MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 4TH OCTOBER, 2012

AT 2.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

TO: MEMBERS OF HEALTH & WELL-BEING BOARD (Quorum 3)

Chairman: Councillor Helena Hart – Cabinet Member for Public Health

Board Members

Cllr Andrew Harper	Cabinet Member for Education, Children & Families
Cllr Sachin Rajput	Cabinet Member for Adults
Dr Charlotte Benjamin	Clinical Commissioning Group Lead, South Locality Cluster
Dr Andrew Burnett	Joint Director for Public Health, LBB/ NHS NCL
Gillian Jordan	Barnet LINK representative
Ceri Jacob	Interim Chief Officer, NHS Barnet
Kate Kennally	Interim Director of Children's Service/Director of Adult Social Care and Health, LBB
David Riddle	NHS Barnet, Vice-Chair
Dr Clare Stephens	Clinical Commissioning Group Lead, North Locality Cluster
Dr Sue Sumners	Clinical Commissioning Group Chair and Lead, West Locality Cluster
Mathew Kendall	Acting Associate Director, Joint Commissioning, LBB/NCL

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

Aysen Giritli – Head of Governance

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Media Relations contact: Sue Cocker 020 8359 7039

CORPORATE GOVERNANCE DIRECTORATE

ORDER OF BUSINESS

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AGENDA ITEM 5

Meeting	Health and Well Being Board
Date	4 October 2012
Subject	**Health and Wellbeing Strategy**
Report of	Director of Adult Social Care and Health
Summary of item and decision being sought	The final version of the Health and Wellbeing Strategy, Keeping Well, Keeping Independent, sets out the Board's approach to improving the health and wellbeing of Barnet citizens and patients. It takes account of feedback from a recent consultation on a draft version of this strategy. The Board is asked to agree the updated Health and Wellbeing Strategy following the consultation that ran from 1 June to 20 July 2012

Officer Contributors	Dr Andrew Burnett, Joint Director for Public Health
Reason for Report	To gain approval of the proposed Health and Wellbeing Strategy.
Partnership flexibility being exercised	The Health and Social Care Act 2012 places on the Health and Wellbeing Board a duty to prepare a Health and Well-Being Strategy.
Wards Affected	All
Appendices	Appendix A – Barnet Health and Wellbeing Strategy, Final Draft (September 2012) Appendix B – Consultation on Barnet's Health and Wellbeing Strategy – Overview Report (August 2012) Appendix C – Full Consultation Report

Contact for further information Andrew Burnett: Andrew.burnett@nclondon.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board approve the final Health and Wellbeing Strategy, 'Keeping Well and Keeping Independent'.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well Being Board, 26 May 2011 – approved the health and wellbeing integrated commissioning strategy scoping document

2.2 Health and Well Being Board, 20 July 2011 – approved the refreshed Barnet Joint Strategic Needs Assessment (JSNA) and identified the priority areas for consideration in the Barnet Health and Wellbeing Strategy.

2.3 Health and Well Being Board, 17 November 2011 – approved the structure of a health and wellbeing strategy and the underpinning delivery vehicles.

2.4 Health and Well Being Board, 19 January 2012 – considered first draft of Health and Well-Being Strategy and requested final draft be presented to the Health and Wellbeing Board (HWBB) on 22 March 2012 prior to public consultation

2.5 Health and Well Being Board, 22 March 2012- approved draft strategy for consultation and endorsed consultation and engagement plan.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Health and Wellbeing Strategy is the principal strategy which will implement the Sustainable Community Strategy priority of 'healthy and independent living'. Under the Health and Social Care Act, the proposed commissioning plans of Clinical Commissioning Groups must be signed off by the Health and Well-Being Board to ensure they conform to the overall Health and Wellbeing Strategy.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Barnet Heath and Wellbeing Strategy has been developed to set out a clear programme of work to address the headline recommendation areas for Barnet identified in the refreshed Joint Strategic Needs Assessment. These were identified as being to:

- continue, and preferably increase, smoking cessation activity, especially in pregnancy
- improve the uptake of breast screening in Barnet to increase early identification and reduce mortality
- tackle the obesity epidemic by promoting the benefits of physical activity and healthy diets and lifestyles
- reduce the rate of hospitalisation among older people following presentation at A&E
- develop more effective campaigns to ensure individuals with mental health problems and those with learning disabilities receive appropriate health checks, and
- support residents to take greater responsibility for their own and their families health.

4.2 An equalities and impact assessment of the Health and Wellbeing strategy will be undertaken to inform the agreement of the strategy by the Health and Wellbeing Board and subsequent monitoring of the impacts on the local community arising from implementation.

5. RISK MANAGEMENT

5.1 There is a risk that the document will not be adopted fully and in a meaningful fashion across the Council, NHS, wider community partners and with families and communities. This risk is mitigated through undertaking an extensive consultation process that includes engagement across the Council; Barnet Clinical Commissioning Group (CCG); Barnet GPs; NHS commissioners and providers; the Local Involvement Network (LINK), third sector networks and other stakeholders.

6. LEGAL POWERS AND IMPLICATIONS

6.1 This Strategy will meet the HWBB's duty in the Health and Social Care Act 2012, to prepare a Health and Well-Being Strategy.

6.2 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. Steps that may be taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the *prevention*, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities.

6.3 In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions.

6.4 Regulations setting out the detailed obligations are yet to be issued.

6.5 Proper consideration will need to be given to the duties arising from the Equality Act 2010 as mentioned above.

6.6 The development of this Strategy is consistent with the target duty as expressed above.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The Strategy represents an overall, high level framework which sets out a series of desired outcomes for Health and Social Care. These will be used to prioritise the allocation of the existing resources of the Council and partners, including the budgets of Adult Social care and Health, the Clinical Commissioning Group and the new ring-fenced public health function. The activities to deliver the strategy will be met from these existing budgets.

7.2 Any specific proposals arising from implementation of the Strategy that have particular resource implications will be reported separately, either as specific items or as part of regular performance reporting on progress against the Strategy.

7.3 The development of the Strategy has required significant time commitment from senior officers and directors across the Council and health and implementation of the strategy will require time and commitment from senior officers and clinicians across health and the Council as an integral part of their regular duties..

7.4 The consultation process was funded from the one off allocation from NHS London of £15,000 to support HWBB development.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Two engagement exercises have already taken place in relation to the integrated commissioning strategy. The first was with providers of health and social care. The second was with service users, their carers and the voluntary sector. These events were designed to inform prioritisation of work to commission more integrated health and social care services.

8..2 A public consultation and engagement exercise took place from 1 June to 20 July 2012. The intention was to engage with a wide range of stakeholders and residents.

8.3 The consultation and engagement exercise was led by the HWB Board Chair and jointly delivered by the Council, Barnet CCG, NHS NCL Barnet and Barnet LINk.

8.4 The consultation also encompassed Partnership Boards; Children's Trust Board; Council members and officers; NHS managers; GPs and other health and care providers.

8.5 The Overview report containing the findings from the consultation can be found at Appendix B.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Providers were specifically targeted at one of the early events to inform prioritisation of work as described at paragraph 8.1 above. They were also specifically engaged with through the stakeholder consultation outlined in paragraph 8.2.

10. DETAILS

10.1 A full report of the consultation on the draft Barnet Health and Wellbeing Strategy is attached at Appendix C. The consultation showed substantial agreement with the strategy's ambition and approach.

10.2 Whilst 75% of respondents agreed with the ambition for residents to harness the support of their family and friends and the community, some expressed concern about the feasibility of this, especially with an increasing number of families living far apart. There was a recurrent theme amongst some respondents that the strategic aim of encouraging people to care more for themselves was an attempt at cost-cutting and 'passing the buck'. It may be that we failed to adequately communicate that the intention of this was to enable and empower people to remain more independent for longer and thus not be in need of professional care rather than simply to reduce the level of care available. This will be dealt with as part of the strategy's implementation.

10.3 A small number of respondents' comments have been added to the strategy to (i) emphasise the need: for parents to work with schools in addressing childhood overweight and obesity, (ii) to promote both healthy eating and increased physical

activity as necessary parts of addressing overweight and obesity, (iii) encourage and enable smokers to quit and people who are overweight and obese to lose weight.

10.4 Many of the other comments made concerned aspects of implementation of the strategy rather than strategic direction, for example, encouraging children to learn about cooking and about mental health issues, drugs, alcohol misuse and sexual health. Other examples included supporting parents and providing them with educational opportunities, developing a child poverty strategy, and establishing intergenerational support schemes. Further examples include increasing bowel screening rates, providing health checks, providing subsidised leisure facilities including outdoor gyms, and encouraging food suppliers to provide 'healthy goods' and to restrict the number of fast-food outlets in deprived areas and near schools. There were also suggestions concerning the provision of free eye screening and encouraging people to save for older age. These have therefore not been included in the strategy but will be taken into account in implementation.

11 BACKGROUND PAPERS

11.1 Overview report of the consultation on the Barnet Health and Well-being Strategy

Legal – HP
CFO – JH/MGC

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Keeping Well, Keeping Independent

A Health and Wellbeing Strategy for Barnet

2012-2015

BARNET LINk Local Involvement Network
Community Health and Social Care

BARNET
LONDON BOROUGH

NHS
North Central London

Contents

Barnet's Health and Wellbeing Strategy

1. Summary

Barnet is a great place to live and people in Barnet can expect to live longer and better than in many parts of London and England. This is not by chance but is linked to a range of factors including relative wealth, housing, levels of family support, lifestyle, access to healthcare and the right support when needed.

While the overall picture is positive, the Barnet Joint Strategic Needs Assessment (JSNA) has shown that there are significant differences in health and well-being across Barnet, between places and between different demographic groups. As a growing and changing Borough with less public money available to spend, this Strategy aims to reduce health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent'.

This can only be achieved through a partnership between residents and public services. Good health is not just the responsibility of the NHS nor is good support for our most vulnerable the sole responsibility of Social Services. So at the heart of this Strategy is the ambition that all Barnet's residents will be able to live as healthily and as independently as possible for as long as possible by:

- being free of avoidable ill-health and disability;
- being able to take responsibility for their own and their family's health and wellbeing; and
- each being able to harness the support of their family and friends and the community.

In order to transform the health and wellbeing of Barnet's people, the Barnet Health and Wellbeing Board and the organisations it brings together intend to:

- take account of the wider determinants of health and support actions at an individual, community and service level to seek to address these;
- work in collaboration with partners in the statutory, commercial and third sectors, and with stakeholders in the community, to enhance individual and family self-reliance
- support the delivery of safe, high-quality health and social care services, within available resources directed to providing the greatest benefit for the greatest number of people in need
- ensure that service users' experiences are good across the range of services available.

1.1. What are we going to do differently?

This Strategy has two overarching aims:

- **Keeping Well** – A strong belief in 'prevention is better than cure.' This Strategy aims to give every child in Barnet the best possible start to live a healthy life, to create more opportunities to develop healthy and flourishing neighbourhoods and communities and to support people to adopt healthy lifestyles to prevent avoidable disease and illness.
- **Keeping Independent** – This Strategy aims to ensure that when extra support and treatment is needed, this should be delivered in a way which enables people to get back up on their feet as soon as possible supported by health and social care services working together.

The Barnet Health and Well-Being Board is responsible for the development of this Strategy and for overseeing its implementation. Further information about the Barnet Health and Well-Being Board and its membership can be found at *Appendix One* to this Strategy.

Like all strategies, it will only be a good Strategy if it leads to improvements for residents. This requires the Council, the local NHS, Schools, Police, Third Sector, employers, community groups and individuals to use this Strategy to shape their priorities for their respective organisations and lifestyles at a family and individual level.

What this Strategy means for the different parts of the community we serve is described in the boxes on the next page.

For individuals and families

Enjoying good health, is the result of responsibility being shared between health services and individuals. Taking responsibility to improve your own health for example stopping smoking, regular exercise and eating well is essential for good health.

Parents need to work with schools and within families to address childhood obesity and to increase the levels of physical activity of all Barnet's young people

For our community partners

Barnet's flourishing Third Sector has a key role to play in the delivery of this Strategy, building resilience and well-being in families, communities and neighbourhoods.

Safe neighbourhoods, the opportunity for paid work and safe workplaces are key elements of Health and Well-Being. We will support Local Business, JobCentre Plus and the Police to play their full part in the delivery of the objectives of this Strategy

For the Council

All Council services have a role to play in promoting health and well-being and must support delivery of this Strategy.

Social care services, joined up with the NHS. should support all individuals and their families to stay as independent as possible, Future social care commissioning priorities should be based on this Strategy.

Early years and schools have an essential role to play in promoting health and well-being in families

For the local NHS

The commissioning priorities of the NHS should be based on this Strategy with a strong emphasis on self-management, early identification of disease and support to manage lifestyles.

All parts of the NHS have a responsibility to promote good health and well-being and to collaborate with patients and other partners to address the broader determinants of health

2. Setting our Priorities for the Health and Well Being Strategy

The key features of our approach to enabling people to be able to experience greater health and wellbeing and better health and social care services are based on both the Barnet JSNA and the Marmot Review "Fair Society Healthy Lives".[1]

The Marmot Review (which adds further weight to a number of other national reviews of the evidence connecting health with socioeconomic status and the importance of prevention, such as 'The Black Report'[2], 'The Acheson Report'[3], and 'The Wanless Report')[4], makes it clear that:

- people in higher socioeconomic groups generally experience better health – there is a social gradient' in health, and work should focus on reducing this gradient;
- action on health inequalities requires action across all of the social determinants of health;
- it is necessary to take actions across all social groups, albeit with a scale and intensity that is proportionate to the level of disadvantage;
- action to reduce health inequalities will have economic benefits in reducing losses from illness associated with health inequalities which currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs – this is in addition to improving people's sense of wellbeing; and
- effective local delivery of this requires empowerment of individuals and local communities.

