Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Monday 20 October 2014**

TIME: **7.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre**

MEMBERSHIP **(Quorum 3)**

Chairman: **Councillor Mrs Rekha Shah**

Councillors:

Michael Borio (VC)	Mrs Vina Mithani
Niraj Dattani	Chris Mote

Reserve Members:

1. Kairul Kareema Marikar	1. Lynda Seymour
2. Jo Dooley	2. Jean Lammiman
3. Sasi Suresh	

Advisers:

To be confirmed	Harrow Healthwatch
Dr N Merali	Harrow Local Medical Committee

Contact: Manize Talukdar, Democratic & Electoral Services Officer
Tel: 020 8424 1323 E-mail: manize.talukdar@harrow.gov.uk

Harrow COUNCIL LONDON

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Sub-Committee;
(b) all other Members present.

3. MINUTES (Pages 1 - 8)

That the minutes of the meeting held on 4 September 2014 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

Questions will be asked in the order notice of them was received and there be a time limit of 15 minutes.

[The deadline for receipt of public questions is 3.00 pm, 15 October 2014. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

7. APPOINTMENT OF ADVISER (Pages 9 - 12)

Report of the Director of Legal and Governance Services.

8. CARE QUALITY COMMISSION CHIEF INSPECTOR OF HOSPITALS INSPECTION COMPLIANCE ACTION PLAN FOR THE NWLHT (Pages 13 - 26)

Report of the Chief Inspector of Hospitals, Care Quality Commission

9. NHS HEALTH CHECKS SCRUTINY REPORT (Pages 27 - 82)

Report of the Director of Public Health.

10. WORK PROGRAMME AND JHOSC UPDATE REPORT (Pages 83 - 86)

Report of the Divisional Director, Strategic Commissioning.

11. ANY OTHER BUSINESS

Which the Chairman has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II - NIL

*** DATA PROTECTION ACT NOTICE**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

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HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

4 SEPTEMBER 2014

Chairman:	*	Councillor Mrs Rekha Shah		
Councillors:	*	Michael Borio	*	Mrs Vina Mithani
	*	Niraj Dattani	*	Chris Mote
Advisers:		Rhona Denness		Harrow Healthwatch

* Denotes Member present

10. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

11. Declarations of Interest

All Agenda Items

Councillor Michael Borio declared a non-pecuniary interest in that he was employed by Independent Age. He would remain in the room whilst the matters were considered and voted upon.

Councillor Mrs Vina Mithani declared a non-pecuniary interest in that she was employed by Public Health England. She would remain in the room whilst the matters were considered and voted upon.

Councillor Chris Mote declared a non-pecuniary interest in that his daughter was employed by Northwick Park Hospital. He would remain in the room whilst the matters were considered and voted upon.

12. Minutes

RESOLVED: That the minutes of the meeting held on 7 July 2014 be taken as read and signed as a correct record.

13. Public Questions & Petitions

RESOLVED: To note that no public questions or petitions were received at this meeting.

14. References from Council and Other Committees/Panels

RESOLVED: To note that none were received.

RECOMMENDED ITEMS

15. Appointment of (non-voting) Advisers to the Sub-Committee 2014/15

The Sub-committee received a report of the Director of Legal and Governance Services, which set out details of nominations for the position of non-voting adviser to the Sub-Committee 2014/15.

An officer advised that the nomination from HealthWatch Harrow had been withdrawn after the agenda had been published. HealthWatch Harrow would be contacted for a replacement nomination, which would be agreed at the next meeting.

The Sub-Committee agreed the nomination from the Local Medical Committee.

Resolved to RECOMMEND:

That Dr Nizar Merali, of the Local Medical Committee, be appointed as a non-voting adviser to the Sub-Committee for 2014/15.

RESOLVED ITEMS

16. Public Health Integration

The Sub-Committee received a report of the Director of Public Health which set out the work and experience of the Joint Public Health Service in its first year of operation from 1 April 2013 to 31 March 2014.

The Director stated that the Joint Public Health Service, which was in its first year of operation, worked for Barnet and Harrow Councils and had the following key areas of responsibility:

- leading health improvement and reducing health inequalities;

- health protection and ensuring appropriate plans are in place;

- public health support to health service commissioning and joint commissioning;

- providing public health knowledge and intelligence.

He added that the team worked with both councils and organisations within the NHS, eg, the Clinical Commissioning Groups, NHS England and Public Health England. It had formal links to all of these organisations in order to fulfil statutory requirements and to ensure effective health provision for both boroughs.

Members made the following comments and asked the following questions:

- What new services and initiatives had been funded with the new investment totalling £1.65m across the two councils?

  The Director advised that the following initiatives had been funded with the investment:

  - £350,000 of new investment was deployed to support work on childhood obesity, a review of the school nursing service in preparation for health visitors joining the Council in April 2015 (to ensure a joined up preventive health support for Children 0-19 is in place), warmer homes, work to improve the older peoples health and social care pathway (undertaken by Adults Services). Harrow Childhood obesity, Alcohol brief advice in pharmacies, and healthy eating in schools and Children's Centres.

- How would childhood obesity be tackled and healthy eating among school children be promoted? What could be done about the proliferation of fast food outlets in our local high streets and in the vicinity of schools?

  The Director advised that schools in Barnet and Harrow had engaged well with the Healthy Schools programme, which was part of the Mayor of London's initiative. Healthy eating, emotional wellbeing, stopping smoking along with the sexual health programme, and services provided as part of the Early Years' services and Children's Centres were key elements of the programme.

  He added that Tower Hamlets had looked at introducing new by-laws to regulate fast food outlets and there the government was considering a proposal to tax fizzy drinks. The Environmental Health team at Harrow was working with schools on healthy catering options.

- Why was the ring fenced grant a higher amount for Barnet than for Harrow?

The Director advised that PCTs in Barnet and Harrow and other outer London authorities had historically received low allocations. Furthermore, the population of Barnet was almost double that of Harrow and the two boroughs had one of the smallest allocations in England, per head of population. The grant amount was based on indices such as deprivation and age and though the two boroughs shared services, they did not share the funding. The residents of both boroughs were considered to be generally healthy and had low levels of deprivation. The allocation for 2015/16 would be announced in December 2014, and it was not clear whether this would continue to be ring fenced going forward.

- How did the procurement and commissioning process work under the new arrangements?

  The Director stated that the Service was currently procuring School nursing with Hounslow as part of the West London Alliance consortium and expected this to be in place by September 2015. Drugs and Alcohol programmes were in the process of being procured and early discussions with providers had taken place. Sexual health, which was a more complex area, would need to be procured in due course.

- How would the problem of social isolation be tackled?

  The Director stated that social isolation was often a key factor in an individual's health and this was part of the Mental Health Prevention Strategy and would be reported in detail to the Health and Wellbeing board.

RESOLVED: That the report be noted.

17. Care Quality Commission's Quality Report on the North West London Hospitals NHS Trust

The Sub-Committee received a report of the Care Quality Commission (CQC) which set out its findings following its recent inspection of the North West London Hospitals NHS Trust (NWLHT).

Following a brief overview of the report by the Interim Medical Director at NWLHT, Members asked the following questions:

- What was the Trust's reaction to the report? Did the Trust agree with the report's conclusions? Did the report highlight areas that the Trust was already aware of or were they a surprise, if so, which ones had come as a surprise?

- Critical care at Northwick Park Hospital had been rated 'Inadequate'. What was being done to address this, when would detailed improvement plans be made available to the Sub-Committee? When was the service expected to improve and to which CQC standard?

The Interim Medical Director stated that in his view, the report was measured and appropriate. The Trust was obliged to submit a Compliance Action Plan in response to the CQC report. The Action Plan was almost complete and the Trust was in the process of producing a Quality Improvement Plan with its partners and the CQC. The report had highlighted the fact that National Audit requirements for critical care had not been taken into account by the Trust, and consequently, critical care units at Northwick Park Hospital had discharged patients too soon, which had led to an increase in re-admission rates for these patients.

A representative from Harrow's Clinical Commissioning Group (CCG) added that the Improvement Plan was owned by Barnet and Harrow CCGs, which had joint monitoring responsibility.

- Would the enhanced A&E services at Northwick Park have the capacity to deal with an increased and more complex workload as a result of the planned closures of the daytime A&E facility at Central Middlesex and Hammersmith being replaced by an urgent care facility? How would this work in practice and would Harrow residents experience increased delays in accessing A&E?

- Why were A&E services at Central Middlesex and Hammersmith being closed despite the anticipated delay in implementing the changes at Northwick Park? Why had the changes not been implemented in phases?

- What effect would the changeover have on staff management and morale?

The Interim Medical Director advised that the Shaping a Healthier Future report had made a number of recommendations regarding North West London hospitals, which had been taken on board by the Trust. A&E facilities at Hammersmith Hospital and Central Middlesex Hospital would be closing the following week. Modelling had suggested that significant numbers of patients would opt to go to access A&E services at either St Mary's or Charing Cross Hospitals following the closures. Furthermore, Central Middlesex already referred its patient overflow to Northwick Park Hospital. He anticipated that there would be an additional 9-12 patients visiting the re-vamped A&E unit at Northwick Park Hospital on weekdays and that this figure would be lower on weekends.

He added that the following measures were being implemented at Northwick Park. These would help mitigate against additional pressures due to the centralisation of A&E facilities :

- increased space, an additional 22 beds and additional trolleys;

- consolidation of staff meant that 30 nurses would be available during each shift;

- both Brent and Harrow CCGs had an assurance process and contingency plans in place;

- plans to strengthen GPs referral process;

- increased focus on ambulatory care;

- close working with the ambulance service;

- staff affected by the merger were not opposed to it and the existing team had been inducted into the new unit. The Trust had extensive organisational development plans which it was committed to;

- all the operations managers would be on call to monitor and manage the bedding-in process, and ensure clinical safety.

The representative from Harrow CCG stated that a phased changeover may have caused confusion among the public regarding which A&E units were open on any given date. The date chosen also took into consideration the rotation timetable for junior doctors and issues of clinical safety.

- Critical care at Northwick Park had been rated as 'Inadequate'. What was being done to address this service area; were there detailed plans regarding this and when and how would they be implemented? Was there capacity to do this? What impact would the Trust's financial position have on its ability to make the required improvements?

- Why had the inspectors interviewed only 3 women from the post-natal ward?

- What was the reason for the low response rate to the Friends and Family Test?

There continued to be cultural and leadership related issues with the maternity unit. The service had made improvements and it was deemed safe. However, it was not as responsive as it should be to the needs of mothers at the unit. Staff at the unit had undergone re-training, however, the impact of previous 'special measures' at the unit and the damage to the unit's reputation had affected staff morale.

Inspectors had surveyed those patients at the post-natal unit on the day. English was not the first language for many of the mothers in the unit. 70% of pregnancies at the unit were in the high risk category and these results were consistent with other London hospitals.

The Interim Director stated that the friends and family tests had seen a marked improvement recently. The representative from the CCG stated that it was difficult for staff to win the hearts and minds of patients and their families during busy shifts at A&E. The recent improved response rates had been largely due to more time being allowed to complete the surveys.

The Interim Director added that the Trust had been told to expect an un-announced re-inspection by the CQC in the next 3 months. He undertook to submit a report regarding the Improvement plan at a future meeting of the Sub-Committee.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.15 pm).

(Signed) COUNCILLOR MRS REKHA SHAH
Chairman

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REPORT FOR: HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	20 October 2014
Subject:	Appointment of (non-voting) Advisers to the Sub-Committee 2014/15
Responsible Officer:	Hugh Peart, Director of Legal and Governance Services
Exempt:	No
Enclosures:	None

Section 1 – Summary and Recommendations

This report advises Members on the appointment of a non-voting adviser to the Sub-Committee. Members are requested to consider and agree the appointment of the adviser to the Sub-Committee for the 2014/15 Municipal Year.

Recommendations:
That, in accordance with the Committee Procedure Rules (Part 4B of the Constitution - Rule 33.9),the nominee named in this report, be appointed as an adviser to the Sub-Committee for the 2014/15 municipal year.

Reason:
To appoint a non-voting adviser for the 2014/15 Municipal Year, to assist in the work of the Sub-Committee.

Section 2 – Report

Background

2.1 Rule 33.9 of Committee Procedure Rules provides for a Scrutiny Sub-Committee to appoint non-voting advisers (to assist in the work of the Sub-Committee either generally or on specific matters).

2.2 At its meeting on 7 December 2010, the Health Scrutiny Sub-Committee requested that Harrow LINK (now HealthWatch Harrow) and the Harrow Local Medical Committee (LMC) be requested to each nominate up to two of their members to become non-voting advisers to the Sub-Committee.

2.3 HealthWatch Harrow have nominated the following individual: Julian Maw, Vice-Chair of HealthWatch Harrow.

2.4 If appointed, the adviser will be required to comply with the Council's Protocol on Co-optees and Advisers (Part 5H of the Constitution).

Financial Implications

2.6 None.

Risk Management Implications

2.7 If not appointed, the Sub-Committee may not have access to expert external advice when conducting its business.

Equalities implications

2.8 The appointment goes towards supporting the Council's Public Sector Equality Duty.

Corporate Priorities

2.9 Promotes 'Making a difference for Communities', by enabling representation on a Scrutiny Committee from the voluntary and community sector in Harrow.

