Haringey Council

Adults and Health Scrutiny Panel

MONDAY, 11TH NOVEMBER, 2013 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Adamou (Chair), Bull, Erskine, Stennett and Winskill

CO-OPTEES: Pam Moffat (HFOP)

AGENDA

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. URGENT ITEMS

The Chair will consider the admission of any late items of urgent business. Late items will be dealt with under the agenda item where they appear. New items will be dealt with at the end of the agenda.

3. DEPUTATIONS

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

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) Must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) May not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. NHS 111 (PAGES 1 - 10)

Attending:

- Jill Shattock, Director of Commissioning, Haringey Clinical Commissioning Group (CCG)
- Dr Ujjal Sarkar, Medical Director, Barndoc Out of Hours Service
- Dr Sam Shah, NHS 111 Clinical Governance Lead – NCL

6. HEALTHWATCH HARINGEY (PAGES 11 - 18)

To receive a progress report on Healthwatch Haringey from Mike Wilson, Interim Director, Healthwatch Haringey.

7. WHITTINGTON HEALTH - INTEGRATED CARE STRATEGY

To hear from:
Dr Greg Battle, Medical Director Integrated Care, Whittington Health
Dr Martin Kuper, Executive Medical Director, Whittington Health

8. NHS HEALTH CHECKS (PAGES 19 - 24)

To receive an update on NHS Health Checks from Dr Fiona Wright, Assistant Director, Public Health.

9. ADULTS AND HEALTH SCRUTINY FORWARD PLAN (PAGES 25 - 26)

10. NEW ITEMS OF URGENT BUSINESS

11. JHOSC MINUTES (PAGES 27 - 36)

To note the minutes of the Joint Health Overview and Scrutiny Committee and receive any feedback from the JHOSC meeting.

12. FEEDBACK FROM AREA CHAIRS

To receive any items from Area Chairs.

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NHS 111 Report: Haringey Health Scrutiny Committee

Dr Sam Shah
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NHS 111 Clinical Governance Lead – NCL
(Barnet, Enfield, Haringey, Camden and Islington CCGs)

Jonathon Baker
NHS 111 DoS Lead
North & East London Commissioning Support Unit

04 November 2013

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1. Introduction

The NHS 111 service for Haringey has been operational since February 2013. The provider that is commissioned for this area is London Central & West Unscheduled Care Collaborative (LCW). Calls made to NHS 111 could however be received by any 111 provider in England.

This report has been assembled by the Directory of Services (DoS) Lead and the Clinical Lead on behalf of the commissioners in relation to the 111 service that delivers care to the area of Haringey. This 111 service is part of the overall service within the North Central London area (Barnet, Enfield, Haringey, Camden and Islington). Unless otherwise stated the information presented here relates to the North Central London service as a whole and not specifically in relation to the Haringey borough boundary. Also the clinical, patient and activity data that is presented here relates to only to one NHS 111 provider (LCW) and does not relate to calls that have been answered by other 111 providers. At present, it is understood that approximately 20% of all 111 calls within the system are received by 111 providers other than the local provider; however neither the Commissioning Support Unit nor Haringey CCG receive any data relating to these other providers; and therefore this information is not reported here. GPs should still however receive a 111 notification relating to their individual patients irrespective of where in England the 111 call received.

This report only indicates how many patients were advised to attend a particular service; it does not present any analysis or findings in relation to patients that may actually have attended a particular service as a result of calling NHS 111.

2. Quality and Safety

The quality and safety of the local provider is monitored through the Clinical Quality Review Group that is chaired by the Senior Responsible Officer for the NHS 111 service within North Central London with support from the North and East London Commissioning Support Unit. The clinical lead on behalf of the commissioners, conducts regular governance reviews and site visits with the local 111 provider, undertakes call audits and examines each complaint, incidents, compliment, healthcare professional feedback and any other patient feedback.

The complaints are not currently segmented by individual CCG or borough, however for the locally commissioned service there have been 5 complaints, 26 compliments and 1 serious incident between 21 February 2013 and 30 September 2013. At the present time, the commissioners are not currently aware of any quality or safety concerns in relation to the local provider, LCW.

The provider continuously carries out patient experience survey which is reported on a quarterly basis. The learning gathered through this process has been reviewed with commissioners and implemented into the service and shared nationally where appropriate. The service provider is compliant with their statutory duties in relation to safeguarding, information governance and CQC registration.

3. Activity and Performance

This table provides an overview of the current performance of the local provider. This demonstrates that the provider has good overall performance, within the expected range of performance for a London based 111 service.

In September 2013, the local service referred 11.7% to an ambulance, this is comparable to other 111 sites within London and therefore within the normal range expected of 111; the referrals to Emergency Department were 8.6% of all calls, which is also similar to other 111 providers. It must be noted that performance relates to all calls taken by LCW for the North Central London 111 pilot service including those calls for patients that are outside of North Central London.

Since the launch of the service in February 2013 performance has continued to improve each month. The abandoned call rate is now only 0.7%. Callers that need to speak to a clinician are 'warm transferred', the warm transfer rate has continued to improve each month.

Table 1. NHS 111 Contractor Performance 2013/14

Quality and Performance Indicators	Qtr 1			Qtr 2		
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Engaged calls	0%	0%	0%	0%	0%	0%
Abandoned calls	5%	1.9%	2.1%	1.7%	0.9%	0.7%
Answer Time (% Calls answered within 30 seconds)	100%	100%	100%	100%	100%	100%
Call waiting time (% Calls answered within 60 seconds)	79%	91%	92%	93%	95.8%	97%
Life threatening referrals (% referred within 3 min where ambulance required)	100%	100%	100%	100%	100%	100%
Meeting individuals needs (% provided with interpretation service within 15mins)	100%	100%	100%	100%	100%	100%
Safeguarding (% frontline staff and advisors trained in safeguarding)	100%	100%	100%	100%	100%	100%
Triage rate (% calls answered that then require 111 triage)*	111%	109%	108%	105%	105%	94%
Transfer to 999 (% of answered calls transferred to 999)	10%	10%	10%	3.7%	11%	11.7%
Attend Accident & Emergency Dept (% advised to attend Emergency Dept)	8%	8%	8%	8.9%	8.3%	8.6%
Referred to Primary Care and other dispositions (% referred)	65%	66%	68%	62%	66.3%	64.9%
Warm Transfers (% transferred to NHS 111 Clinician where required)	33%	43%	46%	40%	54.7%	62.8%
Warm Transfer waiting time (Maximum time in seconds)	98	66	49	150	97	96
Time taken for call back (% called back <10 minutes)	54%	59%	64%	57%	63%	68%
Notifications (Information to patient 's own GP by 8am the next working day)	90%	98%	99%	100%	100%	100%
Patient Education (% of frequent users highlighted to their registered GP)	100%	100%	100%	100%	100%	100%

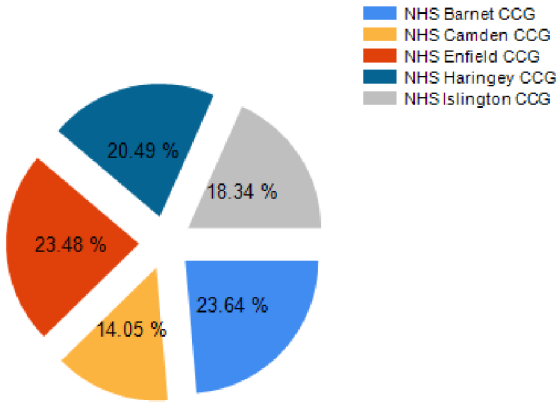
(Source: NELCSU October 2013)

**This can be above 100% as some triaged calls can be received via other 111 services*

4. Service utilisation by borough

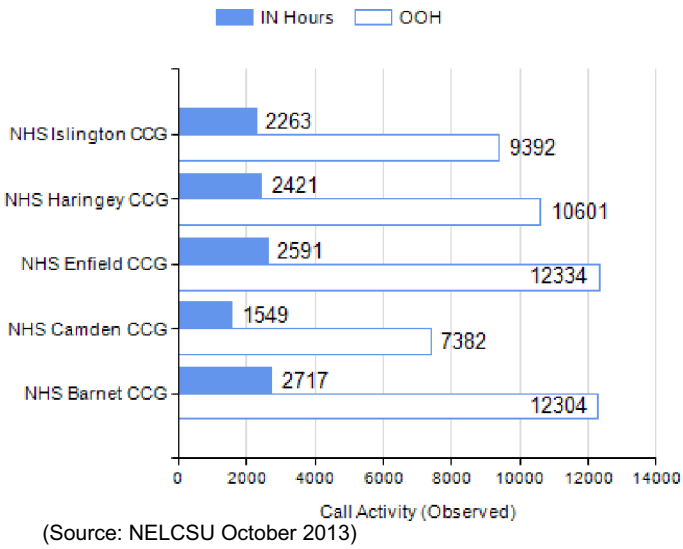
For calls received by LCW for the NCL 111 service, Haringey activity account for 20% of the NCL activity, which equates to 10,601 calls during the out of hours period and 2,421 calls during the in-hours period for the 6 month period that has been examined here.