1 http://www.instituteofhealthequity.org/ (Accessed 26 January 2012)

2 A copy of Sir Douglas Black's report, Inequalities in Health: report of a research working group, can be found at http://www.sochealth.co.uk/Black/black.htm (Accessed 26 January 2012)

3 A copy of Professor Sir Donald Acheson's report, Independent inquiry into inequalities in health, can be found at http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm (Accessed 26 January 2012)

4 A copy of Sir Derek Wanless's report, Securing good health for the whole population: final report – February 2004, can be found at http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm (Accessed 26 January 2012)

2.1. Barnet at a Glance

The Barnet Joint Strategic Needs Assessment (JSNA), refreshed in July 2011, provides the data and information from which we can determine our priorities, using the evidence base on health inequalities set out in The Marmot Review referred to above. The key headlines from the Barnet JSNA are:

- The health of people in Barnet is mixed compared to the England average. Deprivation is lower than average, but 18,195 children are classified as living in poverty (living in a family receiving means tested benefits).
- Life expectancy for both men and women is higher than the England average. But life expectancy is 7.1 years lower for men and 5 years lower for women in the most deprived areas of Barnet (Burnt Oak) than in the least deprived areas (Garden Suburb)
- Over the last 10 years, the overall mortality rate has fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average. However breast screening levels continue to be low.
- About 17.5% of Year 6 children are classified as obese. A lower percentage than average of pupils spend at least three hours each week on school sport.

- 92.6% of mothers initiate breast feeding which is above the London average but 10.0% of expectant mothers smoke during pregnancy which is more than the London average.
- An estimated 16.6% of adults smoke with the prevalence of smoking amongst people living in our most deprived wards who do not normally attend their GP surgery being much higher than the Borough average (32% versus 17% with the difference being most marked in relationship to men).

And Barnet is changing

- There will be a significant increase in 5 to 14 year olds (+6,600 individuals). This includes an incredible 23% more 5-9 year olds projected by 2016.
- A general decline in 30 to 34 years olds is anticipated (-1,000 individuals, 3%) and a slower growth in 25 to 29 year olds (600 individuals, 2%).
- The 40 to 59 year old population will experience sizable growth, especially the 40-45 (+2,200) and 50-54 (2,400 individuals) cohorts.
- There will also be sizeable growth among 65 to 69 year olds (+2,100 individuals, 18%) and significant growth in 90 plus cohort (17%).

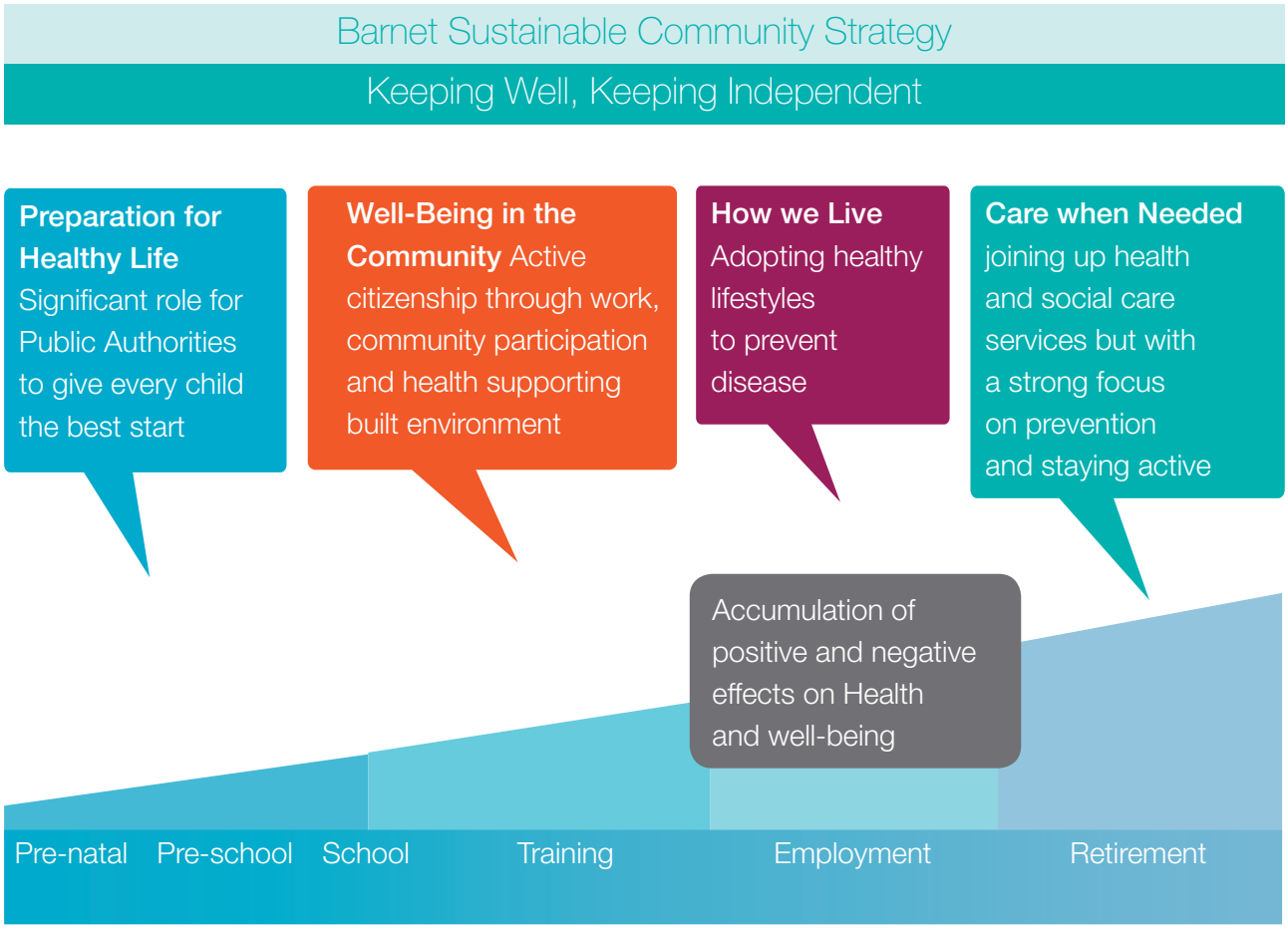
- 17.9% of adults are obese. Adult obesity rates are significantly worse than the England average.
- There were 5,379 hospital stays for alcohol related harm in 2009/10 and there are 353 deaths from smoking each year.

2.2. The four themes of the Barnet Health and Well-Being Strategy

Based on this background of evidence, there are four themes to our approach to improving health and wellbeing and reducing health differences by enabling people to take more responsibility for themselves:

1. **preparation for a healthy life** – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
2. **wellbeing in the community** – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
3. **how we live** – that is enabling and encouraging healthier lifestyles; and
4. **care when needed** – that is providing appropriate care and support to facilitate good outcomes and improve the patient experience.

The main relationships between these four themes and the different components of each person's life course are depicted in the diagram below.



The evidence from the Marmot Review and the concept of the health gradient as show in the diagram above, makes clear that the greatest opportunities to reduce health inequalities, are during childhood where focused preventative activities really can make a lifetime difference. Interestingly the first ONS Survey of the nation's well-being (2011) has found that there appears to be a strong association between self-reported health and adults' subjective well-being scores, so feeling healthy makes you feel happier. Over people's lives, particularly as individuals reach retirement, the opportunity to narrow the gap in terms of health inequalities reduces, especially if people have not led healthy lives during adulthood. Building effective community capacity to provide the right support when needed together with a focus on earlier intervention form the key priorities for this group.

2.3. Our Approach to Implementation

On the basis of policy and experience, we have agreed a number of key principles that will inform the way in which we and our partners tackle together the four themed priority areas.

They are as follows

1. Putting the emphasis on prevention. Energy needs to go towards helping individuals, families, communities and organisations understand what they can do to promote positive health and well being. We need to strengthen the impact of early prevention across the borough and avoid more intense difficulties later, building on the 'Think Family' initiative and the 'Finding the 5000' project to identify those people at greatest risk of cardio-vascular disease.
2. Making health and well being a personal agenda. Our starting belief is that change is most effective when initiated and controlled by individual residents and their families. This means that members of the community need to be actively enabled by information on health and well being and services. Messages and solutions need to be more personal and this can be achieved through more effective use of occasions where members of the public engage with local professionals to assess and plan for improvement; for example personal health assessments, health MOTs and child development visits. The main emphasis needs to be on enabling individuals and families to take action through timely information, advice, education and then reference to supportive services and groups.

3. Making health and well being a local agenda. There is a significant opportunity with the regeneration schemes, neighbourhood plans and focus on our town centres for local neighbourhoods to design and implement local solutions to promote greater health and well-being. But they need to be empowered with good local public health and well being information on issues as well as feedback on progress.
4. Joining up services to ensure timely and effective solutions to individual problems. Joining up might mean the effective transfer of information from one service provider to another but it could mean joint location and joint management of services. The development of the new health and well-being campus at the old Finchley Memorial Hospital site offers an opportunity for much improved integration of services particularly health and social care interfacing with other partners notably schools, housing, leisure and employment. Wherever practical services should be accessible locally within the community or at home.
5. Developing greater local community capacity to achieve change. There is already a track record of working with local voluntary and community groups but it is clear that there is much more that can be done to develop local resources. This has the twin benefits of developing very local and more accessible support on a number of key issues as well as providing the opportunity for local skill development.
6. Strengthening partnerships for change and improvement. We need to build on the existing partnership processes to ensure tighter joint performance expectations from investments and championing of change by leaders across the organisations. Joint commissioning of services will play a key role in ensuring the most effective investments of public money. Through pooling our resources – people and funding – we can work together to develop new and creative solutions that more quickly tackle difficult issues

3. Keeping Well – 'Preparing for a Healthy Life'

Lead Agency: The Barnet Children's Trust

3.1. What does the Barnet Joint Strategic Needs Assessment (JSNA) tell us?

Overall, and in comparison with the national picture, children in Barnet have above average health, educational attainment and life chances. However this experience is not uniform for children across the borough. With significant growth in young people expected in the Borough, it is essential that clear and concerted effort is given to addressing the health inequalities that children in Barnet face and focusing on improving their health and well-being.

Access to effective and culturally sensitive Maternity Services and post-natal support to families facing the greatest risks is essential. Supporting pregnant mothers to stop smoking is especially important, as smoking during pregnancy is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intrauterine growth restriction. While infant mortality rates (IMR) are generally low across Barnet, when analysed at a ward level they show that some wards have relatively poor infant mortality rates even within areas with apparently better rates. Colindale has the highest
IMR in the borough of Barnet – 9.5 (14 deaths).

Immunisation is second only to a clean drinking water supply as a way of improving and maintaining the health of the population with childhood immunisations forming a core part of the Barnet health protection programme. Take-up of the MMR vaccine has increased in recent years following some ten years of significantly low take-up but is still low at the pre-school vaccination levels.

The number of children classified as living in poverty has increased in Barnet to over 18,000 young people. It is important that early years services through Children's Centres and schools, through the disadvantage premium, ensure that children from all of Barnet's diverse communities enjoy and achieve.

Nationally and within Barnet, there has been a rapid increase in the prevalence of those classified as overweight and obese. In children this is considered a primary predictor of obesity in adulthood. The health outcomes of sustained obesity are numerous and include increased incidence of Type 2 Diabetes, CHD, stroke, depression, some cancers and back pain. Obesity throughout adulthood decreases life expectancy by up to nine years.

Within Barnet there are a rising number of children born with disabilities, though the reasons are not clear. The societal and financial impact of chronic conditions in adolescence is increasing as larger numbers of chronically ill children survive beyond the age of ten. Over 85% of children with congenital or chronic conditions now survive into adolescence, and conditions once seen only in young children are now seen beyond. It is imperative that children and adult social care services work effectively together to support young people with complex disabilities to live as independently as possible through effective transition.