Section 3 - Statutory Officer Clearance

Name: Steve Tingle Date: 7.10 .14	x	on behalf of the Chief Financial Officer
Name: Paresh Mehta Date: 8.10.14	x	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact: Manize Talukdar, Democratic and Electoral Services Officer 020 8424 1323

Background Papers: None

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Care Quality Commission
Chief Inspector of Hospitals Inspection Compliance Action Plan

Regulation:
Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

Regulated Activity;
Treatment of disease, disorder or injury
Maternity and midwifery services
Surgical procedures

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
People who use services and others were not protected against the risks associated with ineffective decision-making in order to protect their health, welfare or safety. In that:				
• Very little information was systematically collected on the safety and quality of care and treatment provided within critical care. *Regulation 10 (1) (a) (b) (c)(i) (e)*	ICNARC license application - May 2014 Confirmed joining – June 5, 2014. Data collection in place with NWL *Critical Care Network Quality measures uploaded* for first quarter of 2014/15	Sue Field / Jamie Zanardo	Complete Complete	

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
	Clinical Lead – dedicated 1PA for development, leadership and overseeing of quality measure return. Recruitment to Audit Nurse Post underway – interview date 16/9/14		Complete Sept 2014	
• There was a lack of up-to-date protocols and guidelines for staff to work from within surgery. *Regulation 10 (1)(b) (2) (b)(iv)*	Review protocols and guidelines relevant for staff working within Surgery Identify gaps in delivery that may require specific guidance Develop necessary protocols Ensure that staff are aware of correct policies and guidelines relevant to their area of work	Antony Fitzgerald / Clinical Director Surgery	Oct 2014 Oct 2014 Oct 2014 Oct 2014	
• The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway. *Regulation 10 (1) (a) (b) (2) (b)(i)*	• Ensure clear display of Trust posters and information on: 'Listening, responding and improving your experience' • Audit compliance • Staff engagement workshop • Develop Complaints management improvement plan and trajectory for compliance with response standards and to maintain ongoing compliance.	Carole Flowers Jayne Adams / Gloria Rowland/Onsy Louca James Nugent – Pt relations Pami Kalia - HR	September 2014 September 2014	

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
	• Recruit designated maternity Patient Experience & Quality Improvement Lead. (appoint interim) • Develop women's feedback plan on maternity pathway, to include: ➢ Increased staff engagement and ownership ➢ Local surveys ➢ Parents forum ➢ Improve response rate of F&F test. ➢ Raise profile of Maternity Services Liaison Committee. ➢ Debriefing Service ➢ Themes and trends from on call supervisor of midwives and bleep holder ➢ Repeat of national survey • Update Women's Experience Improvement action plan. • Evidence of feedback, learning and change incorporated into: ➢ Divisional Monthly Clinical Governance meetings. ➢ Divisional performance		Sept 2014 Review appt Nov 2014 September 2014 January 2015 September 2014 Oct 2014 Quarter 3 by	

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
	management meetings. ➢ Report to Clinical Performance & Patient Experience subcommittee of the Trust Board.		Dec 2014 September 2014 and quarterly.	
• The lack of escalation processes in maternity. *Regulation 10 (1)(b)*	• Re-launch Maternity Early warning Signs MEOWS assessment and escalation tool • Audit compliance • Review clinical and bed management escalation protocol and re-launch • audit / evaluate • Establish joint midwifery and obstetrician handover • audit / evaluate	Carole Flowers/Charles Cayley Jayne Adams / Gloria Rowland/Onsy Louca	September 2014 November 2014 September 2014 November 2014 October 2014 January 2015.	

Regulation:

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare

Regulated Activity;
Treatment of disease, disorder or injury
Maternity and midwifery services
Surgical procedures

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date
Women who use maternity services at Northwick Park Hospital were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –			
• Having their individual needs met as comfort checks on the postnatal ward were not regular. *Regulation 9(1)(b)(i)*	• Re-launch Comfort rounds • Comfort Rounds Audit • Evaluate as part of the Women's Experience Improvement action plan	Carole Flowers Jayne Adams / Gloria Rowland	September 2014 November 2014. December 2014
• Having their safety and welfare ensured because behaviour and attitudes of some midwives towards women fell below expectations. *Regulation 9(1)(b)(ii)*	• Develop a Trust- wide customer care policy • Provide ongoing customer care training. • Re-launch expected standards for staff attitude & behaviour ➢ Re-launch Trust 'Working together in partnership: A charter for patients,	Carole Flowers Jayne Adams / Gloria Rowland Colette Mannion – Pt Experience	September 2014 Review training compliance September 2014

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date
	visitors and colleagues' outlines expected attitudes and behaviour ➢ Re-launch Maternity services staff attitude and behaviour charter & card. • Re-launch 'See something say something campaign' for staff to raise concerns • Ensure clear display of Trust posters and information on: 'Listening, responding and improving your experience' • Audit compliance • Develop a women's feedback plan on the maternity pathway. • Undertake Matron's 'ward' rounds to receive feedback from women and take proactive actions to improve their experience in the moment. • Thematic report of outcomes, learning and changes in practice • Undertake observational audits to assess patient safety and welfare standards. • External Peer Review •Implementation of midwifery consultation paper to ensure right staff, right skills right		September 2014 September 2014 September 2014 September 2014 December 2014 September 2014 - ongoing October 2014

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date
	place. Consultation started February 2014 and completed March 2014. Implementation started 1st April 2014, staged programme completion date March 2015. • Increased team and Individual awareness of complaints and taking ownership of their own behaviour through group and personal feedback, reflection and ownership and performance management of improvement plans.		March 2015 (Monthly Review) October 2014 and ongoing

Regulation:

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises.

Regulated Activity;
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
People who use services and others were not protected against the risks associated with the safe and suitability of premises in that:				
Jack's Place: • The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward. *Regulation 15 (1) (a)*	Review of ward configuration undertaken with options for changes being scoped and costed.	Paul Kingsmore/ Carole Flowers Jayne Adams / Kay Larkin	Sept 2014 for scoping to be completed	
• The ward appeared clean, but it was cluttered which meant thorough cleaning could not be achieved. *Regulation 15 (1)(c)(i)*	Weekly monitoring of ward using PLACE template	Paul Kingsmore/ Carole Flowers Jayne Adams / Jackie Waldron	Complete and On going	

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
• The treatment room and store room doors on the ward were left open, potentially allowing access to children. *Regulation 15 (1) (b)*	Door now remains locked with ongoing spot checks	Carole Flowers Jayne Adams / Ward manager Jack's Place	Completed May 2014	
• On the day of our visit, there were blood samples on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the laboratory was out of order. *Regulation 15 (1) (b)*	Review process to implement when we have pneumatic tube failure • HCA on shift identified by shift leader to act as runner and transport the blood samples to the lab, expectation this will be done 4 hrly until pneumatic system back up. • The samples will be stored in treatment room	Carole Flowers Jayne Adams / Jackie Waldron	October 2014	

Regulation:
Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.

Regulated Activity;
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
People who use services and others were not protected against the risks associated with the safety and suitability of equipment in that:				
Jack's place • Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked. *Regulation 16 (1) (a)*	 CQC Inspection-Jacks Plac	Paul Kingsmore / Antony Rankin	Complete	
• Some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward 24% of equipment had passed their due date for servicing. *Regulation 16(1)(a)*	 220814 Jacks Place Completed Maintenar	Paul Kingsmore / Antony Rankin	Complete	Please find enclosed "220814 report. Confirmation of all medical devices serviced within date.

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
Neonatal unit • We noted that a fridge in the neonatal unit was iced up and there were gaps in the temperature recording. *Regulation 16 (1) (a)*	• Fridge defrosted. • Out of samples disposed off • HCA to add to rota of temperature recordings	Carole Flowers / Jayne Adams / Gene Taylor	Complete	

Regulation:
Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.

Regulated Activity;
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff in that:				
• There were inadequate staffing levels to provide safe care to patients within the major's treatment area in the A&E department. *Regulation 22*	Recruitment & Retention – Middle grade recruitment and development Leadership – Increased leadership in A&E, Clinical Engagement Demand & Capacity – map demand surges with Rota capacity, 6 day cover &weekend discharges Beds/4 hour performance – Estates Strategy, Carroll Ward, Treat &Transfer CMH, Modular Units (up to100 beds by Oct 2015)	Chris Pocklington James Walters / Nigel Stephens	On going Sept 2014 Current ED complete New ED – Nov 2014 Spring 2015	

Recommendation / Finding	Action taken	Exec Lead / Manager Responsible	Completion date	Comments
• There were low numbers of middle grade doctors in general surgery. *Regulation 22*	Review middle grade staffing numbers and allocation across general surgery Develop associated recruitment plan with temporary cover if necessary	Charles Cayley Antony Fitzgerald / Clinical Director Surgery	Sept 2014 Sept 2014	
• Medical staffing levels were very low in critical care. A large number of positions were filled by locums and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently. *Regulation 22*	Clinical Lead appointed May 2014 with dedicated time to develop unit Robust weekly MDT Programme and Mortality Review meetings Middle grades – 6 recruited,2 outstanding 1 Consultant recruited commences August 2014, 0.5 WTE commences Oct 2014	Charles Cayley Sue Field / Clinical Director Critical Care	October 2014	

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REPORT FOR: **HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	Monday 20 October 2014
Subject:	NHS Health Checks Scrutiny Report
Responsible Officer:	Dr Andrew Howe, Director of Public Health
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member Councillor Vina Mithani, Performance Lead Member
Exempt:	No
Enclosures:	Appendix A - NHS Health Check Scrutiny Final Report, January 2014

Section 1 – Summary and Recommendations

This report provides an update on progress resulting from the recommendations set out in the NHS Health Checks Scrutiny Report for Barnet and Harrow (January 2014)

Recommendations:

- Note progress on The Scrutiny Review recommendations

Section 2 – Report

Executive Summary

1. Aim of Review

1.1.2 In January 2014, a scrutiny review of the local NHS Health Checks programme was undertaken to assess the delivery model and performance in Barnet and Harrow. It considered the views of key stakeholders and residents regarding the programme, analysed options and made recommendations to inform the commissioning strategy in both boroughs.

1.1.3 This paper sets out the actions undertaken or planned to address the recommendations from the scrutiny review.

1.1.4 The recommendations arising from the scrutiny review cover the following themes:

1. Health Checks promotion
2 Provider /Flexible delivery
3 Treatment Package
4 Referral pathways
5 Restructure financial incentives
6 Resources
7 Targeting
8 Screening Programme Anxiety
9 Barriers to Take-up
10 Learning Disability

1.2 Current Situation

1.2.1 The NHS Health Checks programme is a mandatory service provided by Barnet and Harrow Joint Public Health Service. It is a national risk assessment and lifestyle management programme which assesses an individual's risk of heart disease, stroke, kidney disease, and dementia and alcohol misuse with the objective of reducing death rates and the burden of disease from these conditions.

1.2.2 In 2014/15, the local eligible population (those between the ages of 40-74 without a pre-existing cardiovascular condition) is 64,500. A local target was set to invite 15% of the eligible population to Health Checks. There was also a target to deliver these assessments 10% of the cohort.

1.2.3 There has been an improvement in performance for the first quarter 1. When benchmarked against other London Boroughs, Harrow is now ranked 21st for health checks 'offered' compared to 30th position in 2013/14. Harrow's performance for health checks 'received' has also improved; the borough is now ranked 25th compared to being positioned 29th in 2013/14.

1.2.3 The table below sets out the recommendations from the NHS Scrutiny Review (2014), the actions undertaken and planned activities.

