essential things they needed to know. He suggested the following reasons for non-completion of mandatory training by all staff: the leadership team needed to take training more seriously and communicate this to staff and also staff struggling to meet their targets should not neglect their own training.In the past, there had not been enough access to PCs for online training. This had been corrected. He noted that Chase Farm had performed better than Barnet and the Royal Free in this respect as they had new computers.

Dr Streather reported that there continued to be a growing number of patients attending A&E. The Trust had been receptive and learnt from best practice such as triaging patients. The Hampstead site was slightly ahead of the London average for A&E targets. Barnet Hospital was more difficult with often over 400 patients a day attending A&E whereas it was only designed for 3/5 of this number. It was hoped that some investment could be made ahead of the winter and discussions were ongoing with Barnet CCG. Attempts to get patients not to turn up at A&E when their condition did not warrant urgent treatment had not been successful so far. Sufficient capacity was needed in urgent Primary Care in the medium term.

Dr Streather also commented on the Cancer 62 Day Referral to Treatment Target not being met. He said that a Cancer Clinical Practice Group had been set up which he hoped would improve this.

The Chairman thanked Dr Streather for his open responses and invited him to attend the HOSC meeting on 12 December for an update on progress so far on the Quality Account and on the CQC. Dr Streather agreed to attend.
Action: Dr Streather

RESOLVED that the Committee noted the verbal report.

9. **SUICIDE PREVENTION IN BARNET (Agenda Item 9):**

- **Draft Suicide Prevention Plan 2019-20**
- **Report**

The Chairman invited the following to the table:

- Dr Jeff Lake - Consultant in Public Health, LB Barnet
- Dr. Patricia McHugh - Barnet, Enfield and Haringey Mental Health Trust

- Professor Liza Marzano – Associate Professor in Psychology, Middlesex University
- PC Carl Ford - Mental Health Police Liaison Officer, Metropolitan Police
- Ms Sharon Thompson – Community Services Manager, Barnet, Enfield and Haringey Mental Health Trust
- Ms Seher Kayikci – Senior Health Improvement Specialist, LB Barnet

Dr Lake reported that the National Suicide Prevention Plan appeared to have shown some improvements and a clearer picture had emerged on the most useful actions needed locally and regionally. Significant developments had been made as part of the London-wide Suicide Prevention Framework, including the development of the Thrive London information-sharing portal for partners to exchange information where possible suicide was suspected. Targeted help was available for individuals affected by suicide particularly given that such individuals were known to also be at increased risk of suicide.

Dr Lake presented Barnet's Action Plan which included work on self-harm and ideation, and a review of safety planning for discharge after an episode of self-harm or a suicide attempt. There was also support for those bereaved or affected by suicide and a review of the data would be undertaken to try to identify any hotspots in the Borough. A working group met annually and has six-month review meetings and workshops on particular topics.

Professor Marzano reported that Middlesex University was involved in several projects which make up a piece of work commissioned by the Samaritans and funded by the Rail Industry. Professor Marzano also worked with the media on its portrayal of suicide to try to avoid any unhelpful messaging. She was also keen to apply international work locally such as recommendations by the International Association of Suicide Prevention.

Ms Kayikci reported that as part of the Public Health Team in Barnet, her role is to contribute to the annual Suicide Prevention Report, review data and work with partners to make sure that actions set out are achieved.

Ms Thompson noted that she works directly with patients in collaboration with the CCG in Barnet and has operational responsibility for both inpatient and crisis patients. Her role involves ensuring safe discharge as well as producing support packages for affected families. She noted that a Serious Incident Review is undertaken for every suicide attempt, checking that the service had done all it needed to do including a review within 72 hours.

A Member asked about the risks in relation to SEND adults. Ms Thompson responded that a care coordinator was responsible for coordinating referrals and this depended on individual needs. Dr Lake added that some work had begun with the Lead Commissioner for Learning Disabilities on suicide with a report scheduled to be available around Autumn 2019.

A Member enquired about how referrals could be made. For example, the Samaritans were not able to make direct referrals. Ms Thompson noted that the highest percentage of referrals came from GPs and people could also self-refer. She added that the Samaritans' policy had changed recently in that if someone is thought of as an immediate risk the Samaritans can and should break confidentiality. However, callers were often anonymous. The Barnet Mental Health Team was working with Barnet Homes and other work was ongoing to find out what the barriers were to seeking help. For

example, some residents were not registered with GPs and for some their mental health needs were preventing them from accessing accommodation.

Dr Lake noted that the issue of confidentiality was reflected in the thematic review work that the working group had done. Families typically did not want schools to be notified of events or concerns and often they were not keen to share information. However, safeguarding concerns could override this.

Professor Marzano reported that Middlesex University has a Student Wellbeing Committee as suicide was something the University was very concerned about especially as there had been clusters of suicide at both Bristol and Canterbury Universities.

A Member asked how key performance indicators (KPIs) are driven. Dr Lake responded that these were not in relation to the number of suicides and no specific action was required by partners, although they were willing to do as much as they could. The workshops had been helpful in identifying opportunities. After a few years of creating Action Plans, clarity was appearing about appropriate actions. The Group was considering a KPI around training.

Ms Thompson reported that the Psychiatric Liaison Service had a KPI to hold a review within four hours of an incident. Middlesex University has a specific team that would deal with situations such as first presentation psychosis and this had strict KPIs. In addition, there were KPIs around the support of individuals affected by loss of someone to suicide. For example, these individuals were engaged in the investigation process and were asked how they felt their loved one was looked after.

Dr Djuretic noted suicide prevention should be seen as part of a continuum of mental health. She offered to consider possible wider KPIs with this in mind. Raising awareness of mental health was important. It was thought that one third of individuals with depression were not even registered with a GP.

Prof Marzano noted that Middlesex University was discussing how some of its metrics, for example on student engagement, might be used in suicide prevention. She was likely to have more information on this by the time of the next meeting.
Action: Governance Officer

A Member asked about red flags for suicide, for example, around eating disorders, drinking and self-harm? Ms Thompson responded that over half of suicides were a surprise and patients were not known to any services. Only one third of suicide patients were in contact with mental health teams prior to committing suicide. There are few strong indicators for risk factors, which makes preventing suicide a challenge, though there are a broad range of wider determinants. Safety planning rather than risk assessment was favoured, such as considering triggers that make individuals feel bad, support networks and plans to work with individuals to keep them safe. Ms Thompson reported that evidence-based psychological therapy and giving people support to manage behaviours when they need it were considered to be of benefit. She also stated that self-harm was on the increase.

Dr Lake reported that funding was in place for the intervention service due to be launched in March 2020. This would offer bereavement support and an information hub which should present opportunities. This should be helpful to the police who do not have the opportunity at present to see outcomes of their referrals even though every Met

Police Officer deals with someone in crisis. The service would link in with the Barnet Multi Agency Hub (MASH).