3.2. What needs to be done?

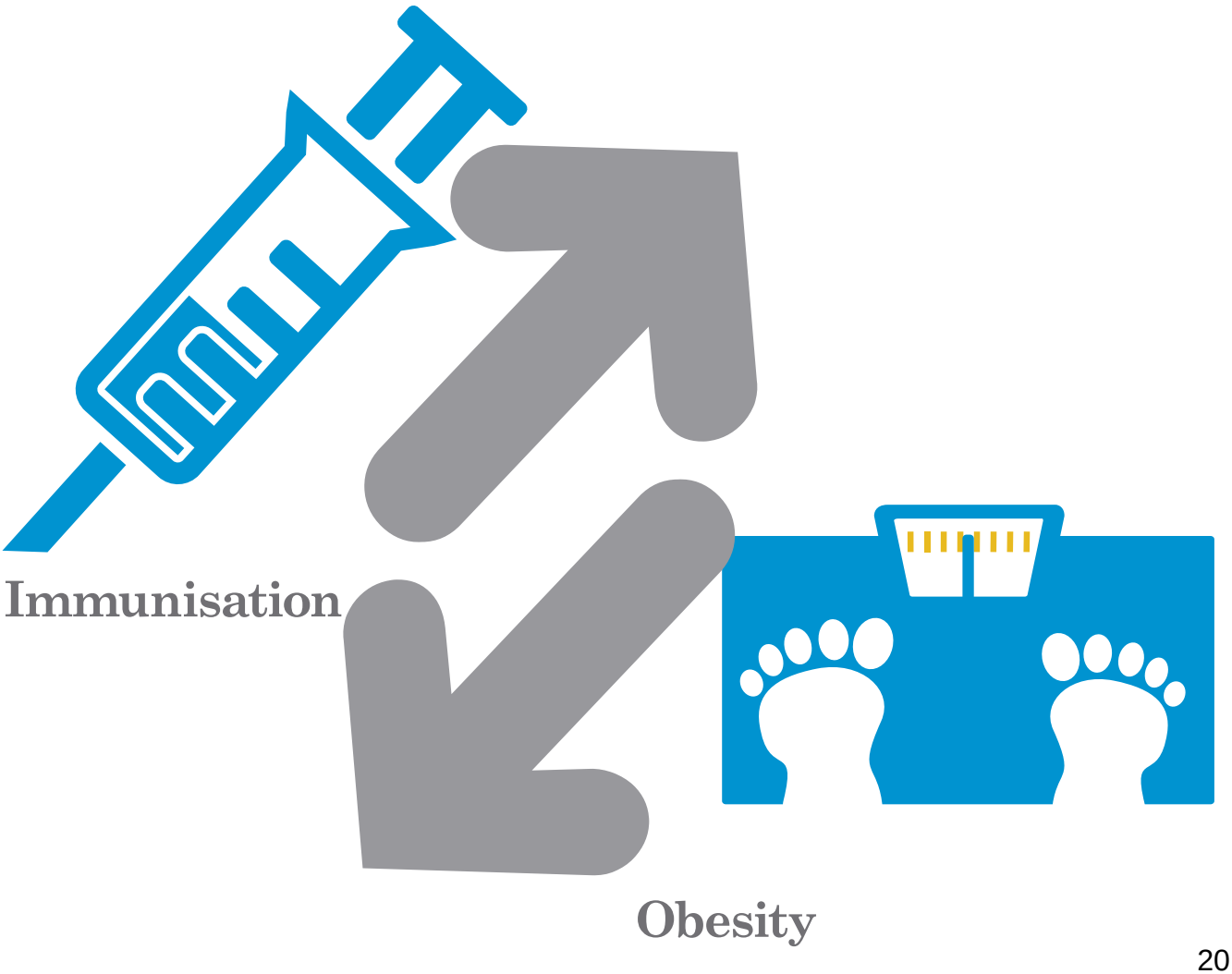
Actions need to take place across all of the statutory agencies with parents-to-be, parents and young people to:

- Enable all women, and particularly those with complex needs such as mental ill health, to plan their pregnancies and to prepare for pregnancy in a way that maximises the health outcomes both for the child and mother.
- Increase the take up of immunisations, particularly the MMR pre-school booster
- Expand the Family Nurse Partnership initiative to support families who are experiencing significant challenges.
- Expand the community budgets programme for children to provide early intervention for children from families with the most complex needs.
- Reduce obesity in children and young people by working with schools, community groups and parents to promote healthy eating and increase the use of active and sustainable school travel plans and the range of organised physical activities available
- Embed Active Lifestyles programmes in primary and secondary schools to encourage healthy lifestyles for parents and children.
- Design and implement a range of interventions designed to reduce risk taking behaviour in children including Sexual Health and substance misuse that are delivered through statutory and voluntary partners.
- Effectively plan for transition from children's services to adult services.

3.3. Measuring progress

Our performance measures for the priority theme ''Preparing for a Healthy Life' are:-

- All women in Barnet to access NICE compliant maternity care by 12 weeks gestation
- Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5%
- Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet.
- Reduce the rate of obesity in reception year school children from 11% to be better than the London average. Reduce the rate of obesity in year 6 children from 17.5% baseline towards the England best of 10.7%
- reduce the number of children and young people misusing alcohol and drugs by 91% by 2014/15.
- Include an additional 705 families with complex needs in the community budget programme - where there is a decrease in the number and range of interventions from statutory organisations.
- Increase the number of young people who have a transition plan when they are 18 to 70% in the first year, and achieve 90% by 2013/14 and 100% by 2014/15.



4. Keeping Well – 'Well-Being in the Community'

Lead Agency: London Borough of Barnet

4.1. What does the Barnet Joint Strategic Needs Assessment tell us?

Major developments are planned in Barnet over the next 10 to 15 years which will see significant population growth in new and improved neighbourhoods and investment in supporting facilities and infrastructure. The range of projects include the regeneration of the four largest estates (West Hendon, Grahame Park, Dollis Valley and Stonegrove) and the development of the three strategic growth areas - the Cricklewood, Brent Cross and West Hendon regeneration area, Colindale and Mill Hill East.

The Barnet Local Development Framework (LDF) acknowledges the impact of access to good quality housing on public health and wellbeing. In 2009/10 65% of category 1 hazards (as defined by the Housing Act 2004) identified and reduced were due to Excess Cold e.g. problems with insulation or heating or damp and mould. Based on the Chartered Institute of Environmental Health Housing Health and Safety rating system calculator, the estimated cost to the NHS of poor health as a result of private sector properties having hazards relating to Excess Cold is £90,400 annually. Using the same calculator the average cost of remedial work has been calculated at £4,993.

There is an important link between how places are planned and developed and the health of the communities who live in them. Planning for health requires consideration of transport issues as the adverse health effects often fall disproportionately on more disadvantaged communities. These communities often suffer from crowded, traffic-ridden surroundings with fewer green spaces, which in turn therefore discourages active travel and active play, and who experience more accidents. There has been an acceleration in research examining the impact of neighbourhood characteristics on health outcomes. This suggests that both physical and mental wellbeing depend on a broad range of characteristics including facilities for active travel, public transport and green spaces. Simply put 'feeling good about where you live' is a key factor in 'feeling good about yourself.' Feeling good about yourself is key to making lifestyle changes which will bring about improvements in health.

The latest unemployment figures reveal that a greater proportion of Barnet's population are struggling to find work than almost any time in the last half decade.

In the year to September 2010, 7.4% of the local population was believed to be unemployed – below the London average (8.9%) but up from the equivalent period in 2005, when local unemployment stood at 6.7%. Just as the benefits of employment to mental health are clear – in providing purpose and structure, developing relationships, and building confidence and self-esteem – so the link between mental health problems and unemployment is also well documented. Only 24% of adults with a long-term mental health problem are in work, and people with mental health problems are at more than double the risk of losing their job. The majority of people who spend more than six months out of work after an episode of mental ill health will never work again. In Barnet less than 7% of those people receiving secondary mental health services are in paid employment.

4.2. What needs to be done?

Actions need to take place across all of the statutory agencies with residents, local communities, housing partners and third sector organisations, to:

- Use the Council's planning and licensing processes to create a built environment that is conducive to healthy living choices such as. walking and the accessibility of safe open spaces.
- Review the opportunity to deliver wider health and well-being objectives through the Borough's regeneration schemes
- Reduce social isolation, especially amongst older people, through schemes that enable the sharing of skills and experience
- Maximise training and employment opportunities, through the Regeneration Strategy for those furthest from the labour market to access new job opportunities.
- Work with private landlords and tenants to bring private rented accommodation up to the Decent Homes Standard
- Target advice and financial support to enable vulnerable and elderly residents to improve their homes in relation to thermal efficiency
- Work in partnership with local employers and other statutory organisations to ensure a range of training and education opportunities and flexible working opportunities are available that will support people into work with a particular focus on young people who are not in education, employment or training and disabled adults. This will be encouraged through local apprenticeships for young people and the Right to Control programme for disabled adults undertaken in partnership between the Council and Job-Centre Plus.
- Work with local community leaders, community groups and service providers to develop mutual support between citizens using people's strengths and experiences

to increase inclusion into local communities, overcome language barriers and develop stronger inter-generational support.

- Working across the Public Sector, in partnership with the Voluntary Sector and community groups, to ensure the availability of information and advice on a range of health and wellbeing related choices

4.3. Measuring progress

Our performance measures for the priority theme 'Well-being in the Community' are set out below. However baselines and specific targets against these measures need to be established through the consultation process.

- Achieve a 5% increase in the number of residents who identify that they have a greater sense of belonging to, and contributing to, the community in which they live to foster greater trust and mutual support, to meet the national average of 79% of residents.
- Reducing the average length of time spent by households in short-term nightly purchased accommodation to 26 weeks through the implementation of our Regeneration Strategy and a target of 25 vulnerable people moving to more independent living by 2012/13, 20 people by 2013/14 and a further 25 people by 2014/15.
- Increase by 9% the number of people with long term mental health problems and people with a learning disability in regular paid employment for 2012/13, increasing to 10% for 2013/14 and 11% by 2014/15.
- Reduce by 4.3% the number of young people who are not in education, employment or training

Employment & Education

5. Keeping Well – 'How we Live'

Lead Agency: Public Health Barnet

5.1. What does the Barnet Joint Strategic Needs Assessment tell us?

Every day people make decisions that affect their health and well-being, whether good or bad.

Tobacco use is the most important preventable risk factor for death from cancer and cardiovascular disease. About 2,600 people die in Barnet each year. Of these, about 440 die from a smoking-related disease. This is more than from any other cause and these deaths are all preventable. People with mental illnesses are likely to be heavier, more dependent smokers. In addition, men from the Bangladeshi community have the highest rates of smoking of 40%. As smoking is the cause of so many deaths, and it is more common amongst people living in more deprived areas, an important cause of the differences in death rates between affluent and deprived areas is likely to be smoking. Seeking to increase the proportion and the absolute number of smoking quitters in deprived areas will thus contribute to reducing health inequalities.

More than 9 out of 10 adults in Barnet do not take part in the recommended level of physical activity with Barnet currently ranked 23rd out of 33 London Boroughs for levels of adult physical activity according to the Sport England Active People Survey 5 (Oct 2010.). Regular physical activity helps to reduce the risk of stroke, type 11 diabetes, development of dementia, incidences of heart disease and high blood pressure. The consequences of this are evident – for example in Barnet, the rates of people with a diagnosis of diabetes are higher than the London average.

The abuse of substances such as drugs and alcohol can have a detrimental impact on an individual's health, their families and society, crime and antisocial behaviour and the economy. In Barnet, the rates of alcohol hospital related admissions has steadily increased over a 6 year period from 696 per annum in 2004/05 to 1444 in 2009/10 and alcohol attributed recorded crime levels are also above the London average in Barnet. Studies reveal that young drinkers are more likely to admit to being involved in violent incidents .and in England, each year, around 1.2 million violent incidents are linked to alcohol misuse.

In December 2011, a detailed review of lifestyle and environmental factors and cancer calculated that one third of all cancers in the UK are caused by 4

common lifestyle factors — tobacco, diet, alcohol, and obesity[5] , challenging the notion that cancer is down to fate or is in the genes. Changing lifestyles will reduce the risk of cancer with screening programmes supporting continued reductions in cancer related deaths. Early deaths from cancer are now Barnet's second biggest reason for premature death after smoking (297 early deaths each year). Although Barnet has a lower mortality rate from breast cancer compared to England, one-year survival is lower and breast screening uptake levels remain low. In addition, Barnet has a lower one-year survival from colorectal cancer than England

5.2. What needs to be done?

Actions need to take place by individuals and families in conjunction with statutory agencies to:-

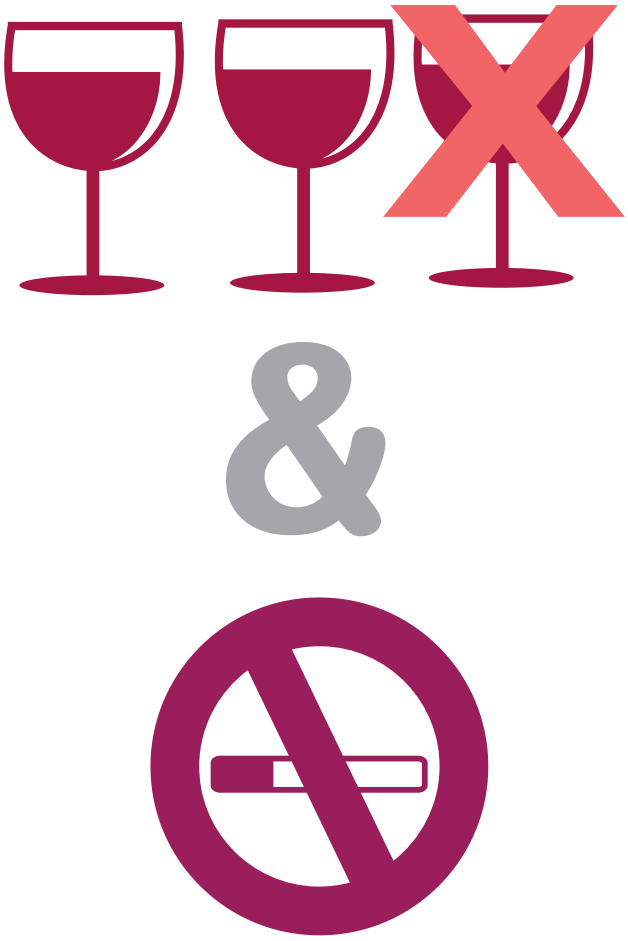
- Discourage uptake of smoking in children by working with partners in education and community groups and to increase the range of people within the public and private sector trained to provide smoking cessation advice.
- Encourage and enable smokers to quit, and people who are overweight and obese to lose weight
- Promote healthy eating through working with local food suppliers, restaurants, public houses, places of entertainment and similar commercial enterprises to help to increase the availability of, and choice for healthy foods and drinks
- 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.
- Make better use of the range of green spaces and leisure facilities in the Borough to increase levels of physical activity. This is being supported by the Council undertaking a Strategic Review of Leisure Opportunities to explore the ways in which residents use their leisure time and the role of the Council's services (parks, green spaces, leisure centres, community centres etc) in promoting health and well-being
- Continue Trading Standards under-age alcohol sales test purchasing programme together with enforcement of Licensed premises licence conditions in relation to sales of alcohol to people who are already drunk.