	Theme	Recommendation and Rationale	Progress (September 2014)
1	**Health Checks Promotion**	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).	In September 2014, Public Health England invited local Health Check programmes to express an interest in piloting a marketing campaign. We have expressed an interest in being a pilot site and are currently awaiting a response. On a local level, the programme has been promoted in 'Harrow People', (August 2014) and at the 'Under One Sky' event (Sept 2014). There are three outreach events planned in Harrow, each will involve a week long promotional campaign in the local area followed by a full day's event delivering Health Checks. This will help raise the profile and awareness of the programme. Planned outreach events at: (1) The North Harrow Mosque (2) The Shree Kutch Satsang Swaminarayan Hindu Temple (3) 'Compass' and 'EACH' (drug and alcohol services)
2	**Providers / Flexible Delivery**	Health Checks should be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit	A GP led outreach programme is currently being piloted in Harrow. We are also plans to deliver Health Checks through community pharmacists and

		at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups) to make Health Checks more accessible.	'Everyone Active' Harrow Leisure Centre can play in delivering Health Checks. To date, four members of staff at Harrow Leisure Centre have been trained to deliver Health Checks. Please see number 1 for update on outreach activities. There are also plans to work with the voluntary and community sector to target vulnerable groups in the community. We will also be delivering Health Checks in local workplaces, including the Council – with a particular focus on men. The outreach programme will be evaluated to assess its effectiveness at meeting the target group.
3	**Treatment Package**	1) All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more attractive. 2) Commissioners should investigate feasibility of tailoring treatment options to specific communities.	1) The need to streamline the process is recognised and as a result point of care testing will be introduced, where possible. This involves carrying out bloods testing as part of the Health Check. A GP practice profiling exercise is currently underway to understand how Health Checks are being delivered and what improvements can be made. Health Check training was recently delivered to practice staff and ways to streamline the service were promoted as part of this training. 2) 'Treatments' for any diagnosed illness would follow standard clinical

			protocol as led by the GP or nurse practitioner. Advice on lifestyle interventions are tailored to individual preferences as per discussions with the Health Check provider.
4	**Referral Pathways**	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment	The patient pathway is an essential element of the programme. Those who have been assessed with 'high risk' of heart disease are referred to their GP for additional investigative tests. Smokers are referred to stop smoking services. Hypertensive patients will commence appropriate medical treatment. Those with high blood glucose levels will be sent for a diabetic assessment. Those assessed with a 'low' or 'medium' risk factor may qualify for any of the above. In addition to this they will be given advice and/or an onward referral to the physical activity programme called 'Healthwise'.
5	**Restructure Financial Incentives**	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.	Tiered payment structures which incentivise GPs to deliver Health Check to those most at risk are being developed for 2015/16. The contract for 2014/15 cannot be altered at this point and we would seek to initiate this new payment structure for 2015/16.
6	**Resources**	1) Public Health England and local authorities must consider the cost	1) and 2): The local authority has a statutory obligation to

		of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. 2) Nationally, Public Health England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended. 3) Health Checks are currently not a mandatory requirement for GPs meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical space) to deliver	deliver Health Checks (the risk assessment element) but is not responsible for the whole pathway. The local authority encourages GPs to provide lifestyle advice to patients who are assessed to have a low risk score. 3) Whilst GPs are not legally obliged to deliver this service, many of them see the value of this preventative screening programme, as demonstrated by a high level of sign up to the programme. 29 out of 35 local GPs in Harrow have signed up to deliver this programme. Public Health England benchmark local authorities' performance against agreed national targets and other authorities. Local authorities see GPs as key delivery partners that enable them to meet their statutory obligation. As a result, GPs are incentivised to improve the uptake of Health Checks.
7	**Targeting**	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- 1) Men (who statistically have a lower up-take than women); 2) Faith communities (who statistically have a high prevalence of certain diseases); and	A GP led outreach programme is currently being piloted in Barnet. This will increase accessibility of the programme to the wider population. Please see number 1 for update on outreach activities. We are also exploring how to deliver Health Checks to Harrow's most deprived communities. The outreach programme will

		3) Deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)	be evaluated to assess its effectiveness at meeting the target group.
8	**Screening Programme Anxiety**	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.	Public anxiety about screening is being managed in a number of ways: 1) Through the above mentioned outreach work in faith centres and working with vulnerable adults through their support agencies, the programme aims to allay any anxiety that may surround the programme. 2) Training sessions for Health Check staff, included a specific section on addressing patient concerns. 3) Public promotions at the 'Under One Sky' event, and an article in the 'Harrow People' July 2014 has provided information about the programme and helped reduced any anxieties.
9	**Barriers to Take-Up**	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.	GP practice profiling is currently being undertaken to establish the reasons for poor uptake. The findings of the practice profiling exercise will be available in November and will be used to shape the future delivery model and improve service uptake. Initial findings from this profiling exercise have indicated that the barriers come from two key areas, one is General Practice and the other is the general public. The barriers include: **General Practice:** Lack of capacity, disinterest

			and non-attendance from patients, unsuitable times for Health Checks and conflicting priorities at the practice. **General Public**: Lack of interest from individuals, lack of awareness of the programme. People unwilling to go to GP if they don't feel ill. The Health Check programme is a screening programme and people who attend may not necessarily feel ill.
10	**Learning Difficulties Disability (LDD)**	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with LDD into the Health Checks programme before age 40 due to their overrepresentation in the health system	There are currently 2,745 adults with LDD in Harrow between the ages of 30-74. Nearly 50% (1,285) of those LDD people are between the ages of 30-44. The programme will engage community groups who support adults with LDD in order to improve the take up, health outcomes and potential life expectancy.

Financial Implications

This report is for information only. Therefore there are no financial implications to this report as the activities outlined above are delivered within the allocated budget.

Performance Issues

Table 1 below shows the performance figures for each quarter of 2013/14. By the end of the year, the programme had underperformed (by 8.2%) against its annual target for 'offered' Health Checks. In relation to the target for 'received' Health Check, the programme had underperformed by 3.2%.

As a result of the actions, described above, performance has begun to improve. Figures for quarter 1 (2014/15), set out in Table 2, show that we have exceeded our target for that period. When compared to other London Boroughs, Harrow is ranked

19th and 25th for Health Checks 'offered' and 'received', respectively. Since 2013/14, Harrow has moved from 30th and 21st, respectively. See chart in appendix 1 for details.

The programme will continue to develop and implement plans to maintain or improve uptake for the remainder of this year and beyond.

Table 1 Performance for 2013/14

HARROW	**Quarter 1** (PHE official figures reported)	**Quarter 2** (PHE official figures reported)	**Quarter 3** (PHE official figures reported)	**Quarter 4** (PHE official figures reported)	**Annual performance 2013/14**
No. offered health check Target – (% of eligible)	3194 (5.00%)	4194 (6.57%)	2694 (4.22%)	2689 (4.21%)	12,771 (20%)
No. offered health check Actual – (% of eligible)	2112 (3.3%)	1801 (2.8%)	1590 (2.5%)	2004 (3.1)	7507 (11.8%)
Population	63,879	63,879	63,879	63,879	63,879
No. received health check Target - (% of eligible)	1597 (2.50%)	1597 (2.50%)	1597 (2.50%)	1597 (2.50%)	6,388 (10%)
No. received health check Actual - (% of eligible)	1,247 (2%)	992 (1.6%)	995 (1.6%)	1001 (1.6%)	4,235 (6.8%)

Table 2 Quarter 1, 2014/15

HARROW	**Quarter 1**
No. offered health check Target – (% of eligible)	1,612 (2.5%)
Actual (not validated)	2504 (3.9%)
Population	64,500
No. received health check Target - (% of eligible)	900 (1.4%)
Actual (not validated)	1059 (2.3%)

Environmental Impact

This report is for information only; therefore there are no environment impacts arising from this report.

Risk Management Implications

None, as this report is for information only

Equalities implications

This report is for information only

Council Priorities

Making a difference to the vulnerable:

Harrow has a larger proportion of older people, when compared to the London average. Health Checks in the older population can help to identify early stage cardiovascular disease and commence follow up care to ensure the best outcomes. The programme will also be exploring how to work with agencies that support the most vulnerable people in the community.

We will also be working with agencies that support people with learning difficulty disabilities (LDD), such as Mencap. People with LDD suffer poorer health and earlier mortality than other groups. We will be making a committed effort to reduce the age of LDD Health Checks to 30 years old and increase the number of Health Checks received in this group.

Late presentation illness typically results in additional strain on social and health care system. The early interventions offered by the Health Check help individuals towards retaining a good quality of life.

Making a difference for communities:

Thirty percentage of Harrow's population is of Asian origin; this group has a high prevalence of diabetes. Harrow's incidence of diabetes across all age groups is significantly worse than the average for England. The Health Check programme will offer early interventions and education to help reduce incidence of diabetes.

Making a difference to local businesses:

The Health Check programme is exploring how to work with local businesses to encourage early interventions/detection of illness where possible, which would help reduce sickness absence.

Contact Details and Background Papers

Contact:
Dr Andrew Howe, Director of Public Health
Audrey Salmon, Head of Public Health Commissioning

Background Papers:
NHS Health Check Scrutiny Final Report, January 2014

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NHS Health Checks Scrutiny Review

Final Report

January 2014

Index

1. Executive Summary

1.1 Aim of Review

1.1.1 The aim of this Scrutiny Review was to review the current delivery model and performance of the NHS Health Checks Programme in Barnet and Harrow, consider the views of key stakeholder and residents on the programme, analyse options and make recommendations to inform the commissioning strategy in both boroughs.

1.2 Background to NHS Health Checks

1.2.1 The NHS Health Checks programme is a national risk assessment and management programme which assesses an individual's risk of heart disease, stroke, kidney disease, dementia and alcohol misuse with the objective of reducing death rates and the burden of disease from these conditions. It is a mandatory service provided by local authority public health teams.

1.2.2 The eligible cohort are aged 40 to 74 – approximately 91,000 people in Barnet and 64,000 people in Harrow. Public Health England expect 20% of the eligible population to be invited each year over a five year rolling programme with an update of approximately 75%. In Barnet this equates to 18,200 per year and 13,650 Health Checks completed. In Harrow this equates to 12,800 per year and 9,600 Health Checks completed.

1.3 Summary of Services / Existing Contracts

1.3.1 Currently in Barnet, 44 of 70 GP practices are signed up to deliver NHS Health Checks. However, 14 out of the 44 have not delivered any checks. At the time of the review, it was not possible to obtain the number of GP practices in Harrow signed up to deliver NHS Health Checks due to data transfer issues. Contracts in Barnet and Harrow have been transferred from primary care trusts and so continue to be delivered on that basis, although the Public Health team are reviewing performance and developing options for the checks to be delivered in the future.

1.4 Activity Levels and Current Performance

1.4.1 In 2012/13, Barnet and Harrow performed below the Department of Health target for performance – offering a Health Check to 20% of the eligible population. However, it should be noted that in 2012/13 Health Checks were still commissioned by primary care trusts and there remains scope to improve performance during the final years to the five year programme.

1.4.2 During the review, undertaking an analysis of performance for both boroughs was problematic as a result of the transfer of data from the primary care trusts to local authorities.

1.5 Strategic Direction and Policy Drivers

1.5.1 Public Health England and the Department for Health have placed an emphasis on the NHS Health Checks programme as a platform to provide a significant opportunity to tackle avoidable deaths, disability and reduce health inequalities in England. Barnet and Harrow are one of five NHS Health Checks Scrutiny Development areas and findings from this review will link into this national programme.

1.5.2 Locally, NHS Health Checks are priorities identified in the Corporate Plans and Health & Well Being Strategies of both Barnet and Harrow councils.

1.6 Best Practice

1.6.1 Barnet and Harrow currently deliver NHS Health Checks primarily though GP practices. The review considered a number of different areas nationally that were high performing or provided Health Checks through alternative or targeted delivery models. Consideration of best practice examples assisted the Scrutiny Review to make recommendations regarding delivery models to inform the future commissioning strategy.

1.7 Evidence

1.7.1 In addition to considering best practice and current performance, the review considered the views of key stakeholders including residents who were eligible for checks, specific sections of the community, commissioners, providers and other interested groups.

1.8 Return on Investment

1.8.1 The review has been conducted using the Centre for Public Scrutiny Return on Investment Model which seeks to quantify what the return on investment would be for a specific course of action being taken as a result of the scrutiny review.

1.8.2 The economic argument behind the NHS Health Checks screening programme is that the early detection of certain conditions or risk factors enables early intervention which can take the form of medical treatment or lifestyle changes. Treating conditions in their early stages or managing risk factors will:

i. be much more cost effective than treating chronic conditions; and

ii. result in an overall improvement in the health and wellbeing of the general population.

1.9 Recommendations

1.9.1 Findings and recommendations are intended to inform the future commissioning and management of the NHS Health Check Programme in Barnet and Harrow.

	Theme	Recommendation and Rationale
1	**Health Checks Promotion**	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).
2	**Providers / Flexible Delivery**	Health Checks should be commissioned to be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups)) to make Health Checks more accessible.
3	**Treatment Package**	All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more attractive. Commissioners should investigate feasibility of tailoring treatment options to specific communities.
4	**Referral Pathways**	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment
5	**Restructure Financial Incentives**	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.
6	**Resources**	Public Health England and local authorities must consider the cost of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. Health Checks are currently not a mandatory requirement for GPs (delivered by Local Enhanced Service contracts) meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical space) to deliver. Nationally, Public Health

		England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended.
7	**Targeting**	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- • men (who statistically have a lower up-take than women); • faith communities (who statistically have a high prevalence of certain diseases); and • deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)
8	**Screening Programme Anxiety**	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.
9	**Barriers to Take-Up**	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.
10	**Learning Disabilities**	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with learning difficulties into the Health Checks programme before age 40 due to their overrepresentation in the health system

2. Scope

2.1 Public Health England (PHE), the Local Government Association (LGA) and NHS England launched the NHS Health Check Implementation Review and Action Plan in July 2013. The purpose of the review was to consider progress made with the NHS Health Checks programme since its launch in 2009 and consider how to use the programme as a platform to provide a significant opportunity to tackle avoidable deaths, disability and reduce health inequalities in England.

2.2 PHE, the LGA and NHS England recognise that the involvement of local commissioners and providers is key to successful implementation of the NHS Health Checks programme.

2.3 In Spring 2013, the Secretary of State for Health launched a call to action to reduce avoidable premature mortality and the NHS Health Check programme has been identified as one of the 10 main actions which will assist in reducing premature mortality and focus on improving prevention and early diagnosis.

2.4 The *Global Burden of Disease* report (2013) highlighted the need to reverse the growing trend in the number of people dying prematurely from non-communicable diseases. Public Health England estimate that each year NHS Health Checks can prevent 1,600 heart attacks and save 650 lives, prevent 4,000 people from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier. As such, there is a national recognition that PHE should support local authorities to commission successful NHS Health Check programmes.