The Chairman enquired about suicide hotspots. Dr Lake responded that even though there was data, no suicide hotspots had been identified. The Transport Police were considering training its staff to help them to identify people at risk.

A Member asked about joint working with other Boroughs. Dr Lake responded that Barnet was collaborating and continuing to look for additional links.

The Chairman thanked all for attending and wished Dr Lake well in his new role as he would be leavingLB Barnet shortly.

RESOLVED that the Committee noted the Draft Suicide Prevention Plan and Report.

10. **URGENT CARE DEVELOPMENTS AND CRICKLEWOOD WALK IN SERVICE (Agenda Item 10):**

The Chairman invited the following to the table:

- Sarah D'Souza - Director of Commissioning, Barnet CCG
- Jenny Goodridge - Director of Quality and Clinical Services, Barnet CCG
- Beverley Wilding, Deputy Director, Urgent and Emergency Care, Barnet CCG

Ms D'Souza presented her report, together with a map and slides which are also part of the pre-consultation engagement.

She explained that the Cricklewood Health Centre comprises two contracts: one is an Alternative Personal Medical Service (APMS) and the other is a Walk In Service. Both contracts are coming to end in March 2020. The APMS contract is currently out to consultation and is managed through NHS England. Every five years, there is a standard process to either recommission as a GP Practice or to disperse the service. Many factors are considered such as capacity and demographics. The consultation ends on 19 July 2019. The Walk In Service decision making will take place after the decision regarding the GP practice is made.

The CCG's intention is to do some early engagement on wider national changes around urgent care. The consultation on the Walk In Service is scheduled to start on 29 July for 12 weeks, finishing on 18 October. A final decision is due to be made in December. Any concerns of the HOSC would be taken into consideration by the CCG as part of the public consultation.

It was pointed out that there was a description in the paper of the changing environment around urgent care and key facts on Cricklewood. Cricklewood Walk In Service is on the south west corner of the Borough close to both Brent and Camden.
Only 24% of the total number of patients using the Centre are registered with Barnet GPs whereas 58% are registered with Brent GPs, and the remaining 18% come from other boroughs. She also noted that the sort of care provided in the Walk In Centres was more limited than in other Walk In Centres as there are no diagnostics and the Centre can only provide episodic care in that it cannot refer to Secondary Care, provide prevention or access patient records.

Ms D'Souza noted that the CCG needs to consider the development of Primary Care Networks (PCNs) and the NHS Long Term Plan. Most of central Government additional funding would centre around PCNs. The funding would include additional community paramedics and pharmacists to support Primary Care and patients better. Care and Health Integrated Networks (CHINs) are already working well in Barnet. She added that the national picture involved changes to Urgent Treatment Centres including the renaming of Walk In and Urgent Care Centres. The national plan was for these services to become part of Community and Primary Care Services, with a focus on integration into local Primary Care networks. In addition, there had been heavy investment in additional Primary Care appointments with an extra 48,000 evening and weekend appointments being provided across ten hubs sites. There had been a 21% reduction in the number of people using the Cricklewood Walk In Service to under 20,000 annual attendances since 2016/17. She noted that the new Primary Care provision was probably absorbing some of the need for walk in care.

A Member enquired about the impact of the Brent Cross South development on the provision of a Health Care Centre in Cricklewood in light of this. Ms D'Souza noted that this would be considered as would the development in Colindale South. The Primary Care and Commissioning Team were working with the Council to ensure that Section 106 funds from developers are used effectively and in line with plans for a growing population. It would be important for the Primary Care Network in this area to be engaged in working in the context of this growing population.

Ms D'Souza noted that the current building for the APMS GP Practice was not ideal and there was no guarantee it would remain in the same location if the service was recommissioned.

A Member noted that £500,000 had been received by Barnet CCG for the Cricklewood Walk in Centre as the money follows the patient so, he was concerned at the idea that there is a problem if patients attend from other Boroughs. This would undermine the principle of the NHS which is based on need. The Brent Cross development was likely to take many more years to complete and there would need to be some provision in the meantime. Also, if the decision is made to move the Ravenscroft Medical Practice into Finchley Memorial Hospital, there would need be additional provision for any patients who did not wish to remain with the Practice.

The Member added that the developers' original plans for the corner site (currently occupied by the Walk in Centre) included a new Medical Centre, with some diagnostics. Also stopping these services in March 2020 would put more pressure on A&E. The area was known to have deprivation and was in great need. The Member was concerned that the report gave the impression that a decision had already been made. He also noted that the Walk In Service could be developed to include an X-ray. Ms D'Souza reiterated that the APMS consultation would be considered as part of the standard process required by NHSE but she understood the Member's concerns. She added that there were two excellent X-ray facilities in the Borough in community settings so the CCG would not look to replicate this elsewhere given the need, cost, staffing and estate required to develop such a facility.

A Member asked, that as Cricklewood had a growing and transitory population, why the CCG would not re-procure the GP Practice and use this to drive the provision of something like an Urgent Treatment Centre in the interim? Ms D'Souza responded that as there was currently a live consultation, it was difficult to respond on that issue but

opportunities to develop local urgent care would come with additional national funding into the Primary Care Networks.

The Chairman then invited the following to the table:

- Cllr Anne Clarke – Childs Hill Ward
- Cllr Peter Zinkin - Childs Hill Ward

Cllr Clarke reported that from her contact with residents it was clear that many used the Cricklewood Walk In facility and it was a well-loved Centre which, if closed, would make the community feel insecure. The main reason residents gave for using it was that they could not get GP appointments. 5500 patients had registered with the Walk In Centre in the last five years. She added she would prefer if it could be recommissioned until the building was demolished – it could then be relocated. Cricklewood has a growing population with thousands more residents due to move into the area and she could not see the point in the Walk In Centre being closed. Those residents had no association with Finchley Memorial Hospital and other areas of Barnet and would not look to go there for healthcare.

Cllr Zinkin reported that as the Walk In Centre is at the edge of the Borough, it seemed impossible to provide for the population without joint working with Brent. Cllr Zinkin had had discussions with members of this distinct population about possibly travelling to FMH. He made the point that FMH is in a completely different part of the Borough and therefore this was unrealistic. Clarity was needed on the type of journeys patients would be expected to make to access healthcare. He did not get the sense that the CCG understood this community which was fairly itinerant and so the Walk In Centre concept was important. It was also one of the main areas of population growth in Barnet. Together with the proposal to relocate the Ravenscroft Medical Centre into FMH, there was concern that groups would be disadvantaged. He added that he had spoken to the Chairman of the local GP Association on whether some surrounding Practices could take extra patients if the relocation went ahead but he was told that this may not be feasible without them recruiting more GPs. There was huge local concern about this.