5 The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010, Authors: Dr D Max Parkin et a. Journal of Cancer Cancer. 2011;105 (Suppl 2):Si-S81

5.3. Measuring progress

Our performance measures for the priority theme 'How we Live' are:

- 3% increase in the number of adults participating in regular physical activity by 2015.
- Reduction of 20% in the number of people smoking in Barnet by 2016 in line with the London target.
- 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%
- Year on year increase based on the 2009/10 baseline of people with a learning disability and those with a mental illness who have received an annual health check.
- Increase breast screening uptake and improve coverage to exceed the target of 70% by 2015
- Increase uptake of bowel cancer screening to meet national indicator of 60% by 2015
- Rates of increasing and higher risk drinking are reduced from 17.7% of the population aged 16+ towards the best performance in England of 11.5%



6. Keeping Independent – 'Care when Needed'

Lead Agency: Barnet Council and Barnet Clinical Commissioning Group

6.1. What does the Barnet Joint Strategic Needs Assessment tell us?

According to forecasts, this elderly population is set to rise by 21% over the next decade. Within this older population, the comparatively small 90+ age group is set to increase by 1,600 (55%). There are an estimated 44,900 people aged 65 or over living in Barnet. This should be viewed positively as the older population particularly those recently retired are amongst the happiest group in the population and provide significant input into society through for example volunteering or support to families. We therefore want Barnet to be a place in which all people can age well, minimising the need for care and support through actively planning for retirement. This will need to include living in 'lifetime' homes, which promote independence, staying active, maintaining friendships and having a valued role.

However, it is older people who are the main users of health and social care services. Older people are three times more likely to be admitted to hospital following attendance at an A+E department. Once there older people are more likely to stay and suffer life-threatening infections, falls and confusion.

Barnet is projected to have some of the strongest growth in the number of elderly residents out of all London boroughs over the next five to ten years. Older people are more likely to suffer from chronic and long-term conditions, mental health issues, and are also more likely to suffer from falls and fractures. It is important that episodes of medical treatment are used as opportunities for people to improve their ability to look after themselves and therefore return home safely. However currently in Barnet, hip fractures are the event that prompts entry to a care home in up to 10% of cases.

In both the NHS and Adult Social Care, the spending profile is skewed towards acute hospital based care and residential care. Better care and support can be delivered in people's own homes avoiding admissions to hospital, promoting choice in end of life care through integrated working across health and social care, joining up services around the individual and providing good support to family carers to sustain them in their caring role.

With an ageing population, we can expect the numbers of people with dementia to increase. Early diagnosis, treatment and support mean people with dementia can

continue to live good lives. A key area affecting the ability of people with dementia being able to remain living in their own home is the availability and quality of informal care, specific support to family carers and the understanding of the attitudes and tolerance of the wider community.

In addition, to needs arising from health issues, one of the main reasons for social care services for older people is social isolation. Tied to this issue is an increased risk of social disconnectedness and isolation. In Barnet there are an estimated 18,300 older adults in living alone, making up 38% of the elderly population in the borough. Over two-thirds of these single pensioner households will be aged 75 or over. As more and more older and frail residents elect to stay at home for longer, the need for local social groups, community health services, and preventative care facilities increases even further.

6.2. What needs to be done?

Actions need to take place across all of the statutory agencies led by health and social care agencies with residents, local communities, housing partners and third sector organisations, to:

- Develop neighbourhood and community based support networks for older people providing information, and support on range of leisure, health, housing and support issues in the Borough.
- Early identification and actions to reduce the impact of disease and disability
- Develop and implement a comprehensive frail elderly pathway that spans Health and Social Care, moving from prevention through multiple episodes of illness to end of life care
- Extensively roll out tele-health and tele-care solutions to provide a cost effective way of supporting more people in their own homes.
- Implement integrated personalised support arrangements for people with social care and health needs through the provision of personal budgets covering both health and social care.
- Develop the offer for supporting Barnet residents in care homes including continence management, wound care, medicine reviews and assessments to improve quality of care and dignity of residents and reduce admissions to hospitals.
- Continue the implementation of the existing multi-agency Barnet Carers Strategy with a specific focus on increasing the number of carers with an agreed Carers contingency plan and the provision of carers breaks.
- Ensure that local residents are able to plan for their final days and to die at home if they would prefer. Work will need to be undertaken to build the skills and capacity in the

community to provide support for those dying and those family members who care for them.

6.3. Measuring progress

Our performance measures for the priority theme 'Care when Needed' are:

- The balance of spend on older people in both the NHS and Social Care has been realigned to provide a greater focus on prevention.
- The percentage of frail elderly people who are admitted to hospital three or more times in a 12 month period is reduced from 2009/10 baseline.
- The number of emergency admissions related to hip fracture in people aged 65 and over is reduced by 10% from the 2009/10 baseline of 457.3 by 2015.
- Increase the percentage of people aged 65+ who are still at home 91 days after discharge into rehabilitation services to 87% in 2013 with a stretch target to reach 90% by 2015.
- That all people who have continuing healthcare needs are able to have a personal health budget by 1st April 2014
- An increase of 20% by 2015 in the number of carers who self report that they are supported to sustain their caring role from the 2011/12 baseline
- Increase in the number of people who are receiving end of life care that are supported to die outside of hospital

7. Target setting and monitoring progress

The targets chosen in this Strategy are considered most relevant to the strategic priorities. Most of the data which will be used to monitor achievement against the targets is already being collected and monitored by one or more of the agencies on the Health and Well-Being Board, which avoids duplication.

The targets will be regularly monitored and reported to the Health and Well-Being Board to assess progress. Detailed Implementation Plans will be set out in an annual Prevention Plan entitled 'Keeping Well' and an Integrated Commissioning plan for Barnet Clinical Commissioning Group and Barnet Council entitled 'Keeping Independent'.

While this is a three year Strategy, the targets will be reviewed annually; taking on board the latest intelligence and recommendations reflected in the annual refresh of the Joint Strategic Needs Assessment (JSNA). The results will be published in the Annual Report of the Director of Public Health so the public can hold the Health and Well-Being Board to account on the delivery of this Strategy.

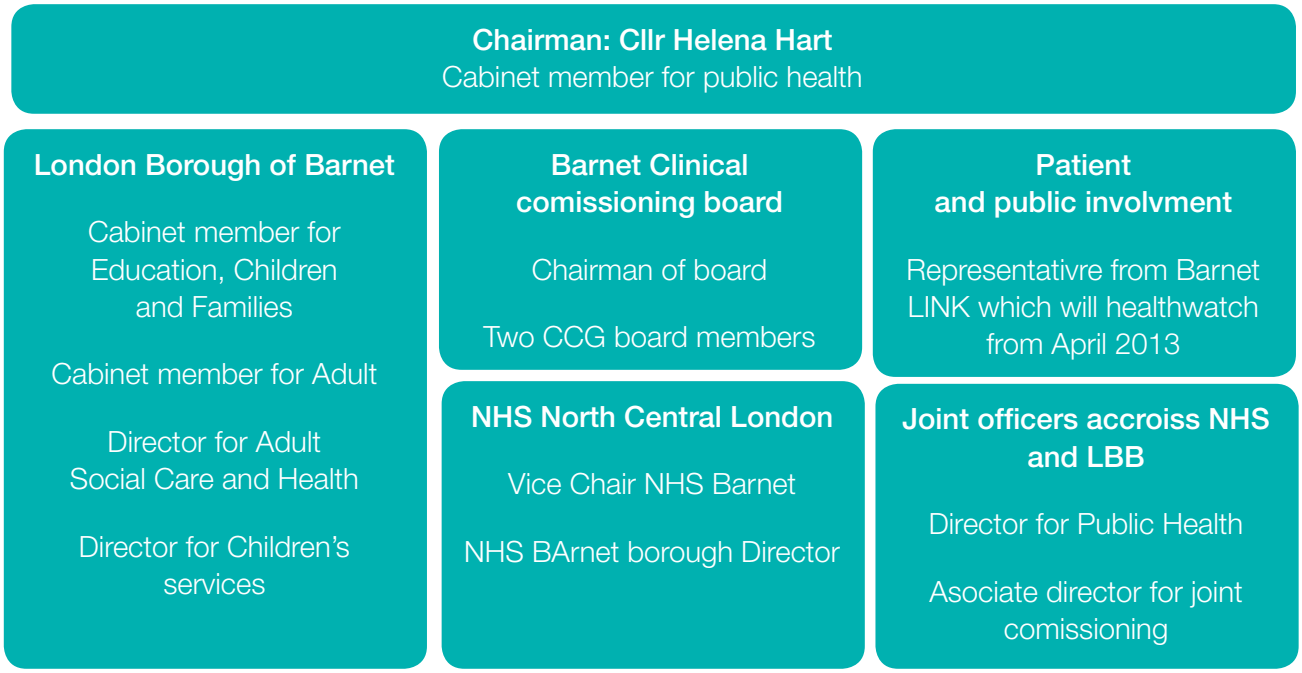
Appendix 1: The Barnet Health and Well-Being Board.

The Barnet Health and Wellbeing Board is currently working in 'shadow' form and is expected to become a statutory body in April 2013.

The Barnet Health and Wellbeing Board is chaired by Barnet Council's Cabinet Member for Public Health and has been established to provide local leadership to improve the health and wellbeing of the people of Barnet through the development and future implementation of this Health and Well-being Strategy.

The current membership of the board is shown in Figure 2.

Figure 2: The membership of the Barnet Health and Wellbeing Board



Reporting to the Barnet Health and Wellbeing Board are a number of multi-agency Partnership Boards which aim through joint working to improve services outcomes for variously, older adults, people with physical and sensory impairment, people with learning disability, people with mental health problems, and carers. Each of these Partnership Boards is expected to contribute to the implementation of this Health and Wellbeing Strategy and to report progress annually. In addition, the Health and Wellbeing Board receives annual reports from the Children and Adult Safeguarding Boards to ensure that safeguarding is at the heart of its work.

BARNET LINK Local Involvement Network
Community Health and Social Care

BARNET
LONDON BOROUGH

NHS
North Central London

Consultation on Barnet's Health and Wellbeing Strategy

Overview Report
August 2012

Background information

- Consultation ran from 1 June until 20 July 2012.
- Consultation was made available online (through the Survey Monkey) and through hard copies (libraries and council offices) , and was in two parts:
  - Part one: questions about the strategy itself (204 responses received)
  - Part two: questions relating to lifestyle issues, and personal responsibility for health and wellbeing. (107 responses received)
- Publicised via website, social media, posters and fliers sent across borough, Barnet Homes Viewpoint register, Events, Provider networks, Barnet Link ambassadors, public stand (with NHS), GPs e-bulletin and intranet
- Possible reasons for low response rate could be:
  - Over-surveying of residents
  - Cynicism that views will be listened to
  - Timing of consultation (holiday period etc)
- There were also engagement workshops to gain more detailed feedback.

High level results for Part One: Questions about the Health and Wellbeing Strategy

The ambition for Health and Wellbeing
There was broad agreement amongst the survey respondents with the elements of our ambition for the health and wellbeing of our residents:

- 94% agreed with the ambition for residents to be free of avoidable ill-health and disability
- 85% agreed with the ambition for residents to take more responsibility for their own and their family's health and wellbeing
- 75% agreed with the ambition for residents to harness the support of their family and friends and the Community.

Some respondents expressed concern about the feasibility of families taking on more responsibility, with issues cited including families not being geographically close, care responsibilities being too great to cope with, and family carers needing to put their lives on hold. There was a recurrent theme of respondents feeling the ambition was an attempt by the Council to "pass the buck" as well as a cost-cutting exercise. However, it must be noted that these comments still represent only a small proportion of overall responses and are very much a minority view.

There were also a few comments questioning where mental health fitted into this strategy, and it was felt there should be a more explicit reference to improving mental wellbeing. This is a theme that also ran through the responses to the rest of the survey questions.

The priorities for action
There was overwhelming agreement with our priorities for Barnet, with between 90% and 97% agreeing with each of the four priorities. Out of the four priorities, the one that received the highest level of agreement was providing care and support for people to get back on their feet after illness.

