

Overview and Scrutiny Committee

MONDAY, 5TH JULY, 2010 at 18:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Bull (Chair), Browne (Vice-Chair), Alexander, Basu, Ejiofor, Newton and Winskill

Co-Optees: Ms Y. Denny (church representative) plus 1 Vacancy, Ms M Jemide (Parent Governor), Ms S Marsh (Parent Governor), 1 Parent Governor Vacancy, Ms H Kania (LINK Representative)

AGENDA

1. WEBCASTING

Please note: This meeting may be filmed for live or subsequent broadcast via the Council's internet site - at the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. The images and sound recording may be used for training purposes within the Council.

Generally the public seating areas are not filmed. However, by entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes.

If you have any queries regarding this, please contact the Committee Clerk at the meeting.

2. APOLOGIES FOR ABSENCE

3. AMENDMENTS TO CO-OPTEE MEMBERSHIP

Church of England representative

To note the re-appointment of Yvonne Denny as Church of England co-opted member.

Parent Governor representatives

To note that Joseph Ejiofor is no longer a co-opted member of the Committee. Elections for a replacement Parent Governor are in progress.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at item 15 below. New items of exempt business will be dealt with at item below).

5. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest **and** if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct **and/or** if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

6. DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

7. CABINET MEMBER QUESTIONS - THE LEADER (PAGES 1 - 8)

To receive the report of the Council Leader, Councillor Claire Kober, on the Cabinet's priorities for 2010/11.

8. COMMUNITY STRATEGY UPDATE (PAGES 9 - 30)

To receive the Sustainable Community Strategy Summary Progress Report.

9. LOCAL INVOLVEMENT NETWORK (LINKS) ANNUAL REPORT 2009/10

To receive the 2009/10 Local Involvement Network (LINKs) Annual Report. **(TO FOLLOW)**

10. POST OFFICE CLOSURES (PAGES 31 - 48)

To receive an update on the review of Post Office closures.

11. BREAST SCREENING REVIEW REPORT (PAGES 49 - 122)

To receive the report on the Scrutiny Review of Breast Screening.

12. JOINT OVERVIEW & SCRUTINY COMMITTEE (PAGES 123 - 128)

To receive the report seeking to appoint two Members of the Committee plus a deputy to the Joint Committee to consider the North Central London Service and Organisation Review.

13. OVERVIEW & SCRUTINY COMMITTEE WORK PROGRAMME

To receive the Overview & Scrutiny Committee Work Programme for 2010/11. **(TO FOLLOW)**

14. MINUTES (PAGES 129 - 136)

To confirm the minutes of the meetings held on 15th March 2010

15. NEW ITEMS OF URGENT BUSINESS

16. FUTURE MEETINGS

Wednesday 21st July 2010 (Child Protection)
Wednesday 28th July 2010 (Health)
Thursday 29th July 2010
Monday 6th September 2010
Monday 4th October 2010
Monday 1st November 2010 (Child Protection)
Monday 29th November 2010
Thursday 2nd December 2010
Monday 6th December 2010
Wednesday 15th December 2010
Monday 31st January 2011
Monday 28th February 2011
Monday 28th March 2011
Thursday 17th March 2011 (Child Protection)
Monday 9th May 2011

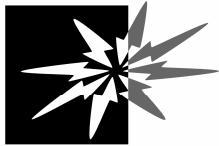
17. SCRUTINY COMMITTEE ACTIONS REQUESTED (PAGES 137 - 176)

To note the actions completed since the last meeting.

Ken Pryor
Deputy Head of Local Democracy and
Member Services
River Park House
225 High Road
Wood Green
London N22 8HQ

Natalie Cole
Principal Committee Co-Ordinator
Tel: 020-8489 2919
Fax: 020-8489 2660
Email: Natalie.Cole@haringey.gov.uk

Friday 18th June 2010



Haringey Council

Overview and Scrutiny

On July 5 2010

Report Title: **The Cabinet's Priorities for 2010/11**

Forward Plan reference number (if applicable): **N/A**

Report of: **Councillor Claire Kober, Leader of the Council**

Wards(s) affected: **All**

Report for: **Information**

1. Purpose

1.1 To report to the first ordinary meeting of the Overview and Scrutiny Committee in the new municipal year what the Cabinet's priorities are for the forthcoming municipal year and beyond.

2. Recommendations

2.1 To note the report and comment on the priorities for 2010/11 as determined by the Cabinet.

2.2 To confirm Overview and Scrutiny Committee's active participation in research and policy through its formal Reviews and consideration of the Forward Plan.

Report Authorised by:

Councillor Claire Kober, Leader of the Council

Introduction by the Leader of the Council

Clearly along with other local authorities we are faced with significant challenges during the next 12 months. We will fundamentally have to re-evaluate all aspects of the way in which we work. We must deal with the challenges effectively while at the same time ensuring we match the aspirations and ambitions of local residents.

The government has already announced £6 billion of savings to be achieved in year across the public sector. Local government is required to provide over £1 billion of savings in year. Clearly the cuts identified elsewhere will effect a number of our partners on the HSP. The specific impact of this on Haringey is yet to be quantified, however what is clear is that it will impact on a number of programmes which the Council and partners had identified.

It is important also for the scrutiny committee to consider that this the beginning of a severe round of public spending cuts which the government has indicated. We will know more about future cuts as we go through the year with the government's emergency budget in June and a spending review in the autumn.

As a Cabinet we will also start implementing the manifesto which as a Labour group we were elected on. Our One Borough approach will be the starting point for what we do and this is reflected in the priorities in this report.

Below I have tried to capture some of those commitments and a number of other areas of work which we will focus on as a Cabinet during the next year. It is important also to reflect on the significant progress we have made over the last 12 months as a Council. This must give us confidence to know that despite the fundamental challenges we can succeed as a Council and Partnership.

Housing

We will focus on the following during the coming four years:

- The delivery of our decent homes programme – maximising the impact of every pound we spend.
- Step up our use of Compulsory Purchase powers to bring empty homes back into use.
- Work with housing associations to ensure improvements to housing management across the borough.
- Seek new, affordable homes in all parts of the borough.
- Work to provide sheltered housing and by 2014 we will also provide extra care housing, so that our older residents can continue to live in dignity with independence
- As resources allow support homeowners to install energy saving measures

2009/10 Performance highlights

The number of households in Temporary Accommodation has fallen significantly over the past year and this is something which has improved living conditions for many households and also reduced the Council's exposure to changes in subsidy rules.

We have continued to take tough action to bring empty properties back into use, through pursuing enforcement action. This has improved the state of housing in the borough and increased opportunities for families in need of a home with 91 properties being brought back into use. As a result of enforcement action, over £120, 000 has been recovered by the Council.

Homes for Haringey have successfully delivered the second year of the Decent Homes programme. This scheme is making a huge difference to residents' lives across the borough. We have undertaken a thorough review of the management agreement to ensure that it reflects our experience and is fit for purpose.

The Council approved a new 10 year Housing Strategy in July 2009 following extensive consultation with key stakeholders. We our launched Haringey's Affordable Warmth Strategy in November 2009.

Neighbourhoods

We will focus on the following during the coming four years:

- Work alongside the Metropolitan Police Safer Neighbourhoods Service and local communities to set priorities for action in all of our neighbourhoods.
- Develop the work of the Street Enforcement Officers network in tackle fly tipping, litter, graffiti and rubbish dumping.
- Continue to take tough penalties for those who do not respect our environment.
- Undertake clean sweeps with residents and our new Neighbourhood Environmental Action Teams.
- Continue to adopt measures which reduce our use of landfill.
- Continue to ensure the proper regulation of houses in multiple occupation to tackle slum landlords through licensing.
- Give Area Assemblies greater control over local decisions and ensure we help people to take action with our support.
- Look to further expand the popular city car club.
- Defend the Freedom Pass so that older and disabled people can continue to use public transport free of charge.
- Establish a Sustainable Transport Commission to consider actions to improve transport, provide fairer parking controls and investment in our transport network.
- Fight for better bus services in Haringey, continued investment in the tube and prioritise east-west links across the borough.
- Use the legislation passed by the previous government to stop sex and lap dancing establishments setting up in our borough.

2009/10 performance highlights

We have rolled out new and improved recycling services so that everyone in the borough can now recycle more items. Residents in approximately 3,500 properties above shops now receive collections from their home, which brings the council closer to providing 100% of households with a dedicated recycling collection.

The My Cleaner Haringey campaign has improved cleanliness in the borough with local clean sweeps and new ways of working by street cleaners across the borough. Latest scores show we are on track to meet all targets on cleanliness.

The car club has been a major success with 27 car club vehicles at 14 on street locations around the borough, with 2,100 streetcar members. We were successful in our bid to become a Biking Borough, a TfL initiative that will help us improve cycling provision.

We have responded to local business requests to improve parking and delivered new parking initiatives across the borough including amendments to the parking restrictions within the Crouch End and Muswell Hill area under experimental powers. This followed extensive meetings with traders from within the two areas. Free parking in council car parks over the weekends throughout December and the lead up to Christmas was well received. The cost of a business permit has been brought down to a standard rate across the borough, which has meant a 50% reduction in some areas.

Area Assemblies have allowed residents to identify key priorities for their local area which have informed the development of local Area Priority Plans. A variety of approaches were used to identify the priorities including workshops and the use of Turning Point voting software.

Community Safety and Cohesion

We will focus on the following during the coming four years:

- Enforce a community-focused, zero-tolerance approach to anti-social behaviour.
- Increase reporting and support to the most vulnerable victims of crime and tackle hate crime and build on the work carried out at Heathstone.
- Work alongside the Metropolitan Police Safer Neighbourhoods Service and local communities to set priorities for action in all of our neighbourhoods.
- Support calls for a national dog registration scheme.
- Promote a responsible dog ownership campaign.
- Look designate all of our parks and open spaces as Dog Control Areas.

2009/10 performance highlights

The latest scorecard shows that we are set to exceed our target for serious acquisitive crime; a reduction of 9.5% has been achieved against a target of 1.4%. Recorded incidents of both gun and knife crime have reduced significantly since the beginning of the financial year.

The Anti-social behaviour team (ASBAT) performance remains well above the national average with 94% success rate on enforcement following surveillance and 97% success on other legal proceedings as below.

Final figures released during 2009/10 showed that NI40 (number of problematic Drug Users (PDUs) in effective drug treatment) was 4% higher than the target of 8% with 1045 PDUs in Effective Treatment. Final figures for All Adults in effective treatment showed 1311 individuals in effective treatment against a target of 1265.

Haringey has produced the second Domestic and Gender Based Violence Strategy with actions to combat domestic violence, trafficking, rape, forced marriage and female genital mutilation.

Planning and Regeneration

We will focus on the following during the coming four years:

- Create 300 new apprenticeships giving our young people the opportunity to forge a successful career.
- Continue our work in creating opportunities for residents to access training and jobs under the Haringey Guarantee and lead on this for North London.
- Continue to develop proposal for our key regeneration sites across the borough.
- Work with the College of Haringey, Enfield and North East London (CHENEL) to bring higher education opportunities closer to our residents.
- Work with traders across the borough to encourage residents to make the most of their local high streets and shop locally
- Use all of our powers to tackle rogue landlords who flout the law through illegal conversions.
- Help businesses to become greener and will support new businesses in the 'green economy'

2009/10 performance highlights

The borough's main additional employment support programme – Haringey Guarantee is on target for delivering its 218 sustained jobs in 2009-10. It also increased the number of community access points in the Borough to 40. Launched in 2008, The North London Pledge (NLP) extends the "Guarantee" to Enfield and Waltham Forest. Following a successful bid of £1.5m to the London Development Agency, the Pledge Programme, (in Haringey) is on target to deliver 110 employment support outputs and 57 people into sustained jobs. In February 2010 Haringey will contract to deliver NLP 2 - £2m over 18 months and 130 Haringey people into sustained jobs.

The Haringey Apprenticeship Programme was launched in 2009-10 and to date 62 places have been created in HSP organisations.

Over 2009-10, five town centre business partnerships have met and developed a range of local improvements including a loyalty parking scheme, Christmas events, local newsletters, loyalty shopping projects, local festivals and shop safely programmes. These happened across Wood Green, Green Lanes, Crouch End, Muswell Hill, Tottenham High Road/West Green.

The Haringey Olympics Programme was launched in Dec 2009. £180k will be allocated in 2010-12 for local projects that support elite athletes, sports participation and community/cultural cohesion.

In 2009-10 the Council consulted on and moved to agree its new Plan for Haringey 2011-26 (LDF Core Strategy). We published our LDF Annual Monitoring Report 08-09 which showed that we were on target for delivery of homes; improvement to parks; maintaining employment space and keeping town centres vibrant and viable. In 2009-10 the Council adopted a challenging target for carbon reduction – 40% reduction by 2020 on a 2005 baseline.

Progress was made on a range of major development sites across the Borough including: Coronation Sidings and Clarendon Square, GLS Site Hale Village, Tottenham Hotspur FC, Tottenham High Road and consultation was carried out on redesigning the Tottenham Gyratory and on options for the Greater Ashley Road Master Plan.

Children's Services

We will focus on the following during the coming four years:

- Open a new community secondary school in Wood Green, Heartlands High, in autumn 2010.
- Lobby government to protect funding for Sure Start children's centres.
- Complete the £212 million Building Schools for the Future programme
- Continue to improve our children's social care service with the aim of developing an outstanding service.
- Keep fighting for fair funding for Haringey children; addressing the inequity which means that central Government provide £1,000 less to teach each child than neighbouring inner London boroughs.
- Every school in the borough will be working towards becoming an eco-school, continuing our pledge that every young Pledge: We will work in partnership with Tottenham Hotspur football club to enhance our youth provision – giving young people an alternative to hanging around the streets.
- Upgrade play facilities

2009/10 performance

We have made significant changes in the way referrals and assessments are managed, and improved the support we offer our social workers through improvements to Framework-I, supervision, management and training.

Extensive auditing has demonstrated an improvement in the quality of practice. Better joint working with other areas of CYPS, particularly through Children's Networks, and with other agencies is ensuring that the service we provide is better able to meet the needs of the most vulnerable children.

Children's Networks services deliver both prevention and early intervention and support to children and young people who have additional needs, as part of a coordinated and joined-up approach to children, young people and their families.

Our services to children with disabilities have been enhanced by delivering the Aiming High programme which has resulted in a sharp rise in the number of families benefiting from short breaks.

Adult and Community Services

We will focus on the following during the coming four years:

- Develop extra care housing for our older people
- Extensive improvements to Lordship Recreation Ground
- Continue to support the work of our Friends of Parks groups

- Encourage the active involvement of all residents in looking after their parks and open spaces
- Aim to attract external funding from organisations such as the Heritage Lottery Fund to develop Bruce Castle to provide a focal point for heritage and culture
- Help people to help themselves and encourage our residents who have disabilities to take control of their own budgets, with our support
- Invest in allotments and seek new places for growing food in new developments
- Establish the “Haringey Circle”, a self-help service to help all generations to work together to solve problems and ensure independence and choice
- Provide an adult learning a facility to provide significant English language programmes as well as basic skills training in numeracy and literacy.

2009/10 Performance

Adult Social Care Services is Performing Well, consistently delivering above the minimum requirements for people, is cost effective and makes contributions to wider outcomes for the community. The next highest score is ‘Performing Excellently’.

The percentage of carers receiving a needs assessment or review and a specific carer’s service, or advice and information was 14.3% against a target of 11.2%. The percentage of vulnerable people achieving independent living was 81.5% against a target of 75%.

The use of libraries in the borough has increased. Bruce Castle Museum has just received the National Customer Service Award for Public Sector and Education. HALS is developing well following the successful Ofsted re-inspection. Enrolments to Adult Learning courses have increased significantly. This year we have extended the popular Libraries for Health by incorporating personal health checks. Two additional wellbeing suites are being installed in our libraries, one at St Ann’s and one at Hornsey.

White Hart Lane Active Strength Gym - Grand Opening Sunday July 09. The gym represents a new chapter in fitness training for borough residents with high quality strength training facilities. Free swimming introduced from April 09 to Over 60s and 16s and under. A new Outdoor Fitness (Trim Trail) facility installed in Albert Road Recreation Ground.

Eleven green Flags in 2009 for parks and open spaces. (2 new, 9 retained), and 4 Green Pennants won by community gardens (1 new, 3 retained). Parkforce Stewards (additional frontline staff presence) engaged /inducted, and deployed across 12 main parks from July, with emphasis upon evening and weekend cover.

Finance and Sustainability

We will focus on the following during the coming four years:

- Protect essential services for residents.
- Undertake a root and branch review of spending to cut waste and deliver better value for money.
- Make substantial progress on our commitment to achieve a 40 per cent reduction in carbon emissions.

- Establish a dedicated Carbon Management Service to maximise our efforts.
- Continue to carry out educational and awareness raising work around energy and water use, recycling, nature conservation, food growing and sustainable transport.
- Help homeowners to install energy saving measures which will not only tackle carbon emissions but cut energy bills
- Support the development of food co-operatives in the borough and help residents into sustainable food schemes.

2009/10 performance highlights.

Tottenham Town Hall: working in partnership with Newlon Housing Trust we are providing new homes, business units and community facilities in the heart of Tottenham. The development agreement will enable the refurbishment of the Town Hall and develop the Clyde Road depot site to include 109 new homes.

A new site at Cranford Way has been purchased to replace the existing recycling site at the former Hornsey Central Depot to provide improved facilities for residents.

We have made good progress with the first phase of our accommodation strategy in the creation of SMART working environments in Alexandra House and River Park House. This will release assets for disposal and reduce costs and improve the working environment for staff.

We set up a new Emergency Out of Hours Services to provide an enhanced service for residents and businesses, enabling people to report emergencies and get support outside the Council's normal office hours.

The Legal Service has developed areas of expertise in contracts; specialist litigation and social case so reducing our external spend in these areas.

For the past 4 years, Haringey Council has hosted and supported the London Energy Project. The project has successfully changed the way in which local government in the UK buys its energy. For this the Council was awarded recognition of Best Procurement Innovation in 2009.

Implementing the e-benefits project – a pilot went live in January 2010. This enables benefit claims to be assessed on line while the claimant is present at the customer services centre so reducing the time to process claims and providing a better service.

Working with Overview and Scrutiny

My cabinet colleagues and I are committed to assisting the Committee in the reviews and investigations you will undertake during the coming year. I would hope that the Committee will play its full part in supporting the delivery of key services and programmes outlined and as such I would like to wish the committee well for the coming year.



Overview & Scrutiny Committee

On 5th July 2010

Report Title: **Sustainable Community Strategy Summary Progress Report**

Report of: **Wayne Longshaw, Assistant Chief Executive.**

Signed :

Contact Officer : **Helena Pugh, Head of Policy, x2509**

Wards(s) affected: **All**

Report for: **Non-Key Decision**

1. Purpose of the report (That is, the decision required)

- 1.1. To present to Overview and Scrutiny the draft summary public-facing report, and to provide Overview and Scrutiny with an opportunity to give feedback on the draft report. The report sets out the key elements of the progress made against the outcomes in Haringey's Sustainable Community Strategy.

2. Introduction by Cabinet Member (if necessary)

- 2.1. The Sustainable Community Strategy sets out Haringey Strategic Partnership's vision and high level priorities for the borough. Extensive consultation was carried out to establish these priorities and the Council's role in delivering them. The second progress report reviews progress against the outcomes and priorities since January 2009 up to March 2010. It also looks ahead to what we will be doing in 2010-2011 to help the Haringey Strategic Partnership (HSP) to achieve what it said it would do. A summary public-facing version has been produced for Haringey's residents.

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. The Sustainable Community Strategy Summary Progress Report considers each of the six outcomes set out in Haringey's Community Strategy. It is supported by the council and partners' overarching plans and strategies.

4. Recommendations

4.1 Overview & Scrutiny is asked to note the report.

4.2 Overview and Scrutiny is asked to review the draft Summary Progress Report and provide any feedback to the Corporate Policy Team by Wednesday 7th July (please email feedback to Helena.Pugh@haringey.gov.uk).

5. Reason for recommendation(s)

5.1 Although the new coalition government has announced its intention to abolish the Comprehensive Area Assessment (CAA) it stresses the need to be transparent and accountable e.g.

- Create a new 'right to data' so that government-held datasets can be requested and used by the public, and then published on a regular basis.
- Ensure that all data published by public bodies is published in an open and standardised format, so that it can be used easily and with minimal cost by third parties.

5.2 The Second Progress Report will help us to demonstrate progress on our priorities over and above the work reported through the LAA. It uses qualitative examples of initiatives to complement our performance reports based on the Haringey Strategic Partnership (HSP) scorecard. The Summary Progress Report will help us to communicate our progress to a wider audience, particularly Haringey residents.

6. Other options considered

6.1. None

7. Summary

7.1 The Sustainable Community Strategy (SCS) second summary progress report sets out the key elements of the progress made against the outcomes of the SCS between January 2009 and March 2010. It also looks ahead to some of the next steps to be taken towards achieving the outcomes and priorities. The summary will be available on the Haringey website and an article will be included in Haringey People which is distributed to every household in the borough. The draft wording

for the summary report is set out in Appendix 1.

7.2 A full progress report has been finalised and was submitted to the Audit Commission as supporting evidence for the Comprehensive Area Assessment (CAA) self-assessment 2010, although following the new Coalition Government's announcement that CAA is to be abolished all the Audit Commission's work on updating the Area Assessment will cease with immediate effect. The full report will be made available on the Haringey website.

7.3 Developing the Progress Report

7.3.1 Contributions for the full progress report have been collated from the Haringey Strategic Partnership (HSP) Coordinators Group and officers from across the Council and the Partnership. The following criteria have been used to select examples for the summary progress report:

- Partnership focus
- Representative of the diversity of the borough
- People focus
- Outcome focus

7.3.2 The summary report is structured around the Sustainable Community Strategy's six outcomes. It showcases key achievements against each outcome and outlines our next steps for 2010-2011. Each outcome also includes a short case study and a 'facts and figures section' which identifies some of our key performance achievements.

7.3.4 Haringey's Press Office has reviewed the content and wording of the summary progress report and the report has been refined to incorporate this feedback.

7.3.5 The summary report will be designed and published on the Haringey website and an article will be included in Haringey People.

8. Chief Financial Officer Comments

8.1 Whilst the report sets out some of the key next steps, these are based on the current Community Strategy, Council Plan and manifesto commitments which were agreed before the general election. The new national coalition government has stated their objective for "a significantly accelerated reduction in the structural deficit over the course of a Parliament, with the main burden of deficit reduction borne by reduced spending rather than increased taxes"; inevitably some of this reduced spending will come from local government and, as part of the forthcoming budget planning process, the Council will need to re-visit its current medium term financial strategy the outcome of which could impact on the delivery of the Community Strategy.

8.2 The summary report will be made available on the Haringey website and an article will be included in Haringey People. All costs will be met from within existing budgets.

9. Head of Legal Services Comments

9.1. There are no legal implications attached to the summary progress report.

10. Head of Procurement Comments –[Required for Procurement Committee]

10.1. [click here to type]

11. Equalities & Community Cohesion Comments

11.1. Haringey's Sustainable Community Strategy was developed through a thorough needs analysis of the borough. Extensive consultation was undertaken with a range of stakeholders, residents, businesses, service users, voluntary and community groups and other organisations. Each of the Thematic Partnerships undertook a range of consultation activities. The needs analysis and consultation was used to inform the development of the outcomes and priorities of the strategy which will help to reduce barriers to equality across the borough.

12. Consultation

- 12.1. The Sustainable Community Strategy Progress Report has been developed in conjunction with the HSP Coordinators group; officers from across the Council and Partnership have also contributed to the document.
- 12.2. The Press Office has reviewed the wording and content of the summary report and their recommendations have been incorporated into the draft document.

13. Service Financial Comments

13.1. The summary report will be made available on the Haringey website and an article will be included in Haringey People. All costs will be met from within existing budgets.

14. Use of appendices /Tables and photographs

Appendix 1: Draft wording for the Sustainable Community Strategy Second Summary Progress Report.

15. Local Government (Access to Information) Act 1985

15.1. [List background documents]

15.2. [Also list reasons for exemption or confidentiality (if applicable)]

This page is intentionally left blank



Haringey's Sustainable Community Strategy

Second Progress Update Summary

January 2009 –
March 2010

A sustainable way forward

Introduction

Welcome to the second progress update on Haringey's Sustainable Community Strategy, which sets out the long-term vision for the borough.

This report gives a flavour of our achievements, which have helped to make a difference to the quality of life in Haringey and move us closer to our vision of being **a place for diverse communities that people are proud to belong to**. It also shows what we will be doing in the year ahead as we continue to improve services, support residents and make Haringey an even better place to live, work and visit.

If you would like a copy of the full version of this report or the Sustainable Community Strategy itself, visit: www.haringey.gov.uk/index/council/hsp/partnership_strategies_and_plans/sustainable-community-strategy.htm

Looking ahead

We know that for thousands of Haringey residents the recession has been an incredibly difficult time and we remain determined, in spite of the cuts, to do all we can to support those people who need our help. We will focus attention on ways of improving the local economy and helping to create work and apprenticeship opportunities for local people so that together we can pull together to minimise the impact of the financial climate.

We are committed to maintaining and improving standards in those areas which make a difference to the day-to-day life of our residents – from housing, health and recycling to libraries, parks, schools and community safety. We are determined to continue with improvements to our children's services and safeguarding to lift standards in Haringey to a level in line with the very best in the country.

Everyone at Haringey knows that it's not going to be easy, but we pledge to do everything possible to minimise the impact on the borough's residents.

Insert signature

Cllr Claire Kober, Chair of the Haringey Strategic Partnership and Leader of Haringey Council

Have your say– Be heard, get involved and shape the future

We are committed to providing services that Haringey people need and deserve and we recognise that listening to you can help us achieve this. We carry out consultations and surveys, and run events, to get the views of people who live, work in and visit Haringey.

We want to hear your views about local services and our future plans for Haringey. You can have your say by:

- attending your local [Area Assembly](#), Council meetings, [Safer Neighbourhood](#) Panel meetings, tenants and residents associations meetings
- taking part in consultation or a survey. Visit www.haringey.gov.uk/haveyoursay to let us know what you think of services delivered in Haringey or look in [Haringey People](#) magazine
- [becoming involved in local activities](#) to help your own community through volunteering, supporting local events, speaking to your local councillor about issues that are important to you, becoming a school governor, or improving your own skills via an adult learning course
- being involved with Haringey Health and Social Care LINK (Local Involvement Network) or [Patient Panels](#) to influence the way your local health and care services are provided. Simply contact the LINK office by phone 020 8888 0579 or email HaringeyLINK@shaw-trust.org.uk
- making a [suggestion, compliment or a complaint](#)
- signing or submitting a [petition](#)

You can find out about events by looking at Council and [HSP Partners' websites](#), [Haringey People](#) magazine, local newspapers and by picking up information at our libraries and customer service centres.

People at the heart of change: A cohesive community and a clean, attractive and well-built environment.

What we have achieved	<ul style="list-style-type: none"> • We have 14 award-winning parks and four award-winning community gardens. • We re-introduced the Clean Sweep Programme in Tottenham Green, Haringay, West Green and St Ann's following consultation with residents. The sweeps included enforcement patrols on litter, dumping and dog fouling, and gardening teams working on hedge cutting, weeding and planting. • During 2009/10 we completed 189 affordable homes through the Homes & Communities Agency's National Affordable Housing Programme. 146 were new builds, 10 were purchased for social rent, and 33 were delivered as shared ownership through the My Choice Home Buy scheme. • Our libraries are the most popular in London with almost 60% of people in the borough using them.
Our next steps	<ul style="list-style-type: none"> • As part of our Building Schools for the Future programme the new secondary school - Heartlands High - will open in September 2010 which will include specialist facilities for pupils with Autistic Spectrum Disorder, and we will complete work on a further 7 secondary schools in 2010. • As part of our programme to improve primary schools we will complete work on 9 primary schools during 2010. • From September 2010 parents will be able to follow their children's progress and attendance at school through a new ICT system. • We will use the Haringey 2012 Fund to encourage participation in sport, such as providing table tennis and coaching for residents aged over 50. • We will make more improvements to our parks and open spaces through a £10m renewal programme.
Facts and figures	<ul style="list-style-type: none"> • During 2009/10 we invested £10.5m to make it easier to get out and about in the borough e.g. street lighting, footways, road maintenance, bus priority scheme, local road safety schemes, cycling, walking and car club schemes. • We are reducing the number of households in temporary accommodation faster than any other authority in the country. • Every year there are around 15 million visits to Haringey's parks and open spaces. • Almost 90% of our schools now provide extended services such as childcare, adult education and leisure activities. • 80% of residents feel that their local area is a place where people from different backgrounds get on well together.

People at the heart of change: case study

Money to Move Smaller scheme.

We have invested a lot of time in helping residents to move out of large family homes and into smaller, more suitable homes of their choice.

Under our Money to Move Smaller scheme, residents living in large Council-owned properties are being asked to consider whether they would be better off moving to a smaller home. The scheme helps residents find a smaller property that they would be happy living in – either in or out of Haringey – and, in some cases, pays moving costs of up to £2,000. Some residents receive help to have their new home redecorated and are provided with new carpets and curtains. Council staff provide help, reassurance and advice throughout the moving process.

During 2009, we helped 63 households move to smaller, more suitable homes. These moves released 2 five-bedroom homes, 10 four-bedroom homes, 30 three-bedroom homes and 21 two-bedroom homes. One resident said: “The stress of moving was taken out of it for me. The housing officer was always available and gave me reassurance and advice when needed. It was a big step for me, but I am glad I took it.”

An environmentally sustainable future: Tackling climate change and managing our environmental resources more effectively.

What we have achieved	<ul style="list-style-type: none"> • We have introduced new and improved recycling services. • We have replaced more than 800 streetlights saving 30% of the energy of the previous lamps. • We have provided funding to set up En10ergy, a social enterprise which will promote and invest in local renewable energy. • We have planted an additional 850 trees. • We have introduced 27 car club vehicles at 14 street locations around the borough. • We have continued to promote cycling by introducing 14 Advanced Stop Lines and laying 400 metres of cycle and walking paths within Parkland Walk local nature reserve.
Our next steps	<ul style="list-style-type: none"> • We will deliver a £1.4m programme of cavity wall insulation in Council homes. • We will work with British Gas to deliver a £3m Community Energy Savings Programme in Northumberland Park Ward. • We will continue to promote recycling during the North London Watch Your Waste week in October 2010 and the National Recycling Week in November 2010. • We will expand the Car Club to 80 bays across the borough by the end of 2010/11 so that every resident and business would be within a five minute walk of a car club vehicle. • We will introduce 16 additional electric vehicle charge points in 2010/11.
Facts and figures	<ul style="list-style-type: none"> • Between 2005 and 2007 we achieved a 4% reduction in carbon emissions in Haringey, a reduction of 907 tonnes. • Haringey Council was the first major local authority to sign a pledge to cut carbon emissions by 40 per cent by 2020. • More than a quarter of the household waste in the borough is recycled • More than 40 Haringey schools have school gardens, growing fruit and vegetables and promoting composting.

An environmentally sustainable future: case study

Muswell Hill Low Carbon Zone

In partnership with the Muswell Hill Sustainability Group (MHSG) we have won support and funding from the Mayor and Greater London Authority (GLA) to create the Muswell Hill Low Carbon Zone (LCZ). The Zone will test how ambitious carbon savings can be achieved through measures which can later be rolled out across and beyond Haringey.

The MHSG has been leading action on climate change locally. The group's links with local residents, organisations and businesses bolstered the bid and meant that we were successful in winning support and funding to become create a low carbon zone. In December 2009 we were awarded further funding for the LCZ through the Department for Energy and Climate Change's 'Low Carbon Communities Challenge'. The project has received support from a number of organisations including Marks and Spencer, London Sustainability Exchange, Groundwork, faith groups, a library and local residents associations. For further details visit www.haringey.gov.uk/lcz

Economic prosperity and vitality shared by all: Increasing employment and educational attainment, tackling low income and poverty.

<p>What we have achieved</p>	<ul style="list-style-type: none"> • Overall education results for Haringey in 2009 were the best ever with continued improvements at Key Stages 2 and GCSE and clear evidence that Haringey is closing the gap with national results • We now offer 11 diplomas, combining class work and hands on experience, for 14-19 year olds. • Our Families into Work project has helped 98 families to access skills development and support into work. 15 people have started jobs, 14 have attended skills courses, and four have been on work placements. • We launched the Haringey Business Board to bring together traders from across the borough to bolster their strength in the face of the recession. • We delivered the 8th Wood Green International Short Festival, with over 200 film submissions, including 74 international films and 23 local films. 800 local people benefited from local screenings, workshops and the awards ceremony, which took place over 3 days in March • We have expanded Tetherdown and Coldfall Primary schools to provide more primary school places.
<p>Our next steps</p>	<ul style="list-style-type: none"> • We will deliver a £1m Future Jobs Fund creating up to 166 jobs for unemployed residents. • The North London Pledge 2 will support 400 people into employment across the Upper Lee Valley area. • We will launch a local Credit Union, a 'local bank for local people', which will help our residents to avoid costly credit. • We will continue to tackle child poverty e.g. we will ensure that new council tenants are offered benefit checks to help them to pay their rent; we will encourage take up of free school meals by providing more parent taster sessions • We will create another five classrooms at the Haringey Adult Learning Service (HALS) main learning centre in Wood Green Library and we will provide crèche facilities.
<p>Facts and figures</p>	<ul style="list-style-type: none"> • Our flagship employment and skills programme - The Haringey Guarantee – worked with 1,133 people during 2009/10 with 201 people supported into employment. • During 2009/10 we supported 700 businesses through workshops and business associations and helped 93 residents to set up their own businesses. • Haringey has been very successful in decreasing the numbers of 16 to 18 year olds not in education, employment or training (NEETs). Over the last five years NEETs have decreased from 11.6% to 6.8%. • Results for those gaining 5+ A*-C at GCSE in Haringey rose from 59.7% in 2008 to 67.7% in 2009 and are now 2.3% below the national result of 70%.

Economic prosperity and vitality shared by all: case study

Reaping the Benefit

The Reaping the Benefits Project (RBP) was set up in February 2007 as a joint outreach income maximisation and debt-counselling project between Haringey Council and Haringey Citizens Advice Bureaux Service. The project works with residents in Northumberland Park, Bruce Grove and Noel Park and provides advice from 12 venues moving locations as needs change. These have included: two children centres; a resource centre; a school; a health centre; a community centre; a learning centre and a housing association specialist employment centre. The project has also carried out door to door leafleting and made direct contact with residents to promote the service.

During 2009/10, 412 new clients received advice and advocacy from the project. The project raised £709,327 of welfare benefits and tax credits for the clients while £885,312 of debt was either deferred or written off with the project's assistance.

Safer for all: Reducing the incidents and fear of crime and anti-social behaviour; safeguarding children and adults.

What we have achieved	<ul style="list-style-type: none"> • We are working with Enfield to tackle cross border violence and gang issues. Our Gangs Action Group is supporting 23 people to deter them from gang activity. • 12 young people aged 18 to 23 have been patrolling the streets of Haringey to tackle anti-social behaviour and offer support to other young people. They have completed a youth work qualification and have also been given training in mediation skills, child protection, first aid and drugs and alcohol awareness. • The most recent external inspection of safeguarding services for children in Haringey judged that we have made good progress and have a good capacity to improve. • We have been taking active steps to retain skilled social workers and have attracted 18 qualified social workers.
Our next steps	<ul style="list-style-type: none"> • We will continue with an intelligence-led approach to tackling crime and anti-social behaviour. We will further develop area based working and the roll-out of zonal working. • We will maintain our focus on safeguarding children and vulnerable adults e.g. we will run a summer campaign with Morrisons to print information & contact details on adults' safeguarding on till receipts & carrier bags at the Wood Green store – their busiest Morrisons store in the UK.
Facts and figures	<ul style="list-style-type: none"> • Overall there has been a 7.4% reduction in the level of crime across the borough. • Robbery, residential burglary and motor vehicle crime have significantly reduced. • We have significantly reduced the numbers of young people aged 10-17 entering the Youth Justice System. • In 2009, there were 700 hours of Parkforce patrols and over 120 hours of additional police presence in our parks every week. • In 2009/10, 85% of residents said that they feel safe when outside in their local area during the day, up from 76% in 2008/09.

Safer for all: case study

Bus Stop Showdown

In 2008 it was recognised that gang issues and anti-social behaviour were increasing at one point on the High Road in N22 where there is a cluster of bus stops serving local schools and residents travelling towards the centre of Wood Green.

Following consultation with all those affected by the issues the Police, Haringey Council, Arriva London Buses, Transport for London (TfL), the I Can Care Ladies Group and the local secondary school worked together to agree the following solutions and improvements:

- Changes to the bus timetable
- Police community support officers travelling on the bus with the groups
- Introducing the use of a CCTV van

The action taken has had a great impact on bus related crime in Haringey such as:

- A reduction in the number of emergency calls made by bus drivers.
- A 33% reduction in robberies in the area close to the bus stop
- An overall reduction of 24% in total bus crime for the borough.

The processes used at this bus stop at school closing times have been so successful that we have used the same approach at other schools across the borough where similar issues have arisen.

Healthier people with a better quality of life: Tackling health inequalities amongst children and adults, promoting healthier lifestyles and independence.