Ms D'Souza noted that there would be an equality impact assessment which would focus on the needs in the area and be part of the information considered before a decision was made. The CCG had put forward its view on what should happen to this contract given the national picture and now wanted to receive views on this before it made a decision. She also noted that Brent and Barnet CCGs were working together on this as demonstrated by the overview of provision in that area set out in the map provided by the CCG.

A Member queried the accuracy of the information in the Consultation such as bus journeys from Cricklewood to FMH. A direct bus (number 460) was available to Granville Road but this then required a long walk to FMH from the bus stop. The number 13 Bus would also require a long walk.

RESOLVED that the Committee noted the written and verbal report.

11. **BARNET HOSPITAL - MEALS FOR PATIENTS (Agenda Item 11):**

The Chairman invited to the table:

- Annabel Eady - Contract Director, Medirest

Ms Eady explained that she was the Contract Director for Barnet Hospital (BH) Chase Farm Hospital (CFH) and Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), managing food, domestics and portering.

Ms Eady presented a sample of 'Steamplicity' packaged food ready for microwaving with a valve to help maintain nutrients. The meals were prepared centrally in collaboration with dieticians. She had already sent a variety of menus to be included in the agenda but gave some more to the Committee at the meeting. She reported that at CFH meals could be ordered at two hours' notice. She noted that BH has protected meal times. There is a choice of 29 hot meals, sandwiches and soups. Chilled food was delivered every other day and she said wastage is under 2%. She commented that as many of the ingredients as possible are locally sourced with around 60% being UK grown.

A Member was most impressed that there was also a choice of six vegan meals on the menu.

A Member reported that at CFH the coffee shop which had replaced the Staff/Visitor Restaurant was not ideal, with limited choice and poor signage. Ms Eady responded that at CFH hot food had not generated sufficient income. The limited amount of space in the shop was a serious problem and work was ongoing to find a solution. She informed the Committee that the Coffee Shop was run by Costa.

The Chairman reported that at BH she had found the food at the Staff/Visitor Restaurant to be correctly labelled and it looked appetising, with free water available. She also mentioned that three meals on the menu were healthy eating options below 500 calories. She thanked Ms Eady for attending the meeting and giving such an informative presentation.

RESOLVED that the Committee noted the verbal report.

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

It was agreed that the following items would be added to the 28 October agenda:

- Full update would be provided on the Ravenscroft Medical Practice
- Update would be provided on GP services at FMH
- Update and APMS/GP Practice in Cricklewood

It was agreed that the following items would be added to 12 December meeting:

- An update on the Cricklewood Walk in Centre consultation

- Half year updates on the three Quality Accounts: Royal Free Hospital NHS Foundation Trust, North London Hospice and Central London Community Healthcare NHS Trust.

RESOLVED that the Committee noted the Forward Work Programme.

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

- **Briefing note on Proposals to relocate Ravenscroft Medical Centre to Finchley Memorial**

The Chairman invited the following to the table:

- Sarah D'Souza – Director of Commissioning, Barnet CCG
- Jenny Goodridge – Director of Quality and Clinical Services, Barnet CCG
- Beverley Wilding, Deputy Director, Urgent and Emergency Care, Barnet CCG
- Councillor Anne Clarke - Childs Hill Ward
- Councillor Peter Zinkin – Childs Hill Ward

The Chairman introduced the Briefing Note (attached) which she had only received from Barnet CCG that afternoon and had immediately forwarded to the Committee. Hard copies were also provided at the meeting for the Committee as well as the two Childs Hill Ward Councillors. The Chairman invited questions and/or comments for the CCG from the Committee and the two Childs Hill Councillors but there were none.

The Chairman suggested that as the decision regarding Ravenscroft Medical Centre was due to be made by the North Central London Primary Care Committee in Common on 22 August 2019, the item was put on the 28 October HOSC Agenda.

RESOLVED that the Committee noted the Briefing Paper.

The meeting finished at 10.00 pm

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Adult Elective Orthopaedic Services Review

Update to the London Borough of Barnet Health Overview and Scrutiny Committee

Will Huxter
Director of Strategy, NCL CCGs
Joint SRO, Adult Elective Orthopaedic Services Review

Monday 28 October 2019

AGENDA ITEM 8

Our vision for a joined-up approach to adult elective orthopaedic services in North Central London

North central London residents should have **timely access to consistent high-quality orthopaedic surgery** regardless of where they live in the area.

Services delivered in **a single network** with two dedicated, **state-of-the-art orthopaedic elective surgical centres** and local, **convenient outpatient facilities**, would deliver the best care for local people.

This vision has been **clinically driven and co-created** with local people and staff to improve patient experience, outcomes, and ensure a service fit for the future.

Timeline…what's happened so far

1 February 2018…

- JCC signed off the mandate for the adult elective orthopaedic services review

August – October 2018….

- Carried out a desktop equalities review to identify impacted groups
- Engaged patients, residents and other stakeholders on the draft case for change and rationale for the review. Five clinical design workshops to establish the model of care.

December 2018…

- JCC approved the design principles for a new model of care and received the feedback from the engagement on the draft case for change

January 2019…

- JCC approved the overarching timeline, revised governance and accepted the recommendation around final contract form

May 2019 the JCC…

- Agreed the **Clinical Delivery Model** and **Options Appraisal Process** and issued them to providers for them to submit options

July 2019…

- Carried out the options appraisal process

August and September 2019

- Drafting of pre-consultation business case, ahead of the NHS England assurance process
- Progressed areas of work to further refine the service model, including workshop to look at transport/access and further work on the finance/activity model

Options appraisal process and outcome

- The panel included local commissioners and GPs and **equal representation from patients and residents**. Purpose was to assess submissions against the status quo, using a scoring system developed through a collaborative process
- **Panel considered two partnership submissions; these were submitted side-by-side and were not competing against each other**
- Taken together the panel felt the two submissions could deliver the clinical model for the service, creating single adult elective orthopaedic service for patients and staff across the whole of NCL, overseen by a clinical network.
- **Panel welcomed the really positive engagement from clinicians and management, lots of thought and effort gone into collaborative submissions – both were definitely an improvement on the status quo.**
- Separate financial assessment, initial view was that the proposals should at have at least a neutral financial impact on the health economy. Further work to do on the detail over August and September.
- **Options appraisal was just the start, we need to work together over the next few months to refine and finalise the emerging options into a single holistic worked up proposition that can be consulted on in the autumn.**