Figure 1. Call proportions 01 Mar 2013 – 30 Sep 2013
Activity for CCG Cluster: NCL



(Source: NELCSU October 2013)

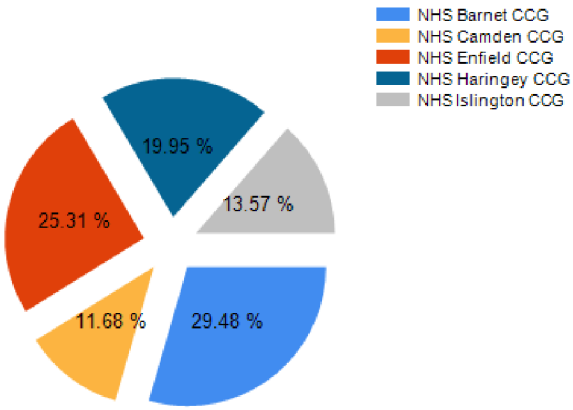
Figure 2. Call volumes 01 Mar 2013 – 30 Sep 2013
In / Out of Hours Activity for CCG Cluster: NCL



(Source: NELCSU October 2013)

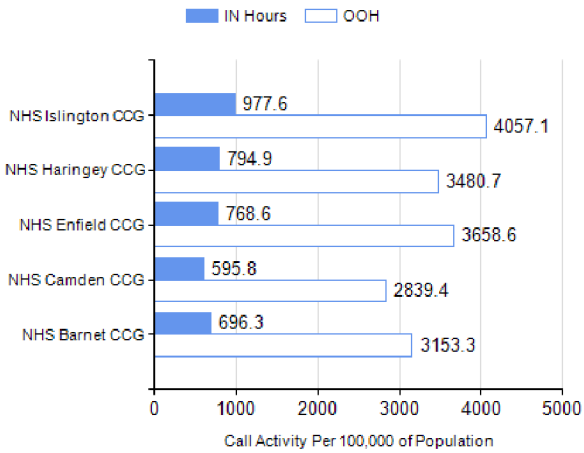
When analysed by calls per 100,000 of population, this represents a moderate proportion of total activity at 20%. However, as the Commissioning Support Unit does not receive information on calls received by other 111 providers, this comparison must be interpreted with caution.

Figure 3. Weighted Activity 01 Mar 2013 – 30 Sep 2013
Activity for CCG Cluster: NCL



(Source: NELCSU October 2013)

Figure 4. Call volumes 01 Mar 2013 – 30 Sep 2013
In / Out of Hours Activity for CCG Cluster: NCL

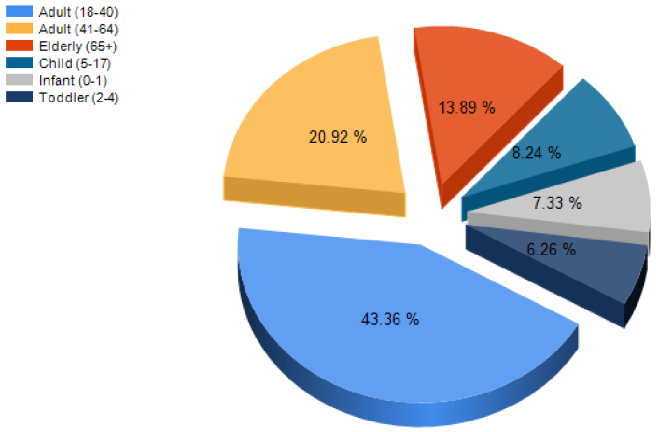


(Source: NELCSU October 2013)

5. Caller age distribution

The caller profile for Haringey indicates that the callers between the age of 18 and 40 most used the service during September 2013.

Figure 5. Age distribution of Haringey callers 01 Sep 2013 – 30 Sep 2013

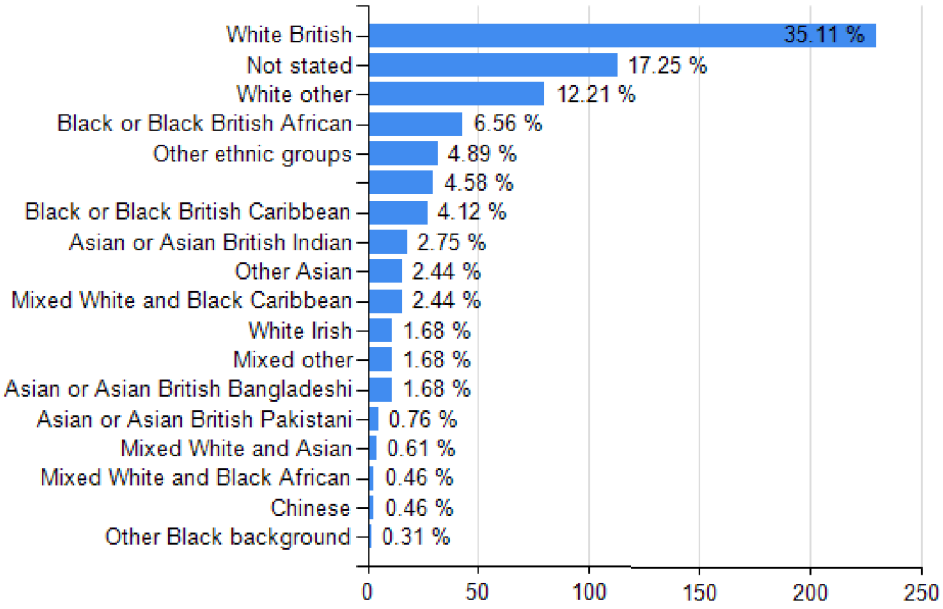


(Source: NELCSU October 2013)

6. Caller ethnicity

The caller ethnicity profile for Haringey callers to this service is not dissimilar to the ethnicity profile by sub group for Haringey that was identified in the 2011 Census. However, the caller data here relates only to the month of September 2013 alone and in order to make a more meaningful comparison a longer time horizon of 111 data would need to be used.

Figure 6. Ethnicity of Haringey callers 01 Sep 2013 – 30 Sep 2013

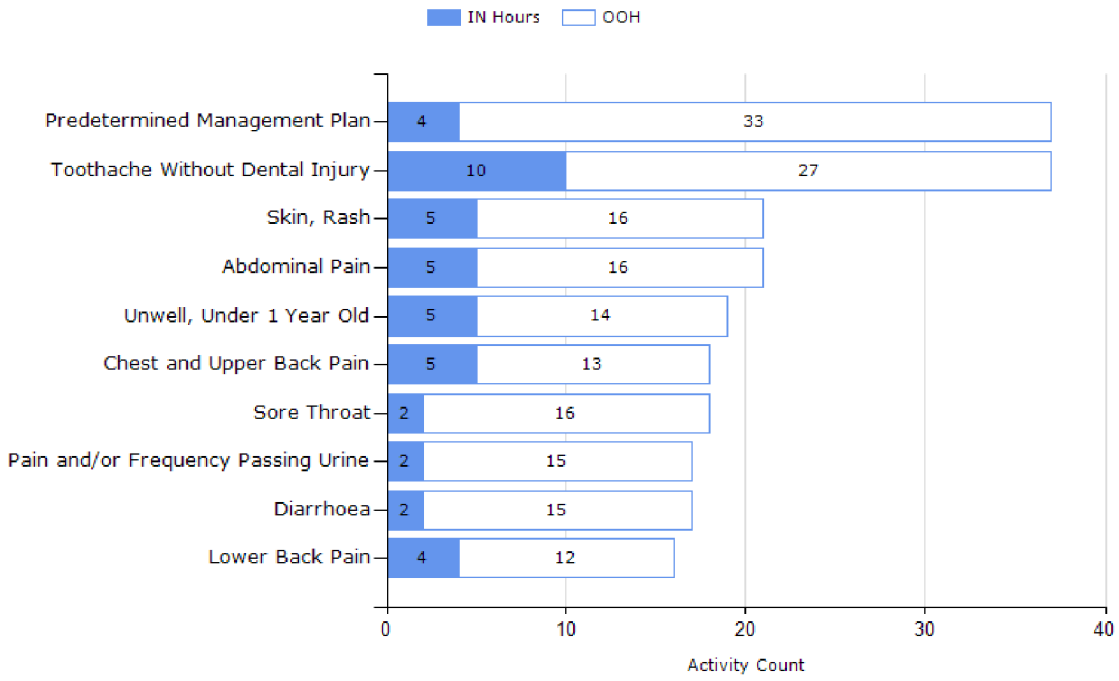


(Source: NELCSU October 2013)