What we have achieved	<ul style="list-style-type: none"> • We have opened Hornsey neighbourhood Health Centre bringing together 18 different health services under one roof, including GPs, an in-house pharmacy, Dementia Day Care centre and drop-in services for sexual health and family planning. • We have developed and piloted NHS Health Checks programme for the 40-74 age group to help prevent heart disease, stroke, diabetes and kidney disease. • Our Community Nutrition Assistants have provided advice on healthy eating to more than 800 older people in their own community languages. • We have piloted a Neighbourhood Wellbeing Network in Bounds Green, Haringay, Noel Park and Woodside to promote a range of services to residents over 75 years who are not already known to the Council's Adult Social Care Service or the Community. We have made contact with 178 residents, and helped 57 to receive the support and services to which they are entitled. • We have increased support to unpaid carers with over 800 receiving a one-off direct payment. • We have launched the HariActive programme to increase participation in physical activity
Our next steps	<ul style="list-style-type: none"> • We will continue to develop 'Personalisation', providing support to all adult social care users to help them achieve what they want to do with their lives. We will run a series of events for residents, current users of adult social care, their families and carers on the reform of adult social care, and the 'personalisation' of services. • By the summer of 2010 we will introduce an e-directory of social care and community support (plus the capability for e-shopping) to give wider access to information about support and services available in the borough. • We will continue our work to reduce smoking locally, including delivering Stop Smoking Clinics in areas with high levels of health inequality and promoting anti-smoking messages in schools.
Facts and figures	<ul style="list-style-type: none"> • Haringey's rate of smoking quitters is significantly above that of England • Life expectancy in the borough continues to improve. Female life expectancy is higher than both London and national averages • During our Chlamydia screening promotion there was a 34 per cent increase in the number of tests requested by phone, online and text. • Teenage pregnancy rates in Haringey have fallen by a quarter. In 2007, 248 young women between 15 and 17 became pregnant, but this reduced to 184 young women by 2008. • Since the launch of the HariActive programme in June 2009, there have been 746,000 attendances at activity sessions.

- 39 schools provide a **breakfast club service** for pupils. Nineteen of these, mainly located in the east of the borough, offer free [breakfast club](#) places for children receiving free school meals or presenting with behaviour problems, poor attendance and punctuality.
- 85% of Haringey's schools are now accredited **Healthy Schools**.

Healthier people with a better quality of life: case study

Libraries for Life.

Our libraries have worked with NHS Haringey and voluntary and community sector organisations to offer a highly innovative range of services to promote health and well-being – the **Libraries for Life** programme.

The Lifestyle Behaviour project - one of four projects running - involves weigh-in days where people are encouraged to achieve their ideal weight and general life ambitions. Another is the Skilled for Health course where adults' numeracy and literary skills are improved so that they can read labels on tins of food to improve awareness of what they are eating. Help with budgeting is also provided.

Libraries for Life is now an accredited centre for delivering YMCA health and fitness courses. During 2009-10, 23,608 people accessed health information through Haringey libraries; 3,161 people received a free comprehensive health check; 730 people had their blood pressure checked by the Stroke Awareness team; 3,300 people have attended free classes including stretch your mind and body classes, yoga classes and Tai Chi; and 989 people used the workshops and 'back to work' coaching sessions which help with CV writing, interview techniques and job application.

People and customer focussed: Promoting opportunities for community involvement and volunteering and delivering high quality, customer focused services that offer value for money.

<p>What we have achieved</p>	<ul style="list-style-type: none"> • We have made it easier for people to get in touch with adult social care services with the launch of the Integrated Access Team. This team is now the first point of contact for new Adult Social Care users and their carers and families, as well as for those looking for general advice and information about services and activities locally. • We have introduced the Family Information Services Directory where you can find services, support and activities in Haringey and national information to help parents, carers and their families. The directory won a National Customer Service Award. • We have created the 'My Service @ 18' partnership, to provide a smoother transition from children's to adults' services for those with learning disabilities • We have set up four patient panels across the borough, which help local people to get involved with the running of their GP practice and share their views to improve services for fellow patients. • As part of National Democracy Week we held a Young People's Question Time, giving local young people a chance to quiz a panel of VIPs including the Leader of the Council and the Borough Police Commander. • Two young people from Haringey helped 'take over' the Houses of Parliament. One of them became the first young person to open a debate in the House of Commons. • 1400 Third Sector Organisations had the opportunity to participate in a mapping project which provided detail data about the Third Sector in Haringey on matters such as their source of income, assets and beneficiaries etc and an action plan has been developed. This work supports the local priority <i>environment for a thriving Third Sector</i>.
<p>Our next steps</p>	<ul style="list-style-type: none"> • We will continue to develop high quality needs assessments to ensure that our services meet the needs of local communities. • We will ensure that our Neighbourhood Plans address the issues that residents of local areas have told us are important to them. • We will make the voluntary sector an integral part of local problem solving through the Area Based Working initiative. Check happening • We will identify and develop community champions and active citizens - focusing on young people and hard to reach communities.
<p>Facts and figures</p>	<ul style="list-style-type: none"> • 81% of people surveyed thought that the Police dealt with the things that matter • 85% of GP's patients are satisfied with the care they receive at their surgery • 100% of Homecare service users surveyed said they were treated with dignity and respect. 74% said that the service they received was very good or good and 23% stated it was satisfactory. • 69% of residents agreed that they had received fair treatment from their local services

- Haringey's **Third Sector Organisations** give a total of 217,000 volunteer hours per month and a total of 2.6 million volunteer hours per year. The approximate value of volunteering work is £25 million per annum.
- In 2009/10, **Haringey Volunteer Centre** referred 1,537 residents to organisations that sought volunteers and 72 volunteer placements were made, the Centre also provided one-to-one support to 69 local people and dealt with 1,380 applications for volunteering.

People and customer focussed: case study

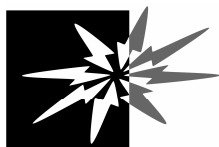
Area Assemblies Priorities Consultation

Between November 2009 and February 2010 we held Area Priority Consultations in all seven Area Assemblies. These sessions gave local residents the opportunity to discuss and record the issues they felt were most important for their local area.

Residents were asked to prioritise different issues such as 'cleaner streets', 'resident engagement in decision-making', 'activities for children and young people', and 'support for local businesses'. Residents were organised into small groups to discuss issues under each Sustainable Community Strategy outcome, and to prioritise them using different coloured stickers.

There was a very positive response from residents to the process. The meetings were lively and interactive with real opportunities for residents to engage in discussions about service provision. 266 residents across the borough as well as Councillors, Council officers and HSP partners took part in the process. The results of the consultations are being used to develop the local plans and shape service delivery. The responses have been shared with the Police and NHS Haringey to inform future work.

This page is intentionally left blank



Haringey Council

Overview and Scrutiny Committee

On 5th July 2010

Report Title: **Scrutiny Review of Post Office Closures: follow up report**

Report of: **Councillor Bull, Chair of Overview & Scrutiny**

Contact Officer : Martin Bradford

Email: Martin.bradford@haringey.gov.uk Tel: 0208 489 6950

Wards(s) affected: **All**

Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

- 1.1. In February 2008, Overview and Scrutiny Committee commissioned a review of post office closures in Haringey which formed part of a local submission to the consultation on London wide post office closure plan.
- 1.2. The attached is a follow-up report which provides details of the outcome of the consultation and possible future developments for the post office network.
- 1.3. That the Overview and Scrutiny Committee note the contents of the attached report.

2. Introduction by Cabinet Member (if necessary)

- 2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

- 3.1 The provision of post offices may relate to desired outcomes from the Sustainable Community Strategy (2007-2016):
 - People at the heart of change: promoting community cohesion.
- 3.2 There are no relevant targets within the Local Area Agreement to which the provision of post offices directly relate.

4. Reason for recommendation(s)

4.1. Overview and Scrutiny follows up the conclusions and recommendations of reviews undertaken by the Committee or commissioned panels. This usually takes place between 12-24 months after the review has been completed.

5. Other options considered

5.1 Post Office Ltd will also be attending the meeting to respond to questions from the Committee.

6. Summary

6.1 In 2008, Post Office Ltd announced the closure of 2,500 post offices as part of the reconfiguration of the post office network (the Network Change Programme). Post Office Ltd conducted a six week consultation on the planned closures in London from February 2008 through to April 2008.

6.2 The Overview and Scrutiny Committee undertook a review of the post office closures in Haringey. The information collected through this review was then submitted as evidence to the consultation on the planned closure programme for London.

6.3 As a result of the consultation, 6 post offices were closed:

- 100, Alexandra Park Road N10
- 434, West Green Road, N15
- Salisbury Road, N22
- 69, Weston Park, N8
- Ferme Park Road, N4
- Highgate High Street, N6.

6.4 One post office earmarked for closure in Haringey was reprieved and was maintained in the local network of post offices:

- Page Green, Broad Lane, N15.

6.5 The report details the national impact of the post office closure in respect of the following:

- The consultation process for the closure programme
- Financial viability of network
- Quality of services provided
- Social impact

6.6 The report sets out how local how local authorities have been involved in supporting local post offices and outlines legislative and policy developments for the post office network being considered for the future.

7. Chief Financial Officer Comments

7.1 There are no direct financial implications arising from the issues raised in this report. The Council currently does not have any budgetary provision regarding Post Office interventions or assistance.

8. Head of Legal Services Comments

8.1. The Head of Legal Services notes the contents of this report and advises that there are no specific legal comments at this stage.

9. Service Financial comments

9.1. There are no immediate financial implications arising from this report.

10. Head of Procurement Comments – [Required for Procurement Committee]

10.1 N/A

11. Equalities & Community Cohesion Comments

11.1 The report makes clear that a significant weakness of the post office closure programme was the paucity of social and economic impact assessment data to accompany the Network Change Programme. Similarly, there has been little research on the social impact of the closures since these have actually taken place.

11.2 What limited assessments have been undertaken would suggest that those with mobility problems (disabled people or older people) or limited access to transport services may have been disproportionately affected by the post office closure programme, particularly where these have occurred in rural areas.

13. Consultation

13.1 A brief survey has been developed to provide a snapshot of local opinion on post office closures, This has been distributed to Area Assemblies in the areas in which post offices have been closed. A verbal summary will be presented at the meeting.

14. Use of appendices /Tables and photographs

14.1 A list of the remaining post offices in Haringey is given in the main body of the report (Appendix A).

15. Local Government (Access to Information) Act 1985

15.1 Information sources are fully referenced within the main body of the report.

1. Introduction

- 1.1 In 2008, Post Office Ltd announced the closure of 2,500 post offices as part of the reconfiguration of the post office network (the Network Change Programme). 169 of the planned closures were in London and seven were located directly in Haringey or adjacent to its borders. Post Office Ltd conducted a six week consultation on the planned closures in London from February 2008 through to April 2008.
- 1.2 The Overview and Scrutiny Committee undertook a review of the post office closures in Haringey. The review heard evidence from a wide range of local stakeholders including elected representatives, sub-postmasters, community groups and local residents. The information collected through the review was then submitted as evidence to the consultation on the planned closure programme for London.
- 1.3 This report provides an overview of the outcome of the consultation on the Network Change Programme, both nationally and more locally here in Haringey. Conclusions from national evaluations of the Network Change Programme are summarised together more recent legislative and policy developments concerning the future of the post office network.

2. Background

- National context for the Network Change Programme
- 2.1 Prior to the development of the Network Change Programme in 2008, a national network of approximately 14,300 post offices was in operation. 3% of these post offices were directly managed by Post Office Ltd (Crown Post Offices) and the remainder were franchised to sub-postmasters and operated as a private business.
- 2.2 Since 2002 however, there has been a marked decline in demand for traditional post office services. This in part has been due to:
- the introduction of direct payments for welfare benefits
 - more people paying utility bills by direct debit
 - use of alternative mail services (i.e. email).
- 2.3 The loss of central government contracts and business has also contributed to a decline in the use of post offices. It is noted that between 2003/4 and 2007/8, the proportion of post office business derived from government contracts fell from 43% to 26%.¹ With a declining footfall, post offices have also found it difficult to market other services that they provide.
- 2.4 As a result of declining demand for services fewer people have been using post offices: in 2005, 1,600 post offices had fewer than 20 customers per day and there were 4 million fewer visits to post offices in 2006 than in 2004.² Declining use and loss of business has impacted on the financial viability of the post

¹ Oversight of the post office Network Change Programme, Public Accounts Committee 2009

² Post Office Network: A consultation Document Department of Trade & Industry DTI, 2006

office network: a £100million operating loss was recorded each year from 2003-2007.

2.5 The Network Change Programme was developed to rationalise the post office network and was part of a broader cost reduction strategy established by Post Office Ltd.³ Although 2,500 post office closures were deemed necessary to help bring the network back in to profitability, closures would be structured in such a way as to maintain minimum access criteria.⁴ The Network Change Programme was expected to cost £176m (mainly through compensation provided to sub-postmasters) but was projected to save £45m annually.

2.6 Consultation for the restructuring of the post office network took place in two stages. Firstly, an 11 week national consultation was undertaken by the government in December 2006. This primary consultation established:

- the economic rationale for the post office closure plan
- the total number of post office closures (i.e. 2,500)
- minimum access criteria for the remaining post office network
- specification for local consultations (i.e. 6 weeks).

2.7 Post Office Ltd were then required to conduct local consultations on post office closures to the criteria established through the national consultation. In total, 42 local area plans were developed, which provided details as to how post office closures would be structured in these areas. Consultation on the first of the area plans commenced in January 2008. The main purpose of the local consultations was to establish whether the facts on which the local closures were based were correct.

Scrutiny review of post office closures in Haringey

2.8 The Overview & Scrutiny Committee commissioned a review of the planned post office closures in Haringey. To support the collection of evidence, a one-day event was held at which a broad range of local stakeholders attended including elected representatives, sub-postmasters, local community groups and local residents. The aim of the review was to collect evidence on the planned closure of individual post offices which would then be collated and submitted to the consultation on the London Area Plan (of the Network Change Programme).

2.9 On the evidence received, the review panel drew a number of conclusions about the Network Change Programme. The panel concluded that:

- the national consultation on the closure programme was inadequate
- the local 6 week consultations were insufficient to allow local people to develop reasoned and meaningful responses
- the local consultation exercise was flawed as this did not:
 - provide financial data on the planned closures
 - fully assess the capacity of alternative post office
 - contain accurate data in branch accessibility reports

³ Other elements of this cost reduction strategy included reducing central administration, restoring crown post offices to profitability and developing new business.

⁴ 95% of total urban population to be within 1 mile of their nearest post office: 95% of rural population to be within 3 miles of their nearest post office.

- the social impact of closures, in particular the implications for community cohesion, were not fully assessed.

2.10 In light of the evidence received within the review process, the scrutiny panel of eight local members concluded that the Network Change Programme would not support key aspirations for a socially and environmentally sustainable Haringey and could not support the closure of any of the planned post office closures. In this context, the panel recommended that the programme of closures should be suspended.

3. Outcome from the consultation on the Network Change Programme

3.1 By March 2009, after 42 consultations on local area plans had been conducted, Post Office Ltd decided to proceed with the closure of 2,383 post offices. Although 92 post offices earmarked for closure were reprieved, a further 48 were substituted for closure. Thus, of the planned 2,435 closures within the Network Change Programme, 98% were confirmed within consultation decisions.

3.2 As of March 2009, there were 11,952 post office branches in the UK, compared to 13,567 at the end of March 2008.

3.3 Of the 169 proposed post office closures in London, 7 were reprieved in the consultation decision. Thus, the remaining post office network in London would comprise of 688 post offices. Under the newly established access criteria, 99.9% of the population would still be within 1 mile the remaining post office network in London.

3.4 Seven post offices were earmarked for closure in Haringey, and although one post office was reprieved within the London area plan consultation decision, Post Office Ltd decided to proceed with the closure of six post offices in or (adjacent to) Haringey. These were:

- 100, Alexandra Park Road N10
- 434, West Green Road, N15
- Salisbury Road, N22
- 69, Weston Park, N8
- Ferme Park Road, N4
- Highgate High Street, N6.

3.5 Thus as a result of the Network Change Programme, the post office network in Haringey was reduced from 25 to 19 post offices. A list of remaining post offices in Haringey is contained in Appendix A.

3.6 Analysis of the consultation decision document suggested that the consultation received two critical pieces of evidence concerning the reprieve of the post office at Page Green, 100 Broad Lane, N15. These were:

- the number of sheltered housing residents adjacent to proposed post office closure and the implications for older and vulnerable residents in accessing alternative post offices

- the prospect of planned future development near the proposed post office closure which may increase future demand for post office services in this area.

3.7 As part of the Network Change Programme, one Crown post office was identified for franchise (824, High Road, Tottenham, N17). As a result of a separate consultation on the franchise of Crown offices, Post Office Ltd decided to proceed with this franchise of this post office.

4. National evaluations of Network Change Programme

4.1 A number of public bodies have sought to assess the Network Change Programme and to determine what impact post office closures have had. Consumer Focus,⁵ ⁶ National Audit Office,⁷ House of Commons Public Accounts Committee⁸ and the House of Commons Business & Enterprise Committee⁹ ¹⁰ have all carried out assessments of the Network Change Programme. A summary of the key findings and conclusions from these assessments are have been grouped together under the following headings:

- the consultation process
- financial impact
- impact on service quality
- social impact

The consultation process

4.2 It was noted that the consultation exercise for the Network Change Programme engaged with approximately 2.7 million people and generated about 190,000 formal responses. Despite these record responses, it was evident that there were a number of inherent problems in the consultation process which led to widespread public concern and frustration.

4.3 A summary of the main problems associated with the consultation for the network change programme is given below:¹¹

- The public were broadly unaware that a national consultation on the post office closures had already taken place and that this had already established the rationale for the closures and the total number of closures to be implemented
- The national consultation and the local area plan consultations were too far apart (18 months) and as a result, any initial public awareness or insight obtained after the national consultation was lost

⁵ How was it for you? Consumer engagement in the post office closure programme. Consumer Focus February 2010

⁶ Evaluating the quality of service and product advice in Crown and Privately managed post offices Consumer Focus December 2009

⁷ Oversight of the post office network change programme, National Audit Office (DBERR) June 2009

⁸ Oversight of the Post Office Network Change Programme House of Commons Public Accounts Committee 53rd report 2008/9 session July 2009

⁹ Post offices – securing their future. House of Commons Business & Enterprise Committee June 2009

¹⁰ After the Network Change Programme: the future of the post office network House of Commons Business & Enterprise Committee June 2008

¹¹ How was it for you? Consumer engagement in the post office closure programme. Consumer Focus February 2010

- The length of consultations on local area plans (6 weeks) were insufficient to allow local communities to engage and respond appropriately
- Local consultations failed to provide adequate guidance on what was being consulted upon (i.e. the accuracy of data on which closures were based) and what information would be acceptable (i.e. evidence not petitions)
- Consultation materials produced to support local consultations were poor.

4.4 Thus although the consultation on the Network Change Programme recorded a record number of participants, it has been suggested that it did not actively engage with local people. As a result, the consultation failed to fully understand what impact post office closures would have on local communities and also gave rise to community frustration as people felt that they could not influence decisions through the consultation process. In its evaluation of the Network Change Programme, Consumer Focus (which incorporates Postwatch) concluded that the evaluation was 'flawed'.

Financial impact

4.5 The implementation of the Network Change Programme was forecast to cost £176m by way of compensation paid to sub-postmasters of closed post offices. It was estimated that the closure programme, if fully implemented, would produce an annual saving of £45m for Post Office Ltd.

4.6 The actual cost of implementing the Network Change Programme was £156m (£20m below forecast) as compensation was not as high as expected. There is evidence to suggest that the Network Change Programme has also achieved the expected annual savings and contributed to an improved financial position for Post Office Ltd:

- The network transformation programme contributed to a £85m reduction in costs for Post Office Ltd¹²
- Improved operating profits from £41m in 2008/09 to £72m in 2009/10¹³
- Post Office Ltd is on track to return to profitability by 2011.

4.7 Ongoing concerns remain however, as to whether the rationalisation of the post office network will achieve lasting financial security for the post office network, when there may be other significant factors contributing to the profitability of Post Office Ltd. Both the Public Accounts Committee and the Business & Enterprise Committee have noted that increasing revenue streams, particularly from central and local government, is critical to the future financial sustainability of the post office network.

4.8 To help maintain unprofitable post offices within the network, especially in rural areas, Post Office Ltd receives an annual Network Subsidy Payment of £150m. It is noted here, as reported Commons committee's assessments; continued receipt of this subsidy is important to overall profitability of Post Office Ltd. At present, this payment has only been agreed until 2011/12.

¹² <http://www.shareholderexecutive.gov.uk/performance/postoffice.asp>

¹³ Postcomm 9th Annual Report 2010

- 4.9 In an overall appraisal of the financial health of Post Office Ltd, it has been noted that considerable improvement has been achieved in the financial position of the company and that there is a 'new vigorous and commercial leadership' which may help to develop new business opportunities.¹⁴

Service Quality

- 4.10 An assessment of the quality of post office services is undertaken each year, most recently by Consumer Focus.¹⁵ The assessment is based on a mystery shopper model, with a team of evaluators providing assessments on over 400 post office branches. The most recent survey was conducted in 2009, after the implementation of the Network Change Programme. For comparability, as far as possible, the same post offices were included within sampling structure for successive assessments. The following highlights some of the key findings from this assessment in relation to queues, waiting times, counter positions and quality of service provided and staff interaction.
- 4.11 Data from the mystery shopper exercise would appear to suggest that in the year to 2009, the average queue length has decreased in Crown post offices though increased in privately managed post offices (Figure 1). 27% of Crown post offices did not have a queue at the time of the visit in 2009 compared to 16% in 2008. 40% of privately managed post offices did not have a queue at the time of the visit (the same as previous years).

Figure 1 - Average queue length at post offices 2006-2009				
	2006	2007	2008	2009
Crown	8.3	8.5	7.3	5.9
Privately Managed	3.8	3.8	2.9	3.1
All	5.9	5.9	4.9	4.3

- 4.12 Although the number of people in post office queues would appear to have reduced between 2008 and 2009, the average time spent queuing increased (Figure 2). Time spent waiting in the queue has increased for Crown post offices and privately managed post offices (Figure 2). It should be noted that the average waiting time in post offices in Greater London (6m 59 sec) is significantly longer than the national average (4 min 38 sec).

Figure 2 - Average time spent waiting in queue 2006-2009				
	2006	2007	2008	2009
Crown	5m 20sec	6m	5m 40 sec	6m 07 sec
Privately Managed	3m	3 m 50sec	3m 10sec	3m 34sec
All	4m 10sec	4m 50sec	4m 20sec	4m 38sec

- 4.13 In terms of counter positions at post offices, the average number of counter positions in each branch appears to have decreased from 2008 to 2009 (Figure 3).

Figure 3 - Average number of counter positions in each branch 2008-

¹⁴ Post offices – securing their future. House of Commons Business & Enterprise Committee June 2009

¹⁵ Evaluating the quality of service and product advice in Crown and Privately managed post offices Consumer Focus December 2009

2009		
	2008	2009
Crown	8.01	7.56
Privately Managed	4.64	4.52
All	6.16	5.79

- 4.14 Data would also indicate that the average number of counters actually open and accepting customers has marginally decreased from 2008 to 2009 (Figure 4). The proportion of counters open and accepting customers across the network however, has increased from 52% in 2008 to 56% in 2009.

Figure 4 - Average number of counter positions open and accepting customers in each branch 2008-2009		
	2008	2009
Crown	4.0	3.9
Privately Managed	2.5	2.5

- 4.15 The evaluation indicated that the time spent with each customer increased at both Crown and privately managed post offices from 2008 to 2009 (Figure 5). It was also noted that the average time spent with customers at post offices in Greater London was significantly longer at 4m 37sec.

Figure 5 - Average time spent with each customer 2008-2009		
	2008	2009
Crown	3m 30sec	4m 11sec
Privately Managed	3m 40sec	3m 50sec

- 4.16 In terms of satisfaction with the quality of services provided, there was a high level of satisfaction with the interpersonal skills of counter staff. In the mystery shopper exercise, over 95% of assessments indicated that counter staff spoke clearly, were easy to understand, listened to requests, dealt with enquiries efficiently and were helpful. It was also noted that satisfaction scores for 2009 were consistently higher than that recorded for 2008. Satisfaction scores at Crown post offices are also consistently higher than those obtained in privately managed post offices.
- 4.17 Although this service quality assessment would suggest that there is some national improvement on a range of performance measures, it should be noted that these are, on the whole, average responses for post offices within the mystery shopper sample. Thus there may be significant local variations in performance to those reported above. There is at present no national set of quality standards for the post office network (e.g. queuing, waiting times, service quality), though this has been proposed in recent assessments.¹⁶

Social Impact

- 4.18 The Network Change Programme has been criticised for the paucity of social and economic assessments of post office closures within consultation

¹⁶ Oversight of the Post Office Network Change Programme House of Commons Public Accounts Committee 53rd report 2008/9 session July 2009

literature.¹⁷ Similarly, there has been little assessment of the social or economic impact of post office closures enacted through the Network Change Programme.

4.19 One of the few studies to assess the social impact of the Network Change Programme was undertaken in Wales. This report from Consumer Focus Wales¹⁸ concluded that:

- Reduced access to post office impacted on the most vulnerable communities the most: elderly, disabled and those with long term conditions, those on low income or reliant on public transport
- Those with a disability or health problem reported difficulties in accessing alternative services and in queuing for long periods of time
- Post office closures have reduced social/community interaction which has broken a community link.

4.20 On the recommendation of the Public Accounts Committee, Postcomm was requested to undertake an assessment of the social and economic value of the post office network (not an impact assessment of the closures). This report seeks to attach a quantifiable monetary value to the post office network as a whole for services that it provides. Three key conclusions reached within this report:¹⁹

- considering the costs and benefits, the post office network delivers excellent social value
- for a sizeable proportion of the population, the post office network provides services which is not readily available elsewhere
- the estimated annual value of the post office network to households and Small and Medium size Enterprises is between £2.3billion and £10.2 billion.

Local impact of closures

4.21 The impact of the post office closures in the remaining post office network in Haringey is difficult to assess given the lack of publicly available data for local post offices (e.g. in respect of queues, waiting times). An issue here is that the vast majority of post offices within the local network are franchised, and as such, are operated as private financial concerns. In this context, Post Office Ltd may be limited as to what information can be placed in the public domain.

4.22 Post Office Ltd will be attending Overview & Scrutiny Committee on the 5th July, for which a detailed list of questions has been prepared from local elected representatives and whose responses will be circulated before the meeting. Members will also be able to question Post Office Ltd at the meeting.

4.23 A short survey has been designed to provide a snapshot of local opinion on the impact of the post office closures. This was distributed via relevant local Area Assemblies. Although a larger and more structured study would be needed to fully assess the local impact of post office closures, it is hoped that this short survey will provide some insight in to local opinion. Given the timing of the

¹⁷ Oversight of the Post Office Network Change Programme House of Commons Public Accounts Committee 53rd report 2008/9 session July 2009

¹⁸ Post Office Closures: the impact of the Network Change Programme, Consumer Focus Wales February 2010

¹⁹ The social value of the post office network NEFRA Economic Consulting (for Postcomm) August 2009

Area Assembly cycle, findings from this will be fed back verbally at the Committee.

5. Local authority role in supporting local post offices

National developments

5.1 In their role as community leader and place shapers, it has been argued that local authorities can play a part in developing a sustainable network of local post offices.²⁰

5.2 Local authorities may support the local post office network through enabling branches to receive payments for a number of council services, for example council tax or rent of local housing. Not only do these provide a revenue stream for local post offices, but they also provide footfall for local branches which may provide an opportunity to market other post office services.

5.3 As has already been suggested in this report, the loss of post offices, particularly in rural areas, may diminish community links and ties. Therefore the prospect of post office closures within the Network Change Programme drew a number of local authorities to consider further options on how the network of post offices could be supported in their area.

5.4 The Local Government Association has provided some illustrative examples of how local authorities have supported local post offices. In general, models of support have centred upon either:

- developing new business streams for post offices (across a local network)
- providing financial grants to ensure the viability of identified post offices (particularly in rural areas).

5.5 A number of local authorities have developed new services to help support business income across a local network of post offices. Some examples of this are provided below:²¹

- Ealing Council: Council tax rebate was administered through post office
- London Councils: post offices used for document submission for Freedom Pass renewal
- Leeds City Council: school clothing payments.

5.6 In terms of grant provision, the Essex Post Office initiative operated by Essex County Council is perhaps the most widely known. This £1.5m scheme has supported the re-opening of 8 post offices through the provision of grant payments. In return, the individual business agrees to provide a range of community information and other council related services from their premises. An evaluation is to be published imminently, where it is thought that this scheme will be substantially remodelled.

5.7 To date, only one post office has been recorded as being operated directly from a local authority building (Newtown St Boswells, Scottish Borders Council).²²

²⁰ Local councils – supporting a sustainable post office network Local Government Association January 2010

²¹ Local councils – supporting a sustainable post office network Local Government Association January 2010

²² <http://www.scotborders.gov.uk/news/29274.html>

The Council hosts the post office for 3 days a week, though this is operated and staffed by Sub-postmaster from a neighbouring locality.

- 5.8 The National Federation of Sub-Postmasters which represents the owners of franchised post offices has published guidance on how to develop a local sustainable post office network.²³ Whilst the NFSP suggest that local authority ownership of local post offices is not a viable support model, it recommends that local authorities play a vital role in supporting the local post office network through:
- Ensuring the provision of council business through local post offices
 - Supporting independent local retailers and ensuring the vitality of local retail centres.

Local developments

- 5.9 Subsequent to the publication and implementation of the Network Change Programme, council officers reviewed the potential of reopening of one or more of those post offices earmarked for closure in Haringey. In liaison with Essex County Council, who had already established a model of intervention, Alexandra Park Library was identified as a possible site at which an outreach service could be developed (to substitute services from the closed Alexandra Park Road post office).
- 5.10 Although initial discussions with a sub-postmaster from a neighbouring post office to operate an outreach service from the Alexandra Park Library site were positive, proposals did not come in to fruition. There were a number of factors which militated against these proposals:
- Post Office Ltd would require a substantial payment to allow a new outreach service to access its support structure (£40k)
 - The sub-postmaster reported significantly increased profits arising from the closure of neighbouring post offices which may have been a disincentive to open an additional post office outreach service.

6. Future developments for the post office network

National legislative developments

- 6.1 In the Queen's Speech of 25th May 2010, a programme of 24 Bills was proposed by the new coalition government. Included within current parliamentary programme is the Postal Services Bill. Although details of the Bill have not been published as yet, it is apparent from the coalition document²⁴ and other summary statements provided thus far, that there will be a number of provisions relating to the operation of the post office network.
- 6.2 The main benefits of the Postal Services Bill would be to safeguard the future of the Royal Mail and the Post Office network. The proposed purpose of the Postal Services Bill concerns the part privatisation of Royal Mail:

²³ Six steps to a sustainable post office network: A report by the National Federation of SubPostmaters (March 2009)

²⁴ The Coalition: our programme for government Cabinet Office 2010

*'...tackle the fundamental and longstanding problems facing Royal Mail.... [and] enable an injection of private capital, along with other measures, to help Royal Mail and ensure the provision of the universal postal service.'*²⁵

- 6.3 A number of commitments to the post office network are also made within the coalition document. These are:
- Post Office Limited will remain in public ownership
 - Post Offices will be allowed to offer a wide range of services in order to sustain the network, and a case for developing new sources of revenue, such as the creation of a Post Office Bank, will be assessed.

The Hooper Review (2008)

- 6.4 The Hooper Review²⁶ was published in December 2008. Although the remit of the review was to find ways to maintain a universal postal service, a number of observations were made about the viability of the post office network which are useful to include here. In addition, suggested solutions for financial viability of Royal Mail Ltd may have implications for Post Office Ltd (being a subsidiary business).

- 6.5 The review recommended that the Post Office Ltd remain in public ownership and formed the following conclusions on the operation of the business:
- Although it is a commercial business, it has a social obligation: ¾ of the network of 12,000 post office do not make a profit and need to be subsidised
 - The operation of the post office network is central to universal postal service
 - There is potential for the post office network to be used more extensively.

- 6.6 One of the options developed within the review was the part-privatisation of Royal Mail Ltd. This option has been included in government Bills in the 2008/9 parliamentary session and of course, the current parliamentary session (see 6.2). It is difficult to predict the impact that part privatisation of Royal Mail may have on post offices, though as the National Federation of Sub-postmasters makes clear, the businesses of Royal Mail and Post Office Ltd are inextricably linked:²⁷
- Royal Mail services accounts for 1/3 of sub postmasters pay
 - ½ of all visits to post offices are for postal services
 - 900 post offices also house Royal Mail delivery staff.

- 6.7 It is noted that the mail regulator Postcomm, supports the complete separation of Royal Mail and Post Office Ltd. Supposed benefits of a de-merger between these public services may:²⁸
- allow both services to concentrate on the separate challenges that face their businesses

²⁵ www.number10.gov.uk

²⁶ Modernise or decline – Policies to maintain the universal postal service in the United Kingdom. An independent review of the postal services sector. Richard Hooper CBE

²⁷ <http://www.nfsp.org.uk/>

²⁸ Postcomm 9th Annual Report 2009

- provide greater commercial freedom for the business (new contracts with other businesses)
- improve financial transparency between Royal Mail Ltd and Post Office Ltd.

6.7 Clearly, the businesses of Royal Mail and Post Office Ltd are closely linked. Therefore a move to part-privatise Royal Mail or separate these businesses may have future implications the post office network.

7. Conclusions

7.1 A summary of the main conclusions that may be drawn from this report are given below:

- The Network Change Programme was developed to rationalise the post office network and help restore Post Office Ltd to profitability. There is evidence to suggest that this has been achieved.
- Local assessments of the consultation process on the post office closure programme concurred with national evaluations: there was little awareness of the national consultation programme, 6 local consultations were too short and there was insufficient analysis of the social and economic impacts of closures.
- Although the consultation on the Network Change Programme allowed for the reprieve of one post office in Haringey, the decision to proceed with a further 6 closures was confirmed. Approximately 2,400 post offices were closed nationally within this programme.
- There were inherent problems with the consultation on the Network Change Programme which precipitated considerable local frustration and has drawn strong criticism from national consumer organisations.
- It is evident that the impact of post office closures has been felt most keenly by more vulnerable groups in the community, especially those who have restricted mobility which may limit their ability to use alternative post office services.
- National data would appear to suggest that there has been little impact on service quality arising from the programme of post office closures: queues lengths are down, queuing times are up though a greater proportion of counters are open. There may however be local exceptions to this pattern of national data.
- Although the Network Change Programme has reduced costs and contributed to improved profitability of Post office Ltd, it is clear that the development of new business streams will be critical in maintaining the ongoing financial viability of the post office network.
- Local authority interventions to support the post office network have been most prominent where post office closures have occurred in rural

communities, as the loss of this service may present a break of community ties.

- A Postal Services Bill is to be tabled in the forthcoming parliamentary session. Although details of the Bill have yet to be published, it is expected that it will confirm that Post Office Ltd will remain in public ownership and will aim to develop new business for the company. It will also provide for the part privatisation of the parent company (Royal Mail), for which the implications for post office services is unclear.

Appendix A - Remaining post offices in Haringey (Total = 19)

Green Lanes, Haringay, N4
Archway Road, N6
Topsfield Parade, Crouch End, N8
High St, Hornsey, N8
Turnpike Lane, N8
Muswell Hill Broadway, N10
Alexander Parade, Colney Hatch Lane, N10
Brownlow Road, N11
Seven Sisters Road, Tottenham, N15
West green Road, Tottenham, N15
Page Green, Broad Lane, N15
534 High Road, Bruce Grove, N17
824 High Road, Tottenham, N17
Great Cambridge Road, Tottenham, N17
Mount Pleasant Road, Tottenham, N17
Park Lane, Tottenham, N17
191 High Road, Wood Green, N22
358 High Road, Wood Green, N22
Lordship Lane, Wood Green, N22

This page is intentionally left blank


Overview and Scrutiny Committee
On 5th July 2010

Report Title: **Scrutiny Review of Breast Screening Services**

Report of: **Councillor Winskill, Chair of the review panel**

Contact Officer : Martin Bradford

Email: Martin.bradford@haringey.gov.uk Tel: 0208 489 6950

Wards(s) affected: **All**

Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

- 1.1. That the Overview and Scrutiny Committee approve the recommendations laid out in the attached report.

2. Introduction by Cabinet Member (if necessary)

- 2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

- 3.1 The Sustainable Community Strategy plan for 2009-2011 identified the need to:
- increase the uptake of cervical and breast screening including amongst non-English speaking communities.
- 3.2 The review may assist achieving the following Local Area Agreement targets:
- NI 119 - Self reported measure of peoples overall health and wellbeing
 - Local - Prevalence of breast feeding at 6-8 weeks (indirect)
- 3.3 The Comprehensive Area Assessment (CAA) has highlighted that one of the key challenges for Haringey is to increase the uptake of breast screening.

4. Reason for recommendation(s)

4.1. Reasons for the recommendations are covered within the main body of the attached report.

5. Other options considered

5.1. N/A

6. Summary

In June 2009, the Overview and Scrutiny Committee commissioned a review of the uptake of breast screening services in Haringey. The review sought to assess how the uptake of breast screening services could be improved in Haringey.

As part of the review process the panel:

- heard evidence from local commissioners and service providers
- heard evidence from specialist screening agencies
- consulted local women who had used the breast screening service
- visited the local breast screening service.

In analysis of the evidence received the panel identified a number of interplaying factors which may influence a woman's decision to take up their invite for breast screening. These were:

- structural issues– the development of screening lists, call and recall system
- operational issues – location of clinics, appointment times, out of hours services
- socio-demographic issues – age, ethnicity, social deprivation
- attitudinal – personal anxiety, perceptions of importance or relevance.

The panel highlighted a number of areas where it was possible to identify a number of interventions which may help improve the uptake of breast screening services in Haringey. The panel made a number of recommendations in three key areas:

- improved accessibility of breast screening clinics
- greater involvement of primary care in the breast screening process
- the need to develop more localised public health information and awareness for breast cancer.

7. Chief Financial Officer Comments

7.1 There are no direct financial implications arising for the Council as a result of the implementation of these recommendations. However, the impact of the recommendations should be closely monitored in order to assess any future financial implications that may arise.

8. Head of Legal Services Comments

8.1 There are no legal comments.

9. Service Financial comments

9.1. The report focuses on strategic and policy issues arising from NHS activity with regards to breast screening services.