Proposed model of care – as a result of joint working by partners

	Northern Hub	Southern Hub
Partnership for orthopaedic excellence: North London*	Working as part of a clinical network, providers would create a standardised approach to pre-assessment, post-operative procedures and protocols, joint school and patient education. In total we envisage around 12,000 procedures taking place per year under this new model of care. **Partners: The Royal Free London, North Middlesex Hospital, UCLH, Whittington Health and RNOH.**	
Providers in the partnership	A partnership between **The Royal Free London** group of hospitals and the **North Middlesex Hospital**	A partnership between **UCLH** and **Whittington Health**
In-patient elective orthopaedic surgery*	**A change.** All in-patient orthopaedic care would take place at an Elective Orthopaedic Centre on the Chase Farm site. Approximately 400 people a year who at the moment have inpatient surgery at the North Middlesex would in the future have their surgery at Chase Farm.	**A change.** All in-patient orthopaedic care would take place in an Elective Orthopaedic specialising in in-patient care at UCLH's new building on Tottenham Court Road (known at the moment as phase 4). Approximately 350 people a year who currently have inpatient surgery at Whittington Health would in the future have their surgery at UCLH.
Day-case elective orthopaedic surgery*	**No change.** It would continue to take place at both at North Middlesex and Chase Farm.	**A change.** Whittington Health would become a centre specialising in day-case orthopaedic surgery and some day-case surgery would move from UCLH to Whittington Health. Approximately 400 people who currently have day-case surgery at UCLH would in the future have their surgery at Whittington Health Day-surgery would also continue to be carried out at UCLH.
Other potential changes	RNOH have indicated that there are a small group of patients referred to them for non-specialist care who may be suitable for treatment in the electives centres	
Pre-operative and post-operative outpatient care	**No change.** Patients would continue to be seen at the three Royal Free sites and North Middlesex both pre- and post-operatively; consultants would follow the patient to where they are going to have surgery.	**No change.** Patients would be seen at UCLH and Whittington Health both pre- and post-operatively; consultants would follow the patient to where they are going to have surgery.
Trauma – emergency orthopaedic care	**No change.** Will continue as now at both the North Middlesex, Royal Free and Barnet hospital.	**No change.** Will continue to take place as now at both UCLH and Whittington Health.

*Volumes are based on forecasts and may be subject to change. There may be some clinical exceptions that determine place of treatment.

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How the changes would impact Barnet Residents

For the majority of Barnet residents **(c. 70%)** there will be no change to current provision with elective orthopaedic surgical services accessed via the hospitals in the **Royal Free London** group (Barnet, Chase Farm and Royal Free) with pre- and post-operative care at all three sites and routine day-case and inpatient surgery at **Chase Farm.**

Although local change in terms of location will be limited, Barnet patients **would benefit** from the many **quality improvement** measures incorporated to the design of elective orthopaedic services including **ring fenced beds**, **care coordinators** and **dedicated theatre space** resulting in shorter waiting times, fewer cancellations, reductions in revision rates and readmissions, joined up care and reduced infection rates.

Barnet residents would benefit from **additional patient choice** with the ability to access the other elective centre, delivered by the partnership of **UCLH and Whittington Health**.

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Building on the model of care – work underway

Clinical areas of assurance:

- Review to be undertaken by independent clinical adviser of three detailed areas in the clinical model
- Checkpoint as part of implementation to confirm the High Dependency Unit at Chase Farm meets requirements of the clinical delivery model
- Further discussions involving the spinal network

Additional workshops to clarify model of care:

- Post-operative community care
- Role of care navigators/coordinators
- Digital interoperability and image sharing as part of the One London programme
- Transport/access
- Discharge arrangements

Proposed service locations and provider partnerships

Patients will travel to the Elective Orthopaedic Centre for inpatient surgery. The surgeon from their base hospital will carry out the operation.

Proposed future patient pathway

A single elective orthopaedic service, delivered by a partnership of hospitals and formally overseen by a network of clinical staff.

REFERRAL → HANDOVER → HANDOVER → HANDOVER

GP & COMMUNITY CARE

Initial assessment and triage

Patient with joint pain is referred to the local musculoskeletal (MSK) service, where they are assessed. They may be given advice, therapy or further tests - or referred to a local hospital if it looks as though orthopaedic surgery may be needed.

REFERRAL

BASE HOSPITAL

Assessment and treatment plan

Further assessments take place.

Patients are either given:

- non-surgical care
- an appointment for day surgery
- if an overnight stay is required, surgery at the elective centre.

Patients who need extra support are allocated a 'care coordinator'.

HANDOVER

Patients have pre-operative classes at 'joint school' to prepare for surgery.

ELECTIVE CENTRE

Surgery

Patients needing an overnight stay have their surgery at the elective centre, with the clinical team they know and receive immediate after-care.

Care coordinators will continue to support patients.

HANDOVER

BASE HOSPITAL

Follow-up care takes place at a patient's base hospital

Patients will continue to receive support from care coodinators

HANDOVER

COMMUNITY POST-OPERATIVE CARE

For patients with ongoing health needs, and those who need extra support, GPs or community teams continue to support patients after their surgery.

Next steps

Autumn 2019

- Further work to refine model of care: following options appraisal
- Validating our plans: NHS England assurance and London Clinical Senate
- Commission: Equalities Impact Assessment and Transport analysis

September 2019

- Joint Health Overview and Scrutiny Committee: update and early conversation about consultation

September – November 2019

- Preparing for public consultation: involving partners

Early December 2019

- Formal decision-making: Commissioners asked to approve both the pre-consultation business case and decide to consult

December 2019 – early March 2020

- Public consultation – subject to agreement

Spring/early summer 2020

- Decision-making business case

NHS

Public consultation – plans in development

- Our proposals are a significant change for patients in NCL, who need elective orthopaedic care
- We plan to consult with affected parties to inform the next stages of the review and continue ongoing engagement with local residents, staff and stakeholders who could help to further improve the model and its implementation
- Prior to consultation a transport analysis and health inequalities and equalities impact analysis will be completed and published alongside the consultation document
- The plan is to begin a 12-week consultation in mid-December

Plans are at an early stage, and we welcome your views and feedback to improve them further

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Preparation for a public consultation

Overseen by programme board. Taking into account:

- Meetings with Healthwatch organisations to facilitate public involvement
- Engagement advisory board

Consultation will draw on:

- Equalities and health inequalities impact assessment
- Travel and transport analysis

Who are our main audiences for consultation?

The people most likely to be affected by any change to the services:

- People who have experienced Adult Elective Orthopaedic care in the past, at one of the existing sites, or other sites in the vicinity
- Those waiting for Adult Elective Orthopaedic care and those who may need services in the future
- The families and carers of affected groups, including local residents and the public
- Community representatives, including the voluntary sector
- Staff in affected Trusts and other partners in health and social care

Key stakeholders:

- Relevant local authorities
- Elected representatives

Subject of the consultation:

We remain open to all suggestions and proposals throughout a consultation….

- How do people view the proposals and how they might be affected by them
- Any alternative suggestions that aren't covered by our proposals
- What matters to patients and families and how this could influence plans

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Consultation process – basic principles

1. The INTEGRITY of consultation

The consultation must have an honest intention. Consultors must be willing to listen…and be prepared to be influenced…

2. The VISIBILITY of consultation

All who have a right to participate…should be made reasonably aware of the consultation

3. The ACCESSIBILITY of consultation

Consultees must have reasonable access,using methods appropriate for the intended audience…with effective means to cater for hard-to-reach groups and others

4. The TRANSPARENCY of consultation

Consultation submissions will be publicised unless specific exemptions apply. FOI requests can now be used to disclose data previously kept hidden.