7. Call outcome: Symptom Group

The top 10 reasons for calling 111 by symptom group are indicated below. The two most common reasons for calling within Haringey were predetermined management plan (7%) and dentistry (7%).

Figure 7. Call outcome by symptom group for Haringey (Top 10) 01 Sep 2013 – 30 Sep 2013

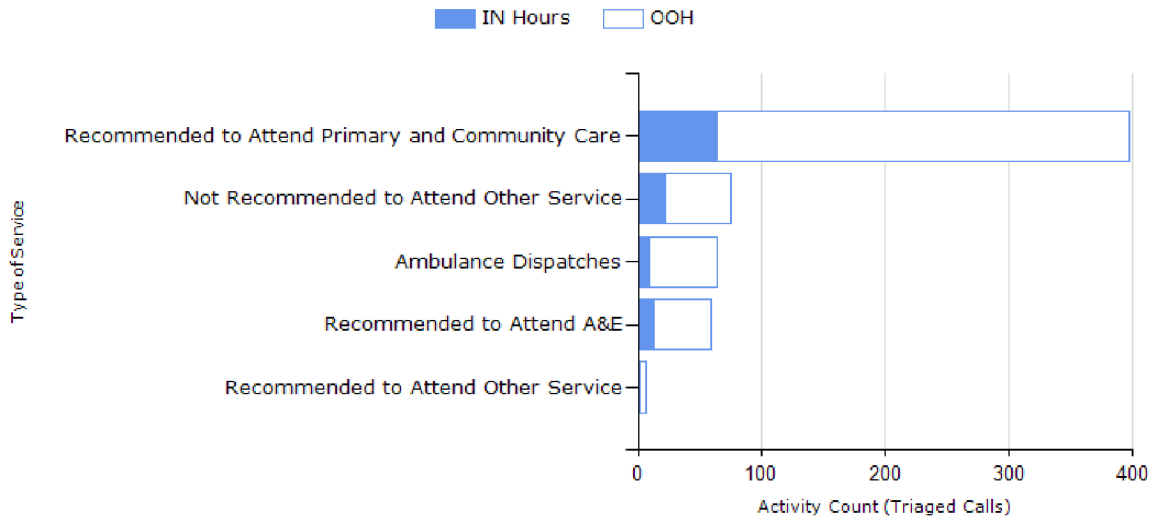


(Source: NELCSU October 2013)

8. Call outcome: Service Type

The call outcome by service for Haringey callers indicates that the main outcome is a primary or community care related service. This means that for most callers they are advised to attend a service that provides a primary care or community care function. However, this does not demonstrate where the patient actually presented and whether or not the service they attended actually handled the patient in this way.

Figure 8. Call outcome by service for Haringey 01 Sep 2013 – 30 Sep 2013



(Source: NELCSU October 2013)

Table 2. Call outcome by service for Haringey 01 Sep 2013 – 30 Sep 2013

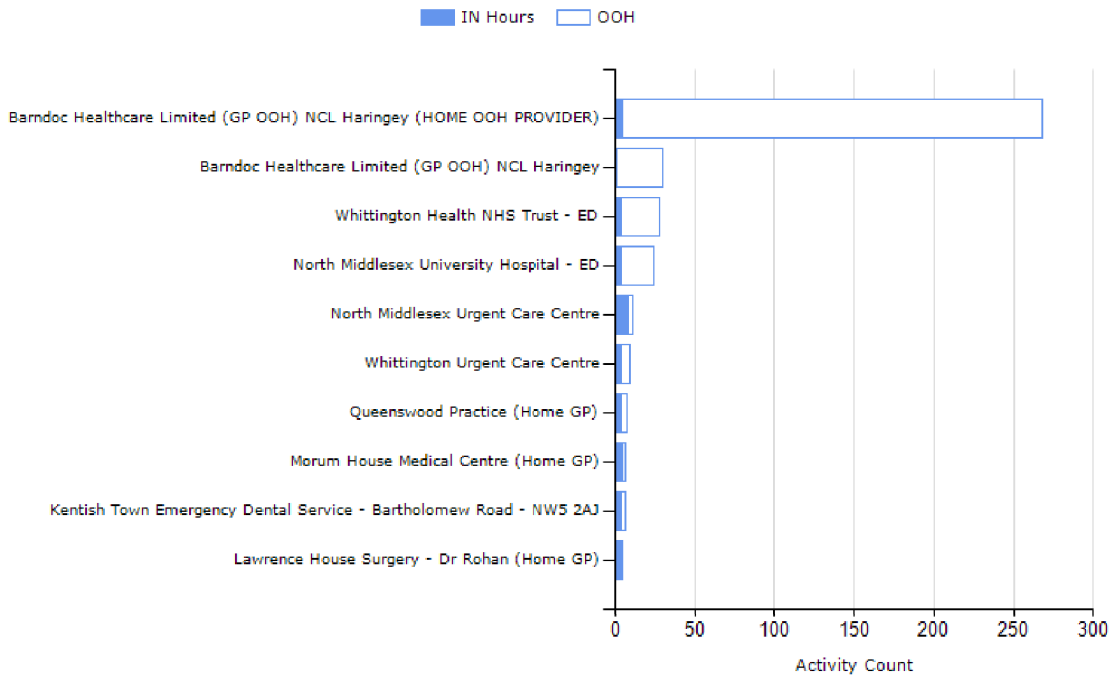
Type of Service	In Hours	In Hours (%) of Total	Out of Hours	Out of Hours (%) of Total	Total Activity
Ambulance Dispatches	9	8.3%	55	11.2%	64
Not Recommended to Attend Other Service	22	20.2%	53	10.8%	75
Recommended to Attend A&E	13	11.9%	46	9.3%	59
Recommended to Attend Other Service	1	0.9%	5	1.0%	6
Recommended to Attend Primary and Community Care	64	58.7%	333	67.7%	397
Total	**109**	**18.1%**	**492**	**81.9%**	**601**

(Source: NELCSU October 2013)

9. Service Referrals

For those calls analysed, the service to which the majority of cases were referred was Barndoc Healthcare Ltd. In total Barndoc Healthcare received 62% of all referrals (both in-hours and out-of-hours) from LCW 111 in relation to Haringey callers during the month of September 2013. Local emergency departments each received a relatively small proportion of referrals from LCW 111 during the same period (Table 3).

Figure 8. Service referrals for Haringey callers (Top 10) 01 Sep 2013 – 30 Sep 2013



(Source: NELCSU October 2013)

Table 3. Service referrals for Haringey Callers (Top 10) 01 Sep 2013 – 30 Sep 2013

Service Name	In Hours	In Hours (%) of Total	Out of Hours	Out of Hours (%) of Total	Total Activity
Barndoc Healthcare Limited - GP OOH	5	6.1%	263	63.8%	268
Barndoc Healthcare Limited - GP OOH	1	1.2%	29	7.0%	30
Whittington Health NHS Trust – ED	4	4.9%	24	5.8%	28
North Middlesex University Hospital - ED	4	4.9%	20	4.9%	24
North Middlesex Urgent Care Centre	8	9.8%	3	0.7%	11
Whittington Urgent Care Centre	4	4.9%	5	1.2%	9
Queenswood Practice (Home GP)	4	4.9%	3	0.7%	7
Kentish Town Emergency Dental Service	4	4.9%	2	0.5%	6
Morum House Medical Centre	5	6.1%	1	0.2%	6
Lawrence House Surgery - Dr Rohan	5	6.1%	0	0.0%	5
Barndoc Healthcare Limited - GP OOH	0	0.0%	4	1.0%	4

(Source: NELCSU October 2013)

For further information please contact:
NHS Haringey CCG

Agenda Item 6

Report to: Adult and Health Scrutiny Committee

From: Mike Wilson - Healthwatch Interim Director

Date: 29th October 2013

Haringey Healthwatch Progress Report

Background

The Government has said that its vision for health and social care reform is based on the principle that patients, service users and the public must be at the heart of health and social care services. The Health and Social Care Act 2012 set out that local Healthwatch (LHW) would replace Local Involvement Networks (LINks) as of April 2013.