1. Preparation for a healthy life

- Most important action: Having active lifestyle programmes in schools for children (53%)
- Least important action: access to a Family Nurse for families with ongoing health problems (24%)

2. Wellbeing in the Community

- Most important action: Increase training and employment opportunities for people who find it particularly hard to get paid work (54%)
- Least important action: working with private landlords to bring private rented homes up to the Decent Homes Standard (25%)

3. How we live

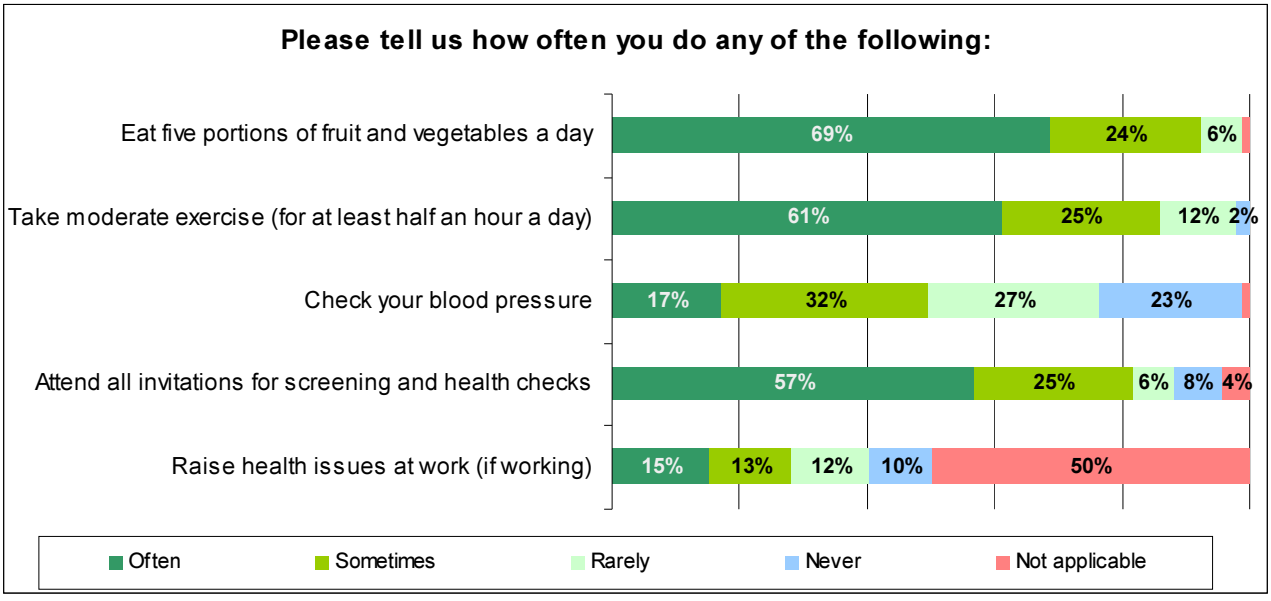
- Most important action: Offer health and lifestyle checks to more people aged between 40 and 74 (64%)
- Least important action: Make sure less licensed premises sell alcohol to people who are already drunk (45%)

4. Care when needed

- Most important action: Improve dignity and quality of care for people in care homes (51%)
- Least important action: Make sure people can plan for their final days (31%)

High level results for Part Two: Lifestyle related issues

Keeping Well and Keeping Independent
The majority of respondents appear to regular undertake the activities mentioned in the table below:



In addition, over half of respondents said they would be willing to do more of the above. They seemed keen to improve both their own and their family's health and wellbeing, with large majorities rating it as very important.

A quarter of respondents often take care of an adult family member or friend who needs help, with a further 30% doing so sometimes.

Respondents appear keen to do more to help out others, particularly taking care of adult family members or friends who need help. Suggestions for what might help included more time, transport provision, information and guidance, and signposting to those who need help.

Preparation for a healthy life
Most respondents agreed that parents should provide the immunisation details of children and agree to be contacted if their children are not up to date with immunisations.

In terms of actions to reduce the number of overweight and obese school children, the most popular seem to be eating a sensible and balanced diet and to walk or cycle to school instead of driving.

Wellbeing in the community
Sharing skills and experience schemes were seen by respondents (around 77%) as the most effective way to reduce the isolation of older people.

How we live
An overwhelming majority of respondents agreed that people who smoke should be required to give up smoking (around 80% of respondents) and that obese people should be required to lose weight before receiving NHS treatment (around 71% of respondents).

Care when needed
There was some disagreement with the idea that it is the responsibility of the family, not social services, to support a disabled adult or older family member. However, 72% of respondents said that they would expect to take a lead role in providing care to a family member.

Feedback from focus groups

A series of meetings were held in the consultation period, including focus groups with:

- Adult Social Care and Health Experts by Experience Group
- Barnet 55+ Forum
- Barnet Link
- Barnet Voice for Mental Health
- Barnet Youth Board
- Community Barnet Providers Networks
- Primary School (Holly Park)
- Secondary School (Friern Park)
- Sheltered Housing Residents

Many of the comments made in these meetings echoed those made in the survey documents:

- There was general agreement with many of the ambitions of the strategy, but each group had concerns over how the council would implement these policies (dependent on the group in question).
- There was a prevalent view that the council, through the strategy, perceived residents as 'social capital' to 'do the council's work for them'.
- The strategy was heavily linked by attendees to budget cuts in the public sector

Areas for improvement in the strategy

- As with respondents to the survey, many focus group attendees felt that the strategy did not cover mental health issues enough
- It was felt that it did not sufficiently address health inequalities

Feedback from particular groups of residents

- From mental health service users, there was concern that more focus needs to be put on early intervention for people with mental health problems
- Disabled residents highlighted the need to prioritise appropriate housing for disabled people, and access issues for the councils buildings and public spaces.
- There was a feeling from sheltered housing residents that they needed more activities to be available to them active both physically and socially. Access to transport services was also mentioned as an issue that needed addressing for older residents.
- Young people mentioned the need for better education on health and wellbeing issues, including sexual health and drugs and alcohol misuse. There should be an emphasis on mental wellbeing and mental health issues in schools, in the same way there is a physical education is included in the curriculum.
- Both younger and older residents agreed that they could mutually benefit from an intergenerational support scheme.
- Respondents widely agreed that access to leisure facilities should be cheaper, and that Barnet could benefit from cycle lanes and more community allotments.

A full report of the findings will be presented to the Barnet Health and Wellbeing Board in advance of their meeting in October 2012.

Health & Wellbeing Strategy

Report on Consultation findings

August 2012

CONTENTS

Health & Wellbeing Strategy Consultation, Survey Findings

1. Executive summary

The consultation took place between 1 June and 20 July 2012, comprising of two surveys and a series of engagement workshops. The first survey was designed to gather residents' opinions on the new Health & Wellbeing Strategy and to help understand if there are any key areas that the council needs to address. The second survey sought to find out from residents how they view their own health and wellbeing. It asked for residents' thoughts on ways that the Council and residents could work together to improve health and wellbeing in Barnet. This survey was an opportunity to gather residents' thoughts on a range of issues so that we can think about the best ways to tackle them in the future. The engagement workshops were used to gather more in-depth and detailed feedback from key interest groups in the borough, and flesh out some of the ideas or reservations that may exist.

All three parts of the consultation aim to start the conversation about health and wellbeing with all Barnet's residents and to make sure that any plans for the future are formed as a partnership between residents and public services.

Key findings

A wide ranging and effective public consultation
The consultation collected a wide range of views and opinions from both local residents and interested organisations. The demographic profile of survey respondents reflected the wide diversity of Barnet's population, and the interest groups represented by the organisations involved are a varied cross-section of Barnet's society.

Overall support for the Strategy's ambition and priorities
Despite some reservations, there was generally broad agreement with Barnet's ambition for health and wellbeing. In particular:

- 85% agreed with the set of ambitions for health and wellbeing
    - 94% with residents being free of avoidable ill-health and disability
    - 85% with residents taking more responsibility for their own and their family's health and wellbeing
    - 75% with residents harnessing the support of their family and friends and the Community

There was also broad agreement with the four priorities set out in the strategy:

- 95% agreed with giving children in Barnet the best start for a healthy life through good maternity care and early years development
- 90% agreed with creating thriving neighbourhoods and supportive communities that encourage people to be healthy
- 95% agreed with helping people to live healthier lifestyles to prevent avoidable disease or illness
- 97% agreed with providing the right support for people to get back on their feet after illness

Concern about increased individual responsibility for families and communities

Although there was widespread agreement that residents should harness the support of their family and friends and the Community, there were weaknesses highlighted in this approach, including families being geographically spread out, an overburdening of responsibility on some families and carers, and modern communities not being set up in such a way to facilitate such an approach. There was concern expressed about the reduction in professional care, and it was felt that there was still a strong role for the Council to provide a safety net for those individuals without appropriate support from their family or community or where the caring responsibilities have become too great. It was also felt the Council should take a strong facilitating role in terms of helping families to help themselves as well as draw on the support of their community.

Education and information is seen as a key facilitator of improved health and wellbeing

The importance of education in schools was identified in terms of promoting healthy eating, tackling obesity, encouraging sport and preventing smoking, but education and information was also cited as necessary in order to change the behaviour of parents and adults regarding their own health and wellbeing and the health and wellbeing of their children.

A range of opinions on the role of families in providing care

Opinion was rather mixed on how roles and responsibilities should be divided between families and social services. Similar proportions agreed and disagreed that it is the responsibility of the family, not social services, to support a disabled adult or older family member who needs support, with social care support being targeted at people who do not have family support. However, interestingly nearly three-quarters of respondents said that they would expect to take a leading role in providing their family members with care, with social care services providing carer support, training and back up cover.

Acceptance that residents should do more to look after their health and wellbeing

Respondents seemed willing and prepared to do more to look after their own health, including eating more fruit and vegetables, exercising more, checking their own blood pressure, and attending screenings and health checks. In contrast, relatively few people raise health issues at work, and only a minority of people would be prepared to do it more often.

Willingness for residents to do more to help others

Nearly six out of every ten respondents said they would be prepared to do more to take care of adult family members or friends in need of help, and nearly half of respondents would be prepared to drop in to help those outside their circle of family and friends or do shopping and other tasks for them. Potential barriers restricting this help though include lack of time, lack of transport, and lack of knowledge about how to find those in need.

Widespread support for compulsory targeted health interventions for those in need

There was general agreement with very overweight patients losing weight in order to get routine operations, as well as smokers meeting with an NHS Stop Smoking Adviser before routine surgery. This suggests that the public recognise that

resources are scarce, and these resources should be restricted to those that try to take care of their own health and wellbeing.

Unclear how elements of the strategy will be implemented
Whilst the vast majority of people agreed with the strategy's ambition and priorities, some felt that it lacked sufficient detail to illustrate how it would all be achieved. There were some who thought it represented simply a wish list, whereas some questioned whether it was in fact realistic or achievable, given the tough economic times the public sector finds itself in but also because of the geographical and economic constraints of families taking on more responsibility.

Residents have a broad range of ideas of how health and wellbeing may be improved
The respondents to the surveys and the participants in the engagement workshops made a wide variety of suggestions on how elements of the strategy may be implemented and how health and wellbeing in the borough may be improved and maintained. These suggestions and documented in this report, and it is important that the Council continues the dialogue with the public to ensure that these good ideas can feed into the ongoing planning and delivery of services.

A need for higher profile for mental health issues
It was felt by some that the strategy lacked sufficient reference to mental health problems and improving the mental wellbeing of Barnet residents. In particular, it was felt that there should be earlier identification and treatment of mental health issues.

2. Introduction

This report sets out the consultation findings that were conducted as a part of the Health & Wellbeing Strategy 2012. The consultation involved two separate surveys, one focusing on the actual strategy and one relating to individual residents' views on their own health and wellbeing, as well as meetings and engagement workshops with key stakeholder groups in Barnet.

The findings are important in order to quantify residents' opinions on the strategy and to help understand if there are any key areas that the council needs to address.

2.1 Background and context

The Barnet Joint Strategic Needs Assessment (JSNA) which was carried out in 2011 looked at the health needs of the population of Barnet and showed that there were significant differences in health and wellbeing across the borough. Some areas of the borough seemed to experience poorer health, as did some particular groups of the population. The Health and Wellbeing strategy aims to reduce these health differences by focusing on how people can 'Keep Well' and 'Keep Independent'.

The strategy is a partnership between residents and public services and stresses that as well as receiving help from the NHS and the Council, Barnet residents must take some responsibility for their own health and wellbeing.

The Barnet Health and Wellbeing Board is responsible for the development of this strategy and for making it happen, and the strategy takes into account the current make-up of Barnet's population as well and the estimated future population and related health statistics.

The strategy has two main aims:

Keeping Well
This aim is based on a strong belief that 'prevention is better than cure.' The strategy aims to give every child in Barnet the best possible start to live a healthy life and to create more opportunities for healthy and supportive communities to exist in Barnet. There is also the aim to support people to have healthy lifestyles, to stop them from getting avoidable disease and illness.

Keeping Independent
The strategy aims to ensure that when people need extra support or treatment, it helps them to get back up on their feet as soon as possible. This means both health and social care services working together to support people where necessary.

The main ideas or principles behind the approach are based on both the Barnet JSNA and the Marmot Review of health inequalities in England, called *Fair Society Healthy Lives*.

The Marmot review makes it clear that:

- Wealthier people generally experience better health than people with lower incomes

- Action on health differences requires action across all of the social factors affecting health (such as where you live, your employment status or education)
- It is necessary to take actions across all social groups, targeting resources according to the level of disadvantage
- Making this happen requires empowerment of individuals and local communities

These points were all taken into account as part of our strategy.

Although many other boroughs have not carried out a consultation on their Health and Wellbeing strategies (including Camden, Ealing, Enfield, Hackney, Hammersmith and Fulham, Islington, Wandsworth and Westminster), we felt it was important to let residents and interested groups have their say. Furthermore, we are proud of the quantity and range of responses that we have collected – as detailed later we received 196 survey responses feeding back on the actual strategy, including responses from a number of interested organisations operating in the borough, as well as 96 survey responses relating to individual health and wellbeing activities and preferences and several meetings and focus groups. In contrast, Haringey received only 50 responses to their strategy consultation which was open between September 2011 and January 2012.

2.2 Methodology and data collection

In summary, the methodology was as follows:

- A consultation document was made available to all respondents which included a copy of the strategy
- Collection of respondents views were fed back via a self-completion survey made available online via http://engage.barnet.gov.uk/ and in libraries, with further copies provided in other council public buildings and customer services, and via meetings and public events
- An easy read survey was made available to those who required it
- Fieldwork for the survey took place between 1 June and 20 July 2012
- Data was collated, analysed and tables produced in-house (the tables can be found in the appendices)
- The survey was also widely promoted via a communications campaign through Barnet online, posters, fliers, social media, public and service user events, NHS internal and external communications channels, Barnet Link ambassadors, Barnet Homes residents' Viewpoint Register, and communications via Community Barnet's contact database, to encourage high response to the survey
- Qualitative data was obtained via a series of meetings with service providers, service users, voluntary groups, schools, meetings held by Community Barnet.