5. The DISCLOSURE of consultation

Consultors must disclose all material information; consultees must disclose significant minority views when representing many parties

6. The FAIR INTERPRETATION of consultation

Objective assessment, with disclosure of weightings if used

7. The PUBLICATION of consultation

Participants have a right to receive feedback of the consultation output and of the eventual outcome of the process

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Consultation feedback and evaluation process

Opportunities to get involved

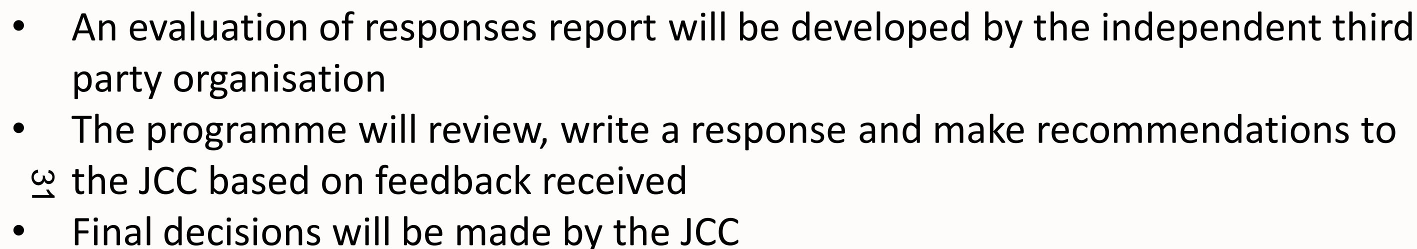
- Open workshops for deliberative discussion
- Deeper-dive discussions on key themes identified in engagement
- Proactively arranged discussions with key groups
- Discussions at regular and existing meetings
- Meetings on request

Response channels:

- Response using the printed questionnaire (freepost return)
- Response using an online version of the same questionnaire
- Feedback captured at patient and carer groups
- Feedback captured at deliberative events
- Feedback given to our evaluation partner on the telephone
- Submissions via letter or email

Capturing the responses:

- All responses go to an independent third-party to ensure impartiality
- Responses will be monitored, emerging themes, reviewed and questions responded to
- Responses will be evaluated regardless of the feedback channel



Post consultation decision making:

- An evaluation of responses report will be developed by the independent third party organisation
- The programme will review, write a response and make recommendations to the JCC based on feedback received
- Final decisions will be made by the JCC

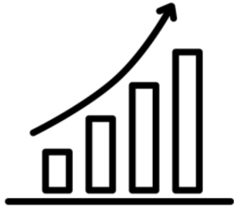
Discussion

HOSC members are asked to:

- **Note** the further progress of the review since the June 2019 meeting
- **Comment** on the outcome of the options appraisal process and proposed model of care
- **Feedback** on early plans for consultation and offer input into the emerging plan

Appendix: supporting information

Our case for change: opportunities to improve patient outcomes and experience



Rising demand for services

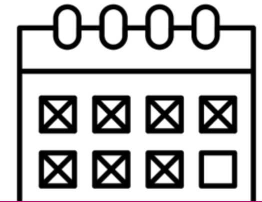
9.5% increase in activity, forecast to 2029

Waiting times

As of January 2019, over 10,500 NCL residents were waiting for orthopaedic surgery

Cancellations

In 2018/19 across NCL there were 10 cancellations a week – almost all on the day of surgery

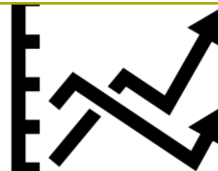


Inconsistent length of stay

Higher total length of stay than the English average in two out of four organisations

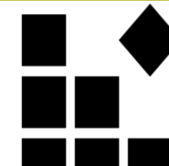
Variation in patient experience of care

Average PROM* scores were lower than the national English average



Infection, readmission and revision rates vary across providers

This leads to variation in the quality of care



Fragmented commissioning landscape

This contributes to variation in the quality of care

* PROMS – patient recorded outcome measures

NHS

Where services are delivered at the moment…

The Kings Oak Hospital

Chase Farm Hospital

The Cavell Hospital

Royal National Orthopaedic Hospital

North Middlesex University Hospital

Highgate Private Hospital

Whittington Hospital

Royal Free Hospital

University College Hospital

National Hospital for Neurology and Neurosurgery

Adult elective orthopaedic surgery currently takes place at ten different hospital sites in north central London

NHS

Feedback from engagement

What we heard…	How this has influenced the next steps of the review…
Patient experience: Vulnerable patients might find it difficult to travel to and find their way around	•**Clinical delivery model:** Inclusion of care co-ordination function •**Options appraisal:** Scored section on vulnerable patients within the patient experience section.
Continuity of care: Location of pre-operative assessments and post-operative care/rehabilitation were a concern	•**Clinical delivery model:** is specific about which organisation is responsible for pre-operative assessment and patient education sit in the pathway. •**Options appraisal:** providers asked to give detailed consideration of how they will deliver both pre-operative assessment and patient education in their proposals
Patients with complex needs: It was not clear where patients with complex needs would have their surgery.	•**Clinical delivery model:** To include an essential requirement for all elective centres to have an HDU. •**Options appraisal:** Assessment of proposals around inclusion of HDU, case-mix and managing clinical complexity.
Integration: Contributors stressed the importance of joined-up working. Integrated IT systems are also important	•**Clinical delivery model:** To include a section on digital requirements •**Options appraisal:** IT and digital considerations are included as part of the deliverability score
Travel: There were repeated comments suggesting that an in-depth transport analysis should be considered	•**Clinical delivery model:** To include a section on travel and transport arrangements •**Options appraisal:** Patient experience will specifically address travel and transport arrangements •**Public consultation:** a detailed travel analysis will need to be carried out and published as part of public consultation.