2.5 Further information on the economic case and health benefits of the NHS Health Checks Programme are set out in detail in the DoH and PHE Health Checks Implementation Review and Action Plan.[1]

2.6 Within the Health Checks Implementation Review and Action Plan, Issue 3 (Providing the NHS Health Check) states that 'PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning of the programme.'

2.7 In accordance with the national programme, the Centre for Public Scrutiny (CfPS) launched a programme in April 2013 to support local authority scrutiny functions to review their local approach to NHS Health Checks using its Return on Investment model. A joint bid for support was made by the London Boroughs of Barnet and Harrow (who have a shared Public Health function) and the bid was successful. Members from both Barnet and Harrow supported the review of NHS Health Checks as it provided an opportunity to

[1] DoH and PHE Health Checks Implementation Review and Action Plan https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224805/NHS_Health_Check_implementation_review_and_action_plan.pdf

consider the local approaches to the check following the recent transfer of public health functions from the NHS to local authorities (from 1 April 2013).

2.6 The scope of the Barnet and Harrow joint review was agreed as follows:

- Identify ways in which NHS Health Checks can be promoted within each borough under the leadership of the Joint Director of Public Health;
- Explore the extent to which NHS services promote the NHS Health Checks to eligible residents;
- Consider the capacity of GPs, local pharmacies or other suitable settings to undertake Health Checks;
- Determine the extent to which secondary services are available to those who have been identified as having undetected health conditions or identified as being at risk of developing conditions without lifestyle changes;
- Identify examples of best practice from across England to inform the approach of Barnet and Harrow to commissioning and monitoring the NHS Health Checks Programme;
- Explore whether GPs could be organised on a cluster basis to deliver NHS Health Checks in each borough; and
- Utilise the CfPS Return on Investment model to undertake an analysis of the cost/benefit of developing the NHS Health Checks Programme. The outcomes from this will influence the recommendations

2.7 The review took place between September and December 2013. This report includes the context, background, policy context, best practice examples, performance, methodology and key findings and recommendations.

3. Background

3.1 NHS Health Checks

3.1.1 The NHS Health Check is a health screening programme which aims to help prevent heart disease, kidney disease, stroke, diabetes and certain types of dementia. Everyone between the age of 40 and 74 who has not already been diagnosed with one of these conditions or have certain risk factors will be invited (once every five years) to have a check to assess their risk. Once the risk assessment is complete, those receiving the check should be given feedback on their results and advice on achieving and maintaining a healthy lifestyle. If necessary individuals should then be directed to either council-commissioned public health services such as weight management services, or be referred to their GP for clinical follow up to the NHS Health Check including additional testing, diagnosis, or referral to secondary care.

3.1.2 There is a statutory duty for councils to commission the risk assessment element of the NHS Health Check programme and this will be monitored by the Public Health Outcomes Framework[2]. Health Checks were previously commissioned by the primary care trusts which were abolished with the implementation of the Health and Social Care Act 2012.

3.1.3 The Public Health Outcomes Framework focuses on two high-level outcomes:

1. Increased life expectancy
2. Reduced differences in life expectancy and healthy life expectancy between communities

3.1.4 The Health Checks programme requires collaborative planning and management across both health and social care. Health and Well Being Boards are therefore vitally important in the local oversight of this mandated public health programme[3].

3.1.5 As part of the Health Checks programme, local authorities will invite eligible residents for a health check every five years on a rolling cycle. Health Checks can be delivered by GPs, local pharmacies or other suitable settings. In Harrow and Barnet Health Checks are currently delivered exclusively at GP surgeries.

3.1.6 The tests comprise a blood pressure test, cholesterol test and Body Mass Index Measurement. Following the test, patients will be placed into one of three categories of risk: low, medium or high. Patients are offered personalised advice based on the outcome of their check.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
[3] www.healthcheck.nhs.uk

3.2 Funding

3.2.1 The public health funding allocation is ring-fenced, to be spent only on public health functions. In Barnet, the current contractual liabilities do not cover all of the mandatory functions for councils in respect of public health. Historically in Barnet there has been no permanent budget line to cover NHS Health Checks. In Barnet and Harrow the 2013/14 commissioning plans allocate approximately £0.5m towards the provision of NHS Health Checks in each borough.

3.2.2 LB Barnet and LB Harrow Health Check Budget:

Barnet

- November 2012 – 31 March 2013 – £150,000
- 1 April 2013 – 31 March 2014 – £500,000

Harrow

- 1 April 2012 – 31 March 2013 – £456,000
- 1 April 2013 – 31 March 2014 – £456,000

3.2.3 Figures are based on national calculator costs of implementation and an enhanced programme offering. In Barnet, this represents a large increase in investment compared to 2012/13. The final cost will depend on negotiations with providers on the unit cost of the health check element of the budget.

3.3 Commissioning

3.3.1 Year 1 – the joint Public Health team have been limited during year 1 (2013/14) due to the transfer of existing contracts from primary care trusts to the local authorities. Whilst this has constrained the service delivery options, this has enabled the Public Health team to carry out a data base-lining exercise which will be used to support de-commissioning or re-commissioning decisions.

3.3.2 Year 2 – the joint Public Health team have an opportunity from year 2 (2014/15) onwards to develop a commissioning strategy for NHS Health Checks in Barnet and Harrow based on findings of this scrutiny review.

3.3.3 At present, Barnet and Harrow have different payment mechanisms. Barnet GPs are paid for both offers and completions, whilst Harrow GPs are paid on completion only. At present, Barnet GPs may be incentivised to make offers only as they will receive payment for this element of the check. The Scrutiny Review are recommending that the financial incentives be restructured to maximise the impact of the programme locally (see recommendation 5).

3.4 Link to Corporate Priorities and Health & Well Being Strategies

3.4.1 In Barnet, the Corporate Plan 2013 – 2016 has a corporate priority "To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health" and priority outcome of working with the local NHS to encourage people to keep well by increasing the availability of health and lifestyle checks for those aged between 40 and 74, and promoting better use of green space and leisure facilities to increase physical activity.

3.4.2 The Barnet Health and Well-Being Strategy (Keeping Well, Keeping Independent) 2012 – 2015 identifies that, in relation to lifestyle factors, that statutory agencies need to "Increase both the offer and take-up of health and lifestyle checks in primary care to all people aged between 40 and 74 years to help reduce risk factors associated with long term conditions." A target of delivering a "Year on year increase based on the 2009/10 baseline of people aged between 40 and 74 who have received an NHS Health Check. In five years our coverage should be 80%."

3.4.3 In Harrow, the Corporate Plan 2013 – 2015 has a corporate priority of "Supporting residents most in need, in particular, by helping them find work and reducing poverty" and a outcome of delivering "…an efficient public health service with the resources available, to positively influence residents' health and wellbeing."

3.4.4 The Harrow Health and Well-Being Action Plan 2013 – 2016 has under the objective of "Early identification of cardiovascular disease and diabetes though the health checks programme" the following targets:

1. Promote uptake of health checks including use of social marketing (June 2013)
2. Evaluate outcomes and referrals onto other services as a result of health checks programme (March 2014)
3. Implement a programme of activity to provide health checks to Harrow residents who are not yet registered with GPs (September 2013)

3.5 Marmot Review

3.5.1 Sir Michael Marmot was commissioned by the Government to review what would best reduce health inequalities in England[4]. The review proposed that health interventions should be offered to everyone (and not just the most deprived) but that it must be 'proportionate to the level of disadvantage' – the principle of 'proportionate universalism.'

[4] http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

4. Context

National Context

4.1 Purpose and Rationale

4.1.1 The purpose of the NHS Health Check has been outlined in sections 1 and 3 above.

4.1.2 The rationale for the NHS Health Check programme is to identify those who are at a higher risk of developing certain illnesses at a stage where the illness may still be prevented and/or future complications of an illness could still be avoided. The NHS Health Checks screening programme is expected to have beneficial effects on people's health, as well as saving money in the health and social care economy in the future as costly interventions will be prevented. Public Health England recommends that 20% of the eligible population should be invited each year and that councils should aim for 75% of those offers to be taken-up.

4.1.3 Local authorities took over responsibility for the NHS Health Check from 1 April 2013. Nationally, the check is most likely to be offered in GP surgeries and local pharmacies. However, a number of areas have offered and/or delivered health checks via different providers and in other suitable and accessible locations in the community. Examples of alternative delivery models are explored in section 5 of this report.

4.2 Responsibilities

4.2.1 Local authorities are responsible for commissioning the Health Checks programme and have a statutory obligation to provide the patients GP with the outcomes and data of an individual's Health Check. Local authorities are responsible for commissioning the checks and for monitoring the amount of invitations and take-up. Clinical Commissioning Groups (CCGs) are responsible for ensuring that there is appropriate clinical follow-up such as additional testing, referral to secondary care and on-going treatment. The connection between these two aspects of the programme is essential in making it successful.

4.3 Budget, Potential Savings and Take-Up

4.3.1 The Department of Health (DoH) has estimated that the NHS Health Check programme is likely to be cost effective in the long-term. The programme is underpinned by cost-benefit modelling which considers cost in relation to quality adjusted life years (QALY – the number of years added by the intervention) which shows that it is extremely cost effective. The programme is also likely to generate significant social care savings as a result of a

reduction of people accessing care through ill health. The cost calculations include two components:

- The cost of the check itself plus any follow-on tests or monitoring; and
- The cost impact of the interventions that are provided as a result of the NHS Health Checks.

Modelling conducted by the Department for Health when the programme began in 2008/09 proposed that a basic NHS Health Check would cost in the region of £23.70. This does not include the cost of lifestyle and other follow-up services provided by local authorities and health to reduce the health risks identified by the check.

4.3.2 The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health and well-being benefits[5].

4.3.3 A substantial number of people will need to receive the NHS Health Check and subsequent support for the programme is necessary in order to achieve its estimated savings. Current data shows that this expected to be a significant challenge. A study analysing data from the NHS Health Checks programme in 2011/12, published in the Journal of Public Health[6] in August 2013, concluded that coverage was too low currently to make the programme pay for itself. An article in PulseToday found that national figures for 2012/13 showed that overall uptake (the proportion of people invited who received the check) was 49%, having fallen back from 51% the previous year[7]. This data indicates that significant steps will need to be taken at a local and national level to improve take-up. Local authorities have a legal duty to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check as part of their statutory duties. The higher the take up rates for the programme, the greater the reach and impact of the programme and the more likely the programme is to tackle health inequalities.

4.3.4 The NHS Health Checks website offers a 'Ready Reckoner' tool which can be used to identify the potential service implications, health benefits and cost savings of NHS Health Checks per local authority. The tool uses 2010 population data from Office for National Statistics to base its estimates on and presumes that 20% of the eligible population is invited to a health check each year, and that the 75% of these people will take up the offer of a health

[5] DoH and PHE Health Checks Implementation Review and Action Plan https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224805/NHS_Health_Check_implementation_review_and_action_plan.pdf

[6] http://jpubhealth.oxfordjournals.org/content/early/2013/07/22/pubmed.fdt069.abstract?sid=0cf9fa5e-eb55-4946-8f48-0d696fbd20e2

[7] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/less-than-half-of-patients-attend-nhs-health-checks-show-official-figures/20003835.article#.Ul_vX9K-qK4

check[8]. The extent to which Barnet and Harrow are achieving this performance will be explored in detail in section 6

Indicative Costs and Savings for Barnet

4.3.5 Applying the Ready Reckoner Tool[9] for Barnet, it is estimated that the total cost of providing NHS Health Check for one year based on national estimates would be £673,408 (against an approved budget of £500,000 for 2013/14). The workforce requirements to undertake NHS Health Check in this year would be 4,243 hours of time to invite people to Health Check and arrange appointments, 5,039 hours of contact time for the Health Check tests and 3,536 hours of contact time for feedback on the results.

4.3.6 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 673,408	£ 107,397	£ (566,011)
5th year after checks	£ 1,373,409	£ 705,042	£ (668,367)
10th year after checks	£ 1,679,593	£ 1,475,877	£ (203,716)
15th year after checks	£ 2,056,281	£ 2,014,528	£ (41,753)
20th year after checks	£ 2,367,931	£ 2,419,419	£ 51,487

Indicative Costs and Savings for Harrow

4.3.7 Applying the Ready Reckoner Tool estimation for Harrow is that the total cost of providing NHS Health Check for one year based on national estimates would be £458,726 (against an approved budget of £456,000). The workforce requirements to undertake NHS Health Checks in this year would be 2,874 hours of time to invite people to Health Check and arrange appointments, 3,424 hours of contact time for the Health Check tests and 2,395 hours of contact time for feedback on the results.

4.3.8 The estimated total cumulative costs and savings that will arise due to the interventions put in place following an NHS Health Check are:

	Costs	Savings	Net savings
1st year after checks	£ 458,726	£ 73,347	£ (385,380)
5th year after checks	£ 936,550	£ 481,750	£ (454,800)
10th year after checks	£ 1,141,916	£ 1,005,487	£ (136,429)
15th year after checks	£ 1,396,064	£ 1,369,713	£ (26,352)
20th year after checks	£ 1,604,439	£ 1,642,587	£ 38,147

[8] http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/ready_reckoner_tools

[9] Total costs and savings will vary across Local Authorities, depending on demographic factors. More detailed information about the health benefits can be found when using the Ready Reckoner Excel tool.