9.2. The recommendations in the report refer to services commissioned by NHS Haringey. There are no direct financial implications within the recommendations for the Council.

9.3. Financial implications arising from the recommendations will be included in the formal response to the review by NHS Haringey.

10. Head of Procurement Comments – [Required for Procurement Committee]

10.1. N/A

11. Equalities & Community Cohesion Comments

11.1 This review has highlighted areas within the established equalities strands (age, gender, religion, disability, ethnicity and sexuality), where potential local inequalities may exist in the incidence of breast cancer, the take-up of breast cancer screening and resultant health outcomes.

11.2 The review has identified the following inequalities in the incidence of breast cancer:

- Gender: women 100x more likely to develop breast cancer than men
- Age: 4 in 5 cases of breast cancer are diagnosed in women over 50 years
- Ethnicity: Ashkenazi Jewish women 1.5x times more likely to develop breast cancer
- Lesbians: convergence of multiple risk factors may make this group more susceptible to developing breast cancer

11.3 The review has identified the following inequalities in the uptake of breast cancer screening:

- Age: younger women in the age screening group (50-70) less likely to attend
- Ethnicity: different cultural beliefs and perceptions of breast cancer impact on screening uptake among black and other minority ethnic groups: e.g. attitudes toward screening and perceptions of risk
- Disability: women with a learning disability or mental health problem are known to have lower levels of attendance at breast screening.

11.4 The review has identified the need to improve breast screening uptake in Haringey,

as this will help to ensure that screening programme reaches the diverse range of cultural and ethnic communities that reside in Haringey. The review also recommends that efforts to improve breast screening uptake should be supported by active awareness raising, health promotion and public health interventions among those community groups at greater risk of developing breast cancer or who are known to not attend for breast screening.

13. Consultation

13.1 Throughout the scrutiny review process, evidence has been considered from commissioners (NHS Haringey and North London Breast Screening Service), service providers (North London Breast Screening Service) and regional screening representatives from NHS London and London Quality Assurance Reference Centre to help inform conclusions and recommendation.

13.2 Women who have used local breast screening services were also consulted in the review process: a survey was administered to service users (65 responses) and two focus groups held (10 participants). Analysis of this data has been used to inform conclusions and recommendations developed in the review.

13.3 NHS Haringey (service commissioners) and North London Breast Screening Service (service providers) have been consulted on the conclusions and recommendations contained within the review.

14. Use of appendices /Tables and photographs

14.1 Please see contents page in main report for appendices.

15. Local Government (Access to Information) Act 1985

15.1 A full list of all data sources are fully referenced in the body of the attached report.



Scrutiny Review of Breast Screening Services in Haringey



www.haringey.gov.uk

**A REVIEW BY THE OVERVIEW AND SCRUTINY
COMMITTEE**

June 2010

For further information:

Martin Bradford
Research Officer
Overview & Scrutiny
7th Floor River Park House
High Road
Wood Green N22 4HQ
Tel: 020 8489 6950
Email: martin.bradford@haringey.gov.uk

Foreword

In 2007 over 45 000 people were diagnosed with breast cancer.

The effects on the individuals and their families and friends is devastating and incalculable. However, like so many other cancers, early detection can increase the survival chances considerably. It is estimated that 1,400 lives are saved each year through the operation of the National Breast Screening Programme.

This scrutiny review set out to examine the reasons why women in Haringey tended to make less use of the North London Breast Screening Service (NLBSS) than their sisters in many other parts London. Working with health professionals and women themselves, our review panel looked at a wide variety of possible reasons why and have come up with a range of recommendations, most of which we feel will not only improve take up rates, but also represent value for money.

The publication of this review also coincides with the digitalisation of the NLBSS. It is expected that this will enable more sensitive imaging help improve quality assurance processes by enabling the comparison of past and present images.

While chairing this review I and my colleagues have been impressed by the depth of knowledge and commitment of those who work in the service and the broader NHS. I would like to thank them for the time and advice they gave our Panel.

I must also thank my fellow councillors who contributed so much, Martin Bradford our excellent support officer and, of course, all the women of Haringey who offered their opinions and ideas on how to improve the Service.



Cllr Winskill (Chair of the Scrutiny Review Panel)

**Other members of the review Panel:
Cllr Alexander, Cllr Beynon, Cllr Bull.**

CONTENTS

1. **Executive Summary**
2. **Recommendations**
3. **Introduction**
4. **Background**
 - Epidemiology of breast cancer
 - Treatment and care
 - National Breast Screening Programme: uptake, coverage
 - Breast Screening Services in Haringey
5. **Legislative and Policy Framework**
6. **Aims of the review**
7. **Methods used for the review**

Key findings from the review

8. **Performance of breast screening service**
9. **Factors which affect breast screening uptake**
10. **Commissioning breast screening services**
11. **Improving uptake - operation of breast screening services**
12. **Improving uptake - primary care and breast screening**
13. **Improving uptake - other community interventions**

Appendix A – Figures and charts

Appendix B – Review participants

Appendix C – Invite to breast screening consultation

Appendix D – Patient Questionnaire

Appendix E – NLBSS invite for screening

Appendix F – Service User Consultation Report

1. Executive Summary

- 1.1 Over 45,000 women are diagnosed with breast cancer each year which makes this one of the biggest causes of cancer among women in the UK. Although there have been significant improvements in the detection and treatment of breast cancer, it is still a major cause of adult female mortality: approximately 12,000 women died from breast cancer in 2007 alone.
- 1.2 The National Breast Screening Programme (NBSP) was launched in 1988, and today, screens nearly 2 million women each year. The introduction of the breast screening programme has led to the earlier detection of breast cancers which has helped to improve treatment options and survival rate for those women diagnosed with this condition. It is estimated that 1,400 lives are saved each year through the operation of the NBSP.
- 1.3 Breast screening services in Haringey are commissioned by a consortium of local PCTs (including NHS Haringey) and services provided through the North London Breast Screening Service (NLBSS). As a result of the temporary suspension of this service in 2006/7, an extended round length was agreed for the service which meant that women were screened every 46 months instead of the nationally agreed standard of 36 months. As a result, the breast screening coverage (the proportion of women who have had a breast screen in the previous 3 years) in Haringey is low at just 51%, the second lowest nationally.
- 1.4 Like many other London boroughs, there is a poor uptake to breast screening invites in Haringey. In 2008/9 just 55% of women in Haringey who were invited actually attended for a breast screen. This was also a 4% decline on the uptake for breast screening invites in Haringey for 2007/8. What is clear, is that both nationally and locally breast screening uptake has been broadly static for a number of years, which would suggest that positive interventions are necessary to help increase the number of women who attend for screening.
- 1.5 The key function of any health screening programme is that it appropriately targets the population most at risk and encourages them to screen, in this case women aged between 47-73 years of age. A high uptake for screening services is also important as it is integral to the effective and efficient operation of screening services. Areas where screening services have a low uptake may exacerbate local health inequalities.
- 1.6 The Overview & Scrutiny Committee at Haringey Council commissioned a review of breast screening services to help identify ways in which local breast screening performance could be improved. As part of the review process the panel:
- heard evidence from local commissioners, breast screening providers and local GP collaborative lead
 - heard evidence from specialist screening agencies
 - consulted local women who had used the breast screening service

- visited the local breast screening service.

1.7 The review received evidence from a range of sources which suggested that there were a number of interplaying factors which may influence a woman's decision to take up their invite for breast screening. Although the panel identified the need for further local research a number of themes were identified which influenced the uptake of breast screening services:

- structural issues– development of screening lists, call and recall system
- operational issues – location of clinics, appointment times, availability of out of hours services
- socio-demographic issues – age, ethnicity, social deprivation
- personal attitudes – individual anxiety, perceptions of individual risk

1.8 The panel noted that work was already being undertaken locally to help improve breast screening uptake, most notably the Social Marketing project and the Health Trainers project, but these projects were in their infancy and had not resulted in practical changes as yet. The panel also welcomed the development of the Breast Screening Action Plan with NHS London, and hoped that this would provide local impetus for prioritising and coordinating efforts to improve breast screening uptake in Haringey.

1.9 The panel highlighted a number of areas where it was possible to identify a number of interventions which may help improve the uptake of breast screening services in Haringey. The panel have made a number of recommendations in three key areas:

- improved accessibility of breast screening clinics
- greater involvement of primary care in the breast screening process
- the need to develop more localised public health information and awareness of breast cancer.

1.10 The panel were mindful of the fact that public finances would be tight in future years and that additional resource to drive improvements may be limited. To this end, the panel have sought to identify recommendations which do not need additional resources, though acknowledged that additional investment may be needed to bring about sustained improvement in breast screening uptake. Similarly, the panel indicated that there were as yet untapped opportunities for further involvement of the wider strategic partnership in developing breast screening uptake, and it is suggested that the newly developed Breast Screening Action Plan provides the kernel for developing a more inclusive and borough wide strategy.

1.11 Screening has the potential to make a significant contribution to the early diagnosis and treatment of breast cancer and can best be achieved through uptake strategies that emphasize wide coverage, improved access and equitable distribution of cancer screening services. It is intended that the following report and recommendations contained within it, will guide and inform the development of local strategies to improve breast screening uptake among women in Haringey.

2. Recommendations

- 2.1 Understanding why women do not attend for breast screening (DNA) is of critical importance to improving screening uptake, to this end, the panel recommended that NHS Haringey should conduct regular research with the screening population to help identify screening needs and the barriers that local groups and communities face in accessing screening services.
- 2.2 The panel recommended that NHS Haringey should ensure that more effective use is made of the lists of women who have not attended for breast screening (DNA reports). As per Westminster Model, NHS Haringey should consider commissioning GPs or local Public Health services to actively follow up non-attendees.
- 2.3 To assist with the identification and analysis of factors that contribute to compliance with breast screening, the panel recommended that there should be improvements to the way that data is collected, collated and analysed of women who **do** attend, particularly in relation to the ethnicity of attendees and other socio-demographic factors (age-group, postcode).
- 2.4 To ensure that breast screening lists are accurate and up to date, the panel recommended that GPs undertake regular, systematic and specific data cleaning to ensure that all eligible women are included in screening lists. (NHS Haringey may wish to consider this as part of a wider Local Enhanced Service for GPs).
- 2.5 The panel recommended that NHS Haringey ensure that there is adequate and fully validated information flow (e.g. eligible population lists, uptake, coverage) between key stakeholders (NHS Haringey, NLBSS and local GPs) in the breast screening pathway and that this informs local initiatives to tackle low screening uptake (i.e. at specific practices).
- 2.6 To ensure that there is adequate patient feedback in to the breast screening commissioning cycle and to help benchmark quality performance, the panel recommended that independent randomised patient satisfaction audits should be undertaken on an annual basis which should explicitly assess service accessibility (and other patient experience data).
- 2.7 To help improve service accessibility for those women who do not speak English, the panel recommended that NLBSS amend the breast screening invite to include a short statement in relevant community languages which refers service users to where they may obtain further breast screening information (this could be done in conjunction with other screening units).
- 2.8 To help improve information available to women prior to screening, the panel recommended that NLBSS amend the breast screening invite to signpost women to the NLBSS website where more detailed information about breast screening can be obtained (on screening location, making and changing appointments and information in community languages).

- 2.9 The panel noted that the invite was of critical importance to service accessibility and as such recommended NLBSS fully test the invite for readability, understanding and relevance on an ongoing basis.
- 2.10 To improve accessibility to breast screening clinics, the panel recommended that NHS Haringey should commission a feasibility study to assess potential suitable breast screening sites in Haringey. In particular this study should assess:
- shorter-term options for developing mobile screening unit access at neighbourhood health centres (polyclinics) and other community locations
 - longer-term options for the development of a static screening site in a central Haringey location.
- 2.11 The panel recommended that NHS Haringey/ NLBSS consider ways in which access to out-of-hours breast screening appointments can be improved for women resident in Haringey, in particular, to develop out-of hours access to sites within the Haringey locality (or neighbouring borders such as NMH, Whittington or Forest Road Polyclinic).
- 2.12 To support local primary care involvement in breast cancer screening the panel recommended that, and in line with other neighbouring primary care organisations, NHS Haringey should consider the implementation of a Local Enhanced Service for Breast Screening. This could be developed on the Westminster model to incentivise general practice to:
- appoint a GP screening lead in each practice
 - issue pre-invitation letters to screening population
 - develop list cleaning procedures
 - undertake training prior to breast screening round
 - promote breast screening during screening during round
 - systematically contact non-attendees at breast screening clinics (or other body named in 2.2)
- 2.13 To support the identification and dissemination of good practice, identification of training needs and effective cascading of breast cancer screening information, the panel recommended that a network of breast cancer leads are identified across the borough: at PCT wide level, local collaborative and individual General Practice level. The panel recommend that screening leads convene biennially.
- 2.14 The panel noted the importance of developing breast screening interventions that are both effective and sustainable, to this end, the panel recommended that a second timed appointment is routinely sent out to non-attendees at the breast screening unit.
- 2.15 To support population wide initiatives to improve breast screening uptake, it is recommended that a programme of community interventions is commissioned by the NHS Haringey, which seek to raise awareness of breast cancer, publicise the benefits of screening and provide interventions which target and promote uptake amongst those women known not to attend breast screening

(i.e. black and minority ethnic groups), or who are at particular risk of developing breast cancer (i.e. Ashkenazi Jewish), where uptake is low (known GP practices) or are particularly vulnerable (women with a learning disability or mental health problem).

- 2.16 To support community interventions to improve breast screening uptake, the panel recommended that newly appointed Local Health Trainers liaise with individual practices at an early stage in the screening round to undertake targeted development and awareness work with community groups and among eligible women in that practice area.
- 2.17 The panel welcomed the development of the Breast Cancer Screening Action Plan which is to be agreed and monitored through NHS London. The panel felt that this process could be supported further through the development of a more localised breast screening action plan which:
- defines how local partners and other community stakeholders can support the improvement of screening uptake
 - establishes clear priorities for directing local action and resources to improve screening uptake
 - sets clear targets and milestones for improving screening uptake.
- 2.18 Whilst there is sufficient capacity for the planned age extension for breast screening (47-73 years by 2012), the panel recommended that NHS Haringey (with other commissioners) should assess future demand and capacity at NLBSS to reflect future demographic changes and anticipated improved screening uptake.

3. Introduction

- 3.1 Breast cancer is the most common cause of cancer amongst women where approximately 45,000 are diagnosed with this condition each year. To help early cancer detection and to improve health outcomes, women aged between 50 and 70 years are invited for a breast screen via the National Breast Screening Programme (NBSP) every 3 years. Almost two million women are screened each year within this programme and it is estimated that this process helps to save up to 1,400 lives annually.¹
- 3.2 For screening programmes to be both clinically and cost effective, it is important to ensure that as many of the target population as possible are invited for screening and encouraged to take up that appointment offered. It has been noted that screening programmes which have a low uptake can be less effective and may exacerbate inequalities in health-service provision.²
- 3.3 As a result of a number of serious untoward incidents³ and safety concerns at the NLBSS, the decision was taken to temporarily suspend this service in 2006. Although the service reopened in May 2007, this was a phased reintroduction of services where breast screens were agreed to be offered at 46 months intervals instead of the national standard of 36 months.
- 3.4 The period of closure and the phased reintroduction of screening services have impacted on the breast screening performance in Haringey, particularly the breast screening coverage.⁴ In 2008/9 the breast screening coverage for Haringey was 51% which was significantly below comparative figures for both London (65%) and England (76%) and was the second lowest nationally.⁵
- 3.5 The proportion of women who are invited for a breast screen who actually attend their appointment is also known to be low across in Haringey. In 2008/9, just 55% of women invited for a breast screen in Haringey attended, which was significantly below the national average (74%).⁶
- 3.6 Against this backdrop, the Overview and Scrutiny Committee commissioned an in-depth review of local breast screening service provision, in particular to assess how the uptake to breast screening services could be improved in Haringey. This report details the work of the review panel and the conclusions and recommendations made on assessment of the evidence it has received. It is hoped that the recommendations within this report will guide and inform local service commissioning to help improve breast screening uptake in Haringey.

4. Background

¹ Screening for Breast Cancer in England: Past and Future, Advisory Committee on Breast Cancer Screening NHSBSP Pub. No 61 (2006)

² Weller et al (2009) Uptake in cancer screening programmes *Lancet* 10 (7) 693-699

³ A serious untoward incident is an event which has serious repercussions for a patient, employee or member of staff for whom the NHS has a duty of care.

⁴ The coverage is the target population who have screened in the past 3 years i.e. women aged 50-70.

⁵ National breast screening data 2008/9 www.cancerscreening.nhs.uk

⁶ National breast screening data 2008/9 www.cancerscreening.nhs.uk

Epidemiology breast cancer

- 4.1 Breast cancer is the irregular development of cells within the breast which may lead to the development of a tumour. There are two types of breast cancer; *ductal carcinoma* which is contained in ducts within the breast and *invasive* breast cancer, where the cancer has spread to broader breast tissue. If left untreated, breast cancer can also spread (metastasis) through the blood stream to other parts of the body.
- 4.2 Breast cancer accounts for 31% of all female cancers and is the most common cause of cancer among women in the UK. Although men may also develop breast cancer, this accounts for less than 1% of all breast cancer cases. In 2006, there were 45,822 new cases of breast cancer diagnosed of which 45,508 (99%) were among women and 314 (1%) among men. The approximate lifetime risk of women developing cancer is 1 in 9 whilst for men this is 1 in 1,014.⁷
- 4.3 The **incidence** of breast cancer is a measure of the likely risk that a person will develop this condition over a specified period of time. In 2006, the age standardised incidence of breast cancer was 122 per 100,000 of the female population. The incidence of breast cancer among women has risen considerably since 1977 (recorded at 75 cases per 100,000), which has largely been due to improved detection through the introduction of the NBSP.⁸
- 4.4 **Prevalence** is a measure of how many people there are living with a particular condition, that is, those who are surviving after diagnosis and treatment. It is estimated that there are currently 550,000 women in the UK surviving with breast cancer which equates to 2% of the total female population or 12% of the adult female population over 65.⁹

The risk factors associated with breast cancer

- 4.5 There are a number of risk factors associated with the development of breast cancer. The main risk factors are summarised in the table below.

Risk factor	Detail – breast cancer risk.
Gender	Women are 100 times more likely to develop breast cancer than men.
Age	81% of breast cancers occur in women over the age of 50 ¹⁰
Childbearing (parity)	Child bearing women have a 30% lower risk ¹¹ and have greater protection through the number

⁷ UK Breast cancer incidence statistics. Research UK (data from 2001-2005) June 2009

⁸ CancerStats Breast Cancer UK Cancer Research UK May 2009

⁹ CancerStats Breast Cancer UK Cancer Research UK May 2009

¹⁰ Cancerstats Key Facts Cancer Research UK (2010)

¹¹ Evertz et al Age at first birth, parity and risk of breast cancer: meta-analysis of 8 studies from the Nordic countries *International Journal of Cancer* 1990 (46) 597-603.

	of children they have and the earlier at which child birth starts. ¹² Uptake and duration of breastfeeding also reduces risk. ¹³
Hormones Hormone Replacement Therapy (HRT) and Oral Contraception (OC)	Early menarche and late menopause are associated with increased breast cancer risk. ¹⁴ Women on HRT have an increased risk of 66%. ¹⁵ Women taking the OC have an increased risk of 24%. ¹⁶
Family history	Women with a first degree relative with breast cancer are twice as likely to develop cancer as those with no family history. ¹⁷
Lifestyle	Women living in more affluent areas may experience up to 20% increased risk than those living in deprived areas. ¹⁸ Post menopausal women who are overweight or obese have an increased risk of between 10-30%. ¹⁹ The link between alcohol and breast cancer is causal ²⁰ where 11% of the total annual incidence attributable to its consumption. High levels of physical activity can reduce risk by between 20-40%. ²¹
Ethnicity	A 1.5 fold increase in risk is recorded among Ashkenazi Jewish population. ²²
Sexuality	Lesbian women exhibit different risk factors which has produced a higher level of overall risk. ^{23, 24}

Breast Cancer treatment and care

4.6

The treatment for breast cancer will depend on the stage of development at which the cancer has been detected, the age of the patient and the size of the tumour. A combination of surgery and radiotherapy is the most common

¹² Breast cancer and breast feeding: collaborative reanalysis of individual data from 47 epidemiological studies and 50,302m women with breast cancer The Lancet 2002 360 p187-95

¹³ Breast cancer and breast feeding: collaborative reanalysis of individual data from 47 epidemiological studies and 50302m women with breast cancer Lancet 2002 360 p187-95

¹⁴ Breast cancer and HRT collaborative reanalysis of 51 epidemiological studies. Collaborative group on hormonal factors in breast cancer The Lancet 1997 (350)1047-59.

¹⁵ Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data of 53,297 women with breast cancer and 100,239 women without cancer from 54 epidemiological studies.

¹⁶ Breast cancer and HRT in the million women study The Lancet (2003) 363 419-427

¹⁷ Family breast cancer: collaborative reanalysis of individual data from 52 epidemiological studies The Lancet 2001 (358) pp1389-99

¹⁸ Cancer incidence by deprivation 1995-2004) National Cancer Intelligence Network 2008

¹⁹ Reeves et al, Cancer incidence and mortality in relation to Body Mass Index in the Million Women Study: cohort study BMJ 2007 (335) 1134

²⁰ Baan et al Carcinogenicity of alcoholic beverages International Agency for Research on Cancer 2007

²¹ Lahmann et al Physical activity and breast cancer risk: the European Prospective Investigation into Cancer and Nutrition. Cancer Epidemiology Biomarkers Prev. 2007 Jan;16(1):36-42. 2006

²² Ferris et al (2007) A population-based audit of ethnicity and breast cancer risk in one general practice catchment area in North London, UK: implications for practice Hereditary Cancer in Clinical Practice 5 (3). pp. 157-160.

²³ Roberts et al, Differences in Risk Factors for Breast Cancer: Lesbian and Heterosexual Women Journal of the Gay & Lesbian Medical Association Vol. 2 No. 3 (1998) pp93-101

²⁴ Dibble et al Comparing breast cancer risk between lesbians and their heterosexual sisters, Women's Health Issues, Volume 14, Issue 2, pp 60-68

approach though most will have some form of surgery (i.e. either a lumpectomy, mastectomy).

- 4.7 The stage at which breast cancer is diagnosed can have a significant impact on the treatment options and subsequent survival rates of those women diagnosed. Generally, earlier detection leads to longer survival rates. One year, five year, 10 year and 20 year survival rates for breast cancer have all improved. In 1971-1975 the five year survival rate for breast cancer among women was 52%, yet by 2001-2003 this had risen to 80%.²⁵ The 10 year survival rates have also increased from 41% to 72% in the period 1991-2003.²⁶ Improved survival rates are attributable to earlier detection (through the NBSP) and improved treatments.
- 4.8 Despite improving survival rates, breast cancer is still a major cause of mortality: 11,990 women died from breast cancer in 2007. Mortality rates however, have fallen dramatically since 1989: the age standardised death rate has fallen from 42 per 100,000 (in 1989) to 27 per 100,000 (a 36% fall).²⁷ This reduction in mortality is, again, largely attributable to earlier detection through the NBSP and improved treatment options.
- 4.9 In seeking to reduce the impact of breast cancer, there are a number of preventative strategies which can be employed:
- For those with a high risk of developing breast cancer **Prophylactic surgery** is available, which can reduce the risk by approximately 90%
 - **Education and awareness** campaigns can seek to modify behavioural risks (alcohol consumption, obesity) or seek to promote positive health behaviours (exercise, breast care, screening)
 - Although **screening** cannot prevent breast cancer, an effective screening programme can help to detect cancers earlier which can lead to improved treatment options, better health outcomes and improved survival rates.

Breast cancer screening (National Breast Screening Programme)

- 4.10 Breast cancer screening (mammography) involves a low dose radiation scan to identify abnormal cell development or growths (tumours). Generally two scans are undertaken, both from above (craniocaudal) and from the side (mediolateral) of the breast as this increases the chances of detecting smaller cancers. It is noted that breast screening helps to detect up to 40% of cancers which could not be detected by other methods (i.e. by hand).²⁸
- 4.11 Breast screening services are coordinated through the NBSP, which was first established in 1988. Breast screening is a cyclical programme where all eligible women (currently aged 50-70 years) are invited to a free breast screen every three years. Invitations are issued by a local breast screening unit to women on a local area, General Practice basis (i.e. practice by practice).

²⁵ CancerStats Breast Cancer UK Cancer Research UK 2009

²⁶ Office for National Statistics Breast Cancer Survival in E & W 1991-2003

²⁷ CancerStats Breast Cancer UK Cancer Research UK 2009

²⁸ CancerStats Breast Cancer UK Cancer Research UK 2009

- 4.12 Those women responding to the breast screen invite will be screened by a radiographer who will take x-rays of the breast and these images will be examined for potential abnormalities (usually two specialists). Those women identified as having an abnormal mammogram will undergo a further second assessment. If the abnormality is confirmed as malignant it will be treated (e.g. lumpectomy, chemotherapy), if it is normal, the woman will be returned to the recall system and invited for screening again in 3 years time. The full breast screening pathway is depicted in Figure 7.
- 4.13 Women aged below 50 years are not included within the NBSP as breast cancer can be difficult to detect in pre-menopausal women. Other women who may be symptomatic or believed to be at risk but who are outside the current screening age range can still be referred for one-off breast diagnosis or onto a family history programme through their GP to a symptomatic service and remain outside the screening programme until they reach 50 years. It is planned to extend the NBSP to women between the ages of 47 and 73 years by 2012, which will involve an additional 400,000 women in the screening process.
- 4.14 There are 82 breast screening units in the UK. Local breast screening units are coordinated by a national service and breast screening practice is overseen by both a national and regional quality assurance network. The NBSP costs approximately £75 million to administer each year, which equates to £37.50 per woman invited or £45.50 per woman screened.

Breast screening services in Haringey

- 4.15 Breast screening services for women in Haringey are provided through the North London Breast Screening Service (NLBSS), one of seven such screening units in London. This specialist service is commissioned by a consortium of 6 PCTs (Barnet, Brent, Enfield, Haringey, Harrow & West Hertfordshire). In 2008/9, this service screened almost 39,000 women across all 6 PCTs making this one of the largest breast screening units in the country.
- 4.16 In 2008/9, there were 19,116 women in Haringey eligible to be part of the screening programme (i.e. aged between 50-70 years). As screening is every three years, approximately 1/3 of this eligible population would be invited for a breast screen each year (though the actual annual number would vary depending on what practices are scheduled in each of the three years of the screening round). Thus on average, about 6,000 women in Haringey would be screened each year.
- 4.17 Responsibility for the planning, commissioning and performance management of breast screening providers rests with Primary Care Trusts (PCT), though quality assurance and other governance issues are managed through NHS London and specialist commissioned agencies (London Quality Assurance Reference Centre). The cost of the NLBSS in 2008/9 was approximately £3.5 million of which NHS Haringey contributed £482k.
- 4.18 As a result of a number of serious untoward incidents in 2006 an evaluation of the NLBSS was undertaken by the London Quality Assurance Reference

Centre (QARC). This identified weaknesses in results procedures, process errors in the issuing of invites and non compliance with established radiography protocols. As a result the decision was taken to suspend the NLBSS in December 2006.

- 4.19 Although the NLBSS service reopened in May 2007, services were reintroduced on a phased basis. It was agreed that the service would operate with a screening round length²⁹ target of 46 months until 2010, which would allow the service to manage screening catch-up in a planned manner. The extended round length has however, severely impacted on other local breast screening performance measures.

Breast Screening Uptake

- 4.20 The uptake for breast screening is defined as 'the proportion of eligible women who have been invited for screening for whom a screening result is recorded'. The national minimum standard for breast screening uptake is 70% though the national target is higher at 80%.

- 4.21 National data from that NBS for 2008-9 reveals that 2.28 million women were invited for a breast screen of which 1.68 million women attended, which produced an uptake rate of 74%. Nationally, this uptake rate has remained broadly static for the past 6 years (**Figure 1**). The proportion of women who take up their breast screening invitation in London and within the North London Breast Screening Service (in which Haringey is located) is significantly below national rate at 61% and 60% respectively (**Figure 1**). Like national trend data, the uptake of breast cancer screening for the London region and within the North London Breast Screening Service has also remained broadly unchanged since 2002/3 (**Figure 1**).

- 4.22 There are wide variations in screening uptake among individual breast screening units. In 2008/9, some breast screening units an uptake of over 80% has been achieved (Leicestershire, Norfolk & Norwich). In the London region uptake was much lower averaging 61%. Wide variations in uptake were also recorded among London breast screening units: in Barking & Havering the uptake was recorded at 67% whilst in Central & East London uptake this was just 56% (**Figure 2**).

- 4.23 Breast screening uptake in Haringey in 2008/9 was recorded to be 55%. This represented a fall of 4% from previous years figures.

Breast screening coverage

- 4.24 The breast screening coverage refers to the proportion of eligible women who have recorded a test at least once in the previous three years. The national target for breast screening coverage was raised to 75% from 70% in 2009/10. Data from the NBS for 2008/9 indicates that the breast screening coverage for women aged 53-70 in England was 76.5%, for London 64.5% and in Haringey 50.7% (as per table below).

²⁹ The round length is the measurement of time between the date of last screening and the first offered appointment. The standard is for 90% of women to be offered an appointment within 36 months of a previous screen.

Region	Population	Women screened	Coverage (%)
England	5,166,515	3,954,050	76.5
London	607,605	391,676	64.5
Haringey	19,116	9,691	50.7

- 4.25 Regionally, in 2008/9, all but one area reported a breast screening coverage of greater than 70%: the one exception being in London (as above). The level of breast screening coverage also varied widely at the primary care organisation level: whilst 38 PCTs achieved coverage above 80%, 13 PCTs had coverage below 60% (a full distribution of PCT coverage is given below).

Distribution of breast screening coverage across all PCTs (2008/9)				
Coverage	50-59%	60-69%	70-79%	80%+
No. of PCTs	13	15	86	38

- 4.26 Whilst the average breast screening coverage for the London region was 64.5%, there were wide variations in coverage among primary care organisations. Thus while in Havering the coverage was 78.9% this fell to 50.2% in Barnet (**Figure 3**). In Haringey, the coverage was 50.7%, making this the second lowest in the country.³⁰ The proportion of women aged 53-70 in London who have never screened was 19%, which is far higher than the national average (11%).

Screening round length

- 4.27 The screening round length is the interval between the date of a women previous screening mammogram and the date of her next first appointment. The round length is measured by the percentage of eligible women whose first appointment is within 36 months of their previous screen. The national minimum standard is 90% or above and the target is 100%.
- 4.28 The round length is an important measurement because if women are screened within a 36 month interval the incidence of “interval cancers” (i.e. those developing cancer between screening appointments) is very low. The risk of developing cancer rises as the interval between screening increases.
- 4.29 The average round length in London was 68.2%, indicating the proportion of eligible women who were screened within a 3 year period. However, the round length figures varied across screening units: two units (South East London Queen Mary and West of London) had coverage above 90%, though in City and East London this was just 47%. The round length for all screening units for London in 2007/8 is given in **Figure 4**.
- 4.30 As part of service recovery plan for NLBSS, a 46 month round length was agreed with the service thus it was not surprising to record that just 15.6% of women in this area had a screen within the national target length (36 months).

5.0 Legislative and policy framework

³⁰ This is operating with a 46 month round length.

5.1 National cancer policy and priorities were originally outlined in the **NHS Cancer Plan** in 2000, though this has largely been superseded by the **Cancer Reform Strategy** (2007). This strategy identified a number of priorities for the development of breast screening services which are summarised below:

- Extended screening age to 47-73 years by 2012
- Digitalisation of mammograms by 2012
- Improved surveillance of women at high risk of familial breast cancer
- Develop service capacity to meet expected population growth
- Ensure that screening services do not reproduce health inequalities
- Raise breast cancer awareness to women outside the screening programme.³¹

5.2 Arrangements for national screening programmes are set out in Department of Health (DH) guidance.³² This guidance provides a framework for breast screening service provision which detail essential features of a screening programme, how services should be commissioned and processes to ensure proper governance and quality assurance mechanisms are in place.

Local policy context

5.3 Developing the uptake of screening services is noted within key strategic documents for Haringey. The Sustainable Community Strategy 2017-2016 (SCS) is the overarching plan of the Haringey Strategic Partnership which details how the Council and its partners will tackle broad community wide issues. Key priorities embedded within the SCS include the need to help people to become healthier with a better quality of life, reducing health inequalities and the provision of high quality services for those in need.

5.3 Within the SCS plan for 2009-2011 there is an identified need to “increase the uptake of cervical and breast screening including amongst non-English speaking communities”. It is anticipated that the scrutiny review will contribute to this process.

Local Area Agreement (2007-2010)

5.4 The Local Area Agreement (LAA) sets out a range of targets for the Council and its partners in delivering the key priorities and objectives of the SCS. There are 80 indicators in Haringey which are made up of statutory (n=16), national (n=35) and local (n=16) targets.

5.5 The following table provides an overview of national indicators which the scrutiny review of breast screening service may contribute:

Indicator	LAA target	Detail
NI 119	Yes	Self-reported measure of people’s overall health and wellbeing
NI 120	No	All-age all cause mortality rate

³¹ Cancer Reform Strategy Department of Health 2007

³² Commissioning and managing screening programmes in the NHS in England DH, (2005).

NI 122	No	Mortality from all cancers at ages under 75
Local	Yes	Prevalence of breastfeeding at 6-8 weeks from birth

Comprehensive Area Assessment (2009)

- 5.6 Comprehensive Area Assessment (CAA) is the process through which local public services are assessed. The emphasis of assessments within the CAA process is on broad public perceptions of the quality of life in an area rather than on the nature and quality of specific services provided. As part of the assessment process, the local strategic partnership is required to submit an annual self assessment of its performance against agreed local priorities.
- 5.7 It is envisaged that there will be two-way relationship between the CAA and overview and scrutiny, where local in-depth scrutiny reviews may provide evidence for the completion of the local self assessments, while the CAA may assist local scrutiny committees identify and prioritise issues to investigate. The current self-assessment has highlighted that one of the key challenges for Haringey is A key priority from the CAA self evaluation 2009-2011 is to increase the uptake of breast screen screening.

6. Aims of the review

- 6.1 The aims and objectives provided a structure for the review process, helped to develop a common understanding of the scope of the review among stakeholders, and created a framework around which review decisions were made. The panel agreed that the overarching aim of the review was:

'To identify how the uptake and coverage of breast screening services may be improved among women resident in Haringey.'

Objectives of the review

- 6.2 It was agreed that the review would aim to address the following objectives:
1. Describe the nature and level breast screening services available to women living in Haringey.
 2. To identify the barriers to improved take up and coverage of breast screening services in Haringey and possible interventions to overcome these.
 3. To identify how local partners may work together better to improve services, raise awareness and increase uptake of breast cancer screening in Haringey
 4. Consider the effectiveness of local breast screening services in relation to meeting local strategic and policy objectives (i.e. well being agenda, health inequalities).
 5. Examine how the uptake and coverage of breast screening services impact on local equalities issues and to assess how access can be improved to minority and other community groups.

6. Evaluate policy and performance data from other screening services and other Primary Care Trusts to identify good practice and improved ways of working to further promote the uptake and coverage of breast screening services in Haringey.
7. Assess whether breast screening services achieve value for money through ascertaining whether: costs are commensurate with performance, outcomes and delivery and compare well against other boroughs.
8. Ensure that the scrutiny review process generates relevant evidence that will contribute to ongoing assessments made within the Comprehensive Area Assessment.

7. Review methods

Panel Meetings

- 7.1 The Overview & Scrutiny Committee commissioned a review panel to undertake this review. The panel consisted of Councillors Alexander, Beynon, Bull and Winskill (Chair).
- 7.2 The review incorporated a range of investigative methods to ensure that the panel had access to information to meet the review objectives (as set out above). A series (n=4) of panel meetings were held to approve the aims of the review, receive oral and written evidence, oversee project progression and formulate conclusions and recommendations.

Evidence Sessions

- 7.3 A number of organisations gave evidence to support the review process, including representatives from local health services commissioners (NHS Haringey), the local breast screening unit (NLBSS) and screening representatives from regional bodies (e.g. NHS London, London Quality Assurance Reference Centre). In total, evidence was heard from 9 representatives from 6 organisations. A full list of all those who gave evidence to the panel is contained in Appendix B.

Assessing internal and external data sources

- 7.4 The panel commissioned reports and ad hoc briefings from the NHS Haringey and North London Breast Screening Services to provide operational, performance and financial data to help assessments of local breast screening services. Comparative data from other NHS trusts and breast screening units was also used to help panel members identify good practice, benchmark local breast screening service provision and identify local priorities for service improvement.
- 7.5 The panel also assessed external data (research, policies and practice) from regional (NHS London) and other healthcare organisations (Screening Improvement Board) to assist the review process. This included *Behind the Screens* (GLA report in to breasts screening in London) and Maximising Screening Attendance (a reference guide developed by the North West Cancer Network). All reports used in the review are referenced within the body of this report.

Panel Visits

- 7.6 The panel also visited the North London Breast Screening Service to help gain a practical insight in to the provision of breast screening services in the locality. The panel met the Chair and Director of Clinical Services at Barnet & Chase Farms Hospital (who operate the North London Breast screening Service), toured facilities with the General Manager and met with key staff (i.e. radiographers).

Community / Public Involvement

- 7.7 Community and public involvement is an integral part of the scrutiny process through helping to maintain local accountability. To this end all scrutiny panel meetings were held in public.
- 7.8 To help understand local patient perspectives of the breast screening service, the scrutiny service conducted a consultation with local women who had recently used the NLBSS. This consultation involved both quantitative and qualitative methods. 200 women from Haringey who had recently attended for a breast screen were sent a questionnaire which sought to ascertain views around the accessibility of the service and ways in which breast screening uptake could be improved. Almost 70 women from Haringey completed and returned the survey. The questionnaire is contained in Appendix D.
- 7.9 Breast screening service users were also offered the opportunity to provide more detailed data through attendance at a focus group. Two groups were held locally and were facilitated by a scrutiny officer and a member of the scrutiny review panel. The focus group offered participants the chance to discuss issues relating to their visit (i.e. service accessibility) and to identify ways in which local uptake could be improved. In total 10 local women participated in the focus groups. The focus group invite is contained in Appendix C.