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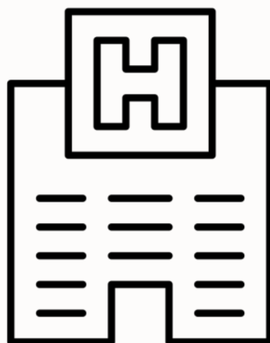
Tiers of hospital in the network



Base hospitals	Elective orthopaedic centre(s)	Super specialist hospital
Support the operation of the elective orthopaedic centres as part of a clinical network, manage outpatients and post-operative follow-up, some day-cases and all trauma care alongside an A&E	Able to undertake a mixture of some complex and all routine elective activity.	Undertake only tertiary and complex patients that cannot be appropriately cared for in local or elective hospitals. This super specialist work **does not form part of this review.**

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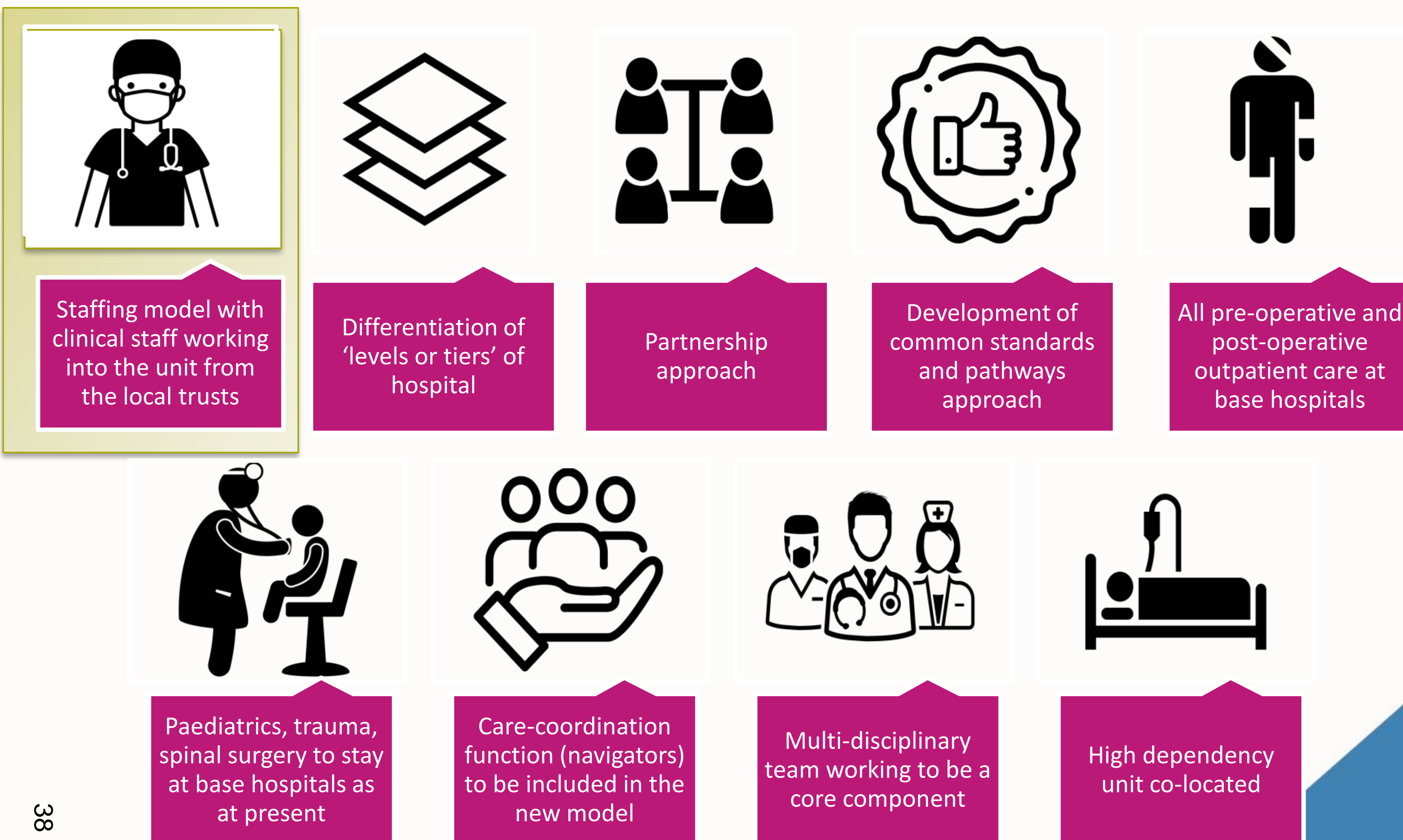
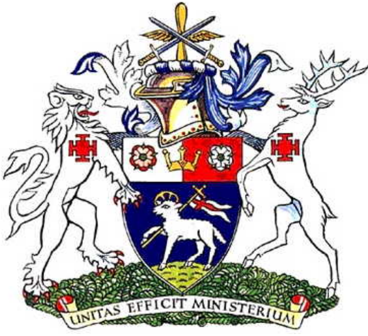
Clinical design principles – agreed December 2018



	**Health Overview and Scrutiny Committee** **28 October 2019**
Title	**HOSC - Childhood Vaccination Rates in Barnet October 2019**
Report of	Emma Waters, Public Health Consultant
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	*Summary of actions from the Barnet Flu and Immunisation Forum's Multiagency Action Plan to address uptake of routine childhood vaccinations in Barnet*
Officer Contact Details	**Dr Emma Waters** **Emma.Waters@barnet.gov.uk**

Summary

Barnet has comparable uptake of childhood immunisations compared to neighbouring boroughs but a low uptake of childhood immunisations compared to the national average. This low uptake of immunisations in Barnet is increasing the risk that Barnet's population will be exposed to vaccine preventable diseases, with potentially serious health implications.

A multiagency forum has been formed to consider flu and immunisations in Barnet. This group consists of representatives from Public Health England, Barnet Council (Public Health and Family Services), NHS England, Barnet CCG, and CLCH (Health Child

BARNET LONDON BOROUGH

Programme provider and school immunisation provider). At the end of July this group agreed an evidence based action plan to address the low immunisation rates in Barnet, the actions cover three main aims:

1. Work towards increasing vaccination rates for the routine childhood vaccination programme in Barnet and undertake opportunistic catch up programmes to increase routine childhood vaccination coverage in older cohorts.

2. Increase awareness of the importance of immunisation amongst Barnet's population

3. Work with specific communities and demographic groups to increase vaccination rates amongst groups at risk of low vaccination rates.

Officers Recommendations

1. **Implement the multiagency flu and immunisation forum's agreed actions to address low immunisation rates in Barnet**

1. WHY THIS REPORT IS NEEDED

1.1.1 Childhood immunisation protects against disease and ultimately saves lives. The World Health Organisation states that "Immunization is not only one of the most successful health interventions ever, protecting children and families from suffering and death. It is a human right and a key element in ensuring health, education and equity; and it represents important social and economic returns that go far beyond the individual person or family (WHO 2015).

1.1.2 For the majority diseases routinely vaccinated against in the UK herd immunity can be maintained in the population if immunisation uptake is high enough, thus preventing the spread of the disease and protecting vulnerable unvaccinated people. However, in Barnet vaccination uptake in children is low; for instance in Barnet only 84% of children have had one dose of MMR by the age of two, whereas 95% coverage is necessary to maintain herd immunity. A recent rise in Measles cases in Barnet earlier this year emphasises the need to ensure the uptake of childhood vaccinations in Barnet is increased.