Local Healthwatch will be the new consumer champion for both health and social care including children's social care. The aim of local Healthwatch will be to give residents and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Local authorities are required to commission a local Healthwatch organisation from 1 April 2013. Haringey Council has commissioned Haringey Citizens Advice Bureau (HCAB) to establish our local Healthwatch, and Sharon Grant; currently Chair of HCAB is its interim Chair. The community engagement function is sub-contracted to Haringey Race and Equality Council, which shares the same building with Healthwatch Haringey in Turnpike Lane. There is a total budget of about £200k per year.

Local Healthwatch will carry forward the functions of the LINk but will have additional functions and powers. It will incorporate the good practice of LINks, establishing relationships with local authorities, Clinical Commissioning Groups (CCGs), patient representative groups, the local voluntary and community sector and service providers to ensure it is inclusive and truly representative of the community it serves.

It is expected that after 2 years Healthwatch Haringey will become a social enterprise in its own right. In the meantime, the Healthwatch Board will be in effect a sub-committee of Haringey CAB, which has ultimate responsibility for delivering the contractual deliverables specified by the Council.

Vision for Healthwatch in Haringey

Healthwatch Haringey will be at the heart of the local community, embracing its diversity, and playing a key part in enabling people to become real partners in health and social care provision. As the independent local consumer champion for health and social care in the borough, it will effectively engage and involve individuals, organisations, professionals and the wider public to facilitate genuine improvements in health and social care services in Haringey.

Healthwatch Haringey will help to ensure people are aware of the health and social care services available to them and how they can get the best out of these services. It will also have a seat on the Haringey Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and others are taken into account when preparing local needs assessments and commissioning strategies, including the Joint Strategic Needs Assessment (JSNA). It will also have a seat as an observer on Haringey's Clinical Commissioning Group.

Healthwatch Functions

Function One: Gathering views and understanding the experiences of people who use services, carers and the wider community

Local Healthwatch will achieve this function in a number of ways:

- by gathering the information that is already available and working with other local voluntary and community groups to understand local views and experiences of health and care services
- by actively seeking the views of those who don't generally come forward
- by publicising information using good information governance, including confidentially, through a range of channels
- by working in collaboration with the Care Quality Commission (CQC)
- by working in collaboration with other local Healthwatch organisations
- by developing the skills to understand and interpret different kinds of data and information
- by collating information as evidence to support recommendations to Healthwatch England and /or the CQC

Function Two: Making people's views known

In order to do this effectively, Local Healthwatch will:

- identify and use existing arrangements to avoid duplication
- develop systematic methods of gathering views from local and national sources, where there are currently gaps
- be responsive to what it finds out and report back on developments
- publish findings and make them fully accessible

- identify causes for concern and celebration amongst the local community and feedback on these findings to the CQC and to local commissioners as part of an ongoing, regular dialogue
- use people's views to influence the relevant decision-making bodies including local commissioning groups, health and wellbeing boards and, through Healthwatch England and the CQC, the national regulators (including Ofsted) and the Secretary of State

Function Three: Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised

If it is to promote the involvement of local people in decisions about health and care provision, Local Healthwatch will need to be completely independent and able to demonstrate its credibility, knowledge and successes. To this end, it will be a highly visible organisation that ensures it:

- is easy to reach – for example, by having a local contact number
- is inclusive of all groups within its local community
- respects, involves and collaborates with existing networks
- provides adequate reimbursement and suitable indemnity for its members
- offers support and training to its staff and volunteers on, for example, equality and diversity legislation, safeguarding and interviewing
- practices and promotes "enter and view" through support and training
- prioritises the need for continuous dialogue with its members and local community
- develops a strong relationship with the local health and wellbeing board, making full use of its representative on the health and wellbeing board to act as a constructive "critical friend"
- is an essential contributor to the local Joint Strategic Needs Assessment

Function Four: Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)

Local Healthwatch and Healthwatch England will work together to create a single system to champion the voice of people who use health and care services, locally and nationally. To ensure the relationship works, they need to:

- agree, establish and ensure timely two-way information flows between Healthwatch England and Local Healthwatch organisations
- use protocols for good information governance
- ensure that urgent concerns are escalated
- enshrine the NHS Constitution as the benchmark of NHS service-users' rights
- understand CQC's essential standards of quality and safety
- be aware of the good practice outlined in Think Local Act Personal

Function Five: Providing advice and information about access to services and support for making informed choices

Local Healthwatch will have to meet specific criteria that will be set out in their contracts. To carry out this function effectively, Local Healthwatch will:

- identify what information already exists and how to access it
- identify unmet needs so gaps in information can be plugged
- have its finger on the pulse of the latest information and news and know where to direct people
- fully understand and champion the NHS Constitution and the concept of personalisation
- build people's knowledge of Local Healthwatch as an information and advice resource, ensuring visibility and ease of access
- develop relationships with commissioners and providers
- make sure people can get information in different formats e.g. electronic, hard copy, Braille, preferred language translations·
- make full use of social networking tools to reach communities that are otherwise under-represented
- have the capacity and systems to direct people to services they require
- ensure that it provides feedback to individual members of the public and other partners

Function Six: Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion

A timely two-way information flow will be established between Healthwatch England (HWE) and Local Healthwatch organisations. The role of local Healthwatch will be to:

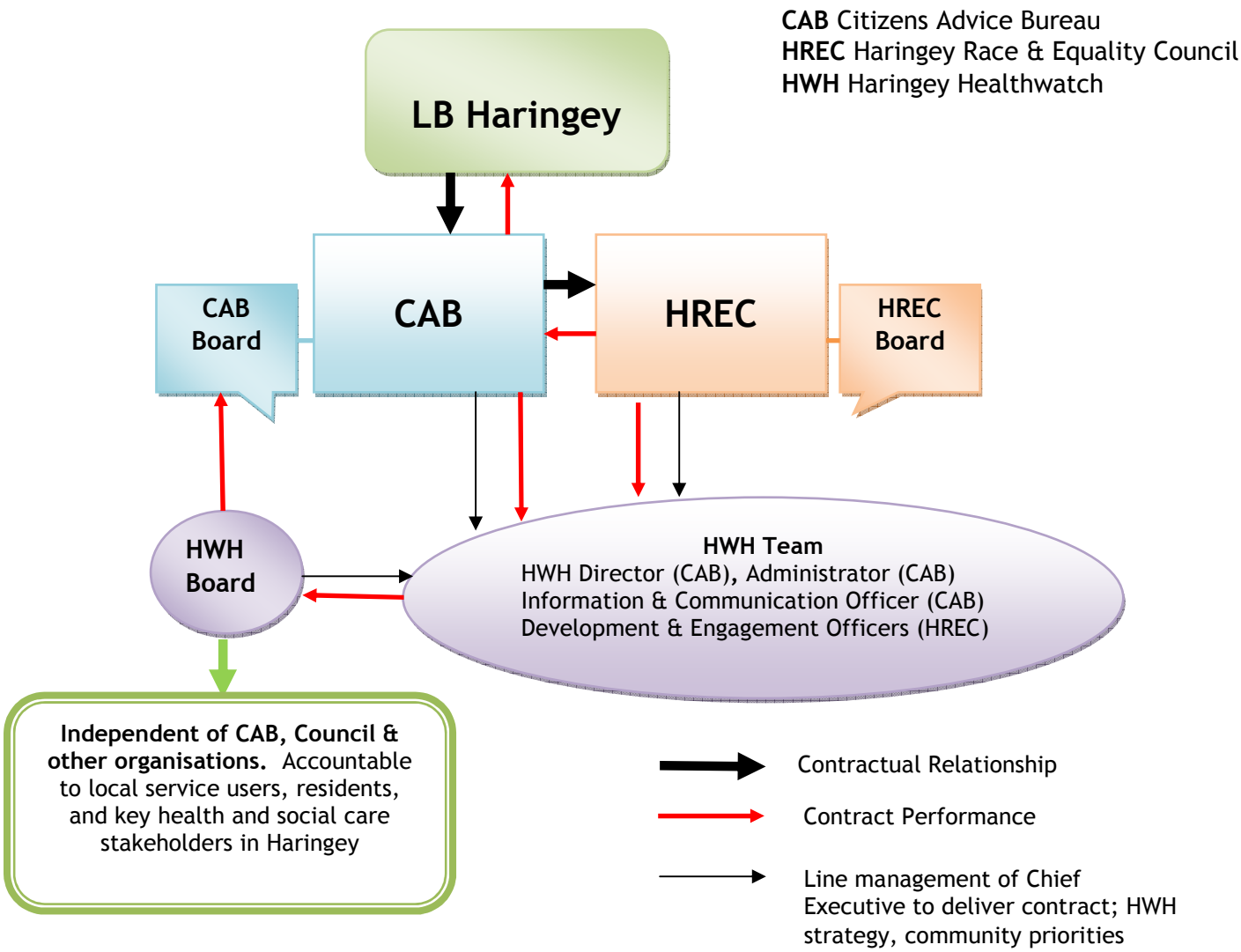
- have robust protocols for keeping HWE up to date with issues and concerns
- ensure that contacts are more than 'a conversation'.
- exercise its influence in steering and directing the emphasis of HWE's work
- ensure that accountability is a central principle in all exchange with and from HWE
- inform HWE of local matters relevant to wider public health agendas, OSCs, NCB, Monitor, FTs, ADASS, Ministers and the Secretary of State.
- ensure that HWE audits the evidence of Local Healthwatch's contributions to improving health and care outcomes nationally
- foster its own independence by enshrining clear rules of engagement, self-assessment tools etc.