4.3.9 The Ready Reckoner tool provides some indicative data on the potential costs and savings in each borough. Whilst the tool highlights that the NHS Health Checks programme will take 20 years to provide net savings, these savings will be across the whole health economy and will result in improved health and well-being for people more generally.

4.4 Approaches to Implementation

4.4.1 The NHS Health Check Programme is most beneficial when it reaches people that would not otherwise be identified as being at risk, for example people who are unlikely to visit their GP's regularly now. Reaching these groups is difficult, but will be an essential aspect of successfully implementing the NHS Health Checks programme in Barnet and Harrow.

4.4.2 The health and financial benefits associated with the programme will not accrue until people's risk of diseases has been reduced. This reduction can be achieved by medication, but also by changes in lifestyle such as increasing exercise, following a healthy diet and giving-up smoking. These changes in lifestyle are often difficult to achieve for people, even when they are provided with support services. There is, therefore, a balance to be achieved between medical interventions and encouraging people to take ownership of their own health and well-being. In line with other public health programmes (such as the Smoke Free initiative), the NHS Health Checks programme commissioned in Barnet and Harrow should seek to achieve a balance between intervention and individual responsibility for healthy lifestyle choices. Measuring the impact of the programme should have a medium to long-term perspective to ensure that lifestyle changes are maintained by individuals on an on-going basis.

4.4.3 The NHS Health Check Implementation Review and Action Plan describes commissioners' and providers' experiences with implementing the NHS Health Checks Programme. The review identifies that several commissioners considered that successful implementation had been driven by a 'mixed model' for delivery. GP's were central to the successful delivery of the Programme as they hold patients records and are a trusted source of care for most patients. However, GP services can be supplemented by a variety of other providers as follows:

- Community Teams – commissioned to make contact with those who are typically resistant to presenting in a doctor's surgery by visiting community centres, shopping centres, leisure centres, church groups, markets, football clubs and work spaces.

- Health Buses – used in supermarket car parks and other public spaces, both for walk-ups and by people notified by their GP's that the service would be available at that time and place.

- Private Providers – commissioned to provide Health Checks in collaboration with GP's who are sometimes able to provide a room in their surgeries.

- Pharmacies – used with mixed success, as they sometimes lack private space to perform the checks and can have difficulties in targeting the right audiences.

4.4.4 Public Health England is currently working on providing a repository of local case studies to support local implementation which will be published on the NHS Health Checks website.

4.5 Experts Views on NHS Health Checks Screening Programme

4.5.1 Whilst it is anticipated that there will be significant potential health and financial benefits as a result of the NHS Health Checks programme, there is a limited amount of peer reviewed evidence to support the success of mass screening programmes. Whilst PHE and DoH advocate the programme and are promoting and investing in it, a number of health care professionals have expressed concern regarding the effectiveness of the programme.

4.5.2 Dr Richard Vautrey, Deputy Chairman of the British Medical Association's GPs Committee, has said that "Last year they were talking about taking money from disease prevention, now they want to do this. We are very suspicious. Previous screening programmes have been introduced after much consideration and analysis of evidence. It doesn't seem like this is." [10]

4.5.3 Professor Nick Wareham, Director of the Medical Research Council Epidemiology Unit, has said that the current programme may not represent the best use of resources. Instead, the advisor to Public Health England urged public health leaders to target high-risk individuals as the evidence suggested this was likely be cost-effective.[11]

4.5.4 A study by NHS Heart of Birmingham, published in BMJ Open in March 2013[12] suggested that the NHS Health Checks Scheme programme overlooks a third of patients at high risk of having or developing diabetes, as patients with high HbA1c levels, but with normal or low body weight were not identified for further tests.[13]

4.5.6 The Chair of the Royal College of General Practitioners, Professor Clare Gerada, has backed a call from Danish researchers for the NHS Health Checks programme to be scrapped.[14] [15] The Danish research evaluated screening programmes run in a number of countries and concluded that general health checks failed to benefit patients and could instead cause them unnecessary worry and treatment.

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[10] http://news.bbc.co.uk/1/hi/health/7174763.stm
[11] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/reconsider-age-based-approach-to-health-checks-urges-public-health-england-adviser/20004268.article#.UlPsGtK-qK4
[12] http://bmjopen.bmj.com/content/3/3/e002219.long
[13] http://www.pulsetoday.co.uk/clinical/therapy-areas/diabetes/health-checks-scheme-fails-to-identify-a-third-of-patients-at-risk-of-diabetes/20002241.article#.UmAebdK-qK4
[14] http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/gerada-scrap-health-checks-programme/20004025.article#.UlPjQNK-qK4
[15] http://www.bbc.co.uk/news/health-23765083

4.5.7 Barbara Young, Chief Exec of Diabetes UK, expresses support for the programme by stating that "…while the £300 million it costs to run might sound like a lot of money, diabetes and other chronic conditions are expensive to treat. This means that once you factor in the savings in healthcare costs, the NHS Health Check is actually expected to save the NHS about £132 million per year." [16]

4.5.8 Despite the concerns outlined above, the NHS Health Checks programme has been identified by the Secretary of State as an important vehicle for improving prevention and early diagnosis and the initiative is supported nationally by, PHE, DoH and the LGA. In addition, Health Checks are corporate priorities for both Barnet and Harrow councils and there is a significant opportunity for both authorities to utilise the data from this review to inform their commissioning strategies to deliver best value for money.

[16] http://www.bbc.co.uk/news/health-23765083

5. Performance

5.1 Targets

5.1.1 There are no nationally prescribed targets in relation to NHS Health Checks. However, PHE suggest that health and well-being boards should aim to offer checks to 20% of their eligible population every year and for 75% of those offered checks to take them up. NHS Health Checks is a rolling five-year programme meaning that 100% of the eligible population should have been offered a check at the end of the period. In relation to quarterly performance, a local authority that has offered the Check to 5% of the population in quarter 1 and sustain that over the following three quarters will have offered a check to 20% of the eligible population at the end of the year.

5.1.2 High performing areas are those that both **offer** to a high proportion of the eligible population cohort and then achieve a high **transfer rate** (i.e. converting the Health Checks offered into Health Checks received).

5.2 Performance Data

Outcomes – 2012/13

5.2.1 NHS England data[17] identifies that Health Checks in Barnet and Harrow in 2012/13 scored slightly lower than the London average, but close to the national average. Data for all London boroughs has been included in Table 1 for comparison purposes:

[17] http://www.england.nhs.uk/statistics/statistical-work-areas/integrated-performance-measures-monitoring/nhs-health-checks-data/

Table 1 – Number of eligible people that have been offered and received NHS

Name	Number of people eligible for a NHS Health Check	Number of people who were offered a NHS Health	Number of people that received a NHS	Percentage of eligible people that were offered a

Health Checks (April 2012 – March 2013) (England and London)

		Check	Health Check	NHS Health Check
England	**15,609,981**	**2,572,471**	**1,262,618**	**16.5%**
London	**2,082,748**	**429,027**	**194,035**	**20.6%**
Havering PCT	69,304	6,529	4,771	9.4%
Kingston PCT	53,678	7,661	5,668	14.3%
Bromley PCT	100,037	23,117	9,042	23.1%
Greenwich Teaching PCT	63,098	15,137	6,511	24.0%
Barnet PCT	**114,883**	**18,357**	**4,758**	**16.0%**
Hillingdon PCT	72,886	6,742	3,783	9.3%
Enfield PCT	79,400	12,746	5,503	16.1%
Barking and Dagenham PCT	41,328	12,821	4,152	31.0%
City and Hackney Teaching PCT	55,561	11,483	6,775	20.7%
Tower Hamlets PCT	48,778	9,365	7,242	19.2%
Newham PCT	40,000	9,500	5,369	23.8%
Haringey Teaching PCT	55,476	12,523	6,461	22.6%
Hammersmith and Fulham PCT	40,050	6,568	4,276	16.4%
Ealing PCT	70,881	15,789	9,931	22.3%
Hounslow PCT	55,297	6,997	4,501	12.7%
Brent Teaching PCT	76,444	15,410	9,505	20.2%
Harrow PCT	**76,840**	**12,477**	**5,827**	**16.2%**
Camden PCT	49,685	14,761	4,378	29.7%
Islington PCT	42,650	10,167	7,142	23.8%
Croydon PCT	100,197	20,047	2,512	20.0%
Kensington and Chelsea PCT	50,475	7,651	590	15.2%
Westminster PCT	61,800	13,307	7,119	21.5%
Lambeth PCT	92,171	26,592	6,382	28.9%
Southwark PCT	79,294	21,145	6,524	26.7%
Lewisham PCT	72,646	19,279	6,622	26.5%
Wandsworth PCT	57,000	15,984	12,766	28.0%
Richmond and Twickenham PCT	49,856	14,305	4,857	28.7%
Sutton and Merton PCT	113,300	24,184	13,364	21.3%
Redbridge PCT	72,000	12,015	6,286	16.7%
Waltham Forest PCT	62,932	8,301	3,388	13.2%
Bexley Care Trust	64,801	18,067	8,030	27.9%

5.2.2 However, the statistics in Table 1 above should be treated with caution. There is a significant variation in the national statistics relating to the number of people eligible for an NHS Health Check (114,883 in 2012/13) and locally derived statistics provided by Public Health (91,139 in 2013/14 (see 5.2.3 below)).

Outcomes – Quarter 1 2013/14

5.2.3 The table below summarises the performance information regarding the NHS Health Check Programme for Quarter 1 of 2013/14:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that were offered a NHS Health Check of those offered
Barnet	91,139	4,911 (5.4%)	1,520 (1.7%)	31%
Harrow	63,879	1,093 (1.7%)	582 (0.9%)	53.2%
London	1,967,213	94,245 (4.8%)	41,517 (2.1%)	44.1%
England	15,323,148	598,867 (3.9%)	286,717 (1.9%)	47.9%

5.3 Comparative Performance

5.3.1 London Boroughs where a higher percentage of people are offered the health check tend to have a lower percentage of health checks received. At the same time, boroughs where a high percentage of the people received a health check tend to have offered health checks to a relatively low percentage of the population. Boroughs with the highest overall performance are those that both offer checks to a high percentage of their population as well as have a high percentage of checks delivered.

5.3.2 The London Borough of Wandsworth has been identified as an example of a local authority where both the percentage of offers made and the percentage of checks received have been on target.

5.3.3 In quarter 1 2013/14, the top five London Boroughs for **offering** the highest percentage of their eligible population a NHS Health Checks are:

Q1 2013-14	Total eligible population 2013-14	Number of people who were offered a NHS Health Check	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of those offered
Camden	50,399	4,925 (9.8%)	924 (1.8%)	18.8%
Greenwich	60,012	5,605 (9.3%)	1,981 (3.3%)	35.3%
Lambeth	65,181	5,870 (9%)	2,013 (3.1%)	34.3%
Islington	44,687	3,429 (7.7%)	1,840 (4.1%)	53.7%
Westminster	52,589	3,971 (7.6%)	1,479 (2.8%)	37.2%

5.3.4 In quarter 1 2013/14, the top five London Boroughs for highest percentage of people that have **received** the health check after being offered it are:

Q1 2013-14	Total eligible population 2013-2014	Number of people who were offered a NHS Health	Number of people that received a NHS Health Check	Percentage of eligible people that received an NHS Health Check of

		Check		those offered
Hounslow	61,153	664 (1.1%)	664 (1.1%)	100.0%
City of London	2,266	72 (3.2%)	72 (3.2%)	100.0%
Havering	70,211	1,507 (2.1%)	1417 (2%)	94.0%
Newham	59,455	1,720 (2.9%)	1376 (2.3%)	80.0%
Wandsworth	64,128	3,203 (5%)	2419 (3.8%)	75.5%