Part 2

Key findings from the review

8. Current performance of breast screening services in Haringey

Issues arising from the closure of the NLBSS in 2006/7

- 8.1 As a priority, the panel sought clarification from both commissioners (NHS Haringey) and the service provider (NLBSS) on events that lead to the closure of the breast screening service and sought reassurance that these issues had been resolved.
- 8.2 The panel noted that a serious untoward incident had occurred at NLBSS in 2006 which involved 11 patients. Both regional and national review teams were brought in to investigate failures and advise on the future development of the service. The panel received written and verbal evidence which noted that safety concerns at NLBSS related to administrative rather than clinical functions at the service. In particular, concerns related to weaknesses in the 'Right Results' procedures.
- 8.3 The panel noted that as a result of these process weaknesses, the decision was taken to suspend the service in December 2006. Although the service was reopened in May 2007, full screening did not recommence until October 2007. The national support team advised against a catch up programme to tackle the backlog as this may have put the service at further risk. Instead, it was recommended that the service operated with a 46 month round length (the interval in which women were screened) and gradual return to the 36 month national standard by October 2010.
- 8.4 The panel heard evidence that the closure of the NLBSS and the decision to operate with a 46 month round length has had longer term repercussions on service performance for NLBSS and indeed, London wide. Most notably, the decision to operate with a 46 month round length severely impacted on the coverage of breast screening services (the proportion of women who have had a screen in the past 3 years). The panel understood that given the complexities of the screening round, it would take a number of years, possibly until 2013, for coverage performance figures to come back in line.
- 8.5 The panel received evidence from a number of sources (NHS London and London QARC) which indicated that the NLBSS was now fully functioning and performing on a par (or greater) with other breast screening units in London. During the course of the review, the panel felt that this was not widely understood among stakeholders and the public and that the fact that the service was fully operational needed to be publicised more widely in the local community.

Breast Screening Uptake

- 8.6 Breast screening uptake is the proportion of women invited for a breast screen for whom a breast screening result has been recorded. The panel received evidence from London Quality Assurance Reference Centre on the screening uptake for Haringey and other primary care organisations within the NLBSS area in 2008/9. The panel noted that this recorded that screening uptake in Haringey was 55%, which was the lowest in the NLBSS area (Figure 5). The

panel noted that this is lower than achieved for 2007/8 (59%) and continues to fall well short of the national target (75%).

8.7 The panel discussed uptake performance data for London. It was noted that regional uptake was 60.1% well below other regions (range 73.2-78.4%). It was noted that most London screening units are also performing at below national target level, which suggested to the panel that breast screening uptake is very much a regional problem. Indeed, it was noted that no London service had attained the national screening uptake target.

8.8 The panel received more detailed data from London QARC and NLBSS on screening uptake in Haringey. From this data the panel noted that breast screening uptake varied:

- month by month (variance 50-67%)
- from general practice to general practice (variance 33%-74%)

8.9 The panel noted that because breast screening is performed on an area basis (general practice by general practice), this resulted in variations in breast screening uptake (assumed to be as a result of socio-demographic characteristic of that practice and other factors in specific areas). The panel were particularly interested in the variations among local practices, and were strongly of the opinion that uptake monitoring data should provide a focus for initiatives to improve screening uptake in specific general practices in Haringey.

Breast Screening Round Length

8.10 The screening round length is the time interval between the date of a woman's previous mammogram and the date of her next screening appointment. The round length is measured by the percentage of eligible women whose next screening appointment is within 36 months of their previous screen. The national minimum standard is 90% or above and the target is 100%.

8.11 The panel noted that due to the suspension of the NLBSS and its phased reintroduction from May 2007, a screening round length target of 46 months was agreed with service commissioners (i.e. 10 months longer than the national standard). From evidence submitted to the panel it would appear that NLBSS is just about achieving the 46 month target: average quarterly performance from Q3 08/09 to Q2 09/10 was 89.8%.

8.12 NLBSS performance against the national round length target of 36 months was understandably poor. In 2007/8 just 15.6% of women were screened within 3 years of their last appointment which is significantly lower than for other screening units (e.g. SW London at 80.6%) and London wide average (68.2%) (Figure 4).

8.13 The panel heard evidence from the London Quality Assurance Reference Centre and the NLBSS itself that considerable progress had been made in reducing the round length in Haringey. It was estimated that the round length would be back to 36 months by the end of June 2010, 4 months ahead of schedule.

Breast Screening Coverage

- 8.14 It was noted by the panel, that the extended round length at the NLBSS had impacted on the breast screening coverage (the proportion of women who had been screened within a 3 year interval). Breast screening coverage in Haringey was recorded to be 50.7% which is the second lowest in London, and indeed, nationally (Figure 3). The panel noted that all of those PCTs in the NLBSS area (Brent, Harrow, Enfield and Barnet) recorded similarly low coverage rates as a result of the 46 month round length operating in NLBSS (Figure 3).
- 8.15 The panel also received evidence which suggested that screening coverage varied widely among local general practices. Evidence received from NHS Haringey indicated that breast screening coverage for individual practices at end of 08/09 varied from below 10% through to above 60% (Figure 6).
- 8.16 The panel heard that, because of the way that the screening programme operates it would take approximately 3 years for an accurate recording of local coverage to be obtained. In this context, an accurate coverage figure would not be obtained until June 2013 (i.e. 3 years on from the date of the planned resumption of a 36 month round length at NLBSS).

9. What factors affect the uptake of breast screening services?

- 9.1 The panel heard that there are many factors that may influence the take up of invitations for a breast screen, however, it was noted that there were few definitive large scale studies to guide such assessments. From the evidence it received, the panel were however able to deduce that number of key factors would appear to influence the take up of breast screening services in Haringey.

Socio-demographic factors

- 9.2 The panel noted research which made an association between ethnic origin and uptake of breast screening services. Research conducted in Brent & Harrow concluded that that poor knowledge, differing health and cultural beliefs and language were central to low attendance by black and minority ethnic groups at breast screening services.³³ Other studies found that BME groups were less likely to attend as they did not perceive themselves to be at risk or were more anxious.³⁴ The panel noted that a study concluded that 28% of the variation in breast screening uptake rates among Primary Care Trusts is due to the ethnic group of potential attendees.³⁵
- 9.3 The panel received evidence from NHS Haringey which would appear to support the link between **cultural and ethnic group** and low uptake of breast screening at the local level. A report commissioned by NHS Haringey

³³ Barriers to effective uptake of cancer screening among BME ethnic groups, *International Journal of Palliative Nursing* 2005 Nov 11 (11) 564-571)

³⁴ Barter-Godfrey & Takert 2005 Women and health: views of women aged 50—64 living Lambeth, Southwark & Lewisham, London South Bank University

³⁵ Eilbert et al, Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets *British Journal of Cancer* 101(S2): S64–S67 (2009)

identified that the highest did not attend (DNA) rates for breast screening were among (using MOSAIC Classifications) settled minorities (Caribbean, African, Cypriot and Pakistani origin) and metro multicultural (black Africans and Asian Origins) groups.³⁶

- 9.4 The panel also noted that a number of studies suggest a link between **social deprivation** and the take up of breast screening invitations. Here, research would appear to suggest that women resident in areas of high social deprivation are less likely to attend breast screening services compared to women from more affluent areas.^{37 38 39}
- 9.5 For the most vulnerable women in the community responding to an invite for breast screen may be problematic. Despite that women with a **learning disability** are now living longer and fuller lives and live to an age where screening is appropriate, lower levels of breast screening are still reported among women in this group.⁴⁰ Similarly, the panel noted that there was evidence to suggest that there was comparatively lower attendance among women with **severe mental health** problems.⁴¹
- 9.6 The panel heard evidence to suggest that the **age group** of women was an influence on uptake rates. Whilst screening is open to women aged between 50 and 70 years of age, the panel heard evidence from London QARC that uptake rate among younger women in this screening target group was lower.
- 9.7 **Personal attitudes** have also been shown to influence a woman's decision whether to attend for breast screening. The panel noted a study in Lambeth, Southwark & Lewisham which found that a positive personal attitude and the perceived personal importance of screening were strongly associated with attendance at breast screening services. Conversely, the study found that some of the most common reasons women gave for non-attendance included the avoidance of anxiety, pain and embarrassment.⁴²
- 9.8 A more recent study has also suggested that there is a link between **personal wealth and mobility** and women attending for a breast screen. Here it was found that women who have access to a car and who own their own home (indicators of personal wealth) were more likely to attend for breast screening than those women who did not have these personal assets.⁴³

Structural factors

³⁶ Increase breast Screening Uptake in Haringey, Barkers Social Marketing/ NHS Haringey (2009)

³⁷ Gatrell 1998 Uptake of screening in breast cancer in South Lancashire Public Health 112 (5) 297-301

³⁸ Maheswaran et al 2006 Socioeconomic deprivation, travel distance, location of service and uptake of breast screening services in North Derbyshire Journal of Epidemiology and Community Health 60 (3) 208-12

³⁹ Banks et al 2002 Comparison of various characteristics of women who do and do not attend breast cancer screening, Breast Cancer Research 4 R1

⁴⁰ Cancer Reform Strategy 2007

⁴¹ Werneke et al Uptake of screening for breast cancer in patients with mental health problems Journal of Epidemiology and Community Health 2006;60:600-605

⁴² Barter Godfrey and Taket 2005 'op cit'

⁴³ Moser et al Inequalities in reported use of breast and cervical screening in Great Britain: analysis of cross sectional survey data BMJ 338 2009

- 9.9 The panel also noted that structural factors, such as the way the screening service are organised, may influence the take up of breast screening services. The panel heard evidence which indicated that that an accurate and up to date **population register** (Exeter Dataset) is integral to the success of breast screening as this is used to invite women from local general practices. This is particularly important in London where there is populations can be transient and population mobility high. The panel noted that if General Practice lists (on which this data set is based) are not routinely cleaned and up to date:
- invites may be sent to the wrong address
 - invites may be sent to women for whom screening is not appropriate (i.e. mastectomy)
 - inflate local DNA rates (e.g. by including women who have moved).

- 9.10 The panel also noted that the uptake rates were also influenced on how effectively local breast screening programmes were organised such as the operation of the **call and recall** system and other quality control procedures.⁴⁴ The panel noted that these were monitored by local and national quality assurance centres (e.g. London QARC).

- 9.11 Other structural problems which were felt to affect local uptake of breast screening services was the non-receipt of breast screening invitations. A number of regional specialists who gave evidence to the panel suggested that anecdotally up to 40% of invites may not reach the intended recipient because of incorrect details were listed, or where the recipient lived gated communities or had shared/communal mailboxes.

Experiential factors

- 9.12 During the course of the review, the panel understood that other factors may influence the take up of breast screening appointments, such as women's experience of breast screening services. Whilst it is clear that women who have previously attended for breast screening are more likely to do so in the future it is not apparent which factors underpin such differences (i.e. quality of services, reduced anxiety, improved understanding).

- 9.13 From the range of evidence presented in this review however, the panel noted that the following factors influence women's perceptions of screening services and perhaps subsequent intentions to screen or not to screen:
- Personal anxieties about screening
 - Location and accessibility of the clinic
 - Accessibility of appointments (appointment system)
 - Quality of care and services provided.

- 9.14 Attendance for invitations to a breast screen is clearly affected by a broad range social, cultural and economic factor, of which just a few have been highlighted above. It is clear that the decision to attend for breast screening is undoubtedly complex and in many cases personal to individual women making this decision.

⁴⁴ London Quality Assurance Reference Centre 2002

- 9.15 The panel were mindful that there were variations in the uptake of breast screening and the impact that this may have on local health inequalities. The panel hoped that local commissioners and service providers would acknowledge such variations in take up and take affirmative action to prevent the exacerbation of local health inequalities (e.g. further research supported by targeted interventions)

10. Commissioning Breast Screening Services

Commissioning

- 10.1 The panel noted that the responsibility for planning, commissioning and performance managing breast screening services rests with Primary Care Trusts (PCT). In Haringey, breast screening services (NLBSS) are commissioned through a consortium of 6 PCTs. The panel understood that whilst there was an overall breast screening lead for the PCTs (located with Enfield PCT), each PCT had a screening lead to deal with breast screening issues.
- 10.2 The panel noted that the commissioning structure for breast screening was in accordance with national guidelines and in widespread operation throughout the London. The panel noted that no specific problems were identified in this commissioning arrangement from any of the stakeholders in the review, or regional governance bodies (NHS London, London QARC).
- 10.3 In their evidence to the panel, local commissioners indicated that funding arrangements had recently been changed to allow for an uplift in funding for the NLBSS. This was identified as a requirement from the national team inspection which was undertaken in 2006/7. Within this new agreement, PCTs in the consortia were required to pay an additional 'fare shares' portion based on the number of women screened in their locality. The new funding agreement also introduced a new tariff based system, from which it was hoped to incentivise providers to improve uptake rates (i.e. proportion of funding now being paid per capita for screens undertaken).
- 10.4 As a result of these funding changes Haringey's funding for breast screening services rose from £419,000 to £482,000 and total funding for NLBSS rose from £3,086,000 to £3,548,00 (as per table below).

PCT	Original SLA 08/9	Proposed fair Share	Fair Share supplement	Total annual payment 08/09
Haringey	£419,000	13.62%	£63,000	£482,000
Total NLBSS	£3,086,000		£461,000	£3,548,000

Data quality and management

- 10.5 The panel noted high quality and up to date information was integral to the screening uptake and the overall effectiveness of the local breast screening programme. In developing interventions to support screening uptake, the panel understood that it was important to develop a more detailed local picture of women who do not attend (DNA) for screening. The Panel noted from

evidence from NHS London, that it was the responsibility of local PCTs to commission such research and shape breast screening programmes and interventions accordingly.

- 10.6 The panel noted that NHS Haringey had begun to research the local breast screening DNA population through a social marketing approach (as described in 9.3), and hoped that this would filter down in to positive local action within the community. This being said, the panel wished to underline the importance of local knowledge about the breast screening population and suggested that ongoing research and intelligence gathering on the breast screening DNA population should form an integral part of local commissioning.
- 10.7 The panel understood that the PCT were responsible for the compilation of accurate and up to date lists of the population eligible for breast screening (i.e. women aged 50-70 years). That is, ensuring that there is effective information flow between Public Health Departments, GPs (from whose practice lists data is derived) and NLBSS (who send out the breast screening invites) to ensure that invitations are appropriately sent out to the relevant population.
- 10.8 The panel received evidence which suggested that there could be improvements to the way that data is shared between stakeholders (these issues were common across London and more locally in the NLBSS consortia area):
- More effective list cleaning processes to ensure the removal of women no longer at the general practice
 - Timely presentation of lists to GPs for effective notation (i.e. removal of women not appropriate to screen).
- 10.9 During the course of the evidence sessions to the panel, it was apparent that the NLBSS develop a list of patients who have not attended for their breast screening appointment (so called **DNA list**). This DNA list is routinely sent to local GPs. From evidence received by the panel, it was apparent that this list is not consistently used by GPs to follow up women who have not attended, indeed, there was some evidence to suggest that active follow up of DNA's in primary care was minimal. The panel felt that this was significant missed opportunity to improve local breast screening uptake.
- 10.10 In fairness to NHS Haringey, the panel noted that the failure to act on DNA lists was a London wide problem, as GPs were not incentivised to follow up on breast screening DNAs from their practice. The panel felt however, that it was imperative that further use be made of DNA lists, and that NHS Haringey as a priority, should commission GPs or their own public health department to actively follow up non-attendees at breast screening services.
- 10.10 In planning and developing breast screening services and interventions to improve uptake, as well as understanding the DNA population, it is also important to know the characteristics of those who do attend for a screen. The panel understood that there were many opportunities to collect data on the women that do attend for screening, yet there was insufficient systems in place to collect, collate and analyse such data.

10.11 For example, a registration form is completed each time a woman attends the breast screening unit (NLBSS), yet this information is not collated, analysed or shared across the stakeholder partnership. Thus while socio-demographic data is collected at this point (age, ethnicity, postcode), this is not collated or used to inform local commissioning or service development.

Capacity of breast screening services

10.12 The panel were keen to assess the future capacity of the NLBSS given the expected increase in demand within the breast screening programme. The panel noted that increased demand was likely to stem from:

- age extension of the screening programme to include women from 47-73 years (from 50-70 years) by 2012
- demographic changes in the screening population i.e. ageing female population
- improved uptake rates as a result of planned local interventions.

10.13 NLBSS gave evidence to the panel which noted that there was sufficient capacity within the service to manage the expected 30% age extension growth in the screening programme through to 2012. The panel noted that excess capacity needed to meet this additional demand would be derived from the return to the 36 month round length from June 2010.

10.14 The panel noted evidence from a number of sources (including the NLBSS) which indicated that the eligible breast screening population would increase in future years due changes in the demographic profile (i.e. the growth of the aged female population). As was noted in the Cancer Reform Strategy, PCT commissioners may be required to make additional planned investment in the medium term to meet this increased demand for services.⁴⁵

10.15 The panel noted that whilst breast screening uptake in the borough was currently low (55%), it was anticipated that uptake rate would improve as a result of focused interventions within the borough in the future (e.g. resulting from the Breast Screening Action Plan and other local initiatives).

10.16 Although it was understandably difficult to predict what increase may result from the above circumstances, the panel felt that such factors should be considered in assessing future demand and planned capacity for local breast screening services.

Breast Screening Action Plan

10.16 The panel noted that given the inclusion of breast screening within the vital signs⁴⁶ indicator set ensured that NHS London was playing a prominent and active role in local breast screening commissioning arrangements. To this end, the panel understood that NHS London signs off commissioning agreements, manages performance and commissions the local Quality Assurance Reference Centre (London QARC).

⁴⁵ Cancer Reform Strategy Department of Health (2007)

⁴⁶ Vital Sign VSA09 the percentage of women aged 47-49 and 71-73 invited for breast screening.

- 10.17 More recently, NHS London has required all PCTs to produce a Breast Screening Action Plan. This is a template of key breast screening activities for local stakeholders (PCT, Breast Screening Units and GPS) which local PCTs are required to self assess. The panel noted that PCTs have been required to submit self assessments and subsequent actions for 2010/2011. NHS London will manage the performance of PCTs against these action plans.
- 10.18 The panel warmly welcomed the development of the local Breast Screening Action Plan as this was felt to provide an important first step in developing a local breast screening strategy. The panel were of the opinion that the Breast Screening Action Plan could be developed further through the following inclusions:
- establish shared priorities across the partnership
 - establish how local partners can work together to breast screening
 - identify clear priorities for action
 - establish clear targets and milestones for improving screening uptake.
- Patient surveys to assess service quality and accessibility
- 10.19 As part of the scrutiny review process, the panel commissioned a survey of breast screening service users to assess the service accessibility and quality. The survey (Appendix D) and analysis of its findings are included within this report (Appendix F).
- 10.20 Both the review panel and local commissioner were in agreement that the survey had produced a range of informative data: physical access to screening sites, convenience of allocated appointments and the quality of screening services provided. The panel felt that such patient satisfaction surveys provide a helpful tool in the commissioning process, and that this should be an ongoing process to help measure and benchmark the accessibility and quality of local breast screening services.

11. Improving screening uptake – operation of breast screening services

Quality of breast screening services

- 11.1 How people experience health services is clearly an important factor service usage. Where service users are welcomed, treated in friendly manner, provided with sufficient information and perceive that their concerns have been dealt with, re-attendance at the service may be more likely. To this end, the panel wished to understand further about how local women experienced the breast screening service.
- 11.2 The consultation with service users undertaken as part of this review identified high levels of service satisfaction with many aspects of the breast screening service. The report found that (Appendix F):
- 84% were satisfied with their welcome to the clinic
 - 84% were satisfied with waiting times at the clinic
 - 87% indicated that staff were friendly and helpful
 - 87% indicated that they were given enough information
 - 92% were satisfied with the overall quality of the service
 - 95% said they would recommend the service to a friend.
- 11.3 In terms of the more qualitative aspect of the service, the main area identified for improvement through the consultation was the need for more personalisation of services, to help reassure women who have anxieties about accessing and using the service. In this context, respondents to the survey and focus groups suggested:
- Opportunities to speak with someone ahead of the appointment
 - More personalised statements in literature
 - Encouraging people to attend with friends for support.
- 11.4 The panel were reassured from the consultation data that an acceptable service was being offered for local women, that women were on the whole having positive experiences of this service and in doing so, encouraged to attend in the future. The panel also noted the importance of ongoing patient surveys to assess service quality.

Location of screening clinics

- 11.5 The panel noted that there was substantive evidence to suggest that the location of the breast screening unit was an important factor in the uptake of invites to breast screening services. The panel received research which found that the distance that women had to travel to a screening site had a significant impact on the uptake of screening services,⁴⁷ whilst another study concluded that after a breast screening service was moved, attendance fell by 2% for each kilometre further women were from the unit.⁴⁸

⁴⁷ Maheswaran et al 2006 Socioeconomic deprivation, travel distance, location of service and uptake of breast screening services in North Derbyshire *Journal of epidemiology and community health* 60 (3) 208-12

⁴⁸ Maxwell 2000 Relocation of a static screening unit: a study of factors affecting attendance *Journal of Medical Screening* (7) 114-115

- 11.6 The panel noted that breast screening services are offered by NLBSS through both static and mobile units at various sites across the 6 boroughs in which the service operates. Mobile units are deployed at a range of locations on a periodic basis (minimum 3 months), usually specific to which general practices are being targeted in the screening round. The panel noted that the main sites where Haringey women could be screened were as set out below:

Location	Screening unit type
Forest Road, Edmonton, Enfield.	Static
North Middlesex Hospital, Enfield.	Mobile
Whittington Hospital, Islington.	Static (periodically commissioned)
St Ann's Hospital, Haringey	Mobile
Edgware Hospital, Barnet	Static (Out of Hours appointments)

- 11.7 In the survey of service users conducted as part of this review, the panel also noted the importance that local women attached to the location of the screening clinic and perceptions of service accessibility (Appendix F). A summary of the main points of relevance from this survey were that:

- women in Haringey were generally required to access screening sites outside of the borough
- the physical distance women needed to travel presented a number access problems (transport, length of journey, time off work)
- more choice was wanted in the location of the screening clinic.

- 11.8 The panel noted that women who participated in the consultation indicated that the availability of more convenient locations for breast screening clinics would improve service accessibility and may help improve uptake of breast screening services in Haringey.

'If it was nearer home or a more convenient location, I think more people would attend.'

'People in my area would be far more likely to attend the clinic if it was more local and on public transport....'

'If you could give appointments closer to where people live it would help.'

- 11.9 The panel noted the complexities that NLBSS faced in delivering accessible screening sites across 6 PCTs at differing times within the 3 year screening round. Potential sites for the mobile clinic were constrained by the physical space required, physical security, personal safety issues for staff and service users and access to utility services (electricity and toilet facilities). It was also noted that the mobile unit would have to be deployed for a minimum of 3 months in any one location to be cost effective.

- 11.10 The panel noted that early developmental work had commenced in modernising the call and recall system for breast screening, which would see women called for screening on the third anniversary of their last screen, rather than on the geographical rotation on where their general practice was located. The panel noted that if fully implemented, this system would see a

shift in service format were services would primarily be delivered through static screening sites. The panel heard evidence to the effect that it would cost a minimum of £150k to equip a static site.

- 11.11 In light of the above, the panel felt that options for developing the accessibility of screening locations in Haringey required further appraisal and assessment. In particular, the panel felt that the development of new neighbourhood health centres (at Park Road and Lordship Lane) had to date remained largely unconsidered as possible sites for mobile breast screening despite their physical accessibility, hours of access (8am-8pm) and that another screening service in London had developed a similar approach (South West).

Access to out of hours appointments

- 11.12 As many women eligible for breast screening were still likely to be working, the panel assessed whether the availability of out-of-hours appointments was a factor in the accessibility of breast screening clinics. The panel noted evidence from NLBSS which indicated that operational hours for breast screening clinics were generally between 9am and 4pm. The panel also noted that whilst out-of-hours appointments were available, these were generally restricted to Saturday mornings and more importantly, were only generally available at one screening site: Edgware Community Hospital in Barnet.

- 11.13 Evidence from the patient survey verified the difficulties that patients experienced in accessing breast screening appointments outside of normal working hours; 28% of women were given an inconvenient appointment time and 22% indicated that they had difficulty to get time off work to attend (Appendix F). Furthermore, qualitative evidence from the survey indicated that where out-of-hours appointments were available, accessibility was restricted because of the physical distance that women resident in Haringey would have to travel to attend (i.e. travelling from Haringey to Barnet).

- 11.14 Analysis of both quantitative and qualitative data from the survey would appear to suggest the need to develop the availability of out-of-hours appointments at breast screening clinics and physical accessibility of these to women resident in Haringey. The panel agreed and concurred that this would be an important process in helping to improve the uptake of screening appointments.

The screening invite

- 11.15 Given the importance of the invite to screening uptake, the panel assessed the screening invite which is sent to women by NLBSS (this is contained in Appendix E). The panel heard that although standard information was required to be included in the letter, there were some variations in the text and layout of screening invites issued by local screening units. The panel also noted that a booklet on breast screening (Breast Screening the Facts) is distributed with the invite letter.

- 11.16 The breast screening invite was tested through the patient survey which was conducted as part of this review. Data analysis found that a majority of

respondents indicated that the invite was easy to read (98%), contained enough information about breast screening (89%) and how to access/ travel to breast screening sites (Appendix F). Proportionally far fewer respondents were satisfied (59%) that the invite was available in different formats (e.g. large print or different community languages).

- 11.17 In assessing the invite to screening services the panel had a number of concerns. Most importantly, the panel noted that there was no detail in the invite in any community language. Furthermore, for recipients who could not understand English, the panel noted that the invite contained no signpost to where further information could be obtained. The panel felt that this was a significant omission given the ethnic and cultural makeup of the residents in the borough.
- 11.18 The panel also made a number of other assessments about the breast screening invite and made the following conclusions:
- It did actively signpost women to the NLBSS website where further information could be obtained (including community languages)
 - It contained a lot of information and the layout was dense
 - It had not been systematically tested for relevance, understanding and readability.
- 11.19 The panel heard that other screening services in London had issued talking invitations which invited women in a number of key languages. Other services had enclosed pictorial guides to breast screening services alongside the invite to help those who do not speak English or who cannot read. The panel noted that whilst these may be effective as short term interventions, they were not sustainable for the target population as a whole.
- 11.20 The panel noted that as a priority, participants in the scrutiny review consultation identified the need to develop local screening information in community languages (Appendix F).

Breast Screening Appointments

- 11.21 The panel noted that invitations for a breast screen are usually sent by NLBSS out 2-3 weeks in advance of the appointment date. The invite provides details of the date, time and location of the breast screening appointment and further information on how to change the preset appointment time if this is not convenient.
- 11.22 If women had not attended this screening appointment and had not contacted the breast screening service, the panel noted that NLBSS issued another letter requesting them to contact to service and to make another breast screening appointment.
- 11.23 The survey of breast screening service users conducted as part of this review brought a number of issues to the attention of the panel (Appendix F). These were noted as thus:
- Just 55% of respondents indicated that the first preset appointment was convenient

- 29% of women who wanted to change their appointment said that it was not easy to do so
- Women were not allocated an appointment at a clinic nearest to where they live (presenting numerous accessibility problems)
- Women had difficulty in contacting the NLBSS to change their appointment
- There were insufficient appointment alternatives (dates, times and locations).

11.24 The NLBSS acknowledged that there had been a number of problems with the appointment system during the time when the survey was administered and that a number of developments had been made since the survey was undertaken. The service changes included:

- Staggering dispatch of breast screening invites so as not to create bottlenecks with women trying to contact the service
- Extending the period in which women may book appointments in advance from 3 weeks to 6 weeks.

11.25 It was noted that the availability of radiographers was critical to service capacity (and availability of appointments) and that the service had worked hard to retain a pool of these skilled workers across acute hospital sites in North London (currently 9 radiologists are employed on a sessional basis). Although the system has its disadvantages, the panel heard that it was less susceptible to service disruptions through staff absence.

11.26 The panel also received evidence which suggested ways in which the breast screening appointment systems could be improved. The panel noted research which suggested that the issuing reminder letters to non-attendees was found to be effective in improving the uptake of breast screening services in 28 reviewed studies.⁴⁹ Furthermore, those reminders which offered another fixed appointment time were also found to improve breast screening uptake further still.⁵⁰ The offering of a second timed appointment was also seen as a key development from regional reports to encourage breast screening uptake.⁵¹

11.27 The panel found this evidence persuasive and felt that this should form one strand of a programme to improve screening uptake in Haringey. The panel also anticipated that the appointment system would continue to be assessed through ongoing patient surveys recommended elsewhere in this report.

Digitalisation

11.28 The panel heard that all breast screening services would be digitalising their service in the coming years. The panel understood that there were a number of benefits from digitalising mammography, which included:

- Improved quality assurance processes (i.e. comparing past and present images)

⁴⁹ Sin & Leger. Interventions to increase breast screening uptake: do they make any difference? Journal of Medical Screening 1999; 6(4): 170-181.

⁵⁰ M J Stead Improving uptake in non-attenders of breast screening: selective use of second appointment J Med Screen 1998;5:69-72

⁵¹ Maximising screening attendance – a reference guide. North West London Cancer Network

- The production of more sensitive images to help identify abnormalities
- Faster production of images which may minimise delays in screening pathway
- Improved image quality may minimise requirement for duplicate screens.

11.29 The panel noted that NLBSS was one of the first services which was fully digitalised which was already producing benefits for the service and for service users. The panel also heard NLBSS is undertaking a pilot project to digitalise past screening images (taken via film) to assess what benefits this would bring for breast screening service.

12. Improving breast screening uptake – involvement of Primary Care

Current involvement of GPs in Breast screening

12.1 Through the process of the review, the panel understood that although GPs involvement in the breast screening process was generally limited, there was further scope for them to become more actively involved at all stages of the breast screening process.

12.2 It was noted that the list of women to be invited for a breast screen was derived through GP practice data (via the national Exeter database). Local lists of invitees are developed by local public health directorates in consultation with local GPs to ensure that lists are up to date and sent to relevant patients (i.e. removal of women with mastectomy). The panel understood that GP list cleaning was critical to ensure that up to date data was being used to formulate lists to issue breast screening invites.

12.3 Ahead of women being screened from a particular practice, the NLBSS writes to GPs to notify that screening is about to take place. In addition, posters and leaflets are distributed to the practice to help publicise breast screening services to local women.

12.4 The panel heard that at the end of the screening operation in a particular practice, GPs receive a list of women who have not attended (the DNA list). The panel heard evidence that although some GPs actively follow up those women who have not attended, this process is not widespread and not routinely undertaken.

12.5 In the course of the review, the panel heard evidence to suggest that primary care involvement in the breast screening process could be supported through strengthening:

- GP contact with the patient in advance of screening
- Improved list cleaning processes
- Active follow up of DNAs
- Systematic processes to refer women to breast screening programme.

Evidence for further involvement for GPs

12.6 The panel noted that there was strong evidence to suggest that interventions which originated within the primary care setting may have positive impact in developing breast screening uptake among women. Although GPs are not

directly involved in the breast screening process, the panel noted that there was national and local evidence to suggest that planned interventions by GPs may prove to be highly influential in a woman's decision to undertake breast screening.

12.7 National research has identified that improved breast screening uptake was recorded where GPs have written or made a call to non-attendees at breast screening services.⁵² Furthermore, given the personal influence of GPs, other research has found that interventions by GPs to improve breast screening uptake override other factors associated with poor attendance at breast screening clinics such as social deprivation and ethnicity.⁵³

12.8 From data provided on the uptake of breast screening services at individual GPs in Haringey, the panel noted that there were wide variations in uptake: 37% in the lowest practice to 74% in the highest. Interestingly, the panel noted that from evidence presented, the general practice with the highest breast screening uptake in Haringey was one which was known to systematically follow up women who had not attended for breast screening (i.e. active use of the DNA list).

12.9 The consultation with service users undertaken as part of this review also found that local women would be receptive to interventions from their local GP to help improve breast screening uptake, indeed, this was an expected role (Appendix F). Data from the focus groups with breast screening service users found that there were opportunities to:

- improve advertising of breast screening in local clinics
- improve structured interventions by GPs (i.e. developing a flag system or carry out as part of vascular checks programme)

12.10 The panel heard that in some localities, the uptake rate of breast screening services from individual general practices was published to enable local practices and other professionals to performance and help target developmental work. The panel hoped that such an initiative here might also focus support on those practices where uptake was known to be low.

Local Enhanced Service

12.11 The panel heard that GPs are not paid for breast screening work within the general medical contract (GMS) or through the Quality and Outcomes Framework (QOF). The panel heard evidence however, which suggested that the development of a Local Enhanced Service (LES) for GPs, may help to incentivise GPs to become more involved in the breast screening process and help improve uptake.

12.12 The panel heard that LES represents an extension of GP medical contract where additional health services are provided for a specified area (in this case breast screening). LES are an agreement between commissioners (PCTs)

⁵² Bankhead et al Improving attendance for breast screening among recent non-attenders: a randomised controlled trial of two interventions in primary care. *Journal of Medical Screening* 2001;8(2):99-105

⁵³ Majeed, et al, Do GPs influence the uptake of breast screening: a general practice based study *Journal of Medical Screening* 1995 4 (1) 19-29. 2005

and GPs to ensure that local services are in place meet local needs or priorities. The panel understood that a growing number of PCTs had developed LES for breast screening in London, most notably Westminster and Tower Hamlets. The panel noted with interest, that other PCTs in the NLBSS area have recently launched a LES for breast screening (e.g. Barnet, Brent).

- 12.13 The panel assessed a number of LES's from other PCTs. Although the precise specifications varied there were a number of common components:
- Awareness invite (sent to women by GP ahead of screening)
 - List cleaning (up to date lists)
 - Practice training prior (to improve staff awareness and interventions)
 - Structured/ opportunistic promotion of screening
 - DNA follow up / reminder
 - Incentive payments (per capita) underpinned by practice sign up payments
- 12.14 The panel understood that LES developed by Westminster PCT was being used as a model by a number of other PCTs (including other PCTs in the NLBSS area).
- 12.15 Estimated costs of developing a LES were put at between £50k and £90k. Although LES for breast screening are in the early stages of operation and few have been operational long enough to be fully evaluated, the panel did however note encouraging preliminary data from the Heart of Birmingham PCT. Data from this PCT would appear to indicate that the LES developed here had been successful in improving breast screening uptake.⁵⁴ Data from the first 4 practices in the screening round have shown a marked improvement as shown below:
- average uptake at practices before LES intervention 66%
 - average uptake at practices after LES intervention 81%.
- 12.16 Given the substantive evidence received by the panel as to the acceptability and effectiveness of greater involvement of GPs in the breast screening process, the panel were in agreement that NHS Haringey should lead further work to develop local GP involvement in the breast screening process.
- 12.17 Whilst the panel were mindful that a LES may initially require additional local investment, it was agreed the development of a LES for breast screening may represent a significant opportunity to improve breast screening uptake as this offered a planned and coordinated approach to increasing GP involvement.

13. Improving breast screening uptake – other community interventions

Principles for improved screening uptake

- 13.1 The panel heard that it was important that initiatives to improve breast screening uptake were sustainable. One-off projects were perhaps useful in raising awareness, but given the nature of the breast screening programme, these would only bring a short lived improvement to breast screening figures. Instead, it was recommended to the panel that there should be a **dedicated**

⁵⁴ Report to Professional Executive Committee, Heart of Birmingham PCT (2009)

programme of initiatives to develop and maintain upward momentum for screening uptake.

13.2 It was also suggested from regional screening representatives that approaches to improving screening uptake should be **multi-layered**, that is, should be undertaken at both the macro (local screening population) and micro (specific community/ group) level. In this context, it was suggested that broad awareness raising campaigns or the sending out of pre-invitations by GPs (macro) should be accompanied by more targeted interventions with local community groups (as evidenced by local research through the PCT).

13.3 It was emphasised to the panel that any interventions to bring about long term improvement to breast screening uptake, should also be **sustainable**, both practicably and financially. Interventions which could be embedded within the screening process and which were of relatively low cost were more likely to impact on breast screening uptake over the longer term, than one off interventions (e.g. pre-invitation letters, 2nd fixed appointment, systematic list cleaning).

Evidence to support more local community interventions

13.4 The panel noted that role of the **media** undoubtedly influences a woman's decision to attend an invitation for screening: as illustrated by the case of Jade Goody and subsequent increase in cervical cancer screening.⁵⁵ The panel also noted that other more specific local advertising campaigns have also been found to be helpful in promoting screening, reassuring attendees and improving uptake.⁵⁶

13.5 The panel heard evidence from regional representatives that the use of different media can be an effective tool in promoting breast screening uptake. This view from those giving evidence to the panel however, was that whilst mass media marketing was not effective in encouraging service uptake (i.e. avoiding the worried well), locally commissioned and targeted campaigns could be effective.

13.6 Within the consultation with service users, participants could not recall any local awareness or public health campaigns to promote the use of breast screening services and none of those who participated in the focus groups said that they had seen promotional literature in their general practice (Appendix F). Despite the lack of community interventions currently taking place in Haringey, the consultation not only suggested that such interventions to promote breast screening would be acceptable, but were also expected.

13.7 There was a broad consensus among both survey respondents and focus group participants that there was a need to actively promote the breast screening service to women in Haringey. In this context, it was felt that there should be more outreach work targeted at women eligible to participate in the breast screening programme.