Evidence based decision making

A theme running through all Healthwatch activities is the use of information to inform strategy and policy making and highlight areas of service failure. In order to be credible Healthwatch must evidence their contributions with information collected from a range of sources and not base their recommendations on anecdotal evidence from individuals, some of whom may have vested interests. Effective community engagement techniques and qualitative and quantitive research methods are tools which will be used to gather evidence from members of the public and other stakeholders to inform the decision

making process.

Organisational arrangements



The team comprises a full time Director, a part time administrator, part-time communications officer and two part time community engagement officers. The staff team is now in place and beginning to put procedures in place to deliver the Healthwatch service. The relationship between the Citizens Advice Bureau and the Council is a contractual one with targets and milestones outlined in the service specification and exemplified in detailed method statements; the HCAB has a sub-contract with HREC to deliver the engagement activities. Contract performance is reviewed quarterly against the performance targets and milestones.

It is clear from the above that the financial and human resources available to Healthwatch are very limited given the scope of the responsibilities and in order to make a difference to commissioning health and social care services the team must work with existing partnerships and networks and train a number of volunteers to be "Healthwatch champions" in the community. Volunteers can perform a number of roles including: mystery shopping, enter and view visits to care establishments, signposting to services, representing Healthwatch on specific forums and disseminating information. Developing extensive networks and channels of communication is fundamental to the success of Healthwatch.

Progress to date

The Team

The team is now recruited and busy putting the administrative processes in place and making contact with a wide range of groups and stakeholders and attending meetings.

It is intended that there will be a Healthwatch Board comprising eight members including the Chair. To date we have been unsuccessful in recruiting board members from an open advertisement and it has been agreed with the Council that we should recruit an interim board until such time as an open recruitment process is likely to be more successful. Every effort will be made to ensure that the interim board will represent the diversity of the Haringey community.

Volunteer recruitment has just started and we are looking forward to having a team of volunteers to support our work and be the "eyes and ears" of Healthwatch Haringey. Once recruited and trained some of our volunteers will undertake "enter and view" activity in social care premises as part of a more rigorous inspection regime.

Publicity

Awareness of Healthwatch and our role will develop over time and at this early stage publicising Healthwatch is a priority. We have produced leaflets, posters and the first of a monthly newsletter and have distributed these to libraries, schools, GP surgeries, leisure centres and other public buildings. An October newsletter has recently been produced and distributed in both e mail bulletin and hard copy, elected members should have received a

copy. The website has been updated and will shortly be replaced by an improved version which is more flexible and interactive: www.healthwatchharingey.org.uk

Engagement

Meeting with local and voluntary sector groups and building up relationships and gathering people's views of health and social care services in Haringey. Seven focus groups organised so far to gather people views and experiences. We have fed back to the CCG re: issues people have with accessing health services in Haringey. One of the issues that comes up at every meeting is the difficulty in making an appointment with some GP practices and in some cases people have a wait of two weeks.

Healthwatch Haringey recently ran a focus group for people with learning disabilities with Haringey Association Independent Living (HAIL) to ask them about their experiences of using health and social care services in Haringey. The people who attended the meeting said that they wanted information with pictures explaining all the symptoms to be available in all doctors' surgeries and hospitals in Haringey. This information has been fed back to the CCG.

Provided feedback to Haringey Council's Engagement Sessions on a Department of Health consultation "Caring for our Future." Contributed to the CCG consultation regarding a consent letter to the over 65's.

There are 170 people who have agreed to be "friends of Healthwatch" and we have already used this group as a sounding board on the consultations above. We will continue to develop the number of "friends" and ensure that we provide them with information and opportunities to become more involved.

Signposting

Some of our publicity must be working as to date we have had 37 people contact us by telephone for advice on how to complain or how to access services. This number will increase over time and we will use it as one measure of the success of our publicity.

Priorities

In order for Healthwatch to make an impact with such limited resources there will be a need to focus on specific priorities which may change each year. The decision on priorities will be informed by the Health and Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA) and in future years Healthwatch will be in a position to influence these priorities.

One area that has already been identified as a potential focus is "complaints procedures" and the use of complaints by health and social care agencies to inform service improvement. The recent report: "A Review of the NHS Hospitals Complaints System, Putting Patients Back In The Picture (October 2013)" set a challenge for the NHS. It has already become clear from Healthwatch early engagement and signposting enquiries that many people do not know

where or how to complain about service failures and we have identified “complaints systems” as an early priority for review both in GP surgeries and NHS Hospital Trusts.

The contract with the Council requires us to identify one or two “hidden communities” who do not access the health and social care services and as a result suffer relatively poor health outcomes. We have initially identified the Muslim community and will be working with the Muslim network developed by Haringey Race Equality Council (HREC) to focus on a particular group in that community. We also know that white males in the east of the Borough have relatively poor health outcomes with life expectancy below the national average and seven years less than the white males in the west of the Borough; they may also be a group that we focus on.

At an organisational level we have recently purchased a database system that enables us to record all contacts with individuals and organisations in order to produce reports on perceived service quality by GP practices and / or hospitals and target individuals with specific interests, e.g. those with diabetes, on their experience of care. This is a very powerful tool which will enable Healthwatch to capture customer / patient feedback at a scale that can pin point failures in different parts of the system and feedback this information both to commissioners of services and the providers themselves. We will have captured enough data by January 2014 to bring this system into effective operation.

END

Agenda Item 8

Haringey Council

Report for:	**Adults and Health Scrutiny Panel**	**Item Number:**	

Title:	**Update on NHS Health Checks 2013/14**

Report Authorised by:	**Dr Jeanelle De Gruchy**

Lead Officer:	**Dr Fiona Wright, Assistant Director of Public Health**

Ward(s) affected: All wards in East of Haringey and Stroud Green and Hornsey Wards	**Report for Key/Non Key Decisions:**

1. Describe the issue under consideration

Background

1.1. The NHS Health Check Programme is an important mechanism for achieving outcome 2 of the Council's Health and Well Being Strategy - reducing the gap in life expectancy between the west and the east of the borough, through preventing people becoming ill and encouraging early diagnosis and management. In addition, delivery of the programme is a mandatory indicator for local authorities.