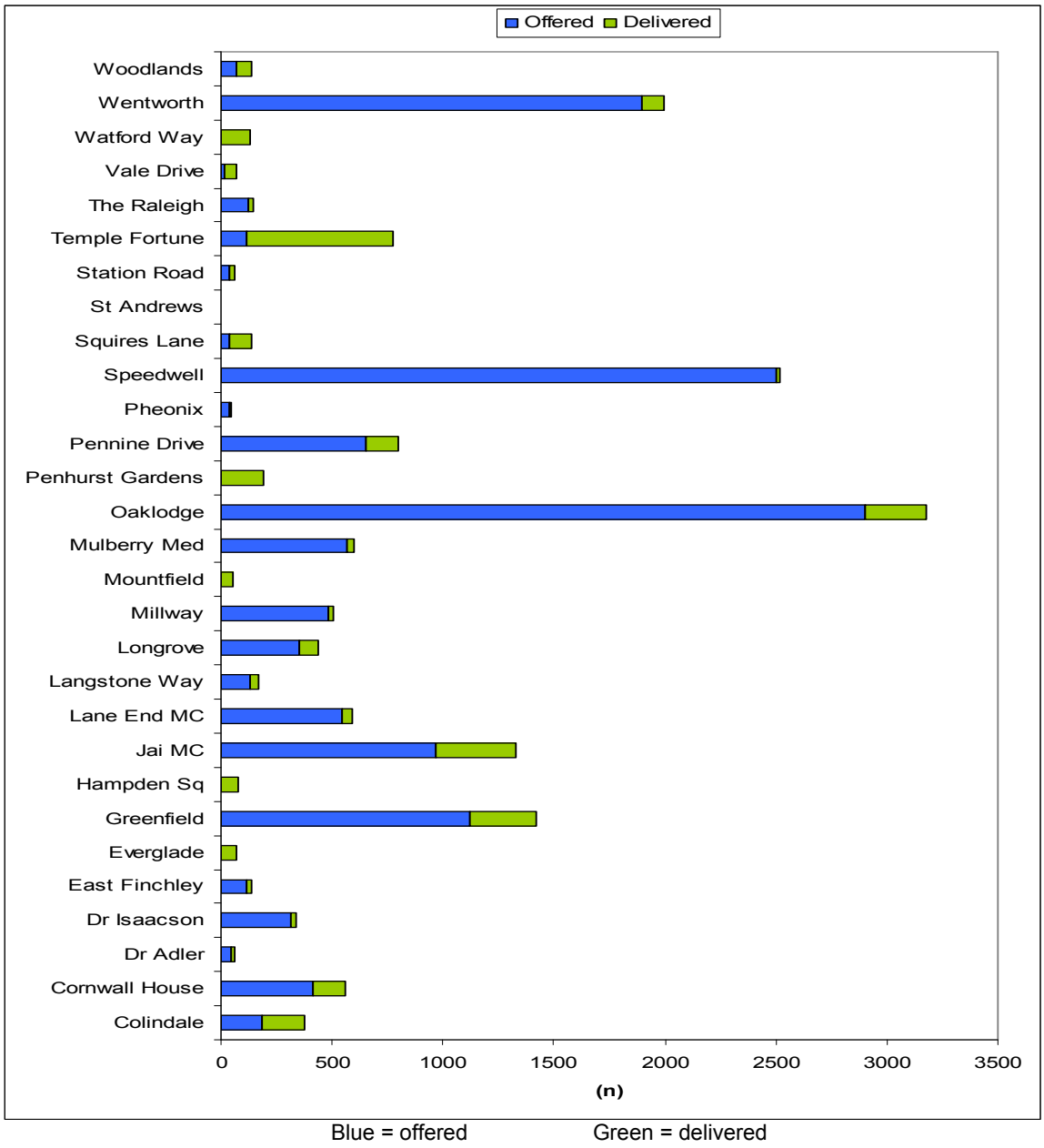
5.3.5 For the NHS Health Checks programme to be successful, commissioners should be seeking to meeting or exceeding both targets to ensure that the reach of the programme is as wide as possible.

5.4 Local GP Practice Performance

5.4.1 As part of the review, the Public Health team provided a breakdown of the performance of individual GP practices in Barnet and Harrow during 2012/13.

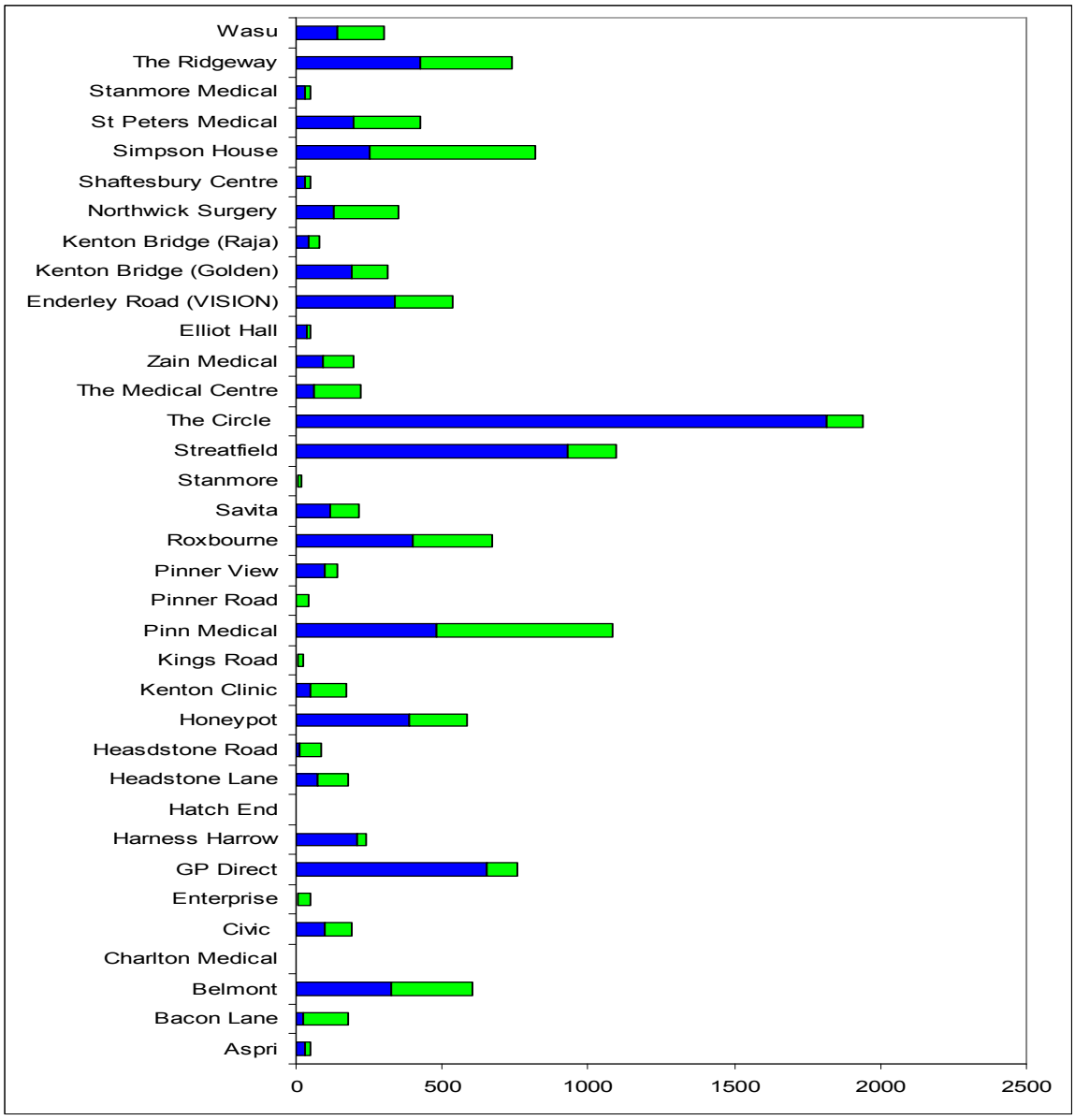
5.4.2 Table 1 provides relevant statistics for Barnet. Due to issues with the data transferred to the council, performance information for Barnet was only available for the period November 2012 to March 2013. Barnet achieved a 19% conversion rate from 'offered' status to 'delivered'. The table shows that larger GP surgeries tended to be the worst performing.

Table 1 – GP surgeries in Barnet performance, Nov 2012 – March 2013



5.4.3 Table 2 shows the statistics for Harrow. Members were advised that Harrow has a 38% conversion rate. As with Barnet, the larger surgeries had the lowest performing rates.

Table 2 – GP surgeries in Harrow performance between April 2012 – March 2013



6. Best Practice

6.1 In conducting the review, Members have explored best practice examples to identify the principal differences between the approach taken in Barnet and Harrow and the approach in high performing areas.

6.2 Haringey

6.2.1 In 2012/13 the activity for NHS Health Check offers in Haringey was 12,523 and 6,461 checks were delivered. This translates to a 52% uptake rate, which is better than the uptake rate for 2011/12 (which stood at 35%).

6.2.2 Haringey's programme is targeted at areas of highest deprivation and CVD mortality: East, Central and part of West Haringey (Stroud Green and Hornsey wards). Over 70% of the Health Checks Programme is delivered by GPs in Haringey. The programme is being supported by behavioural support programmes (e.g. Health Trainers) and these arrangements have been strengthened during 2013/14. Community programmes that ran in 2012/13 included a focus on mental health users and a focus on men.

6.2.3 Haringey identified that to improve uptake they had to:

- increase coverage across eligible practices;
- reduce variation in activity;
- target high risk groups;
- target men;
- improve data quality; and
- improve onward referral mechanisms.

6.2.4 Haringey consider that one of the main reasons for success is that alcohol misuse screening delivered as part of NHS Health Checks programme has encouraged people to take part. They are also planning to deliver some Health Checks at community events in order to expand the reach of the programme.

6.3 Teesside

6.3.1 Teesside have used several techniques to achieve success with delivering NHS Health Checks. Firstly they have invested in a rolling training budget that can be allocated to external providers to help extend the availability of the service. Secondly they have used social marketing techniques to help inform the development of a communications and marketing strategy. By doing this they have made the service more visible. They have delivered Health Checks

under the local identity of ‘Healthy Heart Check’ which has further helped to make the service more accessible and embedded in local culture.

6.3.2 Teesside have targeted certain groups and have created a prioritisation list of certain groups to help tailor the service and to increase take up. They have also invested directly in dedicated primary care informatics (or information management systems), a nurse facilitation team and project management as a way of extending the reach of the service. It is worth noting that death rates from heart disease have reduced at a faster rate in Teesside than England as a whole since the implementation of the Health Checks programme. Health Checks in Teesside have also been provided at particular work places in an effort to make the take-up more substantial.

6.4 County Durham

6.4.1 In comparison to national performance, County Durham has been very successful in delivering NHS Health Checks. They promoted Health Checks via a ‘Check4Life’, campaign which is based on the ‘Change4Life’ national health and well-being programme. They have utilised the same branding as the Change4Life campaign which has improved recognition locally.

6.4.2 County Durham have carried out the service with ‘opportunistic screening’ (when someone requests that their doctor or health professional undertakes a check, or a check or test is offered by a doctor or health professional) with a focus on predicting and preventing vascular disease risk. Health Checks have been conducted on a ‘one-stop-shop’ approach in order to make the delivery of these checks more accessible, attractive and patient focussed. They have also promoted the service at road shows, such as ‘Health@Work’, where Health Checks have been offered in certain work places.

6.4.3 In addition to this, County Durham has focussed on the notion of ‘Mini Health MOTs’, which are targeted at certain groups. This has helped to broaden the scope of the service and has helped to promote the service across the area. In analysing the success of the campaign, County Durham found that 91.3% were very satisfied with the Mini Health MOT, whilst 99.1% would recommend it to others. Intertwined with the NHS Health Checks, it was also reported that 82.2% were very satisfied with the NHS Health Check and that 99.6% would recommend an NHS Health Check to other people. During 2011/12 73.5% of those offered a Health Check in County Durham took the offer. To date 2013/14, 8,509 people have been offered a Health Check and 3,936 people have received one from an eligible population cohort of 164,760.

6.5 Richmond upon Thames

6.5.1 The London Borough of Richmond upon Thames has been successful in delivering NHS Health Checks. They have adopted an approach that relies on a strong advertising premise supported by a strong database to record the

number of checks offered and delivered. As a result, Richmond is one of the leading boroughs in London in delivering NHS Health Checks.

6.5.2 Richmond works with more than 40 different partners including GPs, pharmacies, outreach and external providers to deliver Health Checks. Lifestyle programmes such as weight management, diabetes prevention and a health trainer service have been specifically commissioned for patients to be referred to.

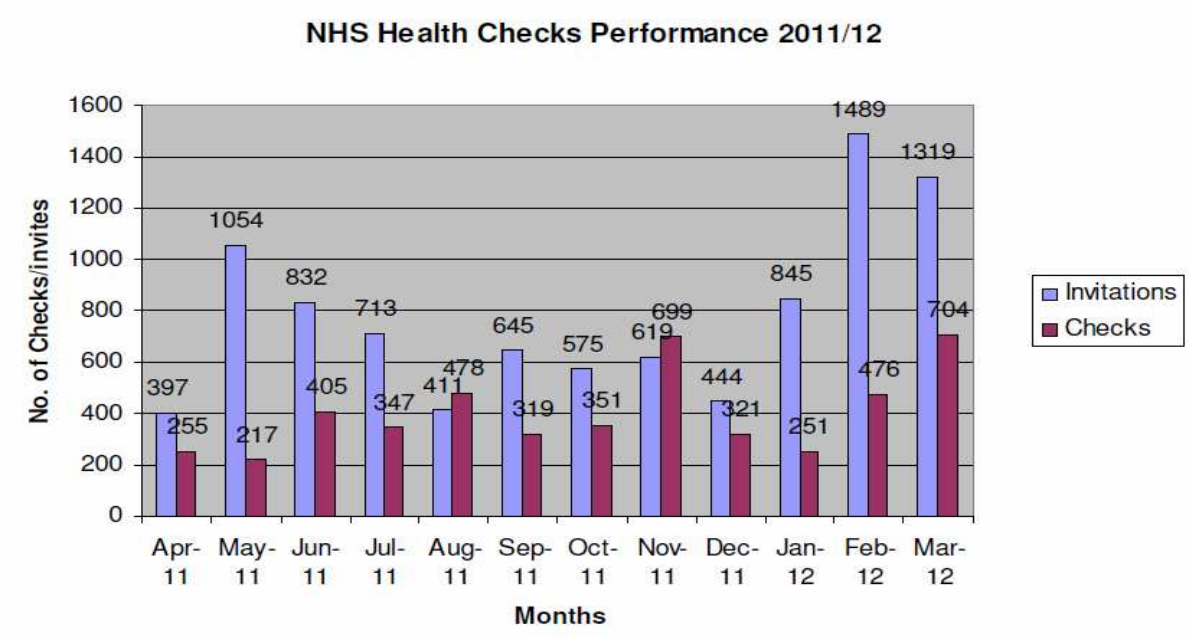
6.5.3 Richmond launched a pilot programme in 2009 in line with the national launch of the NHS Health Checks programme which focussed on delivering Health Checks in the most deprived wards in a pharmacy setting. This helped to make the service accessible both in terms of timing and capacity. The Public Health team also carried out a Health Needs Assessment and selected the top three deprived wards and the six pharmacies which were best suited to run the pilot. Health Checks have been delivered by the *Live Well Richmond* service which also provides an exercise referral scheme in addition to other lifestyle services. This has helped the Health Checks delivery model to become locally known. GPs have been commissioned to deliver targeted invitations based on factors such as age, gender, body mass index, ethnicity, blood pressure/cholesterol levels, physical activity and smoking status.