⁵⁵ Jade Goody effect increases cervical screening rates Nursing Times March 2009

⁵⁶ Cohen, L et al (2000) Promoting breast screening in Glasgow, Health Bulletin, 58(2). 127-32

'It would help some women to hear about the importance of screening from someone in the local community where they come. An idea would be to set up meetings with local community workers with the aim of encouraging women to attend.'

'How about issuing information to churches, women's centres and clubs so that they can make a list of names and addresses of women that are interested that could be referred.'

'...you could offer over 60's groups a chance to attend together?'

- 13.8 It was noted from NHS London it was the responsibility of individual PCTs to undertake health promotion and public health programmes to support breast screening i.e. breast cancer awareness, breast care and promoting of breast screening. Regional screening representatives noted that that PCTs may wish to seek partnerships in developing these roles, for example with the local council, community or voluntary sector. It was noted however that whilst approaches may be collaborative, there should be consistency in the public health message (i.e. breast management, importance of breast screening).
- 13.9 The panel heard that community engagement techniques were important in reaching local target populations (e.g. women aged 50-70, black and minority ethnic groups). NHS Haringey conceded that this was an area where the locality may require additional input from either through a specialist adviser or through the experience of other PCTs where similar work has been undertaken.
- Local initiatives to promote screening uptake
- 13.10 The panel heard evidence which noted that NHS Haringey had initiated a number of projects which were hoped to improve breast screening uptake, these being Social Marketing Project for Breast Screening and Health Trainers Project. The panel noted that these projects were in the early stages of development and had yet to be fully applied within the community.
- 13.11 The panel heard that the most significant piece of work undertaken to date to promote breast screening in Haringey was the **Social Marketing Project**. This project sought to engage local breast screening population to help improve understanding about the barriers that local women face in accessing breast screening services, particularly among local ethnic and cultural groups.
- 13.12 The panel noted some of the key findings from the social marketing exercise concurred with conclusions reached from the consultation with service users in this report, namely the need to:
- to commission more culturally specific/ sensitive intervention
 - to tackle physical and structural accessibility issues
 - to develop a multi-faceted programme of interventions to support breast screening attendance.
- 13.13 Whilst it was recognised that this was a very valuable piece of work, the panel noted that there had been problems with the project and that tangible

developments arising from this initial engagement with the breast screening population had to date been limited. The panel were therefore keen to see the understanding and learning developed from this first stage of the project could influence local initiatives, and more generally, how social marketing principles could be used to promote breast screening.

13.14 NHS Haringey also noted that the **Community Health Trainers** project may also help to promote breast screening services to local women. Within this project, local volunteers would be recruited to conduct community outreach initiatives across the borough. The panel noted that whilst these trainers would be generic (i.e. focussing on a broad range of community health interventions), breast screening would figure prominently in their work programmes given that this was a priority for the locality.

13.15 The panel welcomed the development of community health trainers and their subsequent recruitment and deployment within the community. The panel were particularly welcoming of this community role, as they felt it could work well the operation of the breast screening round. Because the breast screening operates on a locality basis (practice by practice) the panel felt that this offered a significant opportunity for health trainers to undertake targeted work within that community to promote breast screening.

Breast screening and health inequalities

13.16 The panel also noted that a number of key strategy documents have highlighted the range of health inequalities associated with breast screening. These documents^{57, 58} and additional research⁵⁹, conclude that it is important for local commissioning services to investigate and research local service uptake to help identify inequalities and to make appropriate service developments.

13.17 The review of breast screening services also highlighted areas within the established equalities strands (age, gender, religion, disability, ethnicity and sexuality), where potential local inequalities may exist. These are summarised below:

Incidence of breast cancer	<ul style="list-style-type: none"> • Gender: women 100x more likely to develop breast cancer than men • Age: 4 in 5 cases of breast cancer are diagnosed in women aged 50 years and over • Ethnicity: Ashkenazi Jewish women from this group are 1.5 times more likely to develop breast cancer • Lesbians – convergence of multiple risk factors may make this group more susceptible to developing breast cancer
Take up of breast	<ul style="list-style-type: none"> • Age: younger women in the age screening

⁵⁷ Cancer reform Strategy 2007

⁵⁸ Expanding our Reach NHS Breast Screening Programme Annual Report

⁵⁹ Moser et al Inequalities in reported use of breast and cervical screening in Great Britain: analysis of cross sectional survey data BMJ 338 2009

cancer screening	<p>group (50-70) less likely to attend</p> <ul style="list-style-type: none"> • Ethnicity: women from different ethnic groups may have different cultural beliefs about breast cancer which impact on screening uptake: e.g. attitudes toward screening, perceptions of risk • Disability: women with a learning disability or mental health problem known to have lower levels of attendance for breast screening
------------------	--

13.18 Although not an established equality strand, the panel noted that social deprivation was a prominent issue in the take up of breast cancer screening and subsequent treatment options and outcomes. It was recorded that women from poorer backgrounds often present at a much later stage of cancer development and more likely with the presence of other health conditions, which reduce treatment options.⁶⁰ The panel noted that this lead to lower breast cancer survival rates among women living in socially deprived areas.⁶¹

13.19 Through the course of the review, a number of actions have been identified to both commissioners and service providers to help improve access to breast screening services among women in the different equality strands. These are included within the recommendations of the report but which can be summarised as thus:

- Provider to adapt breast screening invite to include information in community languages
- Provider to signpost women to where further information in different languages can be obtained from the internet
- Commissioners to conduct ongoing research to identify and support non groups of non attendees at breast screening programme
- Commissioners to develop a programme of community interventions (public health, prevention) which acknowledge and support breast screening attendance.

13.20 The panel noted that improved uptake of breast screening was critical in helping to reduce breast cancer inequalities, and was therefore keen to ensure that a programme of community interventions was developed to promote screening among those groups known to face increased risk of breast cancer, who were known not to attend or who are particularly vulnerable.

⁶⁰ Macleod et al Socioeconomic deprivation and stage of disease at presentation in women with breast cancer *Annals of Oncology* 11 (1)p105-107 2001

⁶¹ Coleman et al Trends in socioeconomic inequalities in cancer survival in England & Wales up to 2001 *British Journal of Cancer* 90 (7) p1367-73 2004

Appendix A – Figures

Figure 1 – Breast screening uptake 2002-2009

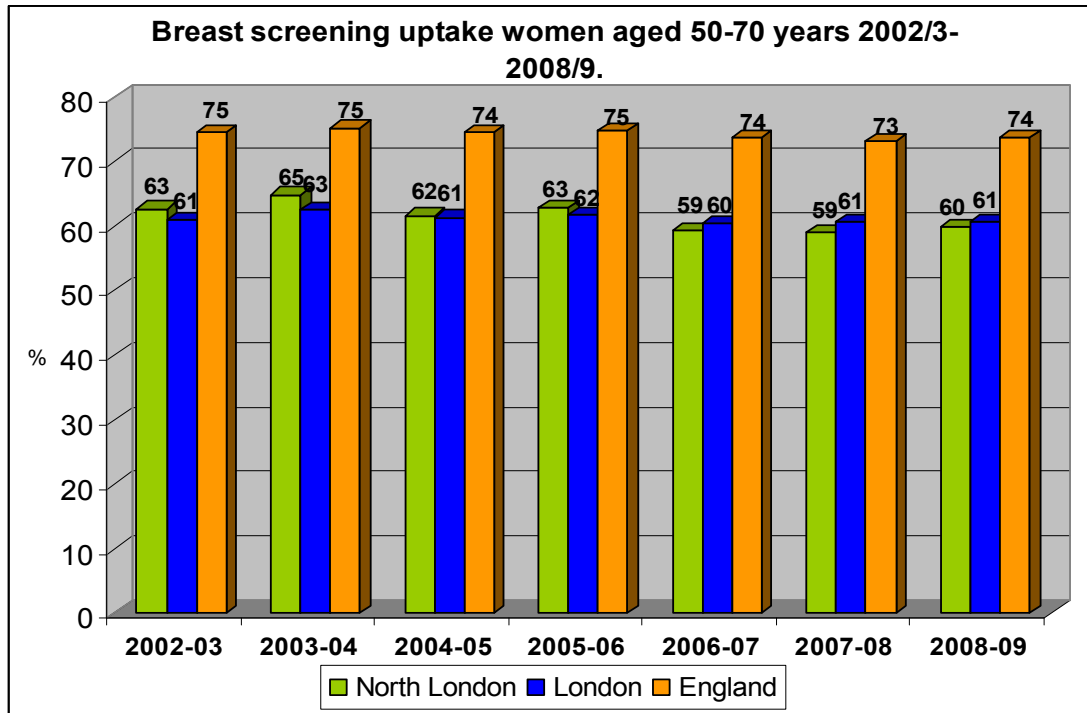


Figure 2 – Breast screening uptake in London.

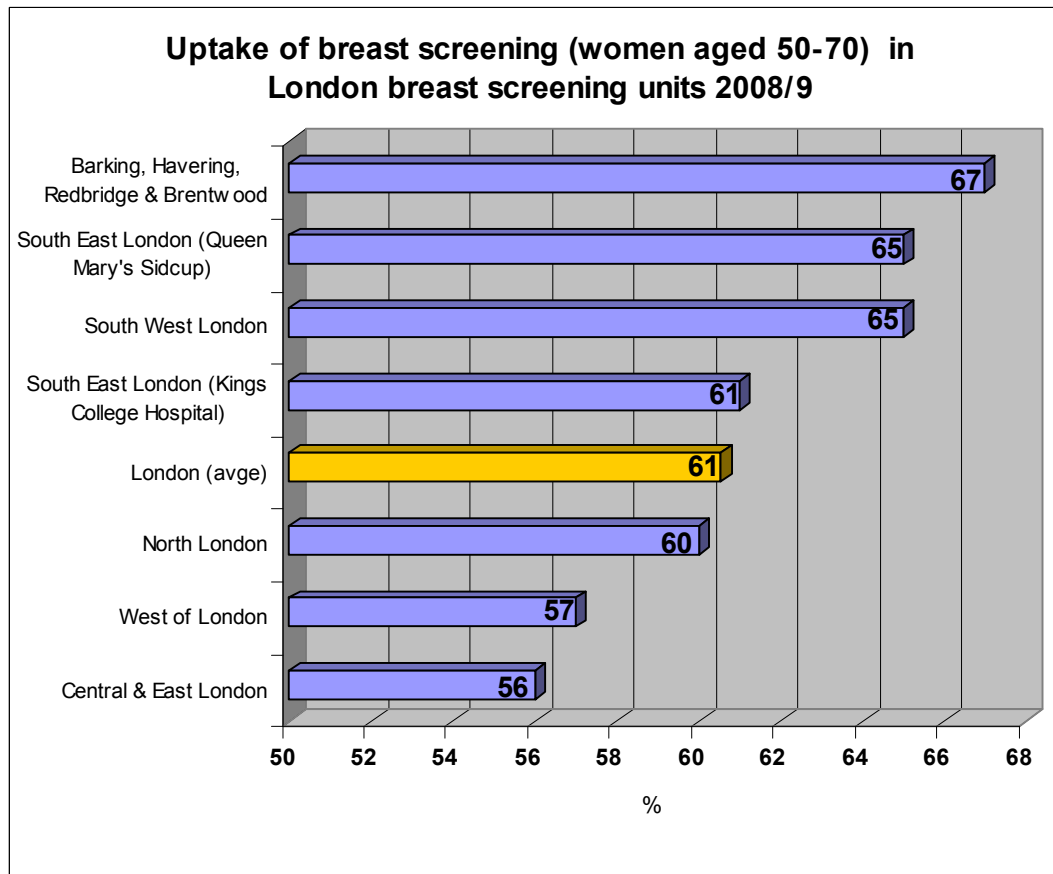


Figure 3 – Breast screening coverage across London PCTs (March 2009)

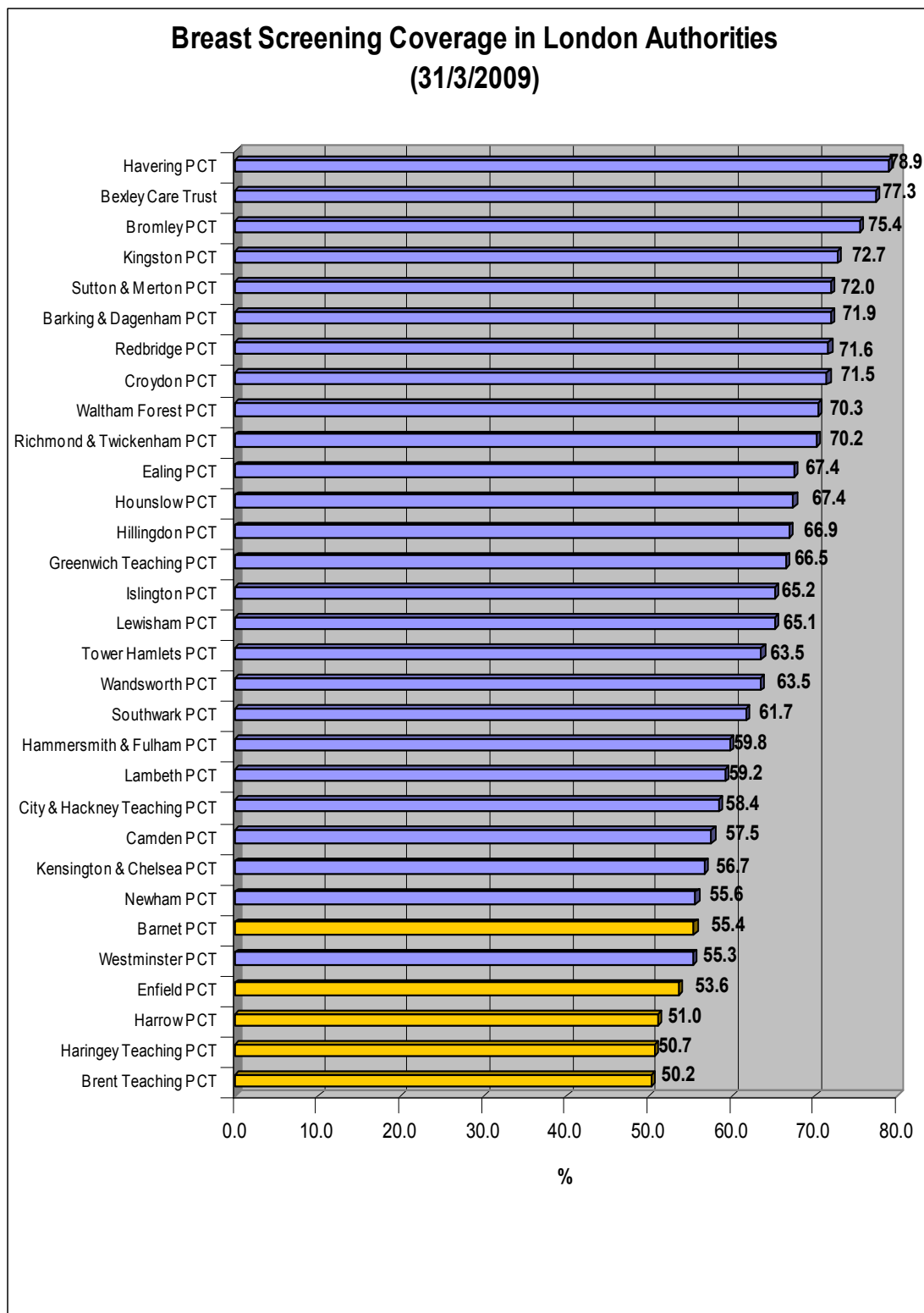


Figure 4 – Breast screening round length in London screening units (07/08).

London Quality Assurance Reference Centre

Breast Screening Roundlength by Unit 2007-08 (Ages 50-64)
 (Target 90% of Women to be re-invited within 36 months of previous screen)

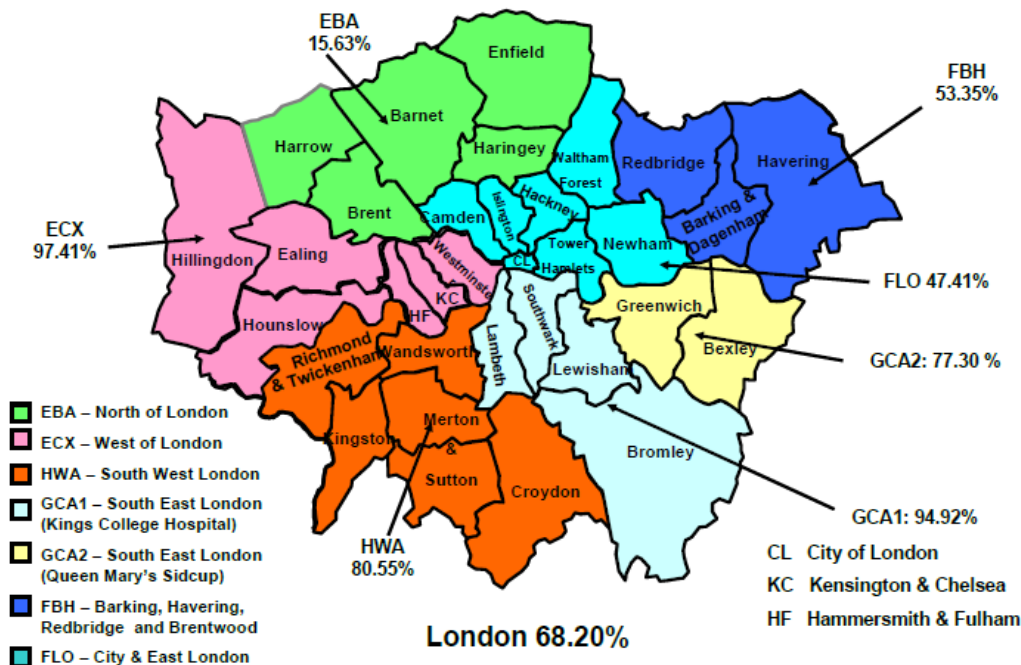


Figure 5 – Uptake of breast screening in NLBSS area (2008/9)

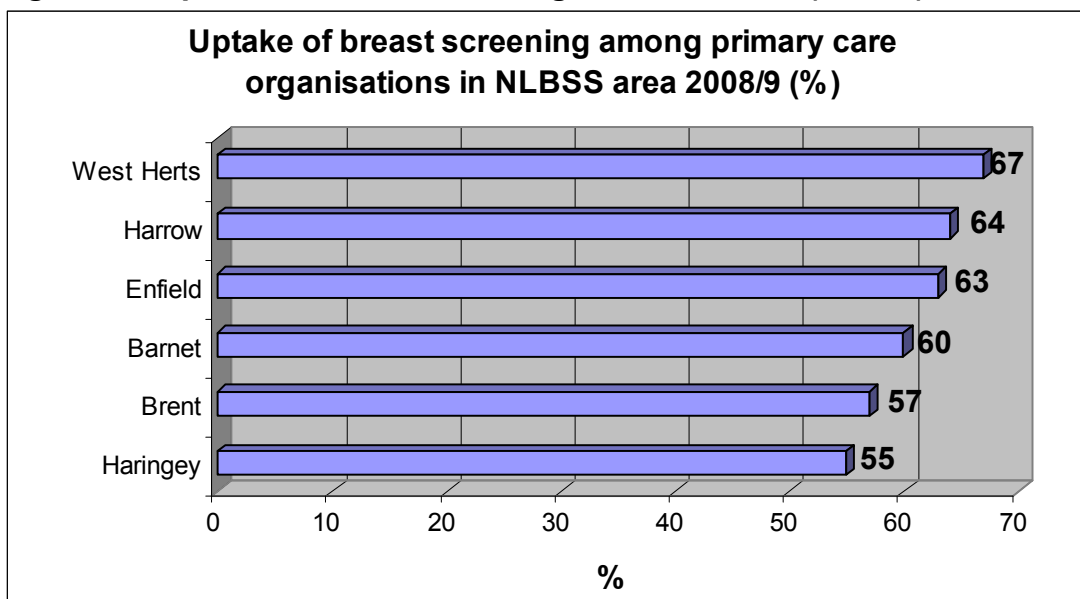


Figure 6 - Breast screening coverage by GP practices in Haringey 08/09

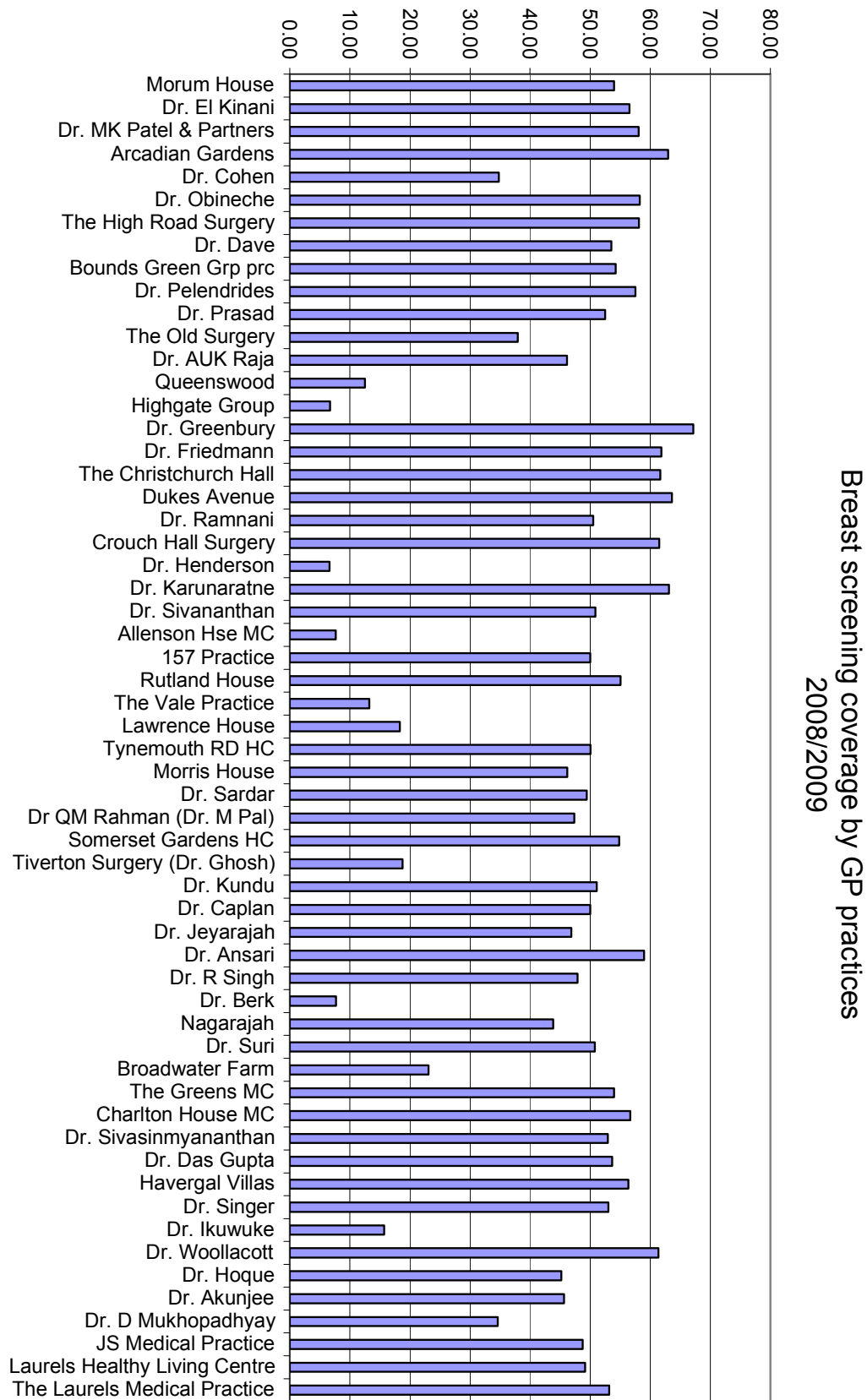
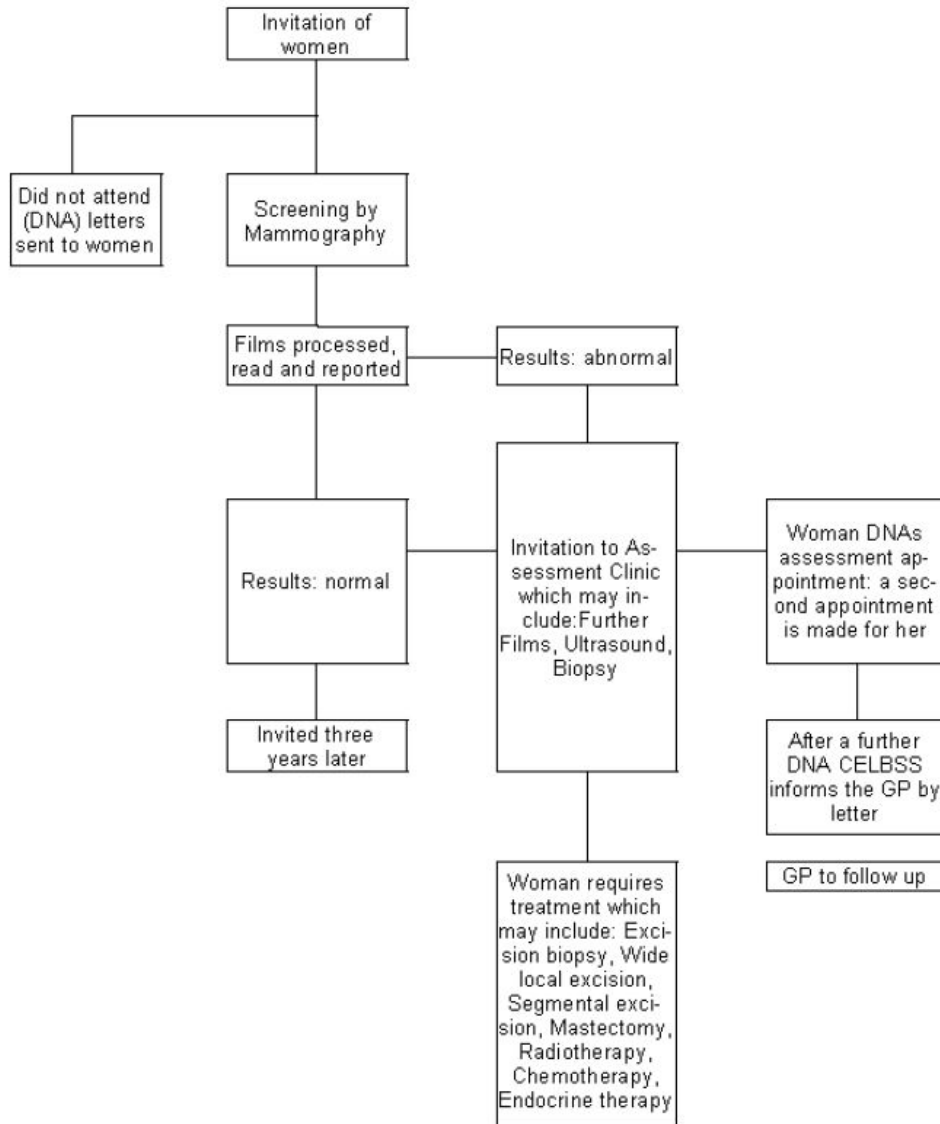


Figure 7 – Breast Screening Pathway



Taken from: Central and East London Breast Screening Service.

Appendix B – List of participants to the review process

Name	Role	Organisation
Dr Kathie Binysh	Director	London Cancer Screening Quality Assurance Reference Centre
Fiona Bonas	Network Director	North West London Cancer Network
Debbie Brazil	General Manager	North London Breast Screening Service
Tamara Djuretic	Public Health Consultant (Lead commissioner for Screening)	NHS Haringey
Alison de Metz	Performance & Programme Manager	NHS London
Dr Jane Moore	Associate Regional Director of Public Health	NHS London
Dr Helen Pelendrides	General Practitioner	NHS Haringey
Duncan Stroud	Associate Director Communications, Stakeholder Engagement and Partnerships	NHS Haringey
Dr Zelenyanselu		North West London Cancer Network

Appendix C – Invite to Consultation

Overview & Scrutiny Team

7th Floor, River Park House, 225 High Road, Wood Green, London N22 8HQ

Tel: 020 8489 6922 Fax: 020 8489 2533 Minicom: 020 8489 2535

www.haringey.gov.uk



Head of Policy & Performance Eve Pelekanos

Haringey Council

Dear Client of the North London Breast Screening Service

The Overview & Scrutiny Committee of Haringey Council is carrying out a review of breast screening services in the borough. The aim of this review is to find out why fewer women take up their invitation to breast screening in Haringey than in many other boroughs and to suggest ways in which access to screening services can be improved.

As a recent user of the screening service, we would like to invite you to a consultation session to hear your views. The session would give you the chance to talk about your experience at the breast screening unit to find out how accessible you found the service and how you think access can be improved. If you are interested in taking part, you can attend one of the following sessions:

Tuesday 26 th January	2.00-3.00pm	Haringey Civic Centre, High Road, Wood Green. N22 8LE
Tuesday 26 th January	6.30-7.30pm	Haringey Civic Centre, High Road, Wood Green. N22 8LE

Please be reassured that the above sessions are women-only and that the information that you provide will be in confidence and will not affect your right to access services in the future. All those women who attend the consultation will be given a £10 voucher to cover any expenses incurred.

If you would like to attend I would be grateful if could confirm before the 26th January 2010 by contacting Martin Bradford either by telephone: **0208 489 6950** or email: martin.bradford@haringey.gov.uk. (Please note each session will be limited to a maximum of 12 women.)

For those women not able to attend the consultation event but who would like to take part in the review, a short survey is attached to this letter. The survey provides a further opportunity to feedback your views about the breast screening service. Again, all information you provide in the survey will be in confidence. All those who complete and return the survey before **22nd January 2010** will also be placed in a draw for a £25 voucher.

May I take this opportunity to thank you in anticipation of your support for the review.

Yours sincerely

Cllr David Winskill

Chair, Scrutiny Review Panel (Scrutiny Review Breast Screening Services)

Appendix D – Breast Screening Survey**Breast Screening Survey****1. Which breast screening site did you attend?**North Middlesex Hospital Forest Road Whittington Hospital **About the letter inviting you to attend for a breast screen****2. Was the invite easy to read and understand?**Yes No Not sure **3. Was the information you received about breast screening available in other formats for example, in other languages, in large print or in audio form?**Yes No Not sure **4. Were you given enough information about what would be involved in attending for a breast screen?**Yes No Not sure **5. Were you given enough information about how to get to the breast screening service (i.e. where the unit was located, public transport routes)?**Yes No Not sure **6. Would you have liked any other information before your screening appointment? (Please describe)**

About your appointment at the breast screening clinic**7. Was the appointment for your breast screen convenient for you to attend?**Yes (go to Q9) No **8. If your appointment was not convenient, was it easy to make another at a more suitable time?**Yes No

If no, please describe why:

Getting to the screening service**9. Did you experience any of the following difficulties in accessing your breast screening appointment?**

	Yes	No	Not sure
Inconvenient appointment time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting time off-work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making arrangements for someone you care for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited public transport to site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parking problems on site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in locating the breast screening service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other problems (please describe)

10. If you experienced any difficulty in accessing your breast screening appointment, was there anything that could have been done differently to make it easier to attend?

Your experience at the breast screening clinic

11. How satisfied or dissatisfied were you with the following at the breast screening clinic?

	Satisfied	Dissatisfied	Not Sure
Welcome/ reception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting time in the clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendly and helpful staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided with enough information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments? _____

12. On the whole, how satisfied were you with the quality of the breast screening service?

Satisfied Dissatisfied Neither satisfied or dissatisfied

13. Would you recommend the breast screening service to a friend?

Yes No Unsure

14. Is there anything else you would like to add about your visit? In particular, we would like to hear how you think we can encourage more people to attend their appointment for breast screening?

15. How old are you? 51-60 61-70 71 and over

16. What is your ethnic group?

White		Black/Black British		Mixed	
British	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	White & Black Caribbean	<input type="checkbox"/>
Greek/Cypriot	<input type="checkbox"/>	African	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>
Turkish/Cypriot	<input type="checkbox"/>	Other	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>
Turkish	<input type="checkbox"/>	Asian/Asian British		Other	<input type="checkbox"/>
Kurdish	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Chinese or other ethnic group	
Irish Traveller	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Gypsy	<input type="checkbox"/>	East African	<input type="checkbox"/>	other	<input type="checkbox"/>

If you would like to take part in the free prize draw for a £25 voucher please leave you contact details below:


Name: _____

Contact telephone: _____

**Thank you for completing this survey. Please return by
22nd January in the prepaid envelope provided.**

Appendix E – Invite letter from NLBSS

Parts of this document have been scrambled to maintain confidentiality

Barnet and Chase Farm Hospitals 

Date of Birth: 16-Dey-1837
Name: Desj Aqig Masxao

North London Breast Screening Service
Deansbrook House
Edgware Community Hospital
Deansbrook Road
Edgware
Middlesex HA8 9BA

Ref: ELA679021

Tel: 020 8951 4045
e-mail: Breastscreening.appointments@bcf.nhs.uk
Fax: 020 8732 6941
Office Hours 9am - 5pm Monday - Friday

PRIVATE AND CONFIDENTIAL

PH034970200000000

Mizm Awaa Aiwnal
49 CENKRESFE MLEJE
EQGIEEW
EIO 8VL



- 8

50 Nec 8467

Dear Sucf Aloo Vavyix

I would like to invite you to come for a free breast test. This test is offered by the NHS to all women aged between 50 and 70 once every three years. The test is a breast x-ray (mammogram) which can detect over 90% of breast cancers. Breast x-rays can help to find breast cancers when they are still very small, before women notice any changes. If we can find breast cancer early the chance of a complete recovery is more likely. Usually women only need one visit every 3 years but some women need to return for further tests. Most of the women who come for a second visit are found to have normal breasts.

An appointment has been made for you

At: 3:87 a.v. On: Wwnexsay 85gt Jooualt 8869

Please come to: UORRH NIDDZEQID NOVAQE 4
XOKYK SELDQELED AOAGEZAY
MOBOEU ABOT
(GEOUGE YATBIBOGT DINIXTNEOK)

Please phone, write or email us if you:

- want to change the day or time of your appointment
- have had a mammogram (breast x-ray) in the last six months
- have breast implants
- are unable to climb a flight of steps (mobile van appointments)
- cannot stand without support or have any other special needs
- do not want to come at all
- would like to change venue
- prefer Saturday and late evening clinic appointments at Edgware Hospital only.

Please allow extra time for your appointment as parking facilities are not always available.

Your result will be sent to you and your doctor (GP). Please read the information on the leaflet enclosed before attending your appointment. If you want to talk to us or have any further questions, please phone us on 020 8951 4045 or email us at breastscreening.appointments@bcf.nhs.uk We will be happy to help you. I hope you will be able to come.

Please fill in the enclosed questionnaire and bring it with you to your appointment.

If you have received this invitation inappropriately please accept our apologies and contact the screening office so that your records can be amended.

Yours sincerely,

Dr Will Teh
Director of Screening

Appendix F - Consultation with service users.

Scrutiny Review of Breast Screening Services in Haringey

Report from the consultation with users of North
London Breast Screening Service.

February 1st 2010

1. Introduction

- 1.1 A review of breast screening services was commissioned by the Overview & Scrutiny Committee in 2009. The review is seeking to assess the reasons behind the low uptake of breast screening services by women resident in Haringey and to identify possible remedies to help improve service uptake. The conclusions and recommendations of the panel will be presented to the relevant commissioning agency: NHS Haringey.
- 1.2 As part of the review process, a consultation was planned with Haringey residents who had used the breast screening service (North London Breast Screening Unit). This following provides an analysis of data from both questionnaire and focus groups used in the consultation. It is hoped that these findings will guide and inform final recommendations for the review.

2. The consultation method

- 2.1 It was decided that a mixed method methodology, which involved both quantitative and qualitative data collection techniques, offered the best approach for this consultation. Firstly, the use of a questionnaire would facilitate the identification of broad themes which could be followed up in greater detail within the subsequent focus groups. Also, given the sensitivity of the subject area, the two methodologies would allow differing levels of engagement and privacy to best suit women considering participating in the review.

The Survey

- 2.2 The questionnaire was designed in consultation with the North London Breast Screening Service. The survey sought to assess service user's perceptions of the breast screening invite, the appointment system, the quality of breast screening services provided and possible suggestions for improving screening uptake.
- 2.3 As the consultation was trying to understand low service take up, it would have been ideal to target the survey distribution to those women who did not attend for their appointment. It should be noted however, that due to data limitations, this was not possible. In this context, some caution should be exercised in interpreting data, especially in terms of accessibility of services, as the survey is likely to have been distributed to those that already attended the service.
- 2.4 The survey was distributed to 200 women resident in Haringey who had been invited to breast screening in December 2009. Participants were reassured that all responses would be treated confidentially and a prepaid envelope was included to facilitate responses. As an incentive, a draw for a £25 voucher was offered to all those that returned completed responses. The survey is contained in Appendix 2.

Focus Groups

- 2.5 An invite to participate in a focus group was distributed in two ways: through inclusion with the postal survey and through a mail out to local women's groups. The invite offered women the opportunity to participate in one of two planned focus groups. Both focus groups were of one-hour duration and facilitated by a member of the scrutiny panel and scrutiny support officer (both female). Focus groups were held in the afternoon and evening to facilitate participation.
- 2.6 Participants in the consultation sessions were reassured that all information provided would be given in confidence and that their participation in the review would not affect their right to access future services. Participants were provided with £10 voucher in lieu of expenses incurred for attending the consultation session. The invite is contained in Appendix 1.

3. Survey and focus group results

Responses

- 3.1 In total, 63 completed questionnaires were returned. This produced a response rate of 32% which can be considered to be good for a postal questionnaire. A further 10 women accepted the invitation to participate in one of the two planned focus groups. In total therefore, approximately 70 Haringey women who had used the breast screening service participated in the review.
- 3.2 The breast screening programme includes women between the ages of 50 and 70 years where invites are distributed practice by practice on a three year rotation. These factors clearly influence the demographic data of respondents. Analysis reveals that almost $\frac{3}{4}$ (72%) of survey respondents were aged between 51-60 years and the majority (72%) of respondents were of white British ethnic origin (Figure 1).