1.2. The overall aim of the programme is to reduce individuals' risks of developing certain serious conditions; it is therefore mainly a prevention programme. All the components of the health check have a strong evidence base to support their inclusion within the programme. Everyone between the ages of 40 to 74, who have not already been diagnosed with heart disease, stroke, diabetes and kidney disease are eligible to be invited for a check. All patients with lifestyle issues are

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offered brief advice and where appropriate referred to lifestyle interventions, e.g. smoking cessation, health trainers, weight management or a dietician. During the check, if an individuals' risk of developing coronary heart disease (CHD) is found to be high (their risk of developing CHD in the next 10 years is greater than 20%) they are offered medication to reduce their risk and in addition invited to attend for a follow up health check in one year to reassess their risk. There is also the possibility that the health check may uncover a previously undiagnosed condition, including hypertension, diabetes or chronic kidney disease (CKD). In these cases the individual will require follow up appointments and possibly medication to be managed in primary care and prevent their condition from deteriorating.

2. Delivery of the programme in Haringey

2.1. The Haringey programme focuses on all wards in the east of the borough and two wards in the west (Hornsey and Stroud Green). All practices in these areas are eligible to undertake health checks. These areas were prioritised due to the higher prevalence of deprivation and cardiovascular mortality.

2.2. The mainstay of the programme is in primary care, and there are 41 eligible GP practices in these wards. Community programmes are commissioned to reach hard to reach groups or unregistered populations.

2.3. Tottenham Hotspur Foundation is commissioned by the council and the Premier League to deliver 3,000 checks in the community over the 3 years 2012-2015. Their aim is to work with men and other hard to reach groups. There is also a community provider working with hard to reach groups including those with mental health problems who are at higher risk of cardiovascular disease (CVD).

3. Data and Outcomes

3.1. Historical Activity

3.1.1. Data received from the providers of the health checks illustrates how both the aims of prevention and earlier identification of previously undiagnosed

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conditions are fulfilled. The outcomes from our providers have shown that between April 2011 and March 2013:

- GPs and community providers undertook over **10,000** checks
- **44%** of checks were to men and **56%** to women
- Registered **400** people onto the hypertension register (newly diagnosed with hypertension).
- Registered **136** people on the diabetic register
- Registered **10** people on the CKD register
- Registered **18** people on the CHD register
- **839** people were prescribed statins.
- **837** people were referred to smoking cessation services
- **1284** people were referred to other lifestyle change programmes, therefore reducing patients' risk of developing CVD in the long term.

3.2. Current Position

3.2.1. The current position in 2013/14 is 21 GP practices actively inviting patients between 40 and 74 for a check, (practices have a target of inviting 20% of their eligible population every year with a target uptake of 55%). In Quarter 1 and 2 2013/14 there were 1855 checks delivered (see table 1) This is lower than expected and this is in part because many practices did not return their data forms on time and partly due to changes in systems in the transition from the NHS to the council. However we are confident numbers for Quarter 3 will reflect an increase in screens as practices are encouraged to submit their data.

3.3. Table 1: Actual Activity Q1 and Q2 2013/14

	April	May	June	Total Q1	July	August	Sept	Total Q2	TOTAL
Number of invitations (recorded by 31/10/13)	368	362	379	**1109**	348	360	328	**1036**	**2145**
Number of checks	304	322	324	**950**	287	361	257	**905**	**1855**

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(recorded by 31/10/13)									

4. Next Steps for 2013/14

- Ensure that all practices that have signed up to deliver health checks are actively inviting patients and delivering their targeted number.
- Ensure that practices not yet signed up to the programme are approached again. There are currently 11 eligible practices in this group.
- Improve data quality from the GPs, through supporting them to complete the data return fully.
- Develop an effective call/recall system for the GP practices and ensure the IT systems allow remote extraction of the data to the Public Health team to reduce the risk of inaccuracies and to make the data submission process more acceptable for practices.
- Continue to access 'harder to reach' groups through partnerships with the Tottenham Hotspur Foundation and other community providers. These are groups who are less likely to attend a health check at their practice, such as people with mental health problems.
- Ensure the programme is high on the publics and professionals' agenda by producing publicity to raise awareness of the programme to improve attendance rates following an invitation.

5. Cabinet Member introduction

N/A

6. Recommendations

That Members of the Adults and Health Scrutiny Panel note the contents of the briefing and consider any comments or recommendations it wishes to make.

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7. Alternative options considered

N/A

8. Background information

8.1. The NHS Health Check Programme was established in 2009 nationally is a mandatory national programme aimed at preventing unnecessary deaths from the major preventable diseases of coronary heart disease (CHD), chronic kidney disease (CKD), some cancers and diabetes. It is aimed at all persons aged 40-74 who are invited every 5 years for a check, excluding those who have already been diagnosed with one of these conditions. It assesses patients' risk of developing CHD within the next 10 years and supports patients in making lifestyle changes to improve their health and reduce their risk through diet, exercise, stopping smoking and other lifestyle changes. National guidance from Public Health England includes a target to invite all eligible individuals on a rolling 5 year basis, equating to 20% per year.

9. Comments of the Chief Finance Officer and financial implications

N/A

10. Head of Legal Services and legal implications

N/A

11. Equalities and Community Cohesion Comments

N/A

12. Head of Procurement Comments

N/A

13. Policy Implication

N/A

14. Reasons for Decision

N/A

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15. Use of Appendices

N/A

16. Local Government (Access to Information) Act 1985

N/A

Adults and Health Scrutiny Panel

Forward plan with submission deadline

Deadline for papers	Date of meeting	Item	Specifics	Contact for papers
10am 4th December	**12th Dec**	**Budget Scrutiny**	Consideration of proposals (savings) arising from MTFP	Cllr Vanier, Cabinet Member Mun Thong Phung, Adults Dr Jeanelle de Gruchy, Public Health
10am 19th February	**27th Feb '14**	**Cabinet Q & A**	Cllr Vanier – Cabinet Member for Health and Adult Services	N/A
		Day Care	Further information tbc	Mun Thong Phung, Adults
		Health and Wellbeing Board	Work being done on role of integrating services	Dr Jeanelle de Gruchy, Public Health
		Improving GP Access	Work being done to improve GP access	Sarah Price, CCG
		Haringey and Francis Report	Work being done to ensure that local hospitals implement recommendations	Sarah Price/Jennie Williams (Lead Director), CCG
		Local pharmacies	Partnership working and link to care pathways	Gerald Alexander/Michael Levitan, LPC Dr Jeanelle de Gruchy, Public Health

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North Central London Sector Joint Health Overview and Scrutiny Committee

4 October 2013

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held at Haringey Civic Centre on 4 October 2013

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Arjun Mittra	LB Barnet
Graham Old	LB Barnet
John Bryant (Vice Chair)	LB Camden
Alev Cazimoglu	LB Enfield
Anne-Marie Pearce	LB Enfield
Dave Winskill	LB Haringey
Martin Klute	LB Islington

1. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Cornelius, Rawlings (Cllr Mittra deputising) and Kaseki.

Members of the Committee expressed disappointment at the late postponement of the visit to the 111 service and requested that a new date be identified before the end of October. In particular, this would enable it to feed into work that was being done by Camden's health overview and scrutiny committee on out-of-hours care. Members also requested that papers for future Committee meetings be made available in advance of the meeting and in one tranche.

In respect of the agenda item on Cancer and Cardiovascular Service Reconfigurations, the Chair reported that this item had been deferred. This was because NHS England had not been able to approve the case for change in time for the meeting. A meeting had taken place recently with the Chairs of all three joint health overview and scrutiny committees (JHOSCS) covering north and north east London with officers from the Commissioning Support Unit, who were leading on the issue on behalf of NHS England. It had been reported at the meeting that it was likely that a full public consultation would be required. There was a statutory requirement for a joint committee of all the local authorities affected to be set up but it had been agreed that consultation, in the first instance, would be through the existing JHOSCs. A larger joint committee of all boroughs affected would be set up in the meantime and this would meet at the end of the process to agree a composite response.

2. DECLARATIONS OF INTEREST

Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda.

3. URGENT BUSINESS

None.

4. MINUTES

RESOLVED

That the minutes of the meeting of 19 July be agreed as a correct record.