2. REASONS FOR RECOMMENDATIONS

2.1.1 The population of children and young people (CYP) in Barnet in 2017 is estimated to be 100,200, representing 25% of Barnet's total population. The most recent year that childhood vaccination data is publicly available for is 2017/18. Although for service development we are given some access to some more recent data., we cannot share this data. Therefore, for the purposes of this report we will discuss the data available for 2017/18. As presented in table 1 only 83.8% of children in Barnet have received their first dose of the MMR by the age of 2, well below the recommended 95% uptake

needed to maintain herd immunity. By the age of 5 only 76% of children have received their second dose of the MMR. MMR vaccination rates at 2 years in Barnet have been consistently below 95% for the past 8 years. Table 1 presents the vaccination rates for the other routine childhood vaccinations in Barnet, which are also all below the average vaccination rates for England. The proportion of children in care in Barnet in 2018 with up to date vaccinations was 92.8% which is significantly above the national average.

1.1 Table 1: Childhood Vaccination Uptake in Barnet

Indicator	Period	Barnet			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Population vaccination coverage - Hepatitis B (1 year old)	2017/18	–	-	*	*	*	-	-	-
Completed Diptheria, Tetanus, Polio, Pertussis, Hib (by age 1 year) <90% 90% to 95% ≥95%	2017/18	↑	4,467	88.6%	-	93.1%	75.6%		98.2%
Population vaccination coverage - MenC <90% 90% to 95% ≥95%	2015/16	–	4,473	83.2%	-	*	-	-	-
Completed pneumococcal conjugate vaccine (by age 1 year) <90% 90% to 95% ≥95%	2017/18	↑	4,494	89.1%	-	93.3%	77.4%		98.2%
Population vaccination coverage - Hepatitis B (2 years old)	2017/18	–	-	*	*	*	-	-	-
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2017/18	↓	2,054	88.4%	91.7%	95.1%	83.7%		98.5%
Population vaccination coverage - Hib / MenC booster (2 years old) <90% 90% to 95% ≥95%	2017/18	↑	1,943	83.6%	-	91.2%	72.9%		96.9%
Population vaccination coverage - PCV booster <90% 90% to 95% ≥95%	2017/18	↑	1,966	84.6%	-	91.0%	74.6%		97.5%
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2017/18	↑	1,947	83.8%	85.1%	91.2%	75.0%		96.9%
Population vaccination coverage - Hib / Men C booster (5 years) <90% 90% to 95% ≥95%	2017/18	→	2,360	85.0%	-	92.4%	79.5%		97.6%
Population vaccination coverage - MMR for one dose (5 years old) <90% 90% to 95% ≥95%	2017/18	↓	2,520	90.8%	-	94.9%	84.5%		98.6%
Population vaccination coverage - MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2017/18	↑	2,110	76.0%	-	87.2%	66.7%		95.8%
HPV vaccination coverage for one dose (females 12-13 years old) <80% 80% to 90% ≥90%	2017/18	–	1,580	76.5%	81.0%	86.9%	67.8%		95.3%

2.2 However, it should be considered that although Barnet's uptake of one dose of MMR by the age of 2 is lower than both the English and London average, and well below the uptake that is considered necessary for herd immunity, the uptake is comparable or better than that for its neighbours in the North Central London Region; compared to the uptake of 83.8% (95% CI 82.3-85.3) in Barnet Islington and Haringey have comparable rates of MMR update at 2 years (84.3% and 82.1% respectively) and Camden and Enfield have significantly lower rates of uptake than Barnet (80.6% and 80.2% respectively). This uniformly low uptake of vaccination across North Central London may indicate a specific issue with the local population could be contributing to the low vaccination uptake.

1.3.1. The 2009 NICE guidance “Immunisations: reducing differences in uptake in under 19s” reported that there was evidence that the following groups and children and young people were at risk of not being fully immunised:

- those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- looked after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness[i]

The 2009 NICE guidance also stated that there was some evidence that MMR vaccination rates had declined the most in affluent areas, and among children with more highly educated parents.

Barnet is an increasingly ethnically diverse borough, in the 2011 census 45.4% of its population identified as White British, compared to 58.6% of the population in 2001. In the 2011 census 14.4% of households in Barnet reported that no one in them spoke English as their first language, this figure is slightly higher than the proportion for London as a whole. Barnet also has a great religious diversity; for the 2011 census 41.2% of the population identified as Christian, 15.2% as Jewish, 10.3% as Islamic, 6.2% of Hindu, and 16.2% as having no religion. Barnet has the largest Jewish population in the country.[ii]

Barnet is a relatively affluent borough, the Index of Multiple Deprivation (2015) score for Barnet is 17.8, which makes it one of the least deprived boroughs in London and less deprived that England overall (21.8).[iii] However, there are significant numbers of children living in poverty in Barnet,.[iv] In 2016, 8,637 students in Barnet were identified as having SEND, this represents 13.6% of pupils in Barnet, which is slightly lower than the London and England averages. Also in 2016 1.8% of Barnet’s resident population had a statement of Special Educational Needs (SEN) or an Education, Health and Care Plan (EHC).[v] Barnet has a lower than average teenage conception rate and low number of teenage mothers.

Compared with the rest of the England, London persistently has low vaccination rates. Reasons for these low vaccination rates may include highly mobile and diverse population, with higher numbers born. Data capture and quality may also contribute to the low reported vaccination rates in London. Additionally, with reference to MMR vaccination rates, the “Wakefield cohorts” born between 1998 and 2004 have the highest proportion of unvaccinated individuals and this cohort effect is more pronounced in London. Thus Barnet may also have high numbers of unvaccinated young people aged 14-21. [11]

The UK Measles and Rubella elimination strategy (2019) states that in communities whose religious or cultural beliefs result in low or delayed vaccine uptake *"immunity extends the benefits of the national immunisation programme to unvaccinated individuals thus intrinsically reducing inequalities, however the extent of this effect will depend on overall vaccine coverage and population mixing patterns. When large numbers of unvaccinated individuals live in close proximity their communities become vulnerable to outbreaks."*[vi]

Barnet is an ethnically diverse borough, but it is unclear if any specific ethnic or religious groups in Barnet are particularly vulnerable to low vaccination coverage. NHS England has not been able to provide information on uptake of vaccination among different demographics. They have however, been able to confidentially provide vaccination uptake by general practice, which we have examined to consider uptake throughout the borough, and also to identify GP surgeries to meet with to discuss both good practice and barriers to improving immunisation uptake among general practices in the borough.

2.1.1 A multiagency forum has been formed to consider flu and immunisations in Barnet. This group consists of representatives from Public Health England, Barnet Council (Public Health and Family Services), NHS England, Barnet CCG, and CLCH (Health Child Programme provider and school immunisation provider). At the end of July this group agreed an evidence based action plan to address the low immunisation rates in Barnet, the actions agreed are outlined in the attached document and cover three main aims:

1. Work towards increasing vaccination rates for the routine childhood vaccination programme in Barnet and undertake opportunistic catch up programmes to increase routine childhood vaccination coverage in older cohorts.