Figure 1 – Demographics of respondents (n=62)

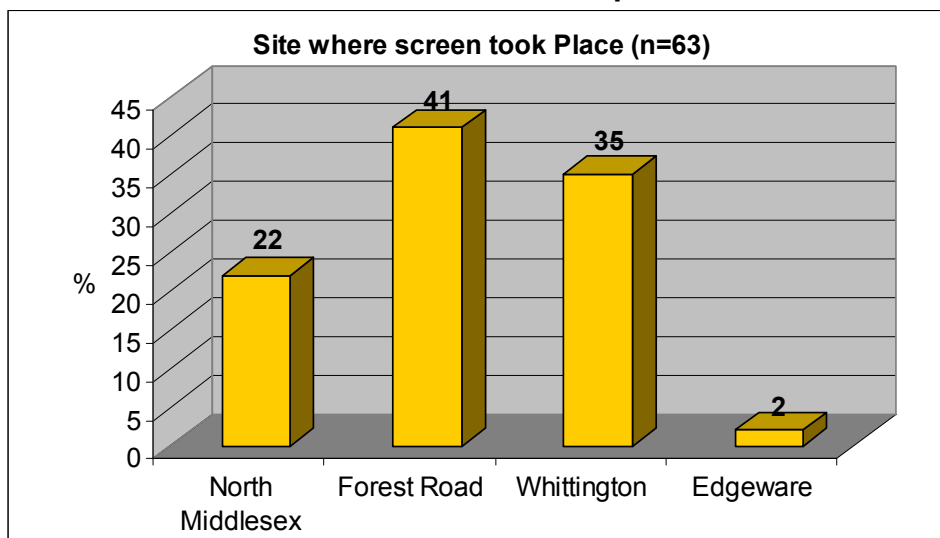
Age group (%)		Ethnic Origin (%)	
51-60	72	White British	72
61-70	28	Black Caribbean	18
		Turkish	2
		Indian	2
		Mixed ethnic origin	5
		Other	2

- 3.3 It had been noted during the review process that proportionally fewer women from the lower end of the screening age spectrum attended for screening. It was therefore interesting within this survey at least, to record that a higher proportion of women in the younger age group responding to this survey. Ethnicity data is unlikely to reflect local population estimates as breast screening invites are issued on a practice by practice basis in individual localities and subject to local population variations.

Screening Location

- 3.4 The NLBSS operates breast screening clinics from a number of sites in North London and respondents indicated that they attended one of four such clinics in this area (Figure 2). In this survey, approximately 2/5 respondents attended the Forest Road Polyclinic and just over 1/3 attended the Whittington Hospital. A very small proportion of respondents (2%) attended the Edgware Hospital site (Figure 2).
- 3.5 It should be noted that breast screening sites detailed in Figure 2, although close to Haringey borough boundaries, none are actually located in Haringey. Thus, 63% of respondents attended clinics based in Enfield (North Middlesex Hospital or Forest Road Polyclinic), 35% attended the clinic in Islington (Whittington) and 2% in Barnet. This is an important factor when interpreting later clinic accessibility data.

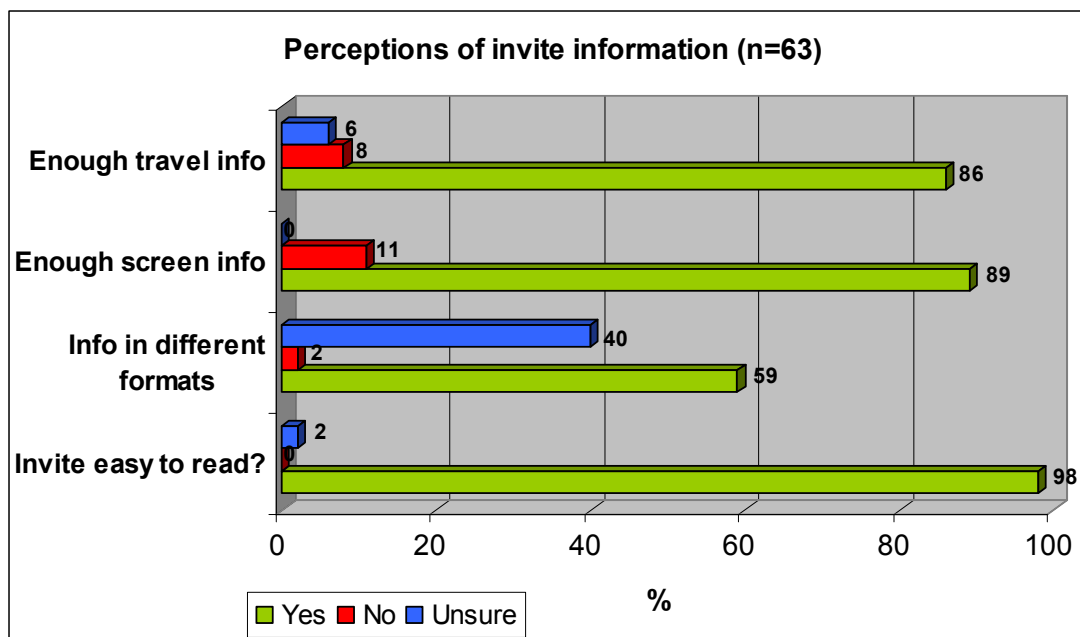
Figure 2 – The site where breast screen took place



Breast Screening Invite

- 3.6 At approximate 3 year intervals, women between the ages of 50 and 70 years are invited for a breast screen at the local breast screening unit, the North London Breast Screening Service (NLBSS). The invitation consists of a letter explaining the importance of regular breast screens and a preset appointment at one of the breast screening clinics. An information booklet on breast screening accompanies the invite letter (Breast Screening: the Facts).
- 3.7 The questionnaire sought to assess women's perceptions of the breast screening invite, in particular, whether the invite was clear and easy to understand and whether the information provided was sufficient for those women about to attend for a breast screen. Figure 3 provides a summary of these responses.

Figure 3 – Service user's perceptions of invite to breast screening service.



3.8 Almost all (98%) survey respondents found the invite easy to read and understand (Figure 2). Proportionally fewer, though still a clear majority of respondents indicated that the invite provided enough information about breast screening (89%) and travel information to access the clinic where there appointment was. Far fewer respondents indicated that they were aware that the invite information was available in different formats (large print, community languages).

3.9 Analysis of qualitative responses from both the questionnaire and the focus groups identified a number of key themes. Firstly, a significant proportion of women had previously attended the breast screening clinic and thus knew what was involved during a visit. As one would expect, this group of women had fewer information needs than those who had not attended before:

'I have been screened before so I knew what would happen.' Whittington

'I have already been through the process.' Forest Road

3.10 Even though there is an accompanying booklet, a number of women, perhaps first time service users, clearly wanted to know more about what would happen in the breast screening clinic. More specifically, what the data reveals was that perhaps some women wanted something more personal than the booklet to explain what would happen at the breast screen:

'[It would be useful to know] I think it would be useful to be told in a reassuring manner what would be involved.' Forest Road

3.11 Analysis of focus group data revealed that a number of participants who spoke a minority language, had concerns that the invite appeared only to be available in English. The focus groups identified a need to have some minimum translation in a key local community languages included within the invite, even if this was just a reference to where further information could be found.

- 3.12 Analysis of the survey data *and* focus group data produced clear evidence for the need to include additional travel information within the invite, to explain how women can access particular breast screening clinics. A significant number of respondents who attended the Forest Road breast screening clinic indicated that additional travel information (public transport, parking facilities or a map) should be made clear within the invite to enable them to make appropriate travel arrangements to the site:

'Improved directions would help, [perhaps to] include a map would be really helpful and make sure they are detailed enough i.e. bus stops, parking, tubes....'

'I can't remember if there was a map, I think not, a little map of the area around the site would have helped as I wasn't sure where to get off the bus...'

'A little map and info about local buses which run close to the clinic would be good.'

'Information should be given in the letter regarding transport facilities to this particular centre such as bus routes tube and parking and this needs to be updated regularly as things do change.'

Breast Screening Appointment

- 3.13 The questionnaire and focus group sought to assess respondents' perceptions of the operation of the appointment system at the NLBSS, in particular whether the preset appointments which are offered to women were convenient, and if not, the ease with which women could change these. The survey data revealed that just 34 out of 62 (55%) of respondents indicated that the first preset appointment was convenient (Figure 4). Furthermore 8 out of 28 (29%) women who found the appointment inconvenient did not find it easy to change this appointment (Figure 4).

- 3.14 Analysis of both questionnaire and focus group data found there to be a number of significant concerns around the operation of the NLBSS appointment system. The location of the clinic at which women were allocated their appointment was the subject of considerable concern among participants in the consultation. In particular, respondents could not understand why the location of their appointment was so far from the area in which they lived:

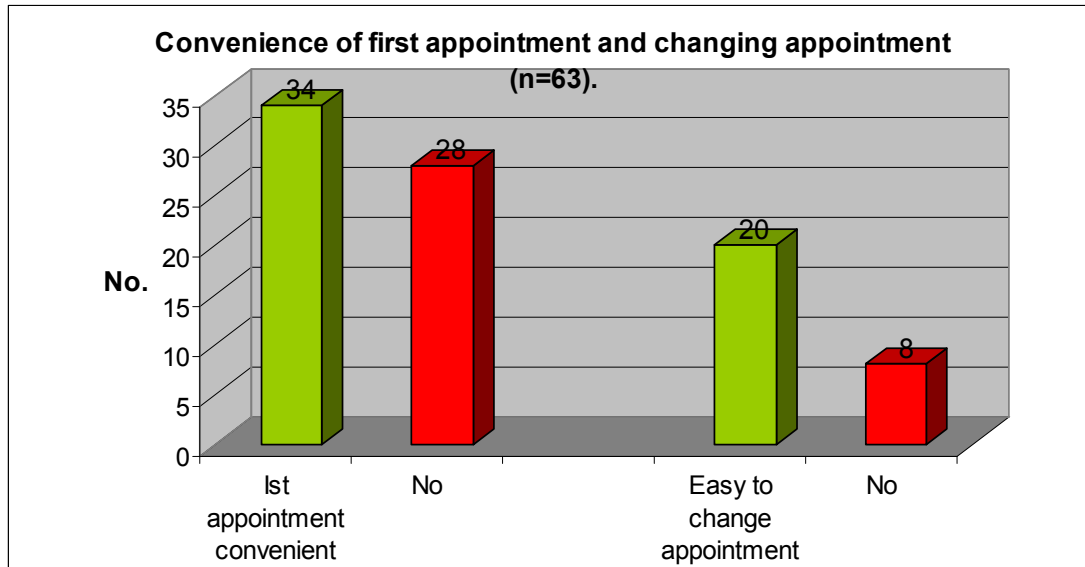
'I would have preferred an appointment nearer home. I was given an appointment at Forest Road when I could have walked to the Whittington.'

'The first appointment I was given was hopeless, an impossible location and no choice of time. I live in Hornsey and was offered an appointment in Edmonton. I can only get to Edmonton by 3 buses... the Whittington [would have been] fine.... '

'No I was not happy, there were no more local appointments available at the Whittington so I had to travel all the way to Edmonton from N8.'

'I would like more choice about where I attended e.g. the North Middlesex Hospital as I only needed to get one bus to get there, in fact I could have walked. (Forest Rd appointment)

Figure 4 – Service user's perceptions of the appointment system.



- 3.15 It is apparent from the analysis of survey data, that respondents are not aware that there are a number of breast screening locations *and* that it may be possible to change their preset appointment to a nearer and more convenient location:

'I was invited to a hospital a long way away it was only when I phoned that I found out it was possible to go to the Whittington which is far more convenient.'

- 3.16 From the analysis of the survey data, it is clear that the location of the breast screening appointment is of critical importance as to whether women attend their allocated breast screening appointment. It would appear that this represents a clear barrier to service accessibility, which perhaps only the more motivated or aware women may overcome:

'I live 10 minutes away from the Whittington and I rang to see if there was a closer site I could attend, but was told Forest Road was the nearest – which was clearly not true! It took me over an hour and a half to get there by bus. I think it's important to attend for breast screening, otherwise given the inconvenient location, I would not have bothered.'

- 3.17 Another strongly expressed concern about the appointment system which was evident within the survey and from the focus groups, was the lack of appointments available outside of normal working hours. Here it was evident that a significant number of women indicated that they were in employment which made it difficult to attend appointments:

'The problem for me is that the appointments are always during daytime working hours, some evening and weekend appointments could be

offered. As I have a full time job I have to make sure I my work is covered (I am a Dr) during my hours of absence.'

- 3.18 Furthermore, where out-of-hours appointments were available, these were situated a long way away for Haringey residents. Within a focus group, a participant noted that in order to be able to go for a breast screen on a Saturday morning, she would have to go to Edgware Hospital which had involved two long bus journeys. The same concerns about the accessibility of the out of hours clinics was also recorded within the survey:

'I would have preferred an appointment outside of working hours at the Whittington but there was only one further away at Edgware.'

'Edgware was the only appointment available on a Saturday.'

- 3.19 A third concern with the appointment system was that women experienced some difficulty in getting through to the NLBSS to try and change their appointment, and the apparent lack of capacity within the system to enable to change their appointment:

'I was told to ring back twice for an alternative appointment. I then gave up and took time off work to attend the screening unit.'

'I rang the number and there was a long wait to get through then it was engaged repeatedly. The receptionist was helpful but did not have appointments beyond the next 2 weeks – so I had to ring back again two weeks later – and go through the whole process again - which was both time consuming and expensive.'

'There was no opportunity to have an alternative date / time when I rang.'

Difficulties in accessing breast screening appointment

- 3.20 Survey respondents were asked to indicate, from a range of preset options, if they experienced any difficulties in accessing their breast screening appointment. Analysis of responses found that 28% of women had difficulty getting to their appointment because of the allocated appointment time slot (Figure 5). The availability of parking (25%) and getting time off work (22%) were other important factors which affected the accessibility of their appointment.

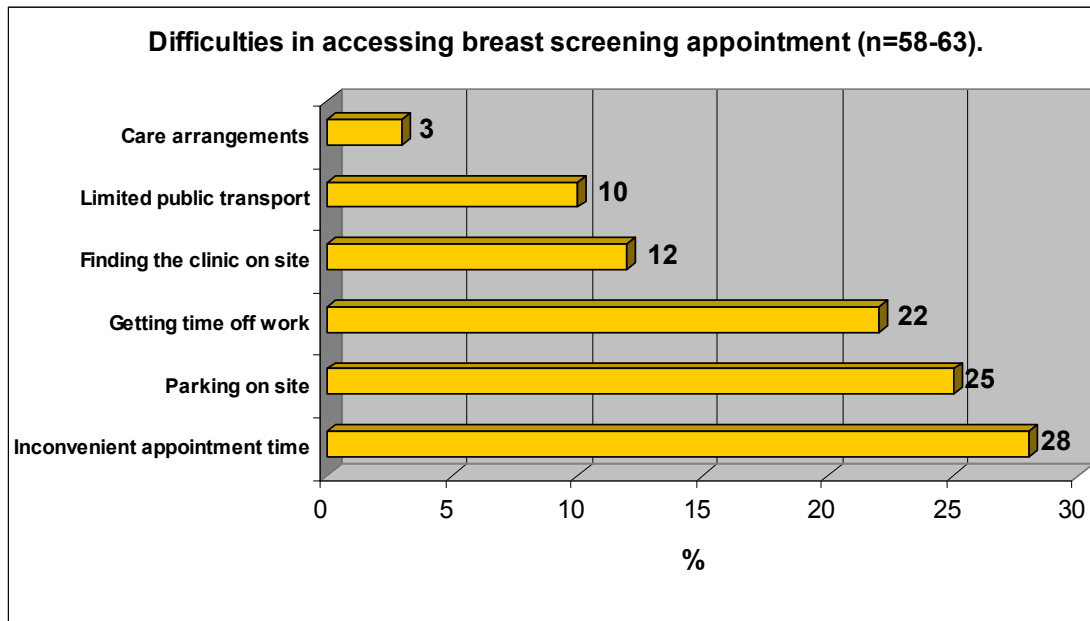
- 3.20 Given the length of journey that women are expected to take in accessing breast screening services, it is likely that many may choose to access the clinic by private car. In this context, a number of respondents highlighted the parking problems associated with a number the screening sites, particularly in relation to the availability of spaces and the cost:

'Car park fees to be cheaper.' (NMH)

'Parking is a problem.' (Whittington)

'I am aware that parking restrictions are not within the remit of the NHS, but they are getting more chevrons year by year.' (Forest Road)

'Had I been arriving by car I am not sure where I would have parked or if there were any spaces?' (Whittington)

Figure 5 – Stated difficulties in accessing breast screening appointment.

- 3.21 The availability and cost of parking may be one area that needs to be addressed in the provision of adequate travel information in the breast screening invite:

'Perhaps give information about the cost of parking and also an estimation of how long screening is likely to take so that parking time can be planned for. I nearly ran out of time and had to run out to my car before the ticket expired.'

- 3.22 Another problem to emerge from the analysis of survey data was the difficulty of accessing the breast screening service whilst on site. A number of women, particularly those that attended the Forest Road clinic, indicated that there was inadequate signage for the screening unit at the polyclinic site and the waiting area not clearly marked:

'Not very clearly signed when I arrived at the centre.' (Forest Road)

'I couldn't find it, there was NO SIGNAGE at all or instructions as to where to wait.' (Forest Road)

'I did not see any information outside the clinic to suggest that breast screening was being done in the building. (Forest Road)

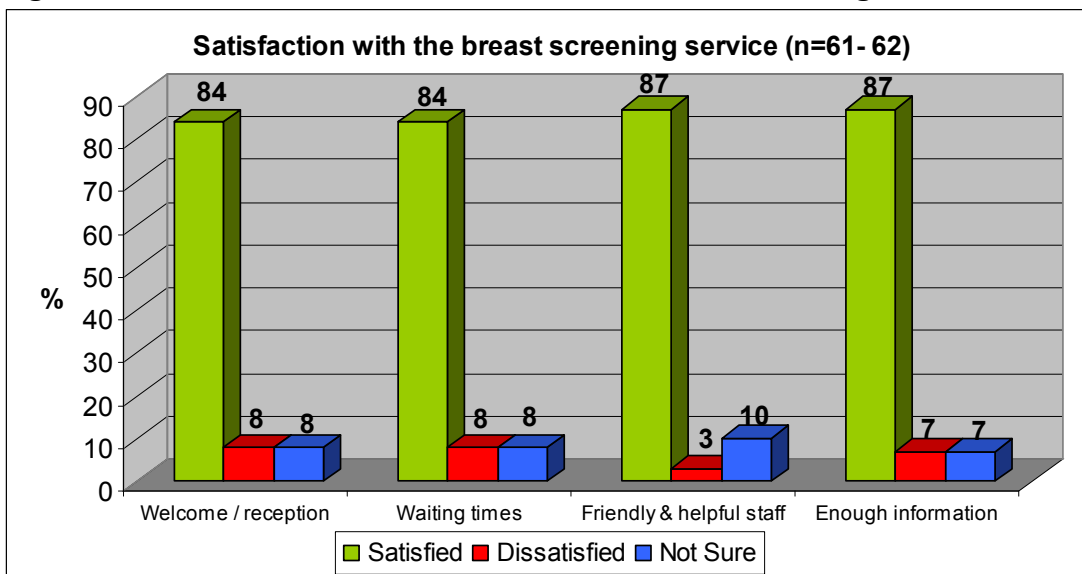
'It wasn't obvious where to go, no signs to mammography and even when I joined the three women sitting waiting I wasn't sure I was in the right place until a nurse appeared. (Forest Road)

Experience of breast screening service

- 3.23 The survey sought to assess women's experiences of the breast screening service as this data may be useful in determining whether women would be likely to re-attend the service in the future. Analysis of service data found high levels of satisfaction with all aspects of the service (Figure 6). Here, high levels of service user satisfaction were recorded for the welcome to the clinic

(84%), waiting times (84%), friendly and helpful staff (87%) and the provision of information (87%) (Figure 6).

Figure 6 – Service user satisfaction with breast screening service



3.24 The high levels of satisfaction recorded quantitatively with breast screening service was verified in the analysis of qualitative comments by respondents. Here it was evident that women found the breast screening services to be friendly, reassuring, informative and efficient:

'The whole experience was made as pleasant as possible and the staff were very considerate.' (Whittington)

'Excellent staff, all very friendly and reassuring.' (Edgware)

'... friendly and informative, keep up the good work.' (Forest Road)

'...very quick and efficient.' (Whittington)

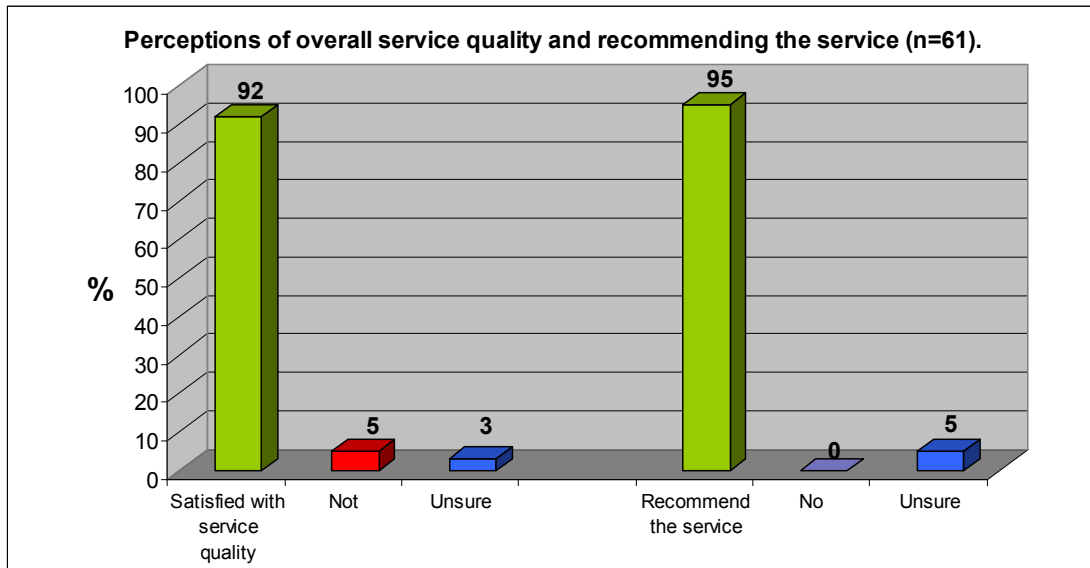
'I think it's a great service, thanks.' (Forest Road)

3.25 Whilst there were high levels of satisfaction with the service, this was not to suggest that there could not be areas of improvement, for example, the waiting areas were all identified as a service area which could be improved. These were not always clearly identified and there could be additional facilities or information at hand to reassure women about to have a breast screen:

'It needs a clearly designated waiting area here.' (Forest Road)

'Maybe show a DVD of what will happen in the breast screen while a patient is waiting.' (NMH)

3.26 The satisfaction that respondents felt with the breast screening service is reflected with overall service perceptions. Here, the overwhelming majority of respondents were satisfied with the quality of the service (92%). Underlining the satisfaction respondents had with the service was the fact that 95% of respondents felt able to recommend the service to a friend (Figure 7).

Figure 7 – Service user perception of overall service quality.

Suggested ways to improve screening take up

- 3.27 Both respondents and focus group participants were asked to identify ways in which breast screening uptake among women in Haringey could be improved. There were a range of suggestions put forward and these are presented in order of priority below.

More Convenient locations

- 3.28 The most important issue to arise from both the survey and focus groups was the need to allocate women to appointments at a breast screening clinic which was more conveniently located to where service users live. It was evident from the survey that many service users had to travel some considerable distance to their allocated appointment, which was clearly a barrier to service uptake:

'If it was nearer home a more convenient location, I think more people would attend.'

'People in my area would be far more likely to attend the clinic if it was more local and on public transport....'

'If you could give appointments closer to where people live it would help.'

- 3.29 Thus as a priority, respondents felt that a wider range of screening locations need to be developed for women in Haringey and ensure that these are actively promoted and developed:

'There needs to be more options of where people can screen.' (Forest Road)

'I think that a broader range of sites would be helpful – none of the sites offered were even in Haringey – what about St Ann's Hospital or the new polyclinic on Park Road or Morrison's supermarket at Wood Green?'(NMH user)

Improve out-of- hours access

- 3.30 Out of hours access to breast screening clinics was seen to be important in the survey, so it is no surprise to record this as an area which women felt should be developed to help improve uptake. The issue here is two fold, firstly to develop out-of-hours options for women seeking to use the service and secondly (as seen from earlier data) ensure that extended opening hours clinics are developed at more convenient locations to Haringey women.

'[Should] increase the number of evening and Saturday appointments.'
(NMH)

'...perhaps evening or Saturday appointments?' (Forest Road)

'If possible, if the appointment was offered for an evening or Saturday morning more women may take the visit up for screening.' (Forest Road)

Community outreach work

- 3.31 There was a broad consensus among both survey respondents and focus group participants that there is a need to actively promote the breast screening service to women in Haringey. In the focus groups, none could recall seeing any posters or any other promotional literature promoting breast screening in local surgeries or other community venues. In this context, it was felt that there should be more outreach work targeted at women eligible to participate in the breast screening programme.

'It would help some women to hear about the importance of screening from someone in the local community where they come. An idea would be to set up meetings with local community workers with the aim of encouraging women to attend.'

'How about issuing information to churches, women's centres and clubs so that they can make a list of names and addresses of women that are interested that could be referred.'

'...you could offer over 60's groups a chance to attend together?'

- 3.32 In particular, a number of respondents suggested that there should be work to target those women who may be hard to reach or who may face particular problems in accessing the breast screening service.

'I fully believe that the system is fine – but I assume that you already make arrangements with third parties such as care workers, Social Workers, Mental Health Workers?'

Service personalisation

- 3.33 Analysis of the survey data and focus group data confirmed that many women access the breast screen service with a range of anxieties. The concern among participants within the consultation was that if these concerns were left unaddressed then this may affect a woman's decision to attend for a screen. In this context, it was felt that developments which personalised the service may reassure women who have concerns or anxieties about attending for a breast screen.

- 3.34 A number of suggestions were put forward for personalising the service. Firstly, it was suggested that women, particularly first time users of the service, should be encouraged to attend with a friend or relative for reassurance:

‘People who are uneasy about attending may be more likely to do so if they could be accompanied.’

- 3.35 A second way in which the personalisation of the service could be improved was through the inclusion of individual service testimonials within the invite information. Here, it was felt if more personal accounts of women who had used the service were included this may help to demystify and explain the screening process better to prospective attendees:

‘Reassurance testimonials from other women may help like “I have small breasts and so I thought it would be painful to squeeze them between two metal plates – but it wasn’t metal and it didn’t hurt. Also the screener was kind and it wasn’t embarrassing”.’

- 3.36 In both the focus groups and the surveys responses, it was also evident that there was a desire for more personalised contact ahead of the breast screen appointment to answer any personal questions or allay any personal anxieties. In the focus groups, it was felt very strongly that there should be more opportunities to speak personally to someone within the service. This was particularly the case for women who were having their first breast screen:

‘This was my first time and even though I was satisfied with the service, someone should have come and spoke to me about what to expect.’

Work with GPs and primary care

- 3.37 In the focus groups, there was strong support for the breast screening service to work more closely with GPs and primary care. It was felt, at the very least, that there should be more promotion of the breast screening service in local surgeries through further publications such as posters or leaflets.

‘...there needs to be more adverts in the GPs....’

- 3.38 It was also felt that there could be more structural developments in the primary care setting which may help boost the uptake of screening appointments. Suggestions from the focus groups included; a flag system for GPs to notify women reaching 50 that they are eligible for breast screening; checking on practice registration whether women were attending the screening programme and thirdly, validate breast screening attendance through the newly established vascular checks (three year programme of checks for 40-74 year olds).

Community languages

- 3.39 As has been previously mentioned within this review, it was noted that the invite and other accompanying information was not available in community languages. Analysis of data from both the survey and focus groups identified this as an area where further work could be done to improve the uptake of breast screening services. Two specific suggestions were put forward from the focus groups:

- Translation of invite and other breast screening information on a website

- The inclusion of a pictorial guide to breast screening

Service promotion / promoting prevention

- 3.40 Another suggestion for improving uptake was to undertake greater promotion of the breast screening service at targeted locations. It was also suggested that there should be further local public health and health promotion work to raise awareness of the risk of breast cancer, to teach women self examination and the benefits of breast screening:

'It is important to look after yourself, the benefits of screening, what screening involves.... .'

'Its better to find things out sooner rather than later... '

- 3.41 Reminder letters/ calls

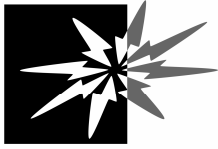
Finally, it was suggested that reminder letters or telephone calls would be helpful in promoting attendance at breast screening service.

'Phone call reminders would be helpful.'

'Phone calls or letters to women to confirm their appointment would be really helpful.'



This page is intentionally left blank



Haringey Council

Overview and Scrutiny Committee
On 5th July 2010

Report Title: Joint Health Overview and Scrutiny Committee to Consider the North Central London Service and Organisation Review – Appointment of Representatives

Report of: Chair of Overview and Scrutiny Committee

Contact Officer : Robert Mack, Principal Scrutiny Support Officer Tel: 0208 489 2921

Wards(s) affected: All

Report for: **N/A**

1. Purpose of the report (That is, the decision required)

1.1 To appoint two Members of the Committee plus a deputy to the Joint Committee to consider the North Central London Service and Organisation Review.

2. Introduction by Cabinet Member (if necessary)

2.1. N/A

3. State link(s) with Council Plan Priorities and actions and/or other Strategies:

3.1. N/A

4. Recommendations:

4.1. That the Committee nominates two Members of the Committee plus one deputy as the Borough's representatives on the Joint Committee

5. Reason for recommendation(s)

5.1. Included within the body of the report.

6. Other options considered

6.1. Included within the body of the report.

7. Summary

- 7.1 A major review of acute services in the north central sector of London is being undertaken by the NHS. This will involve significant changes to local hospital services and how they are configured. A full public consultation exercise is scheduled to be undertaken in the autumn. Local overview and scrutiny committees will need to be consulted as part of this process. Health scrutiny committees can voluntarily agree to join together to carry out health scrutiny reviews or consider health issues that cross boundaries. In addition, where NHS bodies are required to consult with more than one overview and scrutiny committee on proposals for substantial variations or developments to local health services, the relevant local authorities are statutorily required to set up a joint scrutiny committee to respond.
- 7.2 Overview and Scrutiny Members across the five boroughs have indicated their wish to set up a joint committee to engage with the NHS prior to the formal consultation in order to consider any collective issues. To this end, terms of reference for the Joint Committee were approved by Council on 22 March, following recommendation by the Committee at its meeting on 15 March.
- 7.3 It is intended that the work of this body will supplement engagement by individual OSCs with the NHS prior to the formal consultation process. Once formal proposals are developed, the joint committee will take on a statutory role in responding formally to them on behalf of the OSCs of the local authorities most affected.

8. Chief Financial Officer Comments

- 8.1 The Chief Financial Officer has been consulted on the proposal and recommendations and would like to highlight that the creation & operation of the proposed joint committee could lead to additional as yet unfunded costs for the Council.
- 8.2 The meetings will be held and clerked at each authority in rotation and these costs should be able to be contained within existing budgets however, there may be some additional one off costs such as use of external advice or report writing which will need to be met by the 5 authorities. At this stage it is not possible to quantify the likely level of these costs but it is recommended that a discussion on likely costs is held at an early meeting of the Committee so that consensus on an approved budget can be agreed and funding identified.

9. Head of Legal Services Comments

9.1. The statutory provisions relating to the establishment of the Joint Health Overview

and Scrutiny Committee are explained in the body of this report.

10. Head of Procurement Comments – [Required for Procurement Committee]

10.1. N/A

11. Equalities & Community Cohesion Comments

11.1. The joint committee will need to consider whether the proposals by the NHS are likely to adversely affect specific communities and, in particular, the adequacy of the equalities impact assessment.

12. Consultation

12.1. There are specific obligations on the NHS to engage and consult with patients and the public. A key part of the joint committees work will be to consider the NHS's plans for this. In addition, the joint committee will also seek to engage with a wide range of stakeholders, including organisations representing the patients and public.

13. Service Financial Comments

13.1. There are likely to be some cost implications arising from the joint committee but it is not possible to quantify the size of these at this stage. The practice is normally that any costs arising are shared between the participating local authorities. The size of the costs will depend on the level of support that Members of the joint committee decide would be appropriate in order to ensure that they are able to respond effectively to the review. This would include the need for any external independent advice that it is felt is required in order to facilitate effective challenge. The need for this will need to be balanced by the resources that each of the local authorities have to fund such commitments.

14. Use of appendices/tables and photographs

14.1. None

15. Local Government (Access to Information) Act 1985

15.1. Background papers are as follows:

16. Report

Background

- 16.1 NHS London have asked each of the commissioning sectors across the capital to review acute (hospital) provision within their areas. The drivers behind this are both clinical and financial. Haringey is in the north central sector (NC) together with Barnet, Enfield, Camden and Islington. The review for NC London is being led by Rachel Tyndall, the Chief Executive of both Islington PCT and the commissioning agency for the sector.
- 16.2 The view of NHS London is that acute services in London do not yet measure up to the vision within *Healthcare for London*. This aims to offer more care provided closer to home but with some specialist services being centralised, where necessary, to give higher quality and dedicated care. Hospitals are facing the twin challenges of some services being moved out of them into the community (e.g. x rays, physiotherapy) whilst other services are concentrated into larger, specialised centres (e.g. acute stroke, major trauma). In addition, they will face further future pressure on their finances as a result of the moves by PCTs to reduce unnecessary A&E attendances.
- 16.3 There is likely to be an increase in demand for health services in the next few years that will be accompanied by a possible decrease in funding allocated to the NHS by the government. This will result in a significant funding gap. The funding gap for NC London has been estimated as likely to be approximately £560m by 2016/17.
- 16.4 As part of the review, options for the configuration of the five hospital sites in the NC sector are currently being developed. The model that has developed recommends that there be the following:
- Two major acute hospital sites, one in the north of the sector and one in the south
 - A multi-specialist acute provider from where highly specialist and tertiary services will be delivered
 - Rationalisation of specialist services (e.g. cardiac, neurosurgery) across the Royal Free and UCLH and development of networked services for surrounding areas
 - A maximum of two local hospitals – two variants under consideration
- 16.5 In addition, consideration is also being given to in-patient mental health provision.
- 16.6 This model provides various possible potential permutations, which are currently being considered by the NHS. Specific options will be developed for consideration as part of the formal consultation exercise. However, it has also already been agreed that viable options:
- Must reflect known public concerns about reasonable geographic distribution
 - Must be clinically safe and fit within the context of Healthcare for London and the BEH Clinical Strategy (Chase Farm has been left out for this reason)
 - Must fit within the physical constraints of the existing property portfolio
- 16.7 The review has attracted a large amount of publicity with specific concerns raised about the possible consequences for the Whittington Hospital as some of the

options that were being considered involved the loss or downgrading of certain services there. In response to this, indications were given by the Health Secretary that options that involved the reduction of A&E or maternity services at the hospital would not likely to be acceptable and that NHS London would be asked to review the process.

- 16.8 However, the clinical and financial factors that originally determined the need for the review remain. In particular, it was the view of the NHS that the review process enabled the financial challenges to be addressed in a planned way, which had the capacity to deliver better outcomes for residents than an unplanned process would. There is currently no indication from the NHS whether the review will be progressing as planned.

Joint Health Overview and Scrutiny Committee (JHOSC)

- 16.9 Although the formal consultation process is not due to take place until the autumn, the Chairs of health scrutiny committees across the five boroughs have previously agreed to set up a JHOSC now in order to engage with the NHS on the review. Outline arrangements for the JHOSC and the terms of reference have already been approved in order to minimise any delay that could have occurred as a result of the local government elections. Further detailed consideration can be undertaken of the arrangements, at the first meeting of the JHOSC.

- 16.10 There are two specific types of JHOSC:

- Discretionary - Health OSCs can voluntarily agree to join together to carry out health scrutiny reviews or consider health issues that cross boundaries.
- Statutory - Health OSCs are required to establish a JHOSC to consider and respond to proposals for developments or variations that affect more than one local authority area and that are considered “substantial” by the health OSCs for the areas affected.

- 16.11 As there are not, as yet, specific proposals to respond to, the JHOSC will operate as a discretionary joint committee in the first instance and engage with the NHS on cross borough issues relating to the review. It is intended that this will complement the work of individual OSCs, who will engage with their local PCTs on detailed plans for their area.

- 16.12 The proposals that may be put out to public consultation in due course will undoubtedly constitute a “substantial variation” to services across the five Boroughs, as well as possibly some neighbouring local authorities. This is due to the effect that they will potentially have on the accessibility of services, the way that services are provided and the number of patients affected. Directions issued by the Secretary of State in July 2003 require that ‘where a local NHS body consults more than one overview and scrutiny committee pursuant to regulation 4 of the Regulations on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, the local authorities of those overview and scrutiny committees shall appoint a joint overview and scrutiny committee for the purposes of the consultation and only that joint overview and scrutiny committee may:

- a). make comments on the proposal consulted on to the local NHS body under regulation 4(4) of the Regulations;

(b). require the local NHS body to provide information about the proposal under regulation 5 of the Regulations; and

(c). require an officer of the local NHS body to attend before it under regulation 6 of the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation.'

16.13 The JHOSC will therefore assume a statutory role when proposals are finalised. It will be required to respond to the consultation through the production of a report that reflects the views of all local authorities involved in the joint committee and aims to be consensual.