5. MOORFIELDS EYE HOSPITAL

John Pelly, the Chief Executive of Moorfields Eye Hospital reported on the services provided by Moorfields as well as information on its proposed re-location. Moorfields was the oldest established eye hospital in the world. It treated a wide range of eye conditions, including both routine and rare conditions. Just over half of the hospital's activity took place on its City Road site with the remainder taking place in 19 different locations in and around London. In some locations, their services supplemented the work of other hospitals whilst elsewhere Moorfields ran the full range of ophthalmic services. They were also a world renowned centre of research and a teaching centre for undergraduate doctors and other professionals.

The site in City Road was now very old with the Children's Centre being the only new part. The Board had therefore decided to relocate and the Kings Cross/Euston area was considered to be the best potential option for the hospital to re-locate to. There were currently a number of options within the area that were being considered.

The Vice Chair reported that the NHS organisations had previously not always followed through their interest with the developer in the Kings Cross central area and this could possibly influence the developers' attitude to Moorfields. Mr Pelly accepted this but stated that there were nevertheless other options, including sites that may come onto the market in the future. The costs were likely to be around £300 million. Finance would come from a number of sources. Under any scenario, a presence would be maintained on the City Road site. Future plans would be subject to consultation with patients and health overview and scrutiny committees. Engagement would be led by the Clinical Commissioning Groups (CCGs), who had specific responsibility to engage. It was possible that there might be some double running of services when the new buildings opened.

The Committee expressed its support for the proposals. It noted that the hospital was a foundation trust and was therefore able to finance the re-location without external involvement, although the plans would need to be acceptable to Monitor and the Treasury. UCL were the hospital's academic partner and would be contributing to the cost.

In answer to a question, Mr Pelly stated that the hospital was looking at where its patients came from and whether they could be dealt with at another site.

They had noted that 60% of patients being treated at the City Road site passed by another Moorfields facility on their way there. Work was required to persuade patients to go instead access other Moorfields facilities, where they could receive the same level of care.

The Committee emphasised the importance of effective engagement in order to secure full support for the plans. A location close to Kings Cross was likely to attract more foreign patients. In answer to a question, Mr Pelly reported that Moorfields were likely to both stay and expand their presence on the St Ann's site in Tottenham.

RESOLVED

That the Chief Executive of Moorfields Eye Hospital be requested to report further to the Committee on plans for the re-location of the hospital in due course.

6. ACCIDENT AND EMERGENCY (A&E)

The Committee considered A&E performance statistics within acute hospitals in north central London as follows:

Barnet & Chase Farm: Janet Mustoe, Dr Tim Peachey and Dr Bal Athwal, attended the meeting from Barnet and Chase Farm hospitals. They reported that the trust's figures covered two separate district general hospitals sites – Barnet and Chase Farm. The Barnet site was the slightly busier of the two. There had been challenge in improving performance in quarter 1. Post Acute Care Enablement and a Triage Elderly Assessment Team, which aimed to treat elderly people as quickly as possible, were being established on the Barnet site. At Chase Farm, around 40% of patients were now treated by GPs. A Rapid Improvement Plan, which was led by Enfield CCG Urgent Care Board, was in place.

In answer to a question, the Panel noted that there was no hard evidence of patients being misdirected to A&E following consultation with the 111 Service. However, it would be possible to obtain relevant data on referrals from the 111 Service. It was agreed that the Trust would liaise with the 111 Service and analyse referral data to confirm that patients were being referred to A&E appropriately by the 111 Service.

It was noted that there was some anecdotal evidence that patients preferred to attend A&E instead of visiting their GP. Information was passed to GPs on contact between their patients and the 111 Service but this did not specify what happened next as a result of the call. This meant that GPs were not getting a full picture of the situation. It was also noted that Barnet's performance for time to initial assessment was better than some hospitals that had Urgent Care Centres.

In answer to a question, it was noted that Enfield Council was working with the Trust and NHS community services to improve care for older people and had

provided £2 million of funding to facilitate this. In particular, elderly people were now dealt with at the "front door". The Trust had also prioritised actions that made the most impact in treating them.

Dr Peachey reported that disaggregated data was available for each of the two sites that the Trust was responsible for but aggregate data for both sites was required to be published. There were currently challenges in maintaining performance on the Barnet site due to ongoing building work.

North Middlesex University Hospital: David Donegan and Julie Lowe attended the meeting from the North Middlesex Hospital. They reported that the hospital dealt mainly with patients from Enfield and Haringey. A&E operated out of a single site. Additional funding was being invested in it, including the employment of additional doctors. The Trust was part of Haringey Urgent Care Board. Time to decision was currently improving and the Trust was happy with present performance.

Ms Lowe reported that the improvements to the hospital that had been introduced as a result of the Barnet, Enfield and Haringey Clinical Strategy had made it a more attractive option to A&E consultants and it was becoming less difficult to recruit. A large percentage of patients used the Urgent Care Centre and there was a need to make sure A&E was used appropriately. Priority was given to blue light calls but the department was big enough to cope with some demand from patients who could be treated elsewhere. Demand for A&E was currently static but was expected to increase. This had been planned for though and therefore could be accommodated.

Mr Donegan reported that total time in A&E was currently less than 4 hours for 98/99% of Urgent Care Centre patients. Admission avoidance was nevertheless important. The key issue driving the trust's performance challenge was delayed discharges into the community and differences between local authority approaches. The Trust worked closely with partners, including adult social care, to address this. Teleconferencing with GPs was being used and it was planned to expand this.

In terms of referrals from the 111 service, there was no specific information that the trust currently held other than anecdotal.

Royal Free: Dr Steve Shaw and Kate Slemeck attended the meeting from the Royal Free. There had been a presumed impact from the new 111 service but that service now seemed to be "bedding in". The Trust had now been compliant with waiting time standards for 23 consecutive weeks.

Committee Members commented on the fact that the average for total time in A&E had been 239 minutes for all three of the periods quoted in the statistics. The Trust acknowledged the fact the figures might appear questionable and agreed to check them and report back. Aside from these figures, Committee Members felt that the statistics were good.

The Trust reported that urgent care was an integral part of their A&E. The performance of A&E was reflective of that of whole hospital. Senior presence in A&E was particularly important.

Committee Members commented that, despite there being an urgent care centre on site, patients had to wait longer to be seen initially at the Royal Free than other hospitals but that the time that it took for a decision to be taken regarding treatment was significantly better. The Trust stated that this was due to the hospital using a different approach to patients than other trusts.

In terms of the affects of the 111 service, the Trust was of the view that this had now settled down. Camden and Islington CCGs were doing some work on this area through urgent care boards.

University College London (UCL): Dr Jonathan Fielden and Dr Daniel Wallis attended the meeting from UCL. The A&E service had been under pressure, as indicated by the statistics. In particular, the Emergency Department was in the middle of a 3 year rebuild to accommodate current and future pressures. There had been a significant growth in attendances but this had not been translated into a proportionate increase in admissions. The percentage of patients that could have been seen in primary care was relatively unchanged at around 8%. The local population was changeable. It was known that if they went to A&E at UCL, they could be seen very quickly by world class clinicians. Evidence suggested that it tended to be young people (18-45) who were inclined to prefer attending A&E to visiting their GP for a consultation. Patients also came from a wide area across all of london, perhaps due to the convenience of access of UCLH, including some who attended on their way to work. There was concern at the continuing increases in attendance and work was being undertaken to facilitate a cultural shift, although to date no one had managed to achieve this at large scale.

Committee Members highlighted the fact that the figure of 8% for patients that could have been treated instead in primary care differed from other figures that had been given by NHS bodies, which ranged from 15% to 40%. The Trust responded that it was difficult to be exact. The criteria that had been used for their statistics was patients that were seen and did not require any further investigation. There were probably other categories of patients that could also be treated effectively in a primary care setting

Committee Members drew attention to the apparently high figures for the length of time to initial assessment. The Trust reported that there was partly an issue with the quality of data and that this had arisen due to IT problems. The current median was 12 minutes and 60% of patients were seen within 15 minutes. It was very rare for there to be a significant ambulance queue as ambulance handover statistics showed. There were also problems with the time to treatment figure. The Trust understood concerns about the figures, particular in respect to the most recent quarter. However, the Trust had met the necessary standards for 2012/13 and for quarters 1 and 2 of 2013/14. Although there had been an increase in the number of attendances, these had generally been for

minor illnesses and injury. They were not aware of any tangible increase in the number of inappropriate attendances due to the introduction of the 111 service.