2.3 Response rates

A total of 196 residents and organisations took part in Survey One, and 96 residents took part in Survey Two. This achieved sample size is based on the total number of respondents to the survey as a whole, and not the number of respondents to individual questions. The results presented are based on “valid responses” only, i.e. all those providing an answer (this may or may not be the same as the total sample)

unless otherwise specified. The base size may therefore vary from question to question depending on the extent of non response.

Where possible, difference between demographic subgroups has been commented upon, although it should be noted that this type of analysis has necessarily been quite limited given the size of the samples.

3. Survey One: The Strategy

A total of 196 responses were received for Survey One. The responses came from a mixture of Barnet residents and interested local organisations.

In total, 18 responses were received from organisations, including:

- Barnet Mencap
- Barnet Voice for Mental Health
- Community Focus
- Disability in Action for the borough of Barnet
- Ezer North West
- Jain Network
- Mind in Barnet
- One Support
- Saracens Sport Foundation
- The Network

These organisations represent a broad and varied mix of interests and residents, for example:

- Barnet Mencap supports approximately 500 children and adults with learning disabilities, as well as family carers, and has over 100 members
- Barnet Voice for Mental Health has 150 signed up members
- Community Focus provided access to the arts for around 1,500 Barnet residents last year
- Disability in Action for the borough of Barnet supported around 600 people a year
- Jain Network represents approximately 3,000 to 4,000 Jains living in Barnet
- One Support provides helps approximately 60 people in Barnet maintain their tenancy
- Saracens Sport Foundation worked with 9,000 young people last year across all of their projects and programmes
- The Network supports around 250 people with mental health problems

Where possible, responses from these organisations have been separated from responses from individual residents to assess whether they are markedly different, although it should be noted that with such small numbers it is difficult to spot any clear differences.

3.1 Demographic profile of respondents

For those responses from individual residents, the profile of the respondents was typically older than Barnet's general population, and with more responses from women. The ethnic profile is broadly similar to Barnet's, with differences understandable given the relatively small sample size used.

The numbers of responses are too small to analyse responses by different ethnic groups, but where notable differences exist between the responses from males and females and between broad age groups (under and over 55) then these have been commented on in the report.

Gender	Survey Part 1 - respondents	*Barnet 18+ population*
Male	40%	*49%*
Female	60%	*51%*

Age	Survey Part 1 - respondents	*Barnet 18+ population*
18-24	2%	*10%*
25-34	6%	*21%*
35-44	14%	*20%*
45-54	22%	*17%*
55-64	21%	*13%*
65-74	23%	*9%*
75+	12%	*9%*

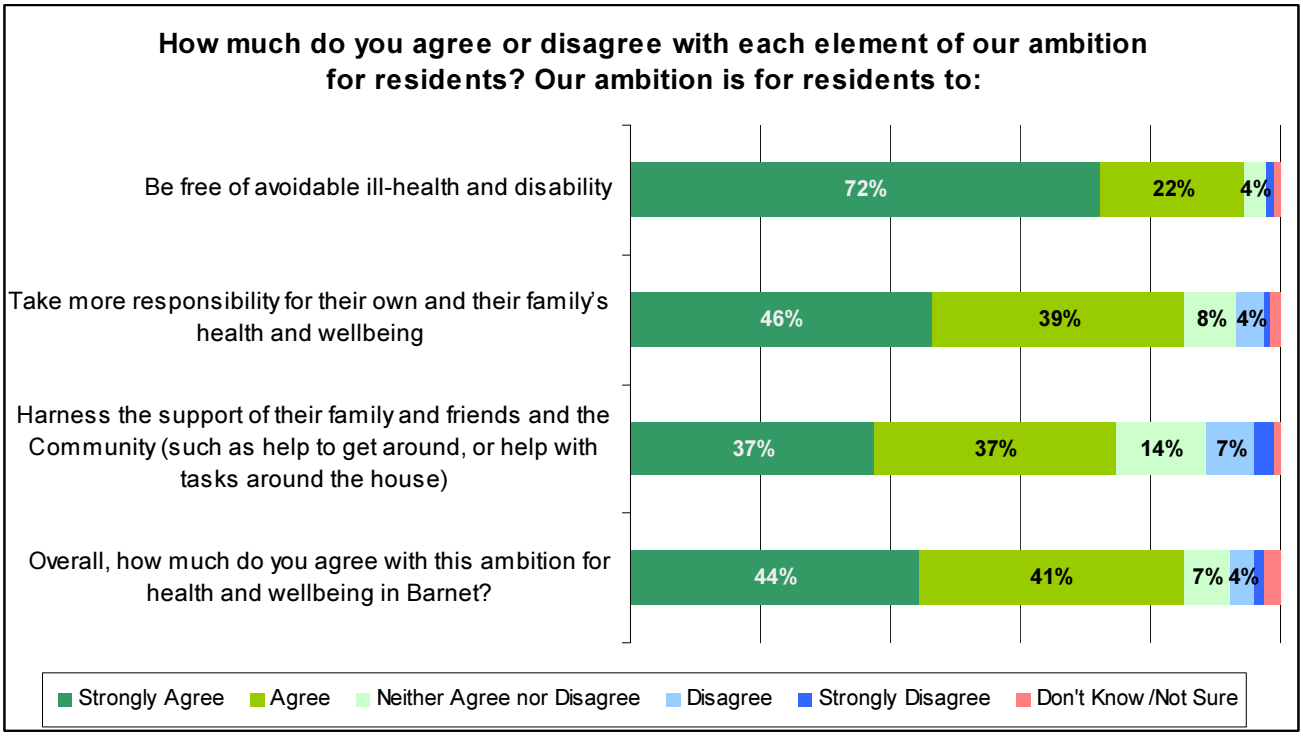
Ethnicity	Survey Part 1 - respondents	*Barnet 18+ population*
White	75%	*73%*
Mixed	5%	*2%*
Asian / Asian British	10%	*14%*
Black / Black British	8%	*6%*
Chinese / Other Ethnic Group	3%	*5%*

In addition to these statistics, we can say 17% of respondents said they were a family carer, and 22% described themselves as disabled.

3.2 Our ambition for health and wellbeing

There was broad agreement amongst the survey respondents with the elements of our ambition for the health and wellbeing of our residents. In particular:

- 94% agreed with the ambition for residents to be free of avoidable ill-health and disability
- 85% agreed with the ambition for residents to take more responsibility for their own and their family's health and wellbeing
- 75% agreed with the ambition for residents to harness the support of their family and friends and the Community
- 85% agreed overall with the set of ambitions for health and wellbeing in Barnet



There was very little disagreement with the ambitions. The highest level of disagreement was regarding the ambition for residents to harness the support of their family and friends and the Community, to which 7% of respondents disagreed and 3% strongly disagreed, whilst there was slightly less disagreement with the ambition for residents to take responsibility for their own and their family's health and wellbeing. Whilst still a small proportion of responses, this disagreement was also reflected in text-based comments provided in the survey.

- *"Harnessing the support of others can easily translate into leaving carers without help and support"*
- *"I don't think families should be relied upon to provide care. They often have other responsibilities, and the care they provide is not necessarily best for the patient"*
- *"Mostly the people living around us are strangers, there is little resemblance of a community. People will not wish to bother those outside the family for assistance"*
- *"It's clearly an insidious ploy to reduce professional care and place the burden on families instead"*

These are just a few examples of the comments provided. Respondents expressed concern about the feasibility of families taking on more responsibility, with issues cited including families not being geographically close, care responsibilities being too great to cope with, and family carers needing to put their lives on hold. There was concern that families might not know how to help themselves, or might not know how and where to access support when needed, thus there remains a strong role for the Council to "facilitate those in need to access support from the local community" as well as provide a "safety net of social services" for those who have little help to draw upon. There was also a recurrent theme of respondents feeling the ambition was an attempt by the Council to "pass the buck" as well as a cost-cutting exercise.

However, it must be noted that these comments still represent only a small proportion of overall responses and are very much a minority view.

There were also a few comments questioning where mental health fitted into this strategy, and it was felt there should be a more explicit reference to improving mental wellbeing. This is a theme that ran through the responses to the rest of the survey questions as well.

In terms of suggestions for what else might have been left out of the ambition for health and wellbeing, comments included improving nutrition and healthy eating through education, providing better and more accessible facilities for sports and leisure, and better access to healthcare. It was felt that there needed to be better information for Barnet residents, better access to support services, and better education for the community.

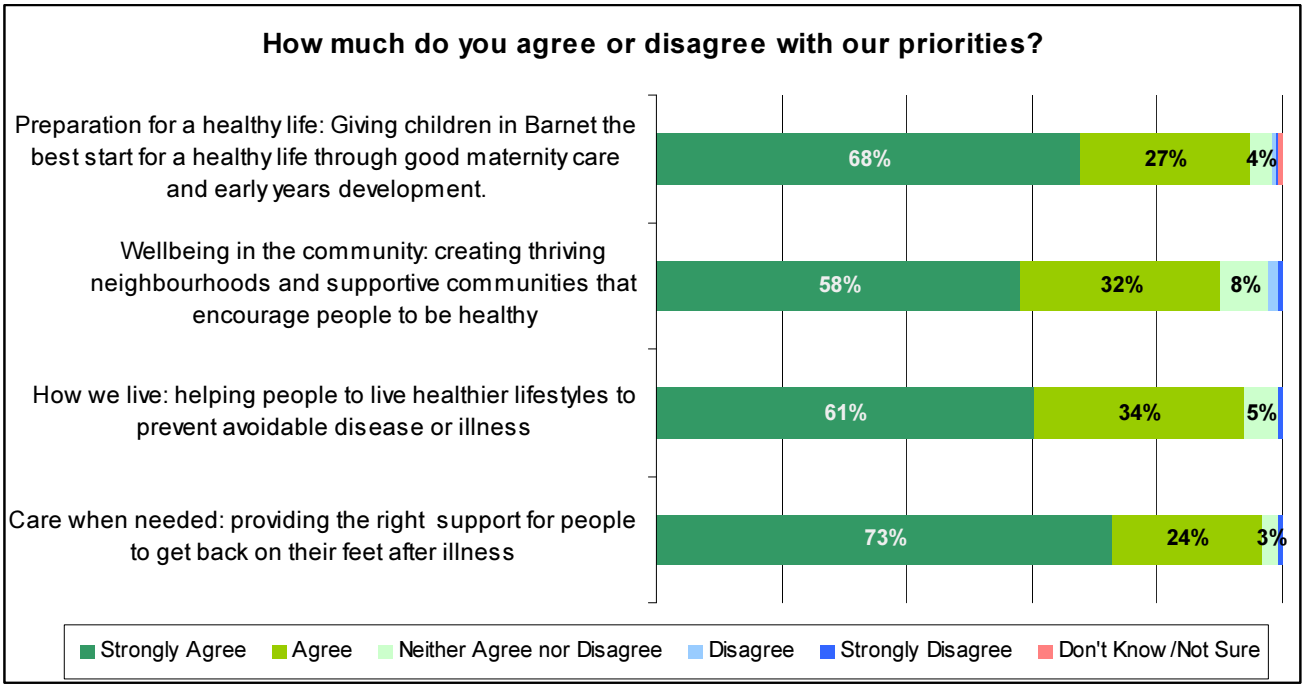
There were a few respondents that felt that the ambitions were unrealistic or hollow, both because of the geographical and economic constraints of families taking on more responsibility, but also because the strategy lacks the sufficient detail to illustrate how these ambitions will be implemented and achieved.

Organisations responding to the survey were generally more positive about the ambitions than individual residents, particularly the ambition overall and harnessing the support of friends and family and the community, For the third ambition, of harnessing the support of friends and family and the community, was strongly agreed with by 34% of individual residents but some 67% of organisations that responded.

3.3 Our priorities

There was overwhelming agreement with our priorities for Barnet, with between 90% and 97% agreeing with each of the four priorities, and disagreement lying between 1% and 2%. Out of the four priorities, the one that received the highest level of agreement was providing care and support for people to get back on their feet after illness.

In general, respondents aged 55 or over were more in support of the priorities than those aged 55 or under, although this relates to the degree of agreement (i.e. strongly agree vs agree) rather than any difference in the proportions actually disagreeing with the priorities. Similarly, male respondents were more in support than women of the first priority regarding good maternity care and early years development. Responses were similar between individual residents and organisations.