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

Councillors Councillors Bull (Chair), Adamou (Vice-Chair), Adje, Aitken, Mallett, Newton and Winskill

Also Present: **Co-optees:** Yvonne Denny (Church Representative), Joseph Ejiofor (Parent Governor Representative), Helena Kania (Local Involvement Network (LINK)), Sarah Marsh (Parent Governor Representative) and Yvonne Denny

Councillors: The Leader & Councillor B. Harris

Officers: Kevin Crompton (Chief Executive), Stuart Young (Assistant Chief Executive People, Organisation & Development), Gerald Almeroth (Chief Finance Officer), Julie Parker (Director of Corporate Resources), Michael Wood (Head of Procurement), Mark Dorfman (Assistant Director for Planning, Regeneration and Economy), Phil Di Leo (Head of Services to Children and Young People with Additional Needs), Zulfigar Mulak (Head of Housing Needs & Lettings), Ian Biggadike (Acting Head of Benefits & Local Taxation), Trevor Cripps (Head of Scrutiny), Melanie Ponomarenko (Scrutiny Officer), Rob Mack (Scrutiny Officer), Natalie Cole (Clerk)

Also attending: Duncan Stroud (Associate Director - Communications, Engagement and Partnerships), Julie Quinn (Deputy Chief Executive NHS Haringey)

**MINUTE
NO.**

SUBJECT/DECISION

OSCO69.	WEBCASTING The meeting was recorded for live or future broadcast on the Council's website.
OSCO70.	APOLOGIES FOR ABSENCE There were no apologies for absence.
OSCO71.	URGENT BUSINESS The Chair agreed that the minutes of the Overview & Scrutiny Committee meeting held on 20 th January 2010 be tabled for approval under item 6 – Minutes.
OSCO72.	DECLARATIONS OF INTEREST Councillor Bull declared a personal interest in agenda item 7 – Cabinet Member Questions: Leader's Portfolio – during discussions about the W3 bus route as he lived in Compton Crescent where the W3 often terminated. Councillor Adje declared a personal interest in agenda item 8 – Cabinet Member Questions: Cabinet Member for Resources – during discussions about trade unions – as he was a GMB branch secretary for the London Fire Brigade.

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

<p>OSCO73.</p>	<p>DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS</p> <p>There were no declarations of interest.</p>
<p>OSCO74.</p>	<p>MINUTES</p> <p><u>Minutes of the meeting held on 20th January 2010 (TABLED)</u></p> <p>The minutes of the meeting held on 20th January 2010 were confirmed as a correct record of the meeting.</p> <p><u>Minutes of the meeting held on 1st February 2010</u></p> <p>The minutes of the meeting held on 1st February 2010 were confirmed as a correct record of the meeting.</p>
<p>OSCO75.</p>	<p>CABINET MEMBER QUESTIONS: LEADER'S PORTFOLIO</p> <p>The Committee received the portfolio briefing from the Leader, Councillor Claire Kober, and answers to advance questions.</p> <p>In response to the Committee's questions and concerns that a final design scheme for the Tottenham Hotspur Football Stadium development was still being reviewed it was noted that discussions had been taking place with the football club and partner agencies for a number of years including Transport for London (TfL) regarding a Section 106 Agreement relating to stations and pedestrian access.</p> <p>In response to concerns raised about the re-routing of the W3 bus on Tottenham Hotspur match days the Leader advised that the responsibility would lie with the football club as part of a Section 278 Agreement which will encompass improvements to the W3 bus routes, rail and underground hubs and key junction and walking routes to ensure the safe dispersal of people from the football club grounds. The Council would continue to campaign for an extension of the rail service but this was not part of TfL's work plan.</p> <p>The Committee asked whether previous plans for a Network Rail train shed in Coronation Sidings was going ahead. The Leader informed the Committee that in February the Council's decision not to grant planning permission was overturned during an appeal.</p> <p>RESOLVED that the briefing be noted.</p>
<p>OSCO76.</p>	<p>CABINET MEMBER QUESTIONS: CABINET MEMBER FOR RESOURCES</p> <p>The Committee received the portfolio briefing from the Cabinet Member for Resources, Councillor Bob Harris, and advance questions.</p>

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

	<p>The Committee asked for a future update about a new software package that could offer feedback to Members on repairs once a defect had been reported, e.g. a pothole fixed.</p> <p>In response to Committee Members' concerns that Ward Councillors were not offered the opportunity to be involved in discussions to improve town centres, the Cabinet Member for Resources agreed to address this issue outside of the meeting.</p> <p>The Committee emphasised the importance of encouraging the use of local labour and services and suggested that consideration be given to raising the target of 10% local labour for major projects.</p> <p>The Committee asked for a briefing note to explain the rationale behind the decision to remove a post from Bruce Castle Museum, highlighting that the service had recently won a national award.</p> <p>Regarding the role of trade unions the Committee wanted to ensure that funding for time off was being resourced from appropriate budgets and it was agreed that the Committee would receive a supplementary report including: clarity on the difference between trade union duties and activities, a breakdown of the days per year that union officers attended regional/national union and/or General Teaching Council meetings (Unison Official – 8 days and NUT official – 60 days per year), whether the Council was reimbursed for the costs of union officers attending such meetings, and giving details of a previous report to the General Purposes Committee reviewing trade union facilities.</p> <p>RESOLVED that the briefing be noted.</p>
<p>OSCO77.</p>	<p>HEALTH UPDATE REPORTS</p> <p>The Committee received the health update reports from NHS Haringey, introduced by Duncan Stroud, Associate Director - Communications, Engagement and Partnerships, and Julie Quinn, Deputy Chief Executive NHS Haringey.</p> <p><u>Primary Care Update</u></p> <p>The Committee asked that the NHS Haringey Associate Director – Communications, Stakeholder Engagement and Partnerships, take back the Committee's concerns about the Lordship Lane Clinic appointment system not working effectively and the fact that users wishing to make appointments were required to call a premium telephone number.</p> <p>The Committee highlighted that there should be discussions with the Probation Service regarding offenders with Mental Health issues and the fact that courts did not order treatment or suspended sentences for these people.</p>

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

	<p>The Committee highlighted that other services such as physiotherapy and foot-care services were not easily accessible and was advised that such other services could be provided in future Neighbourhood Centres/ Poly Clinics.</p> <p>The Committee expressed that further clarity behind the decisions to reconfigure services and better consultation were required in future.</p> <p>The Committee requested that copies of the Going Local – Care Close to Home document (used at a recent consultation event) be sent to all Council Members.</p> <p>It was noted that NHS Haringey had started the process of consultation in order to put services in place to meet patients' needs.</p> <p>RESOLVED that the report be noted.</p> <p><u>NHS Financial Update</u></p> <p>The Committee asked for a list of low priority treatments mentioned on Page 24 (item c) of the agenda pack.</p> <p>RESOLVED that the report be noted.</p> <p><u>Commissioning Out of Hours Services in North London</u></p> <p>Committee Members expressed concerns about how out-of-hours doctors from overseas were monitored and pressures on North Middlesex Hospital if the Whittington Hospital accident and emergency (A&E) was closed. In response, the Deputy Chief Executive - NHS Haringey advised that all doctors were screened and there was legislation to support and ensure doctors wellbeing. The new A&E unit in North Middlesex Hospital was undergoing a 13 month pilot scheme of improved services and any pressures would be supported by other services such as an urgent care centre.</p> <p>In response to the Committee's question on how NHS Haringey dealt with safeguarding it was noted that doctors were expected to communicate with health visitors. There was no statutory responsibility for doctors to attend case conferences and the Deputy Chief Executive – NHS Haringey questions how appropriate GPs input would be if they were required to attend. Health visitors, school nurses and therapists however, did attend case conferences</p> <p>RESOLVED that the report be noted.</p>
<p>OSCO78.</p>	<p>COMPLETED SCRUTINY REVIEW PANEL REPORTS</p> <p>i. <u>Sexual Health in Teenagers</u></p> <p>The Committee received the report on the Scrutiny Review of Sexual Health in Teenagers, chaired by Councillor Bull.</p>

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

ii. Support to Victims of Crime

The Committee received the report on the Scrutiny Review of Support to Victims of Crime , chaired by Councillor Aitken.

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

iii. Support to Small Businesses

The Committee received the report on the Scrutiny Review of Support to Small Businesses, chaired by Councillor Adje and noted that Section 106 Agreements to support small businesses would be negotiated as part of future planning applications and developers are required to attempt to employ local people.

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

iv. Support to Carers

The Committee received the report on the Scrutiny Review of Support to Carers, chaired by Councillor Adamou and noted that the recommendations included suggestions for a review of young carers.

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

v. Engagement with Hard to Reach Communities

The Committee received the report on the Scrutiny Review of Engaging with Hard to Reach Communities, chaired by Councillor Bull.

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

vi. Sustainable Transport in Haringey

The Committee received the report on the Scrutiny Review of Sustainable and commented that more should be done to encourage walking and cycling in the borough and improved accessibility at bus stops and interchanges between routes.

RESOLVED that the recommendations in the report be approved and referred to the Cabinet.

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

	<p>vii. <u>Transition of Young People Between Services</u></p> <p>The Committee received the report on the Scrutiny Review on the transition from Children's Services to Adult Services, chaired by Councillor Newton. In response to the Committee's concerns it was noted that partners were involved in identifying mental health needs early on and young people with such needs were included in monthly panel meetings.</p> <p>RESOLVED that the recommendations in the report be approved and referred to the Cabinet.</p>	
<p>OSCO79.</p>	<p>SETTING UP OF JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE</p> <p>The Committee received the report on the setting up of a Joint Health Overview and Scrutiny Committee to consider North Central London Services and Organisation Review.</p> <p>The Committee expressed concerns about committing to a Joint Health Overview & Scrutiny Committee review during a period of uncertainty due to the forthcoming local elections but agreed that the arrangements for the Joint Committee should be put in place but with the option of changing the Terms of Reference at a later stage.</p> <p>RESOLVED</p> <p>i. That the setting up of a joint health scrutiny overview and scrutiny committee with the London Boroughs of Barnet, Camden, Islington and Enfield under the powers conferred by chapter 3 of the National Health Service Act 2006 and associated regulations be agreed to engage with the NHS on the North Central London Service and Organisation Review and respond, in due course, to the forthcoming formal consultation exercise thereon.</p> <p>ii. That the Council be recommended to approve the terms of reference for the joint health overview and scrutiny committee.</p> <p>iii. That a further report inviting nominations to the JHOSC be submitted to the first meeting of the Committee of the new Municipal Year.</p> <p>iv. That officers be authorised to continue negotiations with other participating local authorities on the constitutional arrangements for the joint committee and associated matters and report back.</p>	
<p>OSCO80.</p>	<p>COUNCILLOR CALL FOR ACTION PROTOCOL</p> <p>The Committee received the report on Councillor Call for Action (CCfA).</p>	

**MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 15 MARCH 2010**

	<p>RESOLVED</p> <p>i. That the report be noted and the proposed Haringey CCfA protocol at Appendix A be agreed.</p> <p>ii. That subject to approval of the Constitution Review Working Group, reference to CCfA be added to the Overview and Scrutiny Committee Terms of Reference and a reference to the CCfA protocol be added to the Overview and Scrutiny Procedure Rules in the Council’s Constitution, as appropriate.</p>	
<p>OSCO81.</p>	<p>REFLECTIONS ON THE PAST SCRUTINY YEAR</p> <p>The Committee requested that all post-meeting briefings be included as part of the following meeting’s agenda pack under matters arising.</p>	
<p>OSCO82.</p>	<p>NEW ITEMS OF URGENT BUSINESS</p> <p>There were no new items of urgent business.</p>	

COUNCILLOR GIDEON BULL
Chair

The meeting ended at 21:10 hrs

Councillor

Chair

SIGNED AT MEETING.....DAY

OF.....

This page is intentionally left blank

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
19	16 Dec 2009	<p><u>Re: request no. 46</u> The Committee asked for a briefing note detailing the cost of two in-house designer posts and what proportion of current spend on external agencies would be each post “earn” by bringing design in-house?.</p> <p>Item 6 – Budget Scrutiny – Review of Pre Business Plan Reviews 2010/11 to 2012/13</p> <p><u>Environment & Conservation</u></p> <p><u>Re: General Question no.3</u> The Committee requested more information on where savings had been made by challenging suppliers and how much money had been saved.</p> <p><u>Resources</u></p> <p><u>Re: request no. 15</u> The Committee asked that more information on the reasons for using agency resources be circulated.</p> <p><u>Re: General request</u> The Committee requested a briefing note on the IT projects that are likely to be approved for funding from the proposed IT capital bid and details of the rigorous justification process used.</p>	<p>ACE PPP&C</p> <p>Dir. Urban Environment/ Head of Procurement</p> <p>Assistant Chief Executive</p> <p>Director of Corporate Resources</p>	

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
28	11 January 2010	Item 7 – Cabinet Member for Leisure, Culture & Lifelong Learning Officers were asked to provide a briefing note on the milestones reached so far during the development of the Cultural Strategy.	AD Culture, Libraries & Learning	
29	11 January 2010	Item 8 – Cabinet Member for Adult Social Care and Wellbeing The Committee requested to be circulated any response that the Council's sends to NHS Haringey once the budget had been clarified.	AD Adult Services	
30	11 January 2010	Item 9 – Quarterly Council Performance Exceptions Report & Quarterly Council Budget Monitoring Exceptions Report The Committee asked for more information on NI 40 (Number of Drug Users recorded as being in effective treatment) to be circulated.	Asst. CE PPP&C	
32	11 January 2010	Item 11 – Comprehensive Area Assessment Comparative CAA data for other Local Authorities who also scored "poor" in an area would be circulated to Committee Members.	Asst. CE PPP&C	
43	1 Feb. 2010	Item 7– Questions for Cabinet Member for Enforcement & Safer Communities 1. The Committee requested copies of the evaluation of the Preventing Violent Extremism programme. (Cllr Winskill) briefings also be provided to the Council's Neighbourhood Area Assembly meetings. (Cllr Winskill) 2.	Dir PPP&C	
45	1 Feb. 2010	Item 9 – Access to Services for Older People The Committee asked for confirmation that that the Cabinet had written to the	Chair/	

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
		Department of Health to encourage more funding to allow the Council to support the low and moderate bandings of Fair Access to Care Services in line with the well-being agenda. <i>(Cllr Winskill)</i>	A.D. Adult Services	
49	1 Feb. 2010	<p>Item 13 – Cabinet Member for Community Cohesion & Involvement</p> <p>1. The Committee requested details of sites where <i>My Haringey</i> posters were displayed, feedback about the posters the Council had received and how the campaign would be evaluated and costings for continuing the campaign, which would be circulated. <i>(Cllr Winskill)</i></p>	Dir. PPP&C	
51	15 Feb. 2010	<p>Item 5 – Minutes Minutes of 9th December 2010</p> <p>OSCO28 - The Committee still had not received the briefing note on milestones and those reached so far during the development of the Cultural Strategy. <i>(Cllr Winskill)</i></p>	Clerk to chase	
54	15 Feb. 2010	<p>Item 9 – Children’s Centres Update</p> <p>The Committee requested a list of services that were provided in each of Haringey’s children’s centres and satellite children centres. <i>(Cllr Newton)</i></p>	Deputy Director – Children’s Network	
55	15 Feb. 2010	<p>Item 10 – School Exam Results</p> <p>Further information on School Exclusions would be provided to the Committee (in the minutes) including prevention methods and figures. <i>(J.Ejiofor)</i></p>	Director Children & Young People (CYPS)	

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
56	8 March 2010	<p>Item 7 – Safeguarding Plan</p> <p>1. The Director of Children & Young People would circulate a report on the recent Ofsted follow-up inspection which judged the Council's progress.</p> <p>2. The Committee asked that more detail be provided on the priorities for further improvement in safeguarding</p> <p>3. The Committee requested an update on progress for milestone 2.12 (Analyse cross-partnership training needs in management, supervision and safeguarding and develop a programme of training).</p> <p>4. Committee Members expressed concerns at the sickness rates in the Service and it was requested that in future these were provided with a more detailed breakdown including long-term and short-term sickness and some commentary to show that rates were not an indicator of problems within the service. The Committee also expressed concerns that sickness targets of 8.5 days were unrealistic. The Director CYPS explained that he would report back to the Committee when he had discussed the possibility of reducing the Service's sickness targets with the Human Resources Departments.</p> <p>5. Some Committee Members highlighted individual cases and expressed concerns that today's reduced Health Visitor service was not adequate in safeguarding children. The Director CYPS suggested providing Members with a report showing how the Council met the needs of families and was properly safeguarding including the mechanisms in place to monitor.</p> <p>6. The Committee raised the issue of Post Natal Depression as this may not be picked up during the initial visit from the Health Visitor Service leading to potential</p>	<p>Dir. CYPS</p> <p>Dir. CYPS</p> <p>Dir. CYPS (by 12 March 2010)</p> <p>Dir. CYPS</p> <p>Dir. CYPS</p> <p>Dir. CYPS & Deputy Director</p>	

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
		<p>problems in the family remaining undetected. The Committee requested that Post Natal Depression, and how this was identified in the first few years was included in any report on how the Council met the needs of families and was properly safeguarding. <i>(Cllr Newton)</i>.</p> <p>7. The Committee agreed that the Chair would write to the Primary Care Trust and Great Ormond Street Hospital (GOSH) expressing concerns that the Committee had not been consulted on the withdrawal of Universal Health Visitor Services in 2008.</p>	Children & Families Chair	
57	8 March 2010	<p>Item 10 – NI 59 Initial Assessments for Children’s Social Care Completed within 7 Days</p> <p>1. The Chair would ask the Cabinet Member for Children & Young People to keep the Committee informed of the judgements by the Independent Auditors on Initial and Core Assessments.</p> <p>2. The Deputy Director Children & Families would provide links to the procedures for assessments followed by the Council.</p>	Chair Deputy Director Children & Families	
58	15 March 2010	<p>Item 8 – Cabinet Member Questions: Cabinet Member for Resources</p> <p>1. The Committee asked for a future update about a new software package that can offer feedback to Members on repairs once a defect had been reported, e.g. a pothole fixed. <i>(Cllr Winskill)</i></p> <p>4. Further to questions on the role of trade unions it was agreed that the Committee would receive a supplementary report including: clarity on the difference between trade union duties and activities, a breakdown of the days per year that union officers attended regional/national union and/or General Teaching Council meetings</p>	Director of Corporate Resources Asst Chief Executive People, Organisation	<p>Circulated to OSC members on 31.03.10</p> <p>Email from ACE to Chair – 10 June 2010 ACE planning to carry out a review of trade union facilities this year</p>

Minute Number	DATE OF COMMITTEE	COMMITTEE REQUEST / ACTION	RESPONDEE RESPONSIBLE	DATE RESPONDED?
		(Unison Official – 8 days and NUT official – 60 days per year), whether the Council was reimbursed for the costs of union officers attending such meetings, and giving details of a previous report to the General Purposes Committee reviewing trade union facilities. (<i>Cllrs Adje & Bull</i>)	& Development	2010/11 and the outstanding action will be part of that review. 14 June – Chair asked for briefing regardless of review
76	15 March 2010	The Committee asked for a briefing note to explain the rationale behind the decision to remove a post from Bruce Castle Museum, highlighting that the service had recently won a national award.	Asst Chief Executive POD	Circulated to OSC members on 01.06.10
77	15 March 2010	<u>NHS Financial Update</u> The Committee asked for a list of low priority treatments mentioned on Page 24 (item c) of the agenda pack.	NHS	Circulated to OSC members on 28.05.10

This page is intentionally left blank

15 March 2010 - Overview and Scrutiny Question – IT systems and pot hole feedback

Asked of Resources in response to supplementary question on report on work of Insurance team.

The issue of providing a response to customers who have reported a pothole to tell them when the pothole repair is completed.

At present the CONFIRM system automatically acknowledges receipt of the reported problem but it cannot provide an update when an inspector has inspected and categorised the defect, or when it has been completed by the contractor. However, because of councillor demand urban environment (UE) have, up until recently been providing this feedback on completions manually for councillors only.

UE now have the software in place on CONFIRM to provide all the updates, but they now need to do the process management and training of both inspectors and the contractor staff in updating it accurately so that the system provides accurate updates to the customer. It had been hoped to get this in place by the end of the financial year, but the extra work on potholes has meant that this has slipped and it will now be operational from the end of May. It will be piloted with reports from the Street Enforcement inspectors.

Meanwhile, because of the demands on the team, UE are not able to provide the manual updates for councillors.

This page is intentionally left blank

Overview & Scrutiny Committee 15th March 2010

Item 8 – Cabinet Member Questions: Cabinet Member for Resources

The Committee asked for a briefing note to explain the rationale behind the decision to remove a post from Bruce Castle Museum, highlighting that the service had recently won a national award.

Post meeting note:

The deletion of one caretaker post from Bruce Castle Museum was made as part of the efficiency savings required of this business unit in 2010/2011. As a result of the closure of the Western Road Modern Records Centre, additional archives staff will be relocated to Bruce Castle and will be available to undertake the reception duties previously undertaken by the caretaker. The deletion of the post will not impact upon the opening hours of the Museum; indeed, we plan to open the Museum for longer very shortly.

Diana Edmonds
Assistant Director, Culture, Libraries and Learning London Borough of
Haringey
0208 489 2559

This page is intentionally left blank

**NHS Haringey paper for the Overview and Scrutiny Committee
on low priority treatments**

Introduction

The Overview and Scrutiny Committee have asked for a paper on low priority treatments in Haringey. Low priority treatments are medical treatments where the evidence of clinical and/or cost effectiveness is limited. The term also applies to where funding such treatment is unlikely to have a significantly adverse effect on the patient's physical or mental health or ability to undertake everyday living activities with reasonable independence.

Background

In 2006, Croydon PCT identified a list of 34 procedures of 'limited clinical value', for which strict access criteria were introduced in order to ensure that only patients likely to benefit from these procedures could access them. The exercise also had an economic component as it focussed on cost benefit and cost effectiveness.

London Health Observatory (LHO) took up this work with 'Save to Invest'(i), building on earlier modelling from Croydon PCT and LHO to estimate the minimum and maximum potential savings for each PCT in London (ii).

The findings were that procedures with 'limited clinical benefit' represented three to ten per cent of activity and could have saved £28m-£93m across London for 2005/6. Some of this work has been expanded further by Ernst and Young to identify actual potential cost savings using this model (iii). London's top ten most common procedures from the 'Croydon List' in 2005/6 were minor skin procedures, cataract surgery, cancelled procedures, inguinal, umbilical and femoral hernia, tonsillectomy, knee replacement surgery, wisdom teeth extraction, varicose vein surgery, carpal tunnel surgery, hysterectomy for menorrhagia.

It is important to recognise that the procedures of 'limited clinical benefit' include a mixture of 'cosmetic' procedures and procedures which always need to be carried out to some extent but where strict adherence to clinical guidelines will ensure procedures are only carried out where necessary (e.g. cataract surgery, hip and knee replacement).

The decision to no longer provide low priority treatments is a reflection of the medical view – based on experience – that providing these treatments on a routine basis is not always beneficial to the patient.

New arrangements

A list of treatments is being adopted by all Primary Care Trusts in North Central Sector to reduce (but not discontinue) the commissioning of low priority treatments (Appendix 1). NHS Haringey, together with the other PCTs, has had informal lists of low priority treatments for many years. The change that is being implemented is that the PCTs will all have identical lists and will all monitor and review these lists on a regular basis as a Sector as well as at individual PCT level. London, particularly North London, is well behind many places in the UK in setting up low priorities groups and forum.

Current uptake of services Haringey being decommissioned

The number of procedures that are currently undertaken in Haringey are relatively small as it can be seen in table 1. Table 1 lists some, but not all of the procedures on the NCL low priorities list. The majority of those treatments that are not list in table 1 are performed relatively infrequently.

Table 1 – Frequency of low priority procedures undertaken in 2009/10

Procedure	Number of procedures undertaken
Carpal Tunnel Syndrome	105
Chronic Sinusitis	226
Complementary medicine of all types	11
Dental Implants	9
Dilation and Curettage	88
Grommets Insertion	39
Hysterectomy For Menorrhagia	86
Implantable Cardiac defibrillator(ICDs)	9
Male Circumcision	1
Minor Oral Surgery (Retained Roots)	460
Palmar Fasciectomy for Dupuytren Contracture	9
Reversal Sterilisation	1
Surgery for Ganglions	40
Tonsillectomy	142
Trigger Finger	26
Varicose Vein surgery	18
Wisdom Tooth Removal	442

Spending

NHS Haringey spent roughly £2m in 2009/10 on the treatments on the low priorities list in Haringey. London Health Observatory has calculated minimum and maximum savings for some of the treatments on our NCL low priorities treatment list (Appendix 2). The anticipated savings vary by medical procedure or treatment as it can be seen in Appendix 2. The expected

savings are in the range of £300,000 to £600,000 but caution needs to be applied to using economic models into clinical reality. Savings at NHS Haringey will be monitored as part of the regular review and evaluation process.

Clinical and public engagement

All GPs in Haringey will be informed by a letter sent from NHS Haringey. The information will also be included in the new GP newsletter and placed on NHS Haringey website.

Patients have not been consulted directly as this is a clinical decision to no longer provide treatments where the outcome is questionable. However, all information will be available on NHS Haringey's website, including the rationale for limiting certain procedures. All patients who meet the guidelines will be able to undergo the procedure in question. Those patients who do not meet the guidelines will not have the clinical procedure undertaken. Occasionally patients who do not meet the clinical criteria may have exceptional circumstances which need to be taken into account in the consideration of whether or not to undertake such procedures. For those patients, the patients own GP may refer directly to NHS Haringey's Individual Cases Panel (ICP).

The 'Individual Cases Panel' (ICP) meets once a month to discuss patients who require funding of new or expensive treatments and have 'exceptional' circumstances. Only those cases that are deemed to have 'exceptional circumstances' are considered by the panel.

The process

This new policy will be implemented on 1st June 2010 with information going directly to GPs via letters, GP newsletter and information available on the internet.

GPs will triage all patients, with those meeting the criteria and requiring the treatments referred directly to the hospital for treatment. The only change is that GPs will be required to complete a form for procedures to be undertaken. GPs will refer patients with exceptional circumstance directly to the Individual Cases Panel at the Primary Care Trust. The process may change in the future as the NCL Commissioning Agency further develops.

Secondary Care

Both the Whittington and North Middlesex Hospitals are aware of these plans. They participate in planning meetings with the five PCTs and NCL Commissioning Agency. The five PCTs are now in discussion on the putting into place the appropriate arrangements for the implementation of the Low Priorities Treatments process. Once agreed, both acute trusts need to be clear on how these arrangements will work..

Monitoring and evaluation

We will monitor the process both from NHS Haringey perspective and look at the Sector as a whole at regular intervals. These are yet to be defined but likely to be initially at six month intervals and then moving to yearly intervals.

Future plans

It is likely that more of this work will be taken over by North Central London Commissioning Agency. The process is also likely to become more streamlined with all PCTs working using the same process and forms as well as a common low priorities list. It is also very likely that the list increases in size in line with other PCTs and Commissioning Agencies.

Dr Nicole Klynman
13th April 2010

ⁱ London Health Observatory. Save to Invest. Developing criteria-based commissioning for planned health care in London.

ⁱⁱ 2009/10 South West London Effective Commissioning Initiative. April 2009

ⁱⁱⁱ NHS London. Delivering the Healthcare for London strategy affordably. Back-up materials. June 2009

Appendix 1

Policy for 'low priority' treatments

1 Introduction

This paper sets out the North Central London PCTs' policy on not commissioning 'low priority' treatments routinely; requests for funding such treatments should be considered individually. This policy has been drawn up in the context of the principles framework used by three of the North Central London PCTs and the new NHS Constitution.

1.1 Context

1.1.1 *Why might some treatments be considered to be of 'low priority'?*

We cannot support the commissioning of services and treatments that are known to be clinically ineffective,ⁱ nor those that are not cost effective. We also consider that treatments that may be clinically and cost effective should not be commissioned if they are unaffordable because of in-year financial pressures, or if their opportunity costs are high and funding them could thereby deny clinically and cost-effective treatments of more significant conditions for others. 'Low priority' treatments are thus those where the evidence of clinical and/or cost effectiveness is limited (or they are only clinically effective in a specific group of people or in certain clinical circumstances, when they might be funded), and/or where not funding such treatment is unlikely to have a significantly adverse effect on the patient's physical or mental health or ability to undertake everyday living activities with reasonable independence.ⁱⁱ

If resources are used for one person then those same resources are not available for someone else. So, if we give resources to one person that are disproportionate to their need or ability to benefit then we deny those resources to others who might benefit more and this would be inequitable.

In addition, if a treatment is funded for one person then that treatment should be funded for all people in similar circumstances; to do otherwise would be inequitable. Thus, if funding a large number of treatments for conditions that do not have a major impact on people's lives would reduce the amount of money available to fund clinically and cost effective treatments for conditions that have a significant effect on people's lives, then we could not use our resources to the greatest benefit of the greatest number. This principle was probably first articulated in court in an NHS context in the 'Child B' caseⁱⁱⁱ (this is referred to in more detail in Appendix 1: the Framework of Principles).

2 What treatments might be considered to be 'low priority'?

i Clinical effectiveness is the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – that is, maintain or improve health, and secure the greatest possible health gain from available resources [NHS Executive. *Promoting Clinical Effectiveness: a framework for action throughout the NHS*. Department of Health, 1996]

ii In contrast, a 'high priority' treatment might be one that was literally life saving or one that might reasonably relieve, or avoid, a significant disability that was far beyond what is usual in terms of causing difficulty or an inability to undertake everyday living activities

iii Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995]

The list of 'low priority' treatments in Appendix 2 is not exhaustive, rather, it is indicative of the types of treatments that we consider are likely to be of lower priority for funding than others and that thus we will not routinely fund. We may formally add to this list and we reserve the right to define other treatments and clinical interventions as being of 'low priority' in the light of further reviews and/or individual patient treatment funding requests and/or proposals for service developments.

The second column in the table in Appendix 2 gives an indication of circumstances in which each of the North Central London PCTs, or the North Central London Acute Commissioning Agency acting on their behalf, might consider it appropriate to fund such a treatment, subject always to consideration of all aspects of the prevailing version of the framework of principles to be found in Appendix 1. It is important to note that exceptionality is a 'threshold condition', i.e. a finding of exceptionality does not mean that the PCT responsible for a particular patient is bound to approve funding, but is the start of the process of making a decision in an individual case because the responsible PCT must balance this with the other components of the principles framework. There are two instances in this list where no such examples are given. This is because we are not aware of any robust evidence to support such treatments. However, were such evidence to be made available then, similarly, the responsible PCT be willing to consider a funding request, in the light of such evidence and balanced against all components of the framework of principles, on an individual basis.

3 Clinical effectiveness

The framework of principles (see Appendix 1) defines clinical effectiveness. It would be inappropriate to fund treatments where there was little or no evidence of clinical effectiveness or where that evidence was weak: if we fund one type of treatment where there is poor evidence of clinical effectiveness then we would be obliged to fund all treatments where there was similarly weak evidence of clinical effectiveness. We also consider that the fact that a condition may be rare and thus its treatment may be more difficult to research does not constitute a valid reason for us to accept poor quality evidence.

For some 'low priority' treatments, as far as we know, robust and convincing evidence of clinical effectiveness is lacking, although the responsible PCT would be pleased to review any good evidence that were made available as part of an individual patient treatment funding request. In other instances, there is good evidence of clinical effectiveness of the 'low priority' treatments but this must be balanced with the other principles in the framework including, but not limited to, cost effectiveness, equity and distributive justice.

4 Cost effectiveness

In assessing cost-effectiveness, we have to consider the balance between cost and benefit, whether the benefit is likely to be long-lasting, and whether the precedent of funding one treatment may require us to fund treatments for other conditions (which would also require us to consider affordability, equity and distributive justice issues, among others). The fact that a treatment may be relatively inexpensive does not mean that it is cost-effective if there is poor evidence of its clinical effectiveness. Similarly, if we agree to fund one type of treatment solely because it is inexpensive then we become obliged to fund all treatments that are similarly inexpensive: funding a large number of treatments that are individually inexpensive costs a large amount of money and this would not be available to support the use of other treatments where the evidence of clinical and cost effectiveness (and other considerations) are more convincing, or to address issues of health inequalities, and this would prevent us from using a limited budget to the maximum advantage of the maximum number of people.

5 Affordability

A multi-million pound levy has been placed on most London PCTs for 2009/10 and 2010/11 to provide deficit support for a number of acute hospital trusts. In addition, some North Central London PCTs are over their capitation position. This means that they expect to receive below-average growth in their funding in 2010/11, in addition to any impact that the current national economic situation will have on public sector spending.

Whilst all North Central London PCTs seek to achieve balanced budgets for 2009/10, there are substantial pressures against this which mean that their individual ability to achieve the statutory financial breakeven duty is likely to be compromised.

It is also now apparent that the NHS will not have a budget uplift in 2011/12 and probably for several years thereafter because of the need for the government to address national budget problems. This means that staff pay raises and any increases in costs ('medical inflation' typically runs at 5-10% each year) will have to be managed within a budget that is, effectively, frozen. North Central London PCTs are therefore having to implement savings this year and next to help mitigate this severely adverse situation.

As the resources available to PCTs are finite and they are statutorily required to balance our budget and not to overspend, they also have to take affordability into account when considering what treatments and other clinical interventions they can fund.

6 Equity

There are three components to this. The first is that, within the requirements of legislation and NHS regulations, and other than where there is good evidence that a particular characteristic (e.g. age) or lifestyle (e.g. smoking) adversely impacts the clinical and/or cost-effectiveness of treatment, the North Central London PCTs will not discriminate between people on personal or lifestyle grounds.

The second component is that health care should be allocated justly and fairly on the basis of need, and the North Central London PCTs will seek to maximise the welfare of all the people for whom they are responsible within the resources made available to them. In this context, equity means that people in equal need should have equal access to care. But everything has an opportunity cost; if resources are used for one person then those same resources are not available for someone else. So, if we give resources to one person that are disproportionate to their need or ability to benefit then we deny those resources to others who might benefit more and this would be inequitable.

In the context of an individual patient treatment funding request, PCTs also need to consider, on an individual patient basis, whether there are exceptional circumstances that might be relevant in their case. Our definition of exceptionality is provided in section 4.1 of the framework of principles (see Appendix 1). Section 4.2 of this framework defines limits to this. As noted earlier, exceptionality is a 'threshold condition' and thus any finding of 'exceptionality is the start of the process of making a decision in an individual patient's case because PCTs must balance this with the other components of the principles framework.

7 Quality and safety

PCTs are sometimes asked to fund treatments (which may or may not be considered to be 'low priority' as referred to in this document) in institutions or that are provided by people who are not within the NHS. Whilst there are good mechanisms in place to assure quality and safety in NHS organisations, this is not necessarily the case in other organisations or with individual practitioners and individual PCTs, and/or the North central London Commissioning Agency acting on their behalf, will also need to take into account the evidence for the safety and quality of the proposed treatment when considering any such funding applications.

8 Ethical considerations

8.1 Autonomy

We should respect a patient's capacity to think and decide what they want for themselves, and we recognise an obligation to help people to make such decisions by providing any and all information that they need. We also recognise that we should respect their final decision, even if it is not what we think is best for them. We assume that most patients will wish to try the proposed treatments that we are being asked to fund (although this is not always the case). However, of itself, this does not mean that any individual PCT should fund such requests.

We also need to consider another aspect of autonomy, albeit not strictly the ethical aspect of this: that some treatments may enable a patient to maintain their independence and/or dignity (e.g. prolonging the time that they can continue to perform everyday living activities with relative independence) and we consider that this is a desirable objective, although it will not necessarily take precedence over other considerations. We would need to see good quality evidence that a proposed treatment might reasonably be expected to benefit the patient in this way and this must be balanced against the other components of the principles framework.

8.2 Beneficence

We recognise an obligation of beneficence, which emphasises the moral importance of 'doing good' to others, entailing doing what is 'best' for the patient or group of people, and we recognise that many treatments might be considered to do so, albeit sometimes only to a very limited extent or in special or poorly predictable circumstances (for example, it is not always possible to know that a patient is likely to respond to a treatment in the way that those in a research trial did, especially if there are aspects of their circumstances that might have led them to have been excluded from the trial or trials put forward as evidence for the effectiveness of the proposed treatment).

We also have an obligation to do good to others and our responsibility is for all people registered with North Central London GPs not just for an individual person. We therefore have to balance the impact of doing good for one person with the effect that that would have on our ability to do good for others. In considering this, we also have to recognise that all decisions set precedents: if we agree to fund this request for one person then we become obliged to fund all requests where the circumstances are similar and this would increase the cost and thus the opportunity cost which could impact on our ability to do good for others. Therefore, even where there may be some evidence that a particular treatment or clinical intervention might 'do good' for an individual, this must be balanced against the other components of the principles framework.

8.3 Non-maleficence

We recognise a duty of non-maleficence, which requires that we should seek not to harm people. However, it is important to recognise a distinction between a duty not to harm someone (which implies actively doing something that may harm them) – which we recognise as something we should not do – and not acting to prevent possible harm. We consider that there is an important difference here because it is not possible for us to prevent harm coming to everybody, and therefore we do not consider that there is an obligation for us to fund an intervention just because it might reduce the risk of some sort of harm coming to an individual.

We also need to consider whether the likely risks of a proposed treatment are balanced by its likely benefits. We also recognise that few, if any, treatments are likely to be without side effects or adverse reactions in all patients in all circumstances. Further, we need to take account of whether not funding a treatment might do the patient harm. However, we also have a duty not to harm others and funding a treatment inappropriately could do this, albeit indirectly, by denying them access to treatment that could otherwise do them greater good.

For similar reasons, a treatment of likely limited benefit and/or of relatively high cost will not necessarily be provided simply because it may be the only active treatment available.

8.4 Distributive justice

The principle of distributive justice emphasises two points: patients in similar situations should normally have access to similar health care; and when determining what level of health care should be available for one set of patients, we must take into account the effect of such a use of resources on other patients. In other words, we should try to distribute limited resources (such as time, money, intensive care beds) fairly, and based on need.