6.5.4 More than 50% of the eligible population have been invited and more than 20% have received a check. More than 200 people have been newly diagnosed with various cardiovascular diseases such as hypertension, diabetes, chronic kidney disease and coronary heart diseases as a result of a health check. In 2011/12, 5,700 health checks were completed in general practice, pharmacy and at community outreach events which exceeded DoH targets.

6.5.6 Richmond have delivered a marketing programme which comprises newspaper adverts, a dedicated webpage[18], letters, posters, leaflets and press releases to attract people for a health check. They also emphasised selling through personal sales (pharmacists, GPs and outreach), incentivising GPs, through focus groups and direct invitations.

6.5.7 Richmond use iCap, an IT system, to keep track of their Health Check performance. This system has enabled them to target checks where necessary and assists in provide statistical analysis as follows:

[18] https://www.live-well.org.uk/richmond/



6.6 Enfield – Innovision Health and Well-being Limited

6.6.1 In November 2012, Enfield Council awarded a contract for Community Health Checks to Innovision Health and Well-being Limited. This was done in an effort to allow targeting of health checks to communities that do not traditionally access primary care or who do not respond to invitations from primary care, which should improve the number of health checks being completed.

6.6.2 Innovision deliver health checks in both primary care and community settings. They perform health checks on behalf of GPs in communities and make a focussed effort to understand communities. By doing so, they are able to deliver health checks regularly. In Enfield, for instance, Innovision have noted that there is a large Turkish and Kurdish population and they have targeted Health Checks in those communities' first languages.

6.6.3 In Enfield, Innovision has established relationships with organisations such as ASDA, Tesco, various health centres and sports centres to enable delivery in these settings to encourage those who would not otherwise go to their GP. In an ASDA in Enfield, there is a weekly footfall of around 55,000; Innovision deliver checks in this ASDA on a daily basis. They determined that this was a good site after surveying the local area both in terms of weekly footfall and the regular attendance from specific communities. Innovision are also aiming to deliver Health Checks in all Boots stores in every London Borough that they are operating within (currently Brent, Haringey, Enfield and Islington). In addition, they deliver checks at community events, particularly in deprived areas in order to achieve their commitment of working with deprived communities.

6.6.4 Innovision have an on-line system where Health Check data is inputted to. This enables Public Health to be provided with non-identifiable data and has

subsequently helped with reporting. This system has been used with Enfield and previously Haringey. The Innovision Health Check comprises the follows:

- BMI, weight and blood pressure checks are undertaken immediately
- The check takes 15-20 minutes
- Results of the above are given straight away
- If the patient falls out of the appropriate health range then they are signposted to their GP. GPs receive this information which they can then use as data in the future; the onus is on the GP to contact any patient who has risk factors or is in need of treatment.
- Innovision stress that primary care settings are the only places where advice can be given; those performing checks for Innovision are directly instructed not to give advice
- Checks are tailored to communities and are performed in appropriate settings (such as mosques, restaurants and wherever is possible)

7. Evidence

7.1 The Scrutiny Review recognised the importance of considering quantitative and qualitative evidence from a variety of sources. On that basis, the Group undertook three separate and distinct elements of engagement with key stakeholders as detailed below.

7.2 Community Engagement

7.2.1 The review commissioned a Community Engagement work stream to identify barriers to take-up across both boroughs. The full findings from the Community Engagement element of this project are attached at **Appendix A**. However, a summary of the key recommendations emerging are detailed below:-

i. Marketing and promotion – people are not familiar with the Health Checks brand and individuals would like to know more about the objectives of the programme. GPs need to be convinced of the value of the programme at a national level.

ii. Value for money – the economic case for Health Checks needs to be developed in greater detail by Public Health England. In addition, residents were concerned about the overlap with other screening programmes and wanted to see a more joined up approach to supporting wellness. The value of investing in Health Checks over other initiatives was questioned. Residents felt that support to make lifestyle changes should be free and have a long-term focus.

iii. Innovative approaches to delivery – residents considered that commissioners should take a more flexible approach to delivery (e.g. community teams, a health bus, clinics at flexible times)

iv. Effective IT – effective and joined up IT systems (across health and social care) would be essential for identifying the target population, collating data and information about individual risks, ensuring that follow-ups timely and evaluating the Health Checks programme. Residents wanted IT systems to provide a joined up and holistic view of their health.

v. Competency of providers – residents considered that the Health Check should be provided by a registered professional to ensure that advice and support started seamlessly in the context of the discussions relating to risk factors.

7.3 Questionnaire

7.3.1 To support the review, Scrutiny Officers conducted a snap survey of Barnet and Harrow residents to gauge awareness and take-up of NHS Health Checks. The survey was promoted locally by both councils communications teams and via local networks, such as Healthwatch. The survey received 47 responses and the detailed findings are detailed in the sections below. Responses to the questions relating to the residents' experience of the checks should be treated with caution due to the relatively small sample size. They do, however, provide some insight into the views of people who have experienced an NHS Health Check:

7.3.2 85.7% of respondents were from Barnet and 14.3% of respondents were from Harrow.

7.3.3 In response to the question 'Have you ever been offered a Health Check from your GP?' 80.9% stated 'no' and 19.1% stated 'yes'. This highlights that the vast majority of respondents had not been offered a check, despite the Health Check programme having been in place in both boroughs since 2009.

7.3.4 Respondents were asked to provide the name of their registered GP surgery. 17 different practices in Barnet and three different practices in Harrow were identified as not offering Health Checks to participants.

7.3.5 Of those respondents that had been offered a Health Check, 100% had taken up the offer. Respondents were asked to identify the reasons why they had accepted the offer and their responses are summarised below:

- General health and well-being check
- Aware of the Health Check programme and wanted to see how it worked in practice.
- Multiple health issues
- Precautionary measure
- Family history of high cholesterol, cardiovascular disease or diabetes

7.3.6 When questioned how important they considered regular health checks to be, 71.4% considered that it was very important and 28.6% considered that it was neither important or unimportant.

7.3.7 When questioned how beneficial they considered the Health Check that they had received to be, 66.7% considered it was beneficial or very beneficial and 33.3% considered it was not very beneficial or not beneficial at all. Respondents were asked to give reasons for their answer. One respondent stated that they were dissatisfied as they were still waiting for their blood test results following a check completed over a week ago.

7.3.8 Respondents were asked whether they considered that there were any areas of the Health Checks process that could be improved. 57.1% answered yes and 42.9% answered no. Respondents were asked to identify specific areas for improvements and the responses are summarised below:

- Consider the option of Integrated Medicine (homeopathy or other natural medicine choices)
- Scans for aneurysm
- Prompt results and more screening around breast cancer, etc.
- Health Checks should consider an individual's mental health too

7.3.9 When respondents were questioned whether they would recommend the Health Check to other people, 85.7% said yes and 14.3% said no. Respondents were asked to give reasons for their answers which are summarised below:

- Early detection of diseases
- Encourage people to make healthy lifestyle choices for them and their families
- Concern for the health and wellbeing of others
- Useful especially for men as they tend not to visit their GPs
- Early detection of health issues and an opportunity to discuss these with health professionals

7.4 Stakeholder Workshop

7.4.1 It was agreed at the outset of the project that engagement with stakeholders was key to understanding the overarching issues. In November 2013, Barnet and Harrow held a Stakeholder Workshop, facilitated by the CfPS Expert Advisor and supported by Scrutiny Officers from Barnet and Harrow. The aim of the workshop was to provide Members of the Scrutiny Working Group and key external stakeholders with the opportunity to:

- Understand the external factors that currently influence the commissioning and delivery of the Health Check in the Barnet and Harrow
- Identify the barriers to delivering the Health Check
- Identify opportunities for effective delivery in the future
- Discuss the improvements in services that could be achieved by change
- Identify and prioritise issues to be considered in the commissioning of the Health Check

7.4.2 The workshop was a deliberative forum which enabled participants to consider relevant information, discuss the issues and options and develop their thinking together before coming to a consensus view. The facilitators used the CfPS Stakeholder Wheel (as shown in Table 3 below) to structure the discussion throughout the workshop and to address the return on investment question of:

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

7.4.3 Based on the discussions that took place, the following recommendations emerged from the Stakeholder Workshop:

	Theme	Recommendation and Rationale
1	**Health Checks Promotion**	It is recommended that Public Health England develop a national communications strategy to promote awareness and advantages of Health Checks, supported by local campaigns. The campaign should seek to incentivise people to undertake a Health Check (e.g. by promoting positive stories relating to proactive management of risk factors or early diagnosis as the result of a check).
2	**Providers / Flexible Delivery**	Health Checks should be commissioned to be delivered through alternative providers (e.g. pharmacies, private healthcare providers etc.) and at alternative times (e.g. evenings / weekends), and in different locations (e.g. mobile unit at football grounds, shopping centres, work places, community events etc. or via outreach (e.g. at home or targeting vulnerable groups)) to make Health Checks more accessible.
3	**Treatment Package**	All elements of the Health Check should be delivered in a single session to streamline the process and make the experience more attractive. Commissioners should investigate feasibility of tailoring treatment options to specific communities.
4	**Referral Pathways**	The patient pathway should clearly define the referral mechanisms for those identified as:- • Having risk factors; and • Requiring treatment
5	**Restructure Financial Incentives**	Barnet and Harrow have different payment structures. It is recommended that contracts are aligned (preferably in accordance with a standard contact agreed via the West London Alliance) and that Health Check providers are paid on completion only.
6	**Resources**	Public Health England and local authorities must consider the cost of the whole patient pathway and not only the risk assessment or lifestyle referral elements of the Health Check. Health Checks are currently not a mandatory requirement for GPs (delivered by Local Enhanced Service contracts) meaning that they may not be incentivised to deliver and nor have the capacity (human resources and physical

		space) to deliver. Nationally, Public Health England and NHS England should consider the cost of the whole pathway and on that basis a whole system review is recommended.

7	**Targeting**	It is recommended that the Health Checks commissioning strategy should deliver a 'whole population' approach (offering checks to eligible population cohort), complemented by targeting of specific groups or communities particularly:- • men (who statistically have a lower up-take than women); • faith communities (who statistically have a high prevalence of certain diseases); and • deprived communities (where there is a statistical correlation between deprivation and a low uptake of Health Checks)
8	**Screening Programme Anxiety**	It is recommended that Public Health England, clinicians and local commissioners give consideration to managing potential public anxiety in participating in a screening programme.
9	**Barriers to Take-Up**	Commissioners are recommended to research the reasons for the public not to participate in the Health Checks programme to identify what the barriers to take-up are. On the basis of the research findings, targeted engagement with under-represented groups is recommended.
10	**Learning Disabilities**	It is recommended that Public Health England, clinicians and local commissioners give consideration to incorporating adults with learning difficulties into the Health Checks programme before age 40 due to their overrepresentation in the health system

7.4.4 Although listed as separate elements above, the Public Health team are recommended to undertake a **whole system review** (offer, appointment, results, advice etc.) to inform the future Health Checks commissioning strategy.

7.4.5 The recommendations at 7.4.3 have been endorsed and adopted by the Scrutiny Review Group.

7.4.5 In addition to the recommendations outlined above, the following have been identified as priority areas for Public Health to consider when commissioning Health Checks in the future:

1. Improve take-up across the board

2. Engage with local Healthwatch to promote

3. Communication – liaise with community leaders

4. Communication – develop and embed a local message articulating the offer

5. Providers and incentives need to be realigned

6. Target Health Checks locally to specific communities

7. Understanding barriers to take up in areas offered

8. Examine the whole system from offer to follow on

9. Communicate the advantages

10. Extent that service providers can encourage take-up (e.g. weekend availability)

11. Follow up with personalised letters and phone calls; state the advantages

12. Improve access based on research

13. Initiate follow-up programmes

8. Return on Investment

8.1 When applying to become a CfPS NHS Health Check Scrutiny Development Area, Barnet and Harrow committed to using the CfPS Return on Investment Model (RoI) to conduct the review.