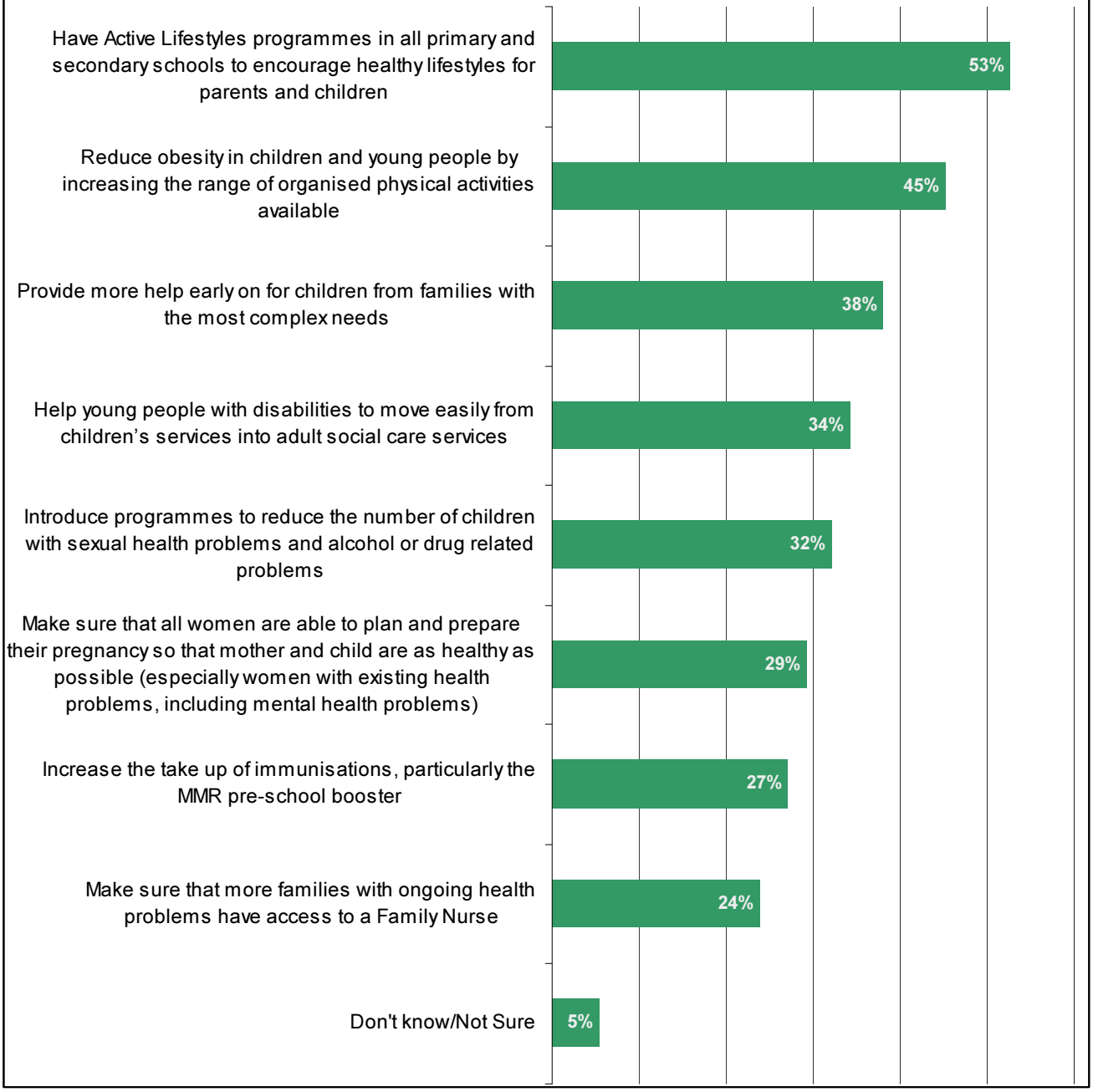


Text-based comments attached to these priorities continue some of the themes already addressed – a lack of focus on mental health issues, a need for educating the community about particular issues, and a lack of detail about implementation.

3.4 Preparation for a healthy life

Respondents were asked to select which three actions to give children in Barnet the best start for a healthy life were most important to them. Over half (53%) of respondents who answered this question ticked Active Lifestyles programmes in schools and a large proportion (45%) ticked an increased range of organised physical activities in order to reduce obesity. The least important actions were seen as access to a Family Nurse for families with ongoing health problems, and increasing the take up of immunisations.

Below are our planned actions to give children in Barnet the best start for a healthy life. Please tick which three of these are most important to you.



Responses between male and female respondents were similar, although female respondents were three times more likely to tick the action of helping young people with disabilities to move easily from children's services into adult social care services. Whereas men were more likely than women to rate Active Lifestyle programmes and the increased take-up of immunisations. Respondents aged under 55 were more likely than those aged 55 or over to rate the introduction of programmes to reduce the number of children with sexual health problems and alcohol or drug related problems. The responses were broadly similar between individual residents and organisations.

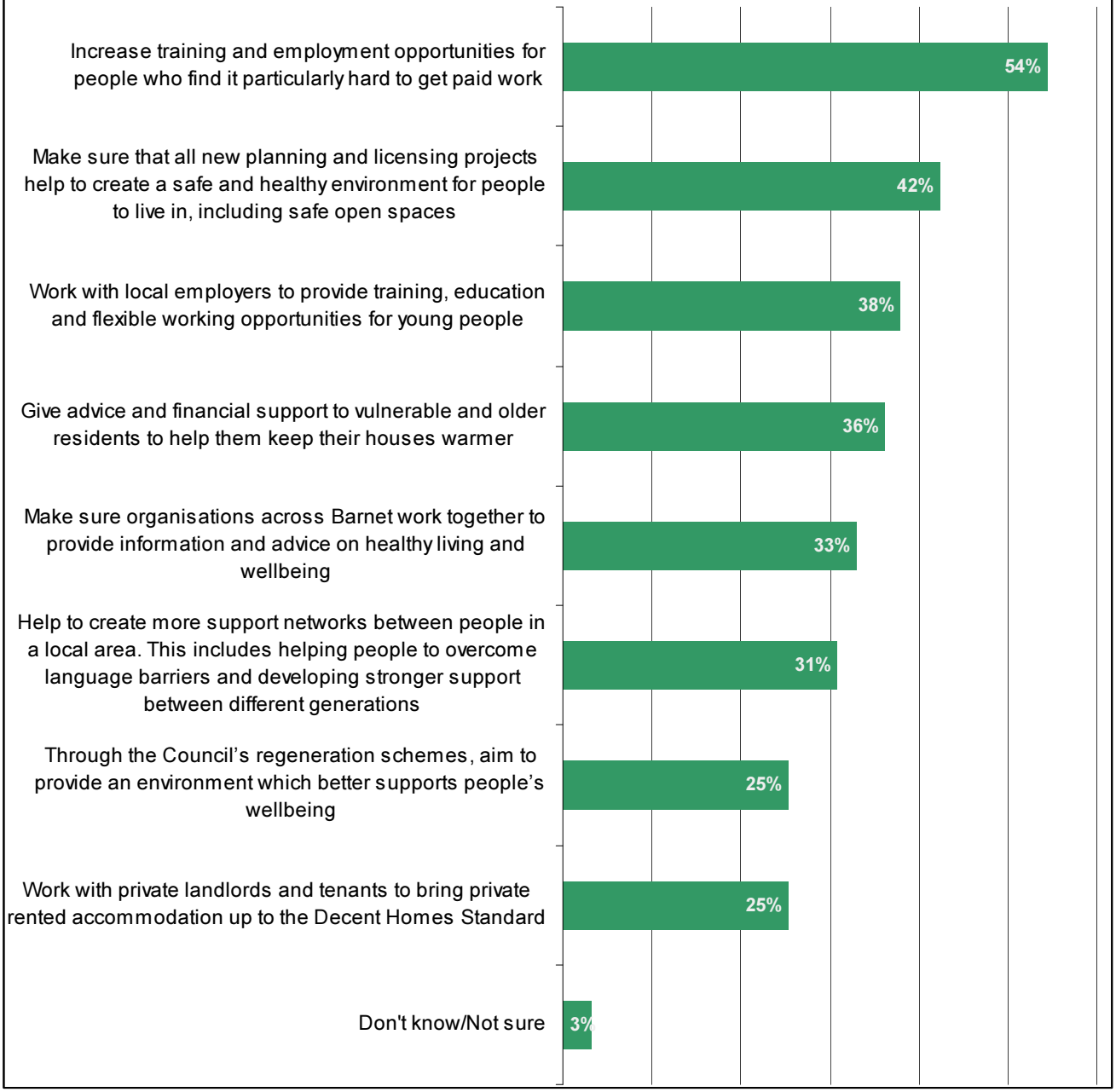
In terms of actions that may have been missed out of the strategy, comments included suggestions for leisure opportunities such as yoga and meditation, army training, sports and youth clubs, and a wider range of enjoyable activities in PE lessons. There were also suggestions for healthy travel to schools, healthy school meals, shock tactics to prevent young people from starting smoking, and birth control programmes. A number of comments focused on the need to target parents in terms of parenting skills, setting a good example, educating families about healthy lifestyles, and addressing bad parenting in the borough.

Again there were a number of comments regarding the need for provision of services for children with mental health needs, and particularly tackling the causes of mental health issues at an early stage.

3.5 Wellbeing in the community

In terms of actions to create more opportunities for healthy and flourishing neighbourhoods and communities, 54% of respondents felt that increased training and employment opportunities for those who find it particularly hard to get paid work were among the three most important actions. 42% cited new planning and licensing projects that help to create a safe and healthy environment for people to live in.

Below are our planned actions to create more opportunities for healthy and flourishing neighbourhoods and communities. Please tick which three are most important to you.



Only 25% of respondents cited as the most important work with private landlords and tenants to bring private rented accommodation up to the Decent Homes Standard, and similarly only 25% cited as the most important regeneration to provide an environment which better supports people's wellbeing.

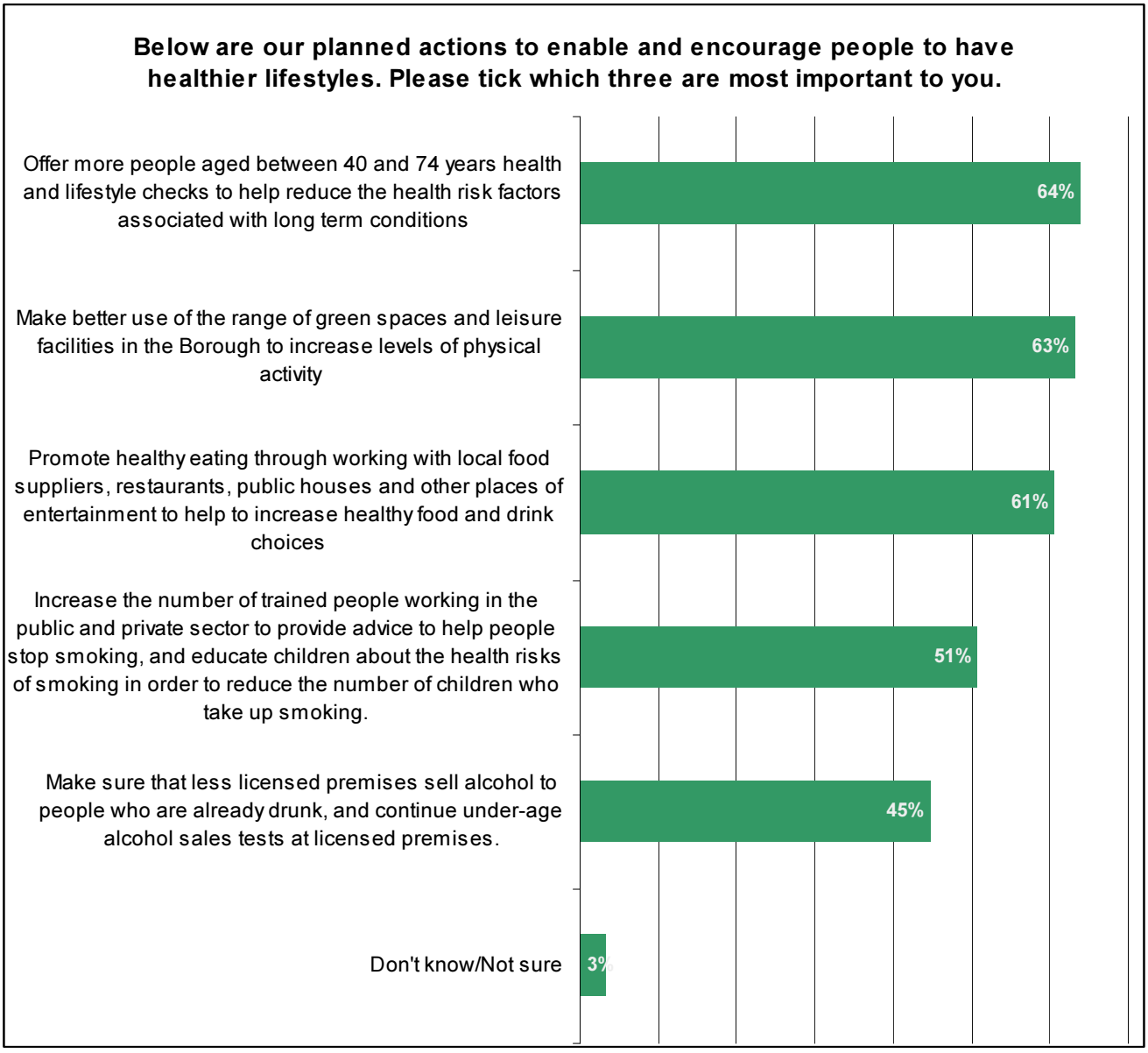
Women respondents were nearly twice as likely as male respondents to cite creating support networks between people in a local area as one of the three most important actions. Respondents aged 55 or over were more than twice as likely than those

aged under 55 to cite working with private landlords and tenants to bring private rented accommodation up to the Decent Homes Standard.

As for the text-based comments, they included the need for affordable housing, benefits advice for vulnerable people, and more support for the voluntary sector. Other comments suggested developing local areas by reducing parking restrictions to boost local shopping, better public transport and cycle lanes, fully accessible communal spaces, and increased and improved sporting and community facilities. There were also suggestions to reduce antisocial behaviour by reducing late night noise and tackling drug and alcohol abuse and crime.

3.6 How we live

In terms of healthier lifestyles, health and lifestyle checks for people aged between 40 and 74 years, better use of green spaces and leisure facilities, and promotion of healthy eating were seen as the most important actions. The other two actions of alcohol restrictions and smoking cessation were less important, although were still ticked by large numbers of respondents.