2. Increase awareness of the importance of immunisation amongst Barnet's population

3. Work with specific communities and demographic groups to increase vaccination rates amongst groups at risk of low vaccination rates.

This forum will meet quarterly and review progress with these aims at each meeting.

3 BACKGROUND PAPERS

3.1 Summary of actions from the Barnet Flu and Immunisation Forum's Multiagency Action Plan to address uptake of routine childhood vaccinations in Barnet

[i] NICE Guidance PH 21. Immunisations: reducing differences in uptake in under 19s (2009)
[ii] Barnet census information briefing note 2.2, available at: www.barnet.gov.uk
[iii] https://jsna.barnet.gov.uk/1-demography
[iv] https://jsna.barnet.gov.uk/7-children-young-people
[v] SEND Joint Strategic Needs Assessment, London Borough of Barnet
[vi] UK Measles and Rubella elimination strategy (2019)

Summary of actions from the Barnet Flu and Immunisation Forum's Multiagency Action Plan to address uptake of routine childhood vaccinations in Barnet

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Actions:

Increasing vaccinations: Pre-natal and 0-5 years
Review GP practice level immunisation data quarterly in the Immunisation Forum and share this practice level data with practices to inform them of the number of children they need to immunise to reach 95% uptake.
Review data on maternal pertussis uptake
Work with maternity services and primary care to achieve: - 95% MMR check as routine part of antenatal care - achieve 80% uptake of post-natal MMR for women without documentary evidence of two previous MMR doses
Ensure all GP practices in each CCG area use robust call/recall systems in place to identify those eligible and invite/schedule appointments proactively.
Identify GP practices that have not provided assurance that they have robust call/recall systems are in place and work collectively with CCG (quality and contracting colleagues) to establish.
Ensure GP practices are using national READ code for MMR vaccination

Ensure all GPs are maintaining accurate, up to date patient lists with a view to removing "ghost" patients. Ensure regular review of lists and review contractual obligations with regards to data submission and removing de-registered patients from lists.
Ensure all GP data sharing agreements are completed and that GP practices are sharing information with CHIS
Ensure all GPs have a designated immunisation lead in the practice and for the lead to proactively identify all those with uncertain or incomplete MMR status. This should include a look back of those aged <5 years who have missed MMR vaccination.
Designated immunisation Leads to ensure Measles Posters, Leaflets and information are accessible in the practice.
Ensure importance of immunisation is routinely discussed with HV and information sharing with GP practice and included in commissioning of HV services (new contract from May 2020)
Ensure that Health Visitors receive adequate training and updates: -to promote vaccination in line with the Best Start in Life programme -check immunisation records as outlined in NICE guidance PH 21
Ensure immunisation status is checked routinely as part of the school nurse health check at reception/year 1 (aged 4 to 5 years) and offer/ refer (new contract May 2020)

Increasing vaccinations: 5-18 years
Ensure all GPs have a designated immunisation lead in the GP practice and for the lead to proactively identify all those with uncertain or incomplete MMR status. This should include a routine catch up of those aged 5 years and older who have missed MMR vaccination.
Ensure all GPs check the immunisation status of all new GP registrants and offer MMR vaccine to complete the course.
Ensure all School Aged Immunisation providers routinely check the MMR status of all adolescents (School Year 8, 9 and 10). Providers to administer MMR vaccines to complete immunisation course.
School nursing teams (in collaboration with GP practices and schools) to check immunisation records of children when they move to a new school or college. Where immunisations are not up to date the importance of immunisations should be explained to parents and referral to an immunisation services offered.
Check immunisation status of young offenders and offering outstanding vaccinations

Increasing vaccinations: 18-25 years
Ensure all GPs have a designated immunisation lead in the practice and for the lead to proactively identify all those with uncertain or incomplete immunisation status. This should include a routine catch up of those aged 18

years and older who have missed MMR vaccination, those of childbearing age and new registrants
Increasing awareness of the importance of immunisation amongst Barnet's population
NHS England and DPH to send joint letter to University Health and Well-being Lead on an annual basis establishing recommended actions for improved uptake rates of MMR and Men ACWY vaccine
DPH letters to schools to promote checking of immunisation status and information to parents.
Support and disseminate national vaccination resources and campaigns
Arrange two childhood immunisations trainings for children centre staff
Share information and campaign resources with children centres through quarterly news letters
Communications campaign in the community, schools, children's' centres and GP practices.
Social media campaign
-Procedures and attitudes in primary care
Ensure annual Practice Nurse immunisation training

Working with specific communities and demographic groups to increase vaccination rates amongst groups at risk of low vaccination rates.
Obtain practice level data on vaccination uptake and assess uptake in specific communities.
Consider using the WHO TIP tool and NICE guidance PH 21 to understand and address the specific needs of their under-vaccinated populations. www.euro.who.int/__data/assets/pdf_file/0003/187347/The-Guide-to-Tailoring-Immunization-Programmes-TIP.pdf https://www.nice.org.uk/guidance/ph21/resources/immunisations-reducing-differences-in-uptake-in-under-19s-pdf-1996231968709

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Health Overview and Scrutiny Committee
Forward Plan October-Dec 2019

Contact: tracy.scollin@barnet.gov.uk

AGENDA ITEM 13

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
28 October 2019			
STP Update	Adult Elective Orthopaedic Surgery	Will Huxtor, Director of Strategy, NCL CCGs	**Non-key**
Barnet Hospital	• Progress on planning application • CPZ and staff permits • Update on investment in A&E ahead of Winter 2019 further to discussions with Barnet CCG	Dr Shaw, Royal Free London Hospital NHS Foundation Trust	**Non-key**
Alternative Personal Medical Service (APMS)	GP Practice in Cricklewood	Kay Matthews, Chief Operating Officer, Barnet CCG	**Non-key**
Ravenscroft Medical Centre - Relocation to Finchley Memorial Hospital		Kay Matthews, Chief Operating Officer, Barnet CCG	**Non-key**
Childhood inoculations		Dr Tamara Djuretic Director of Public Health, LBB	
12 December 2019			
			Non-key

Title of Report	Overview of decision	Report Of *(officer)*	Issue Type (Non key/Key/Urgent)
Integration Barnet CCG	Update on the two key programmes to support integration locally	Barnet CCG	**Non-key**
Update on surplus land owned by Finchley Memorial Hospital		Community Health Partnerships	**Non-key**
Mid-year Quality Accounts	• Royal Free Hospital • North London Hospice • Central London Community Healthcare		**Non-key**
Health Provision Plans for Cricklewood NW2 and impact of Brent Cross South		Barnet CCG	**Non-key**
To be allocated			
Breastfeeding support service		Barnet CCG	

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