8.2 The RoI model seeks to quantify what the return on investment would be for a specific course of action being taken as a consequence of the scrutiny review. As identified in the Stakeholder Workshop section, the RoI question that this review has been seeking to address is

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

8.3 The economic argument behind the NHS Health Checks screening programme is that the early detection of certain conditions or risk factors enables early intervention which can take the form of medical treatment or lifestyle changes. Treating conditions in their early stages or managing risk factors will:

i. be much more cost effective than treating chronic conditions; and

ii. result in an overall improvement in the health and wellbeing of the general population.

8.4 Public Health England has estimated that over the next four years around £57 million will be saved through Health Checks and that over a 15 year period £176 million will be saved. After 20 years the NHS Health Checks programme is expected to have paid for itself and deliver improvements to the general health and well-being of the population.

8.5 The RoI modelling below will seek to analyse cost of this review against the potential financial benefits of implementing the recommendations arising. It is acknowledged that the RoI modelling could be open to challenge as it is based in a number of assumptions. Notwithstanding this, the model does provide a platform to demonstrate the potential financial and social benefits that implementing scrutiny recommendations could deliver if implemented; the model should therefore be considered on that basis.

Return on Investment – Cost of Scrutiny Review vs. Potential Savings

Table 2 (Input Costs)

Input	Scrutiny Officer Review	Public Health	External Engagement	**Total**
	2 x Scrutiny Officers for 1 day per week for 24 weeks (mid-July to mid-December) = 168 hours Plus 5 days of graduate trainee support = 37 hours Total hours 373 hours x £25 per hour = **£9,325**	Public Health Officers (including involvement in planning meetings, providing data and attending) Total hours = 10 days or 74 hours x £25 per hour = **£1,850**	22 days = **£13,370**	**£24,545**

Table 3 (NHS Health Checks – Newly Diagnosed Conditions)

	Number of people eligible for a Health Check	Number of Health Checks offered to the eligible population	Number of Health Checks performed	Transfer rate (take up of those offered)	Number of cases of Hypertension diagnosed as a result of a Health Check	Number of cases of Diabetes diagnosed as a result of a Health Check	Number of cases of High Cholesterol diagnosed as a result of a Health Check
Harrow (2012/13)	62,892	12,680 (20.16%)	3,729 (5.93%)	34%	65	32	815
Barnet (2012/13)	69,904	16,820 (24.06%)	3,263 (4.67%)	19%	146	65	750
Richmond (2011/12)	Approximately 19,000	9343 (c. 50+%)	4823 (c. 25%)	51%	152	19	Data not available

8.6 In considering the financial implications of not treating risk factors or diagnosed conditions early, a review of information available on the cost of treating chronic conditions was undertaken. The result of the modelling below should be treated with caution as the financial assumptions have not been fully tested. The findings do however provide an estimation of the potential

savings across health and social care following the roll out of a successful NHS Health Checks programme in Barnet and Harrow.

8.7 The British Heart Foundation reports that 103,000 heart attacks occur every year, costing around £2 billion per year to treat or £19,417 per case. Diagnosing conditions such as Hypertension can be argued to prevent heart attacks from occurring later on therefore meaning that for every case diagnosed £19,417 is potentially saved. On this premise, the following amount of money will be saved as a result of Health Checks:

8.7.1 LB Harrow

In 2012-13, 3,729 had health checks (5.93% of the eligible population). This led to 65 cases of hypertension being diagnosed, saving a potential of £1,262,105.

If the uptake was improved to 11.86%, then it is possible that around 130 cases of hypertension could be diagnosed, saving a potential £2,524,210.

8.7.2 LB Barnet

In 2012-13, 3,263 had health checks (4.67% of the eligible population). This led to 146 cases of hypertension being diagnosed, saving a potential of £2,384,882.

If the uptake was improved to 9.34%, then it is possible that around 292 cases of hypertension could be diagnosed, saving a potential £5,669,764.

8.8 If the recommendations arising from this review (as set out in the following section) are agreed and implemented, it is anticipated that there will be a significant increase in the uptake of NHS Health Checks in both boroughs, particularly if roll-out of the checks is prioritised based on demographic risk factors.

8.9 **Social Return on Investment**

8.9.1 The Scrutiny Review Group wish to emphasise that the implementation of the recommendations made will deliver social as well and financial benefits. Encouraging people to adopt healthy lifestyles and managing pre-existing conditions before they become chronic will deliver health and well-being benefits in addition to the potential financial savings.

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9. Summary Findings and Recommendations

Summary Findings

9.1 Following consideration of all the evidence received during the review, Members questioned whether GPs were the correct vehicle for delivering NHS Health Checks. Whilst performance in Barnet and Harrow had been around the national average, there was a lack of awareness of the checks in both boroughs. Best practice examples demonstrated that alternative delivery models could improve up-take by targeting to specific groups and making the checks more accessible.

9.2 Data supplied by the Public Health team had indicated that the cohort of patients presenting for health checks were not reflective of the demographics in each borough (e.g. there were a disproportionate number of women from more affluent areas). As such, presentations were not linking with communities identified as being at risk. There should therefore be a focus on hard to reach groups including specific ethnic communities with high risk factors, mental health patients, the homeless and men.

9.3 The Group recognised that there should be a balance between interventions and individuals managing their own risk factors. A communications campaign should therefore seek to strike a balance between promoting the checks locally and encouraging people to adopt healthier lifestyles.

9.4 Members recognised the importance of ensuring that there was a clearly defined pathway for those identified as being most at risk. Medical interventions should be supported later in the pathway by risk management and reduction elements and a joined up approach would be required to achieve this.

9.5 Contracts transferred from primary care trusts were inconsistent and in Barnet did not incentivise completion of the check. The Group considered that when the commissioning strategy was defined, there should be consistent payment by results contracts across both boroughs. Members were supportive of the work being undertaken within the West London Alliance to regularise NHS Health Checks contracts on a sub-regional level.

9.5 The Group recognised that greater work was required to understand the whole costs of the NHS Health Check process. Local authorities are responsible for commissioning the check and CCGs are responsible for ensuring an appropriate clinical follow-up. Further evaluation of the post-check care costs is required to provide an accurate cost benefit analysis.

9.6 The Group were supportive of the recommendation in the PHE / LGA paper titled *NHS Health Check: Frequently asked questions* (September 2013) that "Health and Wellbeing Boards (HWBs) should ensure that NHS Health Check is reflected in the commissioning plans stemming from locally agreed Joint

Health and Wellbeing Strategies (JHWSs) and that it is resourced to operate effectively. Coordinating the programme with wider strategic decision making by the whole council will avoid duplication, and can help maximise the programme's impact and value for money. It is important to ensure that the risk management and reduction elements of the NHS Health Check (lifestyle interventions such as stop smoking services, weight management courses and drug and alcohol advice) are properly linked to other council services like education, housing and family support."

Recommendations

9.7 The Group agreed that the recommendations arising from the Stakeholder Workshop, as detailed in **section 7.4.3** should form the basis of the recommendations to each council's Cabinet and Health & Well-being Board as recommendations were supported by all of the quantitative and qualitative research undertaken as part of this review.

10. Project Activity

A summary of the meetings in carrying out this scrutiny review is provided below:

Date	Activity
25 July 2013	Approved the Project Briefing to enable the review work to commence in advance of formal committee approvals Approved the composition of the Task and Finish Group (3 Harrow Members and 3 Barnet Members Approved the consultation / engagement approach Agreed an outline plan for the utilisation of the CfPS Expert Advisor support available
18 September 2013	Received a summary of activity to date Reviewed and agree the Project Plan Received the results of a data mapping exercise undertaken by the public health team (including trend analysis) Agreed the approach to engaging with key stakeholders and residents / patients
2 October 2013	Received a presentation from the CfPS Expert Adviser on the ROI approach Agreed the format of the Stakeholder Workshop
1 November 2013	Stakeholder Workshop attended by Public Health England (London), GPs, Practice Managers, Healthwatch, Diabetes UK, Cabinet Members, Barnet / Harrow Public Health and Barnet CCG
4 December 2013	Results of an online questionnaire on Health Checks (promoted via Engage Space, Twitter / Facebook, Older Adults Partnership Boards and Members) Results of community engagement exercise which includes focus groups (generic, men and deprived areas) and 1:1 interviews Outline report, co-authored by LB Barnet and Harrow Scrutiny Officers

11. Acknowledgements

The Scrutiny Review Group wishes to thank those attendees and witnesses outlined below in addition the officers in the joint public health team who supported them during their work.

Councillors	
Councillor Vina Mithani	Harrow Council
Councillor Alison Cornelius	Barnet Council
Councillor Graham Old	Barnet Council
Councillor Helena Hart	Barnet Council
Councillor Barry Rawlings	Barnet Council
Councillor Ben Wealthy	Harrow Council
Councillor Simon Williams	Harrow Council
Council Officers	
Dr Andrew Howe	Joint Director of Public Health, Barnet and Harrow
Mary Cleary	Interim Senior Public Health Commissioning Manager
Rosanna Cowan	Public Health Commissioner
Dr Matteo Bernardotto	GP VTS Trainee at North West London NHS Trust, Public Health
Andrew Charlwood	Overview and Scrutiny Manager, Barnet Council
Felicity Page	Senior Professional Scrutiny, Harrow Council
Edward Gilbert	Graduate Trainee / Assurance Officer, Barnet Council
Hannah Gordon	Graduate Trainee, Barnet Council
Witnesses	
Brenda Cook	Expert Advisor, Centre for Public Scrutiny
Stephanie Fade	Managing Director, What Matters Cubed
Paul Plant	Deputy Regional Director – London, Public Health England
Christine Gale	Pinner Road Surgery, Harrow
Smita Mody	Pinner View Medical Centre, Harrow
Dr Sue Sumners	Barnet Clinical Commissioning Group Chairman
Councillor Helena Hart	Cabinet Member for Public Health, Barnet Council
Cllr Simon Williams	Health and Wellbeing Portfolio Holder, Harrow Council
Dr Pandya	Savita Medical Centre, Harrow
Roz Rosenblatt	London Regional Manager, Diabetes UK
Rhona Denness	Healthwatch Harrow

Selina Rodrigues	Healthwatch Barnet

REPORT FOR: HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	20 October 2014
Subject:	Work Programme and JHOSC Update Report
Responsible Officer:	Alex Dewsnap, Divisional Director, Strategic Commissioning
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member Councillor Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides an update on the work of the Joint Health Overview and Scrutiny Committee

Recommendations: That the Sub Committee consider issues for inclusion in its work programme in the light of the work programme recommended to the JHOSC

Section 2 – Report

A Joint Health Overview and Scrutiny Committee (JHOSC) was established in November 2007 to respond to Healthcare for London's consultation on strategic proposals to change the way healthcare is delivered in London, based on the proposals set out by Prof. Lord Ara Darzi. That JHOSC comprised all 33 London Councils and Essex and Surrey County Councils.

The Boroughs affected by the proposals in Shaping a Healthier Future issued by NHS North West London formed a new JHOSC which met 5 times in 2012 and made recommendations on how the Shaping a Healthier Future proposals could be developed and implemented including the risks that needed to be explored. This JHOSC also recommended that the Committee continue to meet to provide strategic scrutiny of the development and implementation of Shaping a Healthier Future.

The next meeting of the JHOSC on 16th October will consider a proposed work plan for the coming 12 months as follows:

- Priority areas for JHOSC:
    - Transport - London Ambulance Performance
        - Patient Access to Services – Request report from TAG
    - Maternity Services Reconfiguration
        - Pediatrics to be packaged into maternity
    - Primary Care Commissioning across North West London – taking on board members interest in out of hospital strategy areas
    - Mental Health Transformation Programme

- Meetings to be taken forward on a quarterly basis with each meeting addressing one of the priority areas plus an item for general update/questions for Daniel Elkeles, Chief Officer for CWHHE Collaboration comprising of the Clinical Commissioning Groups for Central London, West London, Hammersmith & Fulham, Hounslow, and Ealing. He is also is the SRO/Programme Director for the 'Shaping a healthier future' programme .

With the JHOSC taking a lead on these strategic, cross Council issues, there is scope for the Health and Social care Sub-Committee to consider adding all or some of the following items to their work plan:

- the delivery of the local aspects of SaHF;
- the CCG's Commissioning Intentions for 2015/16
- the impact of the Better Care Fund;
- the action plan to address the CQC findings for Northwick Park, including the current dip in performance of the A&E at Northwick Park in relation to the four hour wait target;

- implementation of the Health and Well-being Strategy; and
- the development of the new JSNA.

Financial Implications

None

Performance Issues

Consideration of the implementation of the Health and Well being Strategy will assist in identifying performance issues, if any, in the Council's contribution to well-being

Environmental Impact

None

Risk Management Implications

None

Equalities Implications

The items suggested for possible inclusion in the work programme address the health and social issues arising for all residents of Harrow.

Council Priorities

The topics suggested for possible inclusion in the Sub-Committee's work programme are relevant to the Council's priorities:

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

Ward Councillors notified:	**NO** ** Delete as appropriate.*

Section 4 - Contact Details and Background Papers

Contact: Mike Howes mike.howes@harrow.gov.uk Ext 5637

Background Papers: None