Need usually exceeds the resources available. We therefore cannot always enable every patient to have what some might think of as the 'best possible' care. This concept conflicts with the principles of some clinicians who, understandably, take the view that every patient should be given the 'best possible' care and that every therapeutic option should be tried irrespective of cost. However, if we provide the 'best possible' care for everyone then at some time during the year there will be nothing left for others: we will be giving some patients 'everything' and others 'nothing'. We consider that such an approach would be inappropriate and that we should share resources 'fairly', this usually meaning (i) giving resources preferentially to those who are in greatest need and who can benefit the most from them, and (ii) settling for what is adequate and not necessarily what may be the 'absolute best'. We believe that this approach is consistent with the opinion expressed by Sir Thomas Bingham in his judgment in the 'Child B' case.ⁱⁱⁱ

9 Conclusion

Appendix 2 sets out a non-exhaustive, i.e. an indicative, list of the types of treatments that we consider to be of lower priority for funding than others and therefore that we will not routinely fund. We consider that this is reasonable having taken account of the various components of the framework of principles, and that it is rational in so far as other PCTs have similar lists of 'low priority' treatments and similar principles frameworks. By being willing to consider funding requests for such treatments on an individual basis, and to consider the possibility of exceptionality (as defined in the framework of principles) where there is good evidence for this, we believe that this is also a reasonable approach to take for organisations with finite budgets and more calls on that budget than can be accommodated within their statutory obligations.

Andrew Burnett

Director for Health Improvement/Medical Director NHS Barnet

8 February 2010

Appendix 1: Framework of Principles

This document describes the principles that we have applied in drawing up this 'low priority' treatments policy.

The intent of the North Central London PCTs is to improve the health and well-being of their populations and to ensure that there are good quality, appropriate health promoting and health care services for those people that need them. We wish to ensure that people receive health services that are appropriate for the 21st century.

The experience of the NHS from its inception is that demand has always outstripped supply. There is no evidence that this is changing and thus we must sometimes choose between providing one type of service or treatment over another. The North Central London PCTs are committed to focusing their resources where they are needed most.

The North Central London PCTs are responsible for the health and health care of some 1.24m people registered with local GPs, a population that is expected to grow by some 100,000 over the next few years. We are therefore responsible for the health and health care of a lot of people and the needs of those populations are different in different parts of the North Central London sector. If we spend money or allocate other resources (e.g. staff time) in one area, or for one group of people or for one individual, then those resources cannot be used for someone else. We therefore try to ensure that our resources are used to the benefit of the largest number of people. This inevitably means that it is not always possible for everyone to get exactly what they want or when they want it; we have to prioritise some services and individual treatments over others.

A PCT's decision on an individual patient treatment requestⁱ does not concern whether it is clinically appropriate for a patient to have the treatment recommended by their clinical adviser, but whether it is appropriate for them to fund it. This responsibility has been recognised in the courts, most notably in the 'Child B' case, when the judge said:

"I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much the cost, particularly when a life is potentially at stake.

"It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients."ⁱⁱ

This observation has been quoted with approval in a number of appeal judgments on individual patient treatment requests since and remains an accurate statement of the law. In another case concerning the funding of an individual treatment,ⁱⁱⁱ the court stated that:

i PCTs receive a number of requests for treatments that are outside service level agreements ('TOSLAs') either because a treatment is specifically excluded from a contract (sometimes by national requirement) or because a patient or their clinician proposes treatment to be provided by an organisation or an individual with whom a PCT does not have a current contractual arrangement. Such requests are dealt with on an individual patient basis

ii Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995]

iii *R v NW Lancashire Health Authority, ex parte A, D&G* [1999]

“...in establishing priorities, comparing the respective needs of patients suffering from different illnesses and determining the respective strengths of their claims for treatment, it is vital for an [NHS funding body] accurately to assess the nature and seriousness of each type of illness; to determine the effectiveness of various forms of treatment for it; and to give proper effect to that assessment and that determination in the application of its policy.

“The [NHS funding body] can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition... and the costs of that treatment”.

In this case, the court also stated that:

“It is natural that each [NHS funding body], in establishing its own priorities, will give greater priority to life-threatening and other grave illnesses than to others obviously less demanding of medical intervention. The precise allocation and weighting of priorities is clearly a matter of judgment for each authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible. It makes sense to have a policy for the purpose, indeed, it might well be irrational not to have one.”

In drawing up a policy on ‘low priority’ treatments, we have therefore applied a number of ‘principles’, and balanced these against each other, in determining what we should not fund as a matter of routine. These principles are:

1 Clinical effectiveness

Our resources should be used in the most clinically effective way –

- clinical effectiveness is the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – that is, maintain or improve health, and secure the greatest possible health gain from available resources;¹
- we recognise a distinction between ‘evidence of lack of effectiveness’ and ‘lack of evidence of effectiveness’, and we will seek to avoid supporting the use of interventions for which evidence of clinical effectiveness is either absent, or too weak for reasonable conclusions to be reached;
- as well as strength of evidence for a particular intervention, we will also take into account the likely magnitude of benefit and of safety for patients, as well as the number of people who can reasonably be expected to benefit from that intervention;
- when assessing evidence for clinical effectiveness, we will give greater weight to some outcome measures than to others, for example, but not limited to –
 - randomised controlled trials and large observational studies published in peer-reviewed journals are likely to provide more robust evidence for a finding than individual case reports, small case series or anecdote;
 - trials of longer duration and those with clinically relevant outcomes are likely to provide more robust evidence for a finding than those of shorter duration or those with surrogate outcomes,
 - reported levels of ‘patient satisfaction’ do not necessarily provide good evidence of clinical effectiveness or the likelihood of others having similar outcomes with the same or with similar treatments; and
- we will seek our own expert advice on topics as we may consider necessary.

2 Cost effectiveness

Our resources should be used in the most cost effective way –

- the NHS has finite resources and is required to keep within its budget, so to maximize the care that can be given to patients generally we must extract the maximum value from the money we spend and from the way in which all other types of resources are used;
- the cost of treatment is relevant because every activity has opportunity costs – if resources are used in one area they cannot be used in another, so we must seek to use all resources in the most appropriate way if the greatest number of people possible are to benefit in the greatest possible ways; and
- decisions to fund a treatment have the capacity to set a precedent – if one person or a group of people are given treatment then others in similar circumstances will expect to receive the same treatment. Thus, a decision about the treatment of one person or a group of people can have resource implications beyond that individual or group.

3 Affordability

We should only commission the services that we consider are appropriate if we have enough money or other resources to do so –

- we are statutorily required to keep within the resources available to us, that is, we are legally bound not to spend more money each year than we have been allocated; and
- if we use money or other resources on one investment then we cannot use the same resources for another. So we consider that, even if something is clinically effective and it is, compared to other interventions for the same condition, also cost-effective, this does not necessarily mean that we will be able to support its use because we may not always have enough money or other resources available or because other investments are determined to be of a higher priority.

4 Equity

Our resources should be used in an equitable way –

- within the requirements of legislation and NHS regulations, and other than where there is good evidence that a particular characteristic (e.g. age) or lifestyle (e.g. smoking) effects the clinical and/or cost-effectiveness of treatment, we will seek not to directly or indirectly discriminate between people on the grounds of^v –

– age	– place of abode ^v
– gender	– employment
– ethnicity	– financial status
– physical, sensory or learning disability	– personal lifestyle
– religious beliefs	– social position or status;
– sexual orientation	– suggested ‘individual worth’, e.g. having a particular occupation or being a parent or carer

iv This list is not exhaustive, but is intended to provide examples of the types of differences between people that the we will not use as grounds for determining whether one person or group of people should or should not receive a particular treatment, other than where there is good evidence that a characteristic is associated with poorer or better clinical or cost-effectiveness

v Other than the fact that PCTs are only responsible for the health care needs of the residents of their boroughs, for people registered with their general medical practitioners, for the provision of a range of school nursing services to children attending their local schools, and for visitors to their areas who develop a need of emergency health care whilst there

- health care should be allocated justly and fairly on the basis of clinical need, and we will seek to maximise the welfare of the largest possible number of people within the resources available to us. However, we will be willing to be flexible so that variations from this approach may (but will not necessarily always will) be made in certain circumstances, such as (but not necessarily limited to) –
 - treatment that may be ‘life-saving’ in acute circumstances,^{vi}
 - treatment for those whose quality of life is extremely severely affected by disabling chronic condition,^{vii}
 - special characteristics of an individual patient justifying treatment of higher cost than normal, e.g. where an intervention may be less cost-effective for a particular person because of a disability or other characteristic but would normally be available under the NHS and funded by this PCT to others who did not have that disability or other characteristic.

4.1 Commissioning services or treatments in individual cases

PCTs commission care for patients suffering from various clinical conditions. Care pathways are usually agreed at the beginning of the financial year as part of a PCT’s budget setting process. This means that clinicians and service users can know what medical treatments they can expect and which treatments are not funded by a PCT. PCTs get better value for money by commissioning in this way. However PCTs accept that there may be individual cases where their established commissioning policies have not taken account of the particular circumstances of an individual. The North Central London PCTs are prepared to consider commissioning treatment for such individuals who can demonstrate that they have exceptional circumstances. The onus of proving exceptionality is on the patient and on the clinical team supporting the application.

If a patient or their clinician seek to show that they are ‘exceptional’, this will be considered on an individual basis and in comparison within the group of patients with the same clinical condition. Generally, we will consider two components to exceptionality (although the presence of one or both factors to some degree may not be sufficient to lead to a decision by a PCT that the case is exceptional) –

1. the clinical circumstances of the patient may be exceptional. For example there may be good evidence that they may reasonably be expected to respond much better than others with the same condition to the proposed treatment and they may be highly unusual in not being able tolerate the treatment usually provided for a patient with their clinical condition;
2. The patient may have exceptional personal circumstances, but these would normally need to be ‘far beyond what is usual’ in order to be exceptional. For example, being a carer for an elderly relative or having dependent or disabled children is unlikely to be considered in this way as it would not be ‘far beyond what is usual’.

It might be possible for a patient to prove that they are exceptional because they suffer from a condition for which there is no established care pathway or no established treatment which is routinely provided.

vi This exception does not include treatment that may prolong life or slow disease progression, rather, it refers to treatment that could be required immediately to significantly reduce the chance of someone dying within minutes or hours of the sudden onset of a life-threatening situation.

vii Such disability would be far beyond what is common, for example, it might include someone who is paralysed below the neck and dependent upon nursing care for all of their bodily functions. but it is unlikely to include someone who is disabled but who has no significant difficulty in undertaking everyday living activities

If a treatment for a condition has been considered for funding as part of the PCT's annual process and has not been approved for funding, it is not open to a patient to seek to make a case for funding for that treatment solely or substantially on the basis that they suffer from the condition or suffer from symptoms which are usually associated with that condition.

Funding will only be approved on an individual basis for exceptional patients where the proposed treatment for which funding is sought is both proved to be likely to be clinically effective and is proved to be cost effective, and subject to consideration of the other principles in this framework. For example the fact that a patient may:

- have a rare (or 'orphan') condition, does not mean that –
 - their proposed treatment should be funded simply because their condition is rare. It would be inequitable to preferentially fund those with uncommon conditions over those with more common ones,
 - we will accept a lower standard of evidence of clinical effectiveness or a different level of cost-effectiveness or other consideration in comparison with that which we would consider for people with more common conditions,
 - we will accept that the treatment, because the rareness of the condition, need necessarily be more expensive, especially as many governments grant various allowances and dispensations to manufacturers of orphan drugs to compensate for the smaller market available for their products;
- be suffering from a rare condition, does not necessarily mean that their symptoms are rare and thus require special treatment, for example for the management of pain;
- have a clinical picture that matches the accepted indications for a treatment that is not routinely funded does not, in itself, constitute exceptional circumstances. Hence, for example, a patient may not be able to tolerate the usual treatment for a chronic condition due to side effects which occur in a proportion of patients with that condition. The fact that the patient is in that cohort is highly unlikely to make the case exceptional so as to justify treatment options which are not made available to other patients;
- have already received a treatment (however this may have been funded, including by other NHS organisations) and/or to be deemed in some way to have already responded to treatment does not, in itself, constitute an exceptional circumstance or mean that they should automatically receive funding by a PCT for further such treatment or related treatment;^{viii, ix}

The presence of one or more such potentially 'exceptional' factors may not be sufficient to justify a PCT agreeing to shift resources to support the requested investment as PCTs have to balance that request with all the principles in this framework.

We also take the view that whilst we will broadly follow a system for assessing clinical and cost-effectiveness and take affordability, equity and other factors into consideration, especially where a treatment is of extremely high cost, whether or not it is for a rare condition, we will not make an exception just because the condition is rare or is a more common condition which, for a particular patient, has manifested itself in some way which makes the condition difficult to treat.

viii We consider that it would be inequitable to fund in such circumstances alone and that such funding requests should be considered individually against the principles in this framework

ix Related to this, we will not reimburse costs or fees that patients or their family or friends or others may have incurred in their choosing to undergo investigation or treatment outside the NHS

4.2 A limit to the consideration of individual cases:

Whilst we will be willing to consider possible exceptionality in making individual patient treatment and population-based service funding decisions, if we consider that there is no realistic possibility of a treatment or a service being proved to be clinically effective, cost-effective, affordable, equitable to fund, or reasonable to fund on other grounds, we will not normally be prepared to look at the case as an individual one based on alleged exceptionality. However, we will be willing to consider an individual case if there is compelling evidence that the anticipated cost of the proposed treatment in that individual case is significantly less than the anticipated cost of treating other patients with the same condition who could benefit from the same proposed treatment, or if there is compelling evidence that the outcome for an individual patient is very likely to be significantly and beneficially greater. We will also be willing to keep a 'no exceptions' policy on any such treatment or service under review and be willing to reconsider our general approach to commissioning such treatment in the light of new and compelling evidence.

Similarly, it may be that, in some circumstances, a PCT will not fund treatment for a particular condition, even if the condition is medically recognised as an illness requiring intervention categorised as medical and/or curative, rather than merely cosmetic or a matter of convenience or lifestyle, but we may – as appropriate – consider some treatments as service developments and deal with them en bloc by tender or as part of a service level agreement negotiation with a provider rather than as an individual patient treatment request.

Further, whilst we consider that people should generally be able to access health and health care services on the basis of equal need, we note that –

- there may be occasions or circumstances when some categories of care or specific interventions will be given priority in order to help address health inequalities in the community;
- health and health care services should be allocated justly and fairly on the basis of both need and capacity to benefit, in order to maximise benefits to the population within the resources available. However, in the absence of evidence of health need or reasonable capacity to benefit, treatment will not generally be given solely because an individual person or a group of people request it. Similarly, a treatment of likely limited benefit and/or of relatively high cost will not necessarily be provided simply because it may be the only active treatment available;
- sometimes the needs of the wider population conflict with the needs of individuals, especially when an expensive treatment may possibly produce some clinical benefit but only for a relatively limited time. For example, such a treatment may do something to improve a patient's (or group of patients') condition to some extent or slow the progression of disease but not change the ultimate outcome, i.e. it will not 'cure'. However, more people may gain greater benefit if the same money or other resources were used for other purposes, even if that may not be in the best interests of an individual or smaller group of people; and
- we cannot always enable every patient to have what some might think of as the 'best possible' care. This concept conflicts with the principles of some clinicians who, understandably, take the view that every patient should be given the 'best possible' care and that every therapeutic option should be tried irrespective of cost.^x However, if we provide the 'best possible' care for everyone then at some

^x Whilst clinicians have a direct legal duty of care to their patients, NHS funding bodies only have a 'target duty' (i.e. 'something to be aimed for') and are not legally required under sections 1 and 3 of the National Health Service Act 2006 to provide the 'best' or 'most expensive' treatment available

time during the year there is likely to be nothing left for others: we will be giving some patients 'everything' and others 'nothing'. We consider that this would be inappropriate and that we should share resources fairly, this usually meaning (i) giving resources preferentially to those who are in greatest need and who can benefit the most from them, and (ii) settling for what is adequate and not necessarily for what may be the 'absolute best'.

5 Quality and safety

The services we commission should be safe and of high quality to minimise risk to people and to minimise waste –

- high quality care can be thought of in terms of doing the right thing, in the right way, to the right person, at the right time and doing it right first time; and
- failing to do this risks harming people and wasting finite resources (and thus harming other people by denying them access to services that can no longer be afforded).

Thus, we will need to be satisfied that any service provider has adequate quality and safety mechanisms in place. Generally, these will have to be equivalent to NHS governance mechanisms, and we will expect all standards set by the relevant health and social care standards bodies to be met in full.

6 Ethics

The approach that we take to determining health and health care priorities should take account of ethical considerations, specifically² –

- *respect for personal autonomy* – which requires that we help people to make their own decisions (e.g. by providing important information), and respect those decisions (even when we may believe that a patient's or a group of people's decision may be inappropriate), noting that this does not require us to fund a specific treatment just because someone wants it, but only if it satisfactorily meets sufficient other criteria in this framework and that this does not require us to fund a treatment in a particular place other than as the patient may be entitled to under the requirements of the national 'Patient Choice' initiative or other NHS regulations;

and, we recognise that some treatments may enable a patient to maintain their independence and/or dignity, e.g. prolonging the time that they can continue to perform everyday living activities with relative independence, and we consider that this is a desirable objective, although it will not take precedence over other considerations in this framework;

- *beneficence* – which emphasises the moral importance of 'doing good' to others, entailing doing what is 'best' for the patient or group of people,^{xi} although this will not take precedence over other considerations in this framework and must be balanced with an equal obligation for us to seek to 'do good' for all of the people in the population for which we are responsible;
- *non-maleficence* – which requires that we should seek not to harm patients, and, because most treatments carry some risk of doing some harm as well as good, the potential goods and harms and their probabilities must be weighed to decide

xi The question of who should be the judge of what is 'best' is often interpreted as focusing on what an objective assessment by a relevant health professional would determine as in the patient's best interests, with the patient's own views being considered through the principle of respect for patient autonomy, the two only conflicting when a competent patient chooses a course of action that might be thought of as not in their best interests

what, overall, is in a patient's or group of patients' best interests. We will also consider whether not funding a particular treatment or service might 'do harm', but it must also be noted that we have a duty of non-maleficence to others – we could indirectly harm others because a decision to fund treatment for one person or group of people could prevent others from receiving other care of proven clinical and cost-effectiveness, so this consideration in the context of an individual treatment or service will not take precedence over other considerations in this framework; and

- *distributive justice* – which recognises that time and resources do not allow every patient to have the 'best possible' treatment and that decisions must be made about which treatments can be offered within a health care system. This principle of justice emphasises two points:
 - people in similar situations should normally have access to similar health care, and
 - when determining what level of health care should be available for one group, we must take into account the effect of such a use of resources on others (i.e. the opportunity costs).

7 General principles

In determining which treatment priorities to focus on, we will use mechanisms that –

- *follow technology appraisal guidelines (TAGs) from the National Institute for Health and Clinical Excellence (NICE) where they exist and where the circumstances of patients meet NICE TAG criteria precisely and in full;*
- *are based on good quality evidence* – using both local data (to enable effective targeting) and the results of high-quality research, including systematic literature reviews in peer-reviewed publications, and including clinical guidance from national health-professional bodies (to enable us to support care that is appropriate for the largest number of people possible);
- *are transparent*, i.e. the reasoning behind our decisions made should be clear and available to anyone who wishes to see them (as long as patient confidentiality is preserved);
- *are ethical*, i.e. that meet principles of fairness and appropriateness and that seek to provide the greatest good for the greatest number of people whilst not discriminating against people who, because of their personal circumstances (e.g. a disability) would benefit from treatment provided in a less cost-effective way than were their circumstances otherwise to be similar to those of others with the same condition; and
- *are managerially robust*, i.e. that follow due process and can be seen to have done so.

8 Accountability

We will be accountable for our decisions, through –

- *publicity* – decisions and their rationale will be publicly accessible, i.e. the processes and the principles behind them will be 'transparent',
- *reasonableness* – our decisions and their rationale should reflect an 'even-handed' and 'sensible' interpretation of how we should ensure both value for money and equitable access to the services that we commission for the varied health needs of the population, within the resources available to us;
- *an appeal process* – there may be objections from individuals or from groups to decisions made on recommendations made by a PCT and these will be dealt with

by the PCT responsible for the individual patient using their own appeal and/or complaints mechanisms; and

- *enforcement* – there will be regulation of these processes by the PCT to ensure that these various conditions are met.

9 Ensuring probity

People involved in making decisions using this framework will be bound by the 'Seven Principles of Public Life' defined by the Nolan Committee. These are:

- **selflessness** – holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;
- **integrity** – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.;
- **objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.;
- **accountability** – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **openness** – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **honesty** – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **leadership** – holders of public office should promote and support these principles by leadership and example.

10 Developing this framework

The principles described in this document will be developed:

- in the light of our experience and that of other organisations, especially to ensure a fair and ethical approach;
- in response to new scientific evidence coming to light concerning the effectiveness of health and health care interventions;
- as public values and perceptions change; and in response to changes in legislation and regulatory requirements.

REFERENCES

1 NHS Executive. *Promoting Clinical Effectiveness: a framework for action throughout the NHS*. Department of Health, 1996

2 Parker M, Hope T. Ways of thinking about medical ethics. In *Ethics*. The Medical Publishing Company Ltd. 2000

Appendix 2: A list of ‘low priority’ treatments that will not be funded routinely but only on consideration of individual patient circumstances, i.e. on a ‘prior approval’ basis

Treatment that will not be routinely funded	Potential exceptions, but subject to consideration on an individual patient basis and in the context of all of the principles in the Barnet PCT framework	Comment
Grommet insertion	<p>Children between the ages of 3 and 12 years at the time of the proposed treatment who have otitis media with effusion (OME) where:</p> <ul style="list-style-type: none"> ■ there has been a period of at least six months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT AND the child is placed on a waiting list for the procedure at the <u>end</u> of this period, AND ■ OME persists after six months AND the child suffers from <u>at least one</u> of the following: <ul style="list-style-type: none"> • at least 5 recurrences of acute otitis media in a year • evidenced delay in speech development • educational or behavioural problems attributable to persistent hearing impairment together with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss) • a significant second disability, e.g. Down syndrome, when, in addition to the above age criterion, where there is OME, a proposal to insert grommets is made by the multi-disciplinary team managing the patient and they agree that (i) hearing aids have been tried and failed or are considered to be wholly inappropriate, (ii) this is a practical proposition with 	<ul style="list-style-type: none"> ■ the evidence of effectiveness is limited ■ surgery may resolve glue ear and improve hearing in the short term compared with non-surgical treatment, but there is less certainty about long-term outcomes and large variation in effect between children ■ a Cochrane review showed that the benefits of grommets in children is small compared with myringotomy or non-surgical treatment.^a The effect of grommets on hearing diminished during the first year. It recommended an initial period of watchful waiting for most children with OME. ■ there continues to be debate about how best to select children for surgery and there is a high rate of spontaneous resolution of glue ear, particularly in younger children ■ the Scottish Intercollegiate Guidelines Network (SIGN) recommend that children under three years of age with persistent bilateral otitis media with effusion and hearing loss of ≤ 25 dB but no speech and language, development or behavioural problems can be safely managed with watchful waiting.^b If watchful waiting is being

a Cochrane review: Grommets for hearing loss associated with otitis media with effusion. January 2005

b SIGN. Diagnosis and management of childhood otitis media in primary care. February 2003

	<p>a very low likelihood of extrusion.</p> <p>For children with cleft palate, in addition to the above age criterion, a proposal to insert grommets is made by the multi-disciplinary team managing the patient and they agree that (i) hearing aids have been tried and failed or are considered to be wholly inappropriate, (ii) grommet insertion is to be undertaken at the time of primary closure of the cleft palate</p>	<p>considered, the child should undergo audiometry to exclude a more serious degree of hearing loss. Children with persistent bilateral otitis media with effusion who are over three years of age or who have speech and language, developmental or behavioural problems should be referred to an otolaryngologist.</p>
Tonsillectomy and adenoidectomy (separately or in combination)	<ul style="list-style-type: none"> ■ where there is significant severe impact on quality of life indicated by at least seven episodes of tonsillitis in the preceding year, or five episodes/year in each of the preceding two years, or three episodes/year in the preceding three years, and documented evidence of absence from school or attendance at GP or other health care setting. ■ obstructive sleep apnoea confirmed by overnight oxygen saturation monitoring 	<p>A Cochrane systemic review^c concluded that there is no evidence from randomised controlled trials to guide the clinician in formulating the indications for surgery in adults or children^d</p> <p>Grommets and adenoidectomy represents a trade off between benefits and harms; adenoidectomy on its own is of unknown effectiveness^e</p>
Cochlear implants	<p>Normally, Cochlear implants will only be funded where the patient meets the criteria of the National Institute for Health and Clinical Excellence technology appraisal guideline on this treatment precisely and in full and then only if the least expensive implant available is used assuming that this is clinically appropriate</p>	<p>A cochlear implant in one ear is recommended as a possible option for everyone with severe to profound deafness if they do not get enough benefit from hearing aids after trying them for 3 months. Cochlear implants in both ears are recommended for the following groups with severe to profound deafness only if they do not get enough benefit from hearing aids after trying them for 3 months and the implants are placed during the same operation:</p> <ul style="list-style-type: none"> ■ children ■ adults who are blind or have other disabilities which mean that they depend upon hearing sounds for spatial awareness. <p>In all cases, if more than one type of cochlear implant is suitable, the least expensive should be used.</p>

d Cochrane review. *Adenotonsillectomy for obstructive sleep apnoea in children*. 2003

e Clinical Evidence. Review of adenotonsillectomy. 2005

<p>Varicose veins, reticular veins, telangectasia</p>	<ul style="list-style-type: none"> ■ substantial skin changes including varicose eczema, lipodermatosclerosis, moderate to severe oedema; ■ intractable ulceration secondary to venous stasis; ■ bleeding from a varicosity that has eroded the skin or they have bled and are at risk of bleeding again; or ■ recurrent phlebitis (more than one documented episode) ■ severe and persistent pain and swelling interfering with activities of daily living and requiring chronic pain management ■ severe symptoms attributable to the venous disease not acceptably relieved by 6 months documented conservative management including compression hosiery and exercise 	<ul style="list-style-type: none"> ■ symptoms attributable to varicose veins are common but their relationship to visible trunk varices is not clear^f ■ most patients with varicose veins are never harmed by them and good explanation and reassurance are fundamental.^g ■ the National Institute for Health and Clinical Excellence has published detailed guidance on what treatment should be considered for varicose veins and when^h ■ treatment for reticular veins and telangectasia is generally considered to be cosmetic (see section on cosmetic surgery)
<p>Dental implants</p>	<ul style="list-style-type: none"> ■ major loss of tissue as a result of trauma or cancer surgery ■ significant congenital abnormalities, such as cleft lip and palate and hypodontia, where the abnormality or the process of correcting it, make it impossible for other prostheses to be used ■ significant neuromuscular disorders and other conditions (e.g. Parkinson's Disease, Bell's palsy), which make it impossible for patients to manage conventional dentures ■ some oral mucosal conditions, e.g. Sjogren's syndrome ■ severe jaw atrophy or alveolar bone resorption making retention of conventional dentures impossible 	<p>Primary predictors of implant failure are poor bone quality, chronic periodontitis, systemic diseases, smoking, unresolved caries or infection, advanced age, implant location, short implants, acentric loading, an inadequate number of implants, and absence/loss of implant integration with hard and soft tissues. Inappropriate prosthesis design also may contribute to implant failure.^{i,j} Implant treatment for patients who have undergone irradiation to the maxilla and/or mandible has a significantly higher failure rate.^j Patients who are over 60 years of age, smoke, have a history of diabetes or head and neck radiation, or are postmenopausal and on hormone replacement therapy experience significantly increased implant failure compared with healthy patients.^j</p>

f Bradbury A, Evans C, Allan P et al. What are the symptoms of varicose veins? Edinburgh vein study cross sectional population survey. *Br Med J* 1999;318:353-356

g Campbell B. Clinical Review- Varicose veins and their management. *BMJ* 2006;333:287-292 (5 August)

h NICE 2001. Referral Advice: A guide to appropriate referral from general to specialist services. <http://www.nice.org.uk/nicemedia/pdf/Referraladvice.pdf>

i Porter JA, von Fraunhofer JA. *Gen Dent.* 2005 Nov-Dec; 53(6):423-32

j Moy PK, Medina D, Shetty V, Aghaloo TL. *Int J Oral Maxillofacial Implants.* 2005 Jul-Aug; 20(4):569-77

Surgical treatment of carpal tunnel syndrome	<ul style="list-style-type: none"> ■ symptoms persisting after conservative therapy with local corticosteroid injection and/or nocturnal splinting ■ significant neurological deficit present, e.g. sensory blunting, muscle wasting, or weakness of thenar abduction ■ severe symptoms that significantly interfere with everyday living activities 	
Hysterectomy for menorrhagia (heavy menstrual bleeding)	<ul style="list-style-type: none"> ■ documented medical contra-indication to Minera® coil insertion when other treatments have failed or are contraindicated ■ severe anaemia, unresponsive to transfusion or other treatment whilst a Mirena trial is in progress ■ recent sexually transmitted infection (if not fully investigated and treated) ■ distorted or small uterine cavity (with proven ultrasound measurements) ■ genital malignancy ■ active trophoblastic disease 	NICE has published clinical guidelines on menorrhagia which do not necessarily require a prior trial of treatment before hysterectomy. These guidelines include recommendations on the use of other procedures, currently covered by NICE interventional procedures guidance, which should be considered in the context of a patient pathway for managing menorrhagia
Cosmetic surgery, including minor skin surgery	<ul style="list-style-type: none"> ■ suspicion of malignancy ■ significant adverse effect on activities of daily living ■ significant disfigurement ■ major weight loss leaving significantly excessive skin folds ■ severe, post-pubertal gynaecomastia ■ congenital facial anomalies ■ significant post-surgical or radiotherapy deformity ■ following severe trauma 	<p>This includes (but is not limited to) –</p> <ul style="list-style-type: none"> – abdominoplasty – breast reduction/augmentation – face lifts and similar facial surgery, including blepharoplasty – acne treatment other than with drugs – skin flap excision, e.g. after substantial weight loss – pinnaplasty – removal or obliteration of benign skin lesions including, but not limited to – <ul style="list-style-type: none"> • benign pigmented moles • comedones • corn/callouses • lipomas • milia • molluscum contagiosum

		<ul style="list-style-type: none"> • sebaceous, epidermoid or pilar cysts • seborrhoeic keratoses • basal cell papillomas • skin tags (including anal tags) • spider naevae and other telangiectasia • warts • xanthelasma • neurofibromata • rosacea <ul style="list-style-type: none"> – rhinoplasty – treatment of skin hypopigmentation – treatment of erythema for cosmetic purposes – surgical treatment of rhinophyma – skin resurfacing – botulinum toxin or other treatment for the appearance of skin-ageing – scar revision or excision (including keloid scarring) – liposuction and other surgical treatments of excess fatty tissue or contouring (e.g. buttock lift) – male pattern baldness treatment – hair removal or obliteration for hirsutism other than as referred to in the Barnet PCT policy on the management of facial hirsutism – tattoo removal – cosmetic genital surgery
<p>Wisdom tooth (third molar) removal</p>	<ul style="list-style-type: none"> ■ unrestorable caries ■ non-treatable pulp and/or periapical pathology ■ cellulitis ■ abscess and osteomyelitis 	<p>See NICE guidance^k</p>

k <http://www.nice.org.uk/nicemedia/pdf/wisdomteethguidance.pdf> (accessed 8 February 2010)

	<ul style="list-style-type: none"> ■ fracture of tooth, ■ internal / external resorption of the tooth or adjacent teeth ■ disease of follicle including cyst / tumour ■ tooth/teeth impeding surgery or reconstructive jaw surgery ■ when a tooth is involved in or within the field of tumour resection ■ plaque formation and pericoronitis depending on severity and frequency of episodes. 	
Male circumcision and other genital surgery for cosmetic or significant functional problems	<ul style="list-style-type: none"> ■ scarring of the opening of the foreskin making it non-retractable (i.e. pathological phimosis). This is unusual before 5 years of age ■ recurrent, significantly troublesome episodes of infection beneath the foreskin ■ restoration of functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous 	Female circumcision is prohibited by under the Prohibition of Female Circumcision Act 1995
Ganglions	<ul style="list-style-type: none"> ■ significant pain or dysfunction unrelieved by aspiration or injection ■ in patients presenting with significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts ■ diagnostic uncertainty 	
Dupuytren's contracture	<ul style="list-style-type: none"> ■ function of hand is significantly impeded or deformity is significantly disabling so that everyday living activities cannot be undertaken and surgery is likely to resolve this 	
Trigger finger	<ul style="list-style-type: none"> ■ the patient has failed to respond to conservative measures (e.g. hydrocortisone injections); or ■ the patient has significant fixed deformity 	A Cochrane review has shown that corticosteroid injections can be effective for the treatment of trigger finger, but evidence is limited by being based on two small studies in secondary care, and there were only data available for effectiveness of up to four months. The authors concluded that the initial treatment for

		patients should be corticosteroid injection rather than surgery, and other non-invasive interventions such as splinting may also be appropriate first-line interventions. ^l
Bartholin's cysts	<ul style="list-style-type: none"> ■ significant infection and/or rapid growth causing significant pain that is unresolved by non-surgical treatment 	
Hyperhidrosis	<ul style="list-style-type: none"> ■ significant focal hyperhidrosis and a 1–2 month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition ■ intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone 	
Dilatation and curettage for heavy menstrual bleeding in women aged under 40 years		There is no evidence that this procedure has any therapeutic value
Surgical treatment of chronic sinusitis	<ul style="list-style-type: none"> ■ suspected complications, e.g. periorbital infection ■ suspected sinonasal tumour ■ ENT referral may be appropriate if there is: <ul style="list-style-type: none"> – recurrent or chronic sinusitis of uncertain cause – unremitting or progressive facial pain – a trial of intranasal corticosteroids for three months has been ineffective – a significant anatomical abnormality 	<p>NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for 3 months for treatment in the first instance.^m</p> <p>Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.^m</p> <p>Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.ⁿ</p>

^l Peters-Veluthamaningal C, van der Windt DAWM, Winters JC, Meyboom- de Jong B. Corticosteroid injection for trigger finger in adults. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD005617. DOI: 10.1002/14651858.CD005617.pub2.

^m http://www.cks.nhs.uk/sinusitis/management/quick_answers#-369973 (accessed 8 February 2010)

ⁿ NICE Balloon catheter dilation of paranasal sinus ostia for chronic sinusitis. IPG 273 NICE September 2008.

Temporo-mandibular joint (TMJ) dysfunction		<p>There is little evidence available on the safety and efficacy of surgery for this condition. Conservative therapy includes self care practices e.g. eating soft foods, jaw stretching, ice packs, and pain relief. Stabilisation splints (bite guards) are the most widely used treatments for TMJ disorders.</p> <p>Failure to respond to conservative treatment is not an indication to proceed to irreversible treatments such as TMJ replacement. There is limited evidence of effectiveness and no agreed diagnostic classification scheme for TMJ replacement</p>
Minor oral surgery for retained roots	<p>Symptomatic retained roots may be removed in the dental surgery under local anaesthetic. Referral to a specialist may be necessary :</p> <ul style="list-style-type: none"> ■ where anatomical or pathology considerations make the extraction difficult, ■ where the patient has medical complications, ■ where the operator does not have the relevant training or experience, or ■ where previous attempts at extraction have failed 	<p>GDC guidelines indicate that 'particular care must be taken when referring patients for treatment under general anaesthesia or sedation'</p> <p>It is also in line with minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals.^o</p>
Varicocoele	<ul style="list-style-type: none"> ■ persistent discomfort or pain despite adequate conservative management 	There is no evidence that treating varicocoele can help male sub-fertility problems
Refashioning scars	<ul style="list-style-type: none"> ■ following severe burns or severe trauma and/or where there is a significant difficulty in undertaking everyday living activities, including severe psychosocial problems following facial scarring 	
Complementary medicine of all types	<ul style="list-style-type: none"> ■ there is some evidence that some forms of complementary treatments can be effective in certain conditions 	
Reversal of sterilisation	<ul style="list-style-type: none"> ■ extreme personal circumstances, e.g. establishing a stable relationship with a new partner following the 	Most studies are retrospective and success rate variable. ^p

^o Minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals, Sue Gregory, 2006

	death of the patient's partner and all children when there are no children living with the patient and their new partner	The Royal College of Obstetricians and Gynaecologists guidelines on male and female sterilisation advise that men and women requesting sterilisation should understand that the procedure is intended to be permanent, they should be given information about the success rates associated with reversal, should this procedure be necessary. ^q
Treatment of ME/chronic fatigue syndrome outside NHS service level agreements		No evidence has been forthcoming from units purporting to specialise in this condition to support claims of treatment success. Clinical guidance from the National Institute for Health and Clinical Excellence provides information for health care providers on how this condition could be managed, but do not place any obligation on service commissioners ^r
Implantable cardiac defibrillators	Funding will be made available for patients who meet the criteria of the NICE technology appraisal guideline on the use of implantable cardiac defibrillators precisely and in full ^s	This NICE technology appraisal guideline appraisal does not cover the use of implantable defibrillators for non-ischaeic dilated cardiomyopathy.

p Yossry M, Aboulghar M, D'Angelo A, Gillett W. In vitro fertilisation versus tubal reanastomosis (sterilisation reversal) for subfertility after tubal sterilisation. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD004144. DOI: 10.1002/14651858.CD004144.pub2.

q Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p.

r <http://www.nice.org.uk/nicemedia/pdf/CG53FullGuidance.pdf> (accessed 8 February 2010)

s <http://www.nice.org.uk/nicemedia/pdf/TA095guidance.pdf> (accessed 8 February 2010)