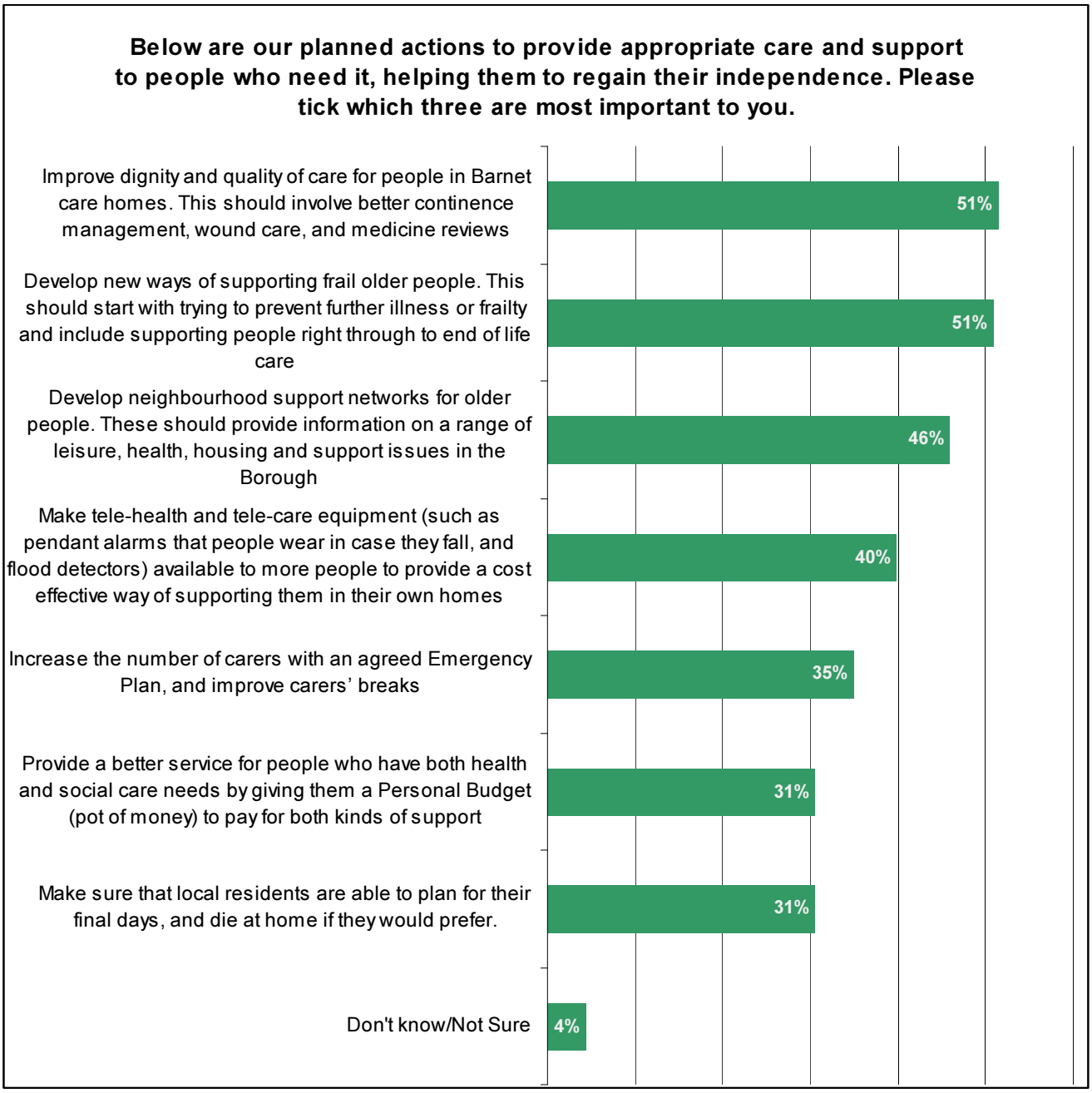


In terms of healthy eating, comments included the need to limit junk food availability and promotion, increase allotment provision and encourage people to grow their own food, and make sure academies and free schools adhere to national standards for school meals. However, one respondent felt that the council should not be interfering with the menus of cafes and restaurants, and instead should be tackling the root causes of unhealthy eating. Text-based comments also cited the need to provide and develop free or low cost exercise classes, affordable activities such as walking groups and yoga, and the need to provide transport for elderly residents to get out and about.

3.7 Care when needed

Improved dignity and quality of care for people in Barnet care homes and developing new ways of supporting frail older people were seen as the most important actions to provide appropriate care and support to people who need it. At the other end of the

scale, Personal Budgets and making sure local residents are able to plan for their final days were seen as the least important. Interestingly, respondents aged 55 or over were less likely than those aged under 55 to cite the development of support networks for older people, but more likely to rate dignity and quality of care in care homes as important.



Although the numbers are small, proportionally more organisations rated Personal Budgets as important compared to individual residents, whereas residents were more concerned with the quality of care in care homes and being able to die at home if they prefer.

Text-based comments included the need to improve existing services, publicise services, and make services affordable. There was a feeling amongst respondents

that this section focussed too heavily on older people, and that there should be more initiatives to tackle issues relating to learning disabilities, physical disabilities or mental health problems, such as social isolation. There were also comments highlighting the needs of carers and the need for support to the voluntary sector to increase social interaction and “reduce social isolation and disengagement”.

4. Survey Two: Lifestyle Issues

A total of 96 residents took part in Survey Two. This achieved sample size is based on the total number of respondents to the survey as a whole, and not the number of respondents to individual questions.

4.1 Demographic profile of respondents

The profile of the respondents of the second survey followed a similar pattern to the first survey, with respondents typically older than the local population, and with more females. Again there are slight differences in the ethnic profile but this is to be expected given the relatively small sample size.

Gender	**Survey Part 2 - respondents**	***Barnet 18+ population***
Male	43%	*49%*
Female	57%	*51%*

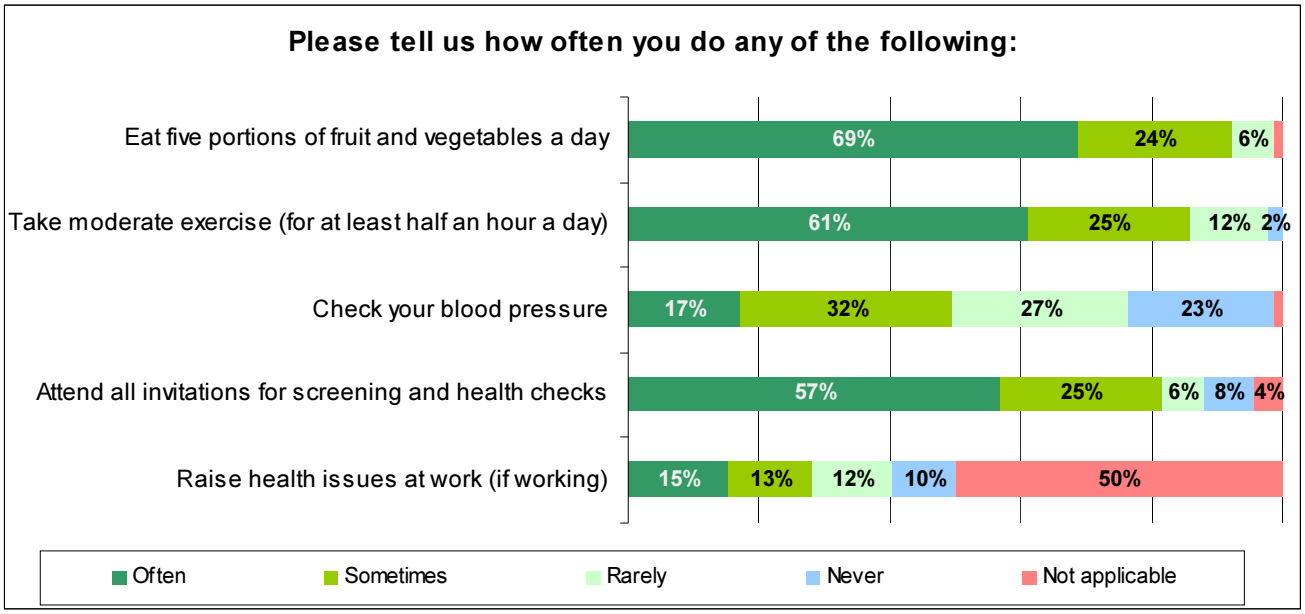
Age	**Survey Part 2 - respondents**	***Barnet 18+ population***
18-24	4%	*10%*
25-34	6%	*21%*
35-44	18%	*20%*
45-54	15%	*17%*
55-64	19%	*13%*
65-74	25%	*9%*
75+	13%	*9%*

Ethnicity	**Survey Part 2 - respondents**	***Barnet 18+ population***
White	76%	*73%*
Mixed	5%	*2%*
Asian / Asian British	11%	*14%*
Black / Black British	5%	*6%*
Chinese / Other Ethnic Group	4%	*5%*

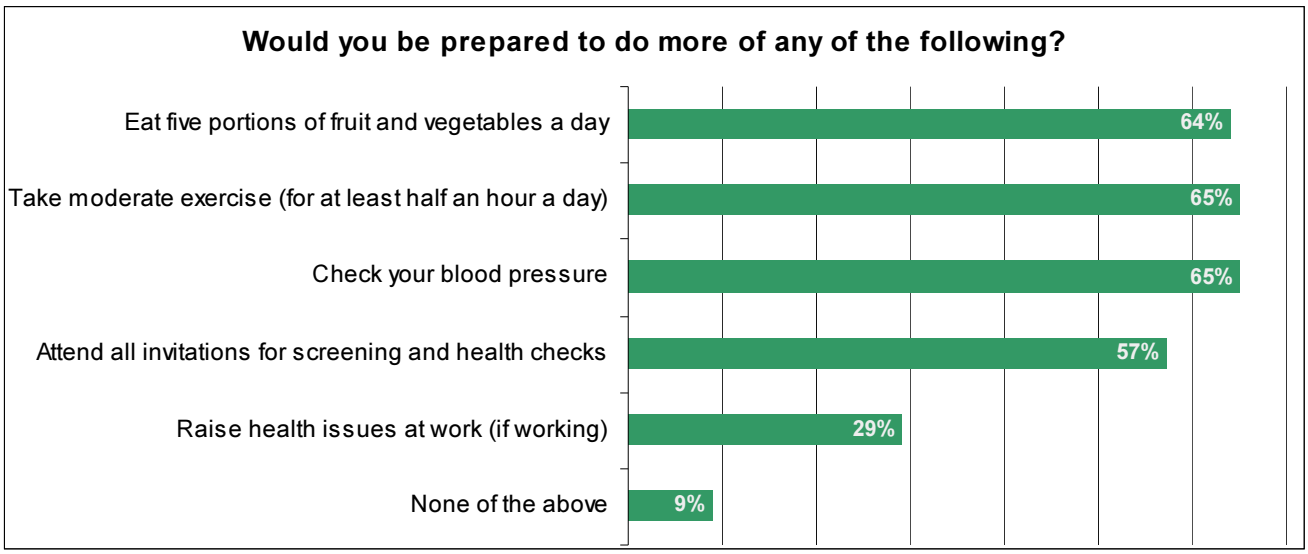
Amongst respondents to this survey, 18% are a family carer and 24% are disabled. Thus the interests of these two groups are well represented in the results,

4.2 Keeping well

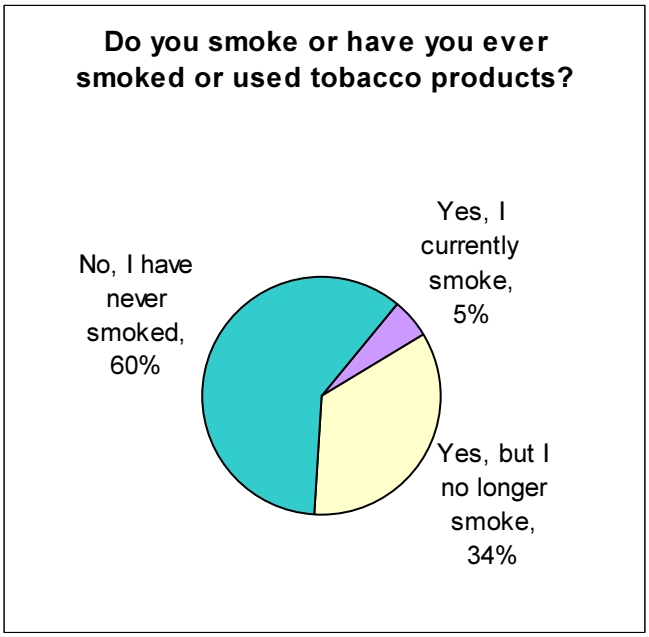
In terms of how respondents look after their own health, it seems that the majority of respondents eat five portions of fruit and vegetables a day, take moderate exercise and attend all invitations for screening and health checks, at least on a regular basis. Regular checks on blood pressure are less common, and even once those not in work are excluded, there is also less evidence of people raising health issues at work.

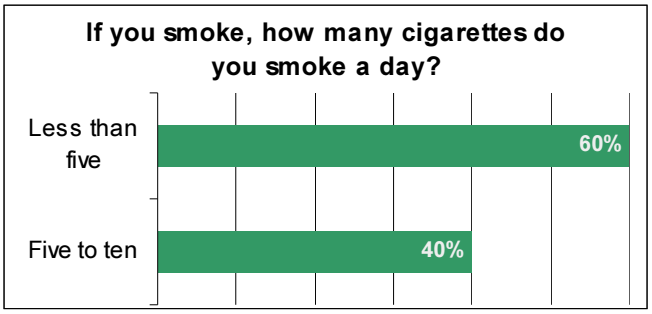