Whittington: Carol Gillen attended the meeting from the Whittington Hospital. She reported that the time to treatment had proven to be the biggest area of challenge and the focus was currently on improving the statistics for this. Quarter 1 had been particularly challenging, with an extended winter season. As part of ongoing work, the Emergency Department was reviewing its staffing levels and skills mix. The Trust had received NHS winter pressures funding. It was working with partners in Haringey to provide a rapid response to vulnerable patients. This involved joint work being undertaken with district nurses and social workers.

There had been a surge in attendances earlier in the year but this had now subsided. A snapshot of activity had been undertaken in September for Camden and Islington Urgent Care Boards and it was agreed that this would be shared with JHOSC Members.

Committee Members commented that the unplanned re-attendance rate was very low. The Trust responded that this was due to close working with community health services and social care. A whole systems approach was followed and this had led to real improvements, especially in Haringey. Good practice was shared informally, through Urgent Care Boards and UCL partners. In Islington, integrated working was being progressed with shared posts and budgets.

RESOLVED

1. That Barnet and Chase Farm hospitals be requested to liaise with the 111 Service to provide details of referrals and whether patients are being referred to A&E appropriately by the 111 Service;

2. That the Royal Free be requested to confirm the validity of their data in respect of total time in A&E; and

3. That the Whittington be requested to share their snapshot of A&E activity with the Committee.

7. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY ROYAL FREE

Kim Fleming, from the Royal Free, reported on the potential acquisition by the Royal Free of Barnet and Chase Farm hospitals. The acquisition was intended to advance the clinical strategy of the health economy for the next five years. There were a number of challenges that needed to be addressed. There were likely to be marked changes in population. In particular, there was likely to be more older people, especially in outer London. There would also be changes to the NHS. Standards were rising and more care was consultant delivered. There was also likely to be a significant gap in funding by 2018-19. A final decision

would be made in the spring regarding the acquisition. This would be after the final decision on the implementation of the BEH Clinical Strategy.

The only changes that were envisaged to clinical services and their distribution between the hospitals that would be part of the trust should the acquisition go through would be to the most specialised services. Most of these had already been subject to change or were in the process of changing. It was recognised that the Royal Free Hospital had accessibility issues and it was therefore not intended to require patients currently treated elsewhere to go there instead. The benefits of the acquisition would arise from being better able to assist commissioners in achieving their objectives, economies of scale and better buying power.

Mr Fleming stated that the Royal Free would need to determine the achievability of savings from the acquisition in order to decide whether it was a viable proposition. No decision had been made as yet. The trust was aware of changes implicit in the BEH Clinical Strategy. They were also aware of the potential for surplus land on the Chase Farm site but had not made any decision about disposal or the ring fencing of receipts.

The Committee noted that the potential transaction had not arisen from any financial challenge that the Royal Free might face. There were gains to be made from learning and there had been a number of meetings regarding specialities. The potential benefits to be gained from the acquisition had been looked at and the results so far were very positive. For example, there would be easier access to research trials for patients.

Committee Members commented that there was now only 7 weeks until the BEH Clinical Strategy went live and the acquisition would now mean the involvement of another hospital. It was unclear what the impact of this would be. It was felt that clarity was needed on exactly what was being proposed and the rationale behind it. Concern was also expressed at how the Committee had found out about the proposed changes. It was felt that there was not yet enough information available to form an opinion regarding the potential benefits. There was a need for the Committee to be apprised of the strategic factors influencing the decision. The Committee had been given the impression that there was little alternative for Barnet and Chase Farm hospitals than to go along with the acquisition.

Mr Fleming stated that the Trust was happy to respond and participate in dialogue. He was happy to come back to the Committee to discuss the issue in greater detail. It was up to the Royal Free board and Monitor to decide whether the acquisition should go ahead. The alternatives that might be available for Barnet and Chase Farm were a matter for their trust board to decide. Any delay in implementing the BEH Clinical Strategy could possibly have implications for the timetable for the acquisition. They also felt that the views of commissioners needed to be considered as part of this discussion.

Mr Fleming stated that the acquisition, if it went ahead, would likely to be completed in April, and therefore it might make sense to have such a discussion

ahead of this date. Overall the clinical benefits of the potential acquisition remained clear. However, there was some caution regarding financial issues.

RESOLVED

That a further detailed item regarding the acquisition of Barnet and Chase Farm hospitals by the Royal Free including the strategic factors influencing decision making and the potential implications be considered by the Committee at an appropriate time and that this include specific input from commissioners.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS

The Chair reported that this item had been deferred until the next meeting as the case for change had not yet been agreed by NHS England.

9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - UPDATE

Julie Lowe, Chief Executive of North Middlesex University Hospital and Siobhan Harrington, Programme Director, BEH Clinical Strategy reported on progress with the implementation of the strategy. The overall aim of the strategy was to provide safer, high quality care. A joint meeting of the CCGs of Barnet, Enfield and Haringey in September had agreed to the changes proceeding this winter. The two acute trusts had previously confirmed that they were ready to implement the changes.

It was considered that undue delay could jeopardise patient safety. On 20 November, the labour ward at Chase Farm would close whilst on 9 December, A&E would close to ambulances from 3am, with the Urgent Care Centre opening at 9am. However, the vast majority of patients who were currently using A&E would still be able to receive their treatment at Chase Farm Urgent Care Centre. Recruitment for additional posts at the North Middlesex Hospital was going well. In particular, the Trust has successfully recruited A&E consultants.

Committee Members questioned whether a merger between Barnet and Chase Farm and the North Middlesex Hospital (NMUH) might be more appropriate. Barnet and Chase Farm hospitals were viewed as not being viable financially as stand alone foundation trusts whereas the NMUH was considered to be on its journey to Foundation Trust. It was noted that had been a feasibility study conducted some time ago considering the potential viability of a merger of Chase Farm and NMUH which concluded that this was not a viable option for Foundation Trust.

Committee members expressed concerns that the acquisition of Barnet and Chase Farm by the Royal Free could lead to changes to the Clinical Strategy, but Ms Harrington confirmed that the Royal Free was committed to implementing the Strategy in full.

Ms Lowe reported that the National Trust Development Agency was responsible for determining the long term future of Barnet and Chase Farm hospitals and

NMUH as they were both currently not foundation trusts. NMUH currently had little involvement with the Barnet site of Barnet and Chase Farm hospitals.

Committee representatives from Enfield stated that their position was already well known and that it was the Council's decision to seek judicial review of the decision to implement the strategy. Ms Harrington stated that she was disappointed by the Council's decision. There were significant concerns at the possible impact on patient safety if the action by the Council led to delays in implementing the strategy. There was commitment from the CCGs and the acute trusts to progress the implementation of the strategy to the planned timescale.

10. MEETING OF MEMBERS FROM BARNET, ENFIELD AND HARINGEY TO CONSIDER ISSUES RELATING TO BEH MHT

Rod Wells and Dave King, from Haringey Needs St Ann's Hospital, addressed the meeting regarding concerns about mental health provision on the St Ann's N15 site. The number of mental health beds on the site had been reduced in recent years from 50 to 35 and they were of the view that expanded mental health provision on the site needed to be provided as part of its redevelopment as current capacity was inadequate. In addition, they felt that there needed to be an integrated child care centre within the plans. They felt that the Committee needed to look closely at mental health services and, in particular, should re-visit the issue of the response by Barnet, Enfield and Haringey Mental Health Trust to the recent CQC reports at an early stage.

Committee Members stated that mental health trusts were facing continuing increases in demand for their services whilst their funding was being reduced every year. There were also differences in the funding levels provided for each of the three boroughs that the Mental Health Trust covered.

RESOLVED:

That health scrutiny committees within Barnet, Enfield and Haringey be updated in three months time on progress achieved by Barnet, Enfield and Haringey Mental Health Trust in responding to issues raised by the Care Quality Commission in recent inspections of services.

12. FORWARD WORK PROGRAMME

The Committee noted that NHS England were ultimately responsible for the allocation of GP funding and requested that an item be placed on a future agenda on this issue.

RESOLVED:

That the issue of GP funding be added to the work plan for future meetings.

Gideon Bull
Chair

Meeting finished at 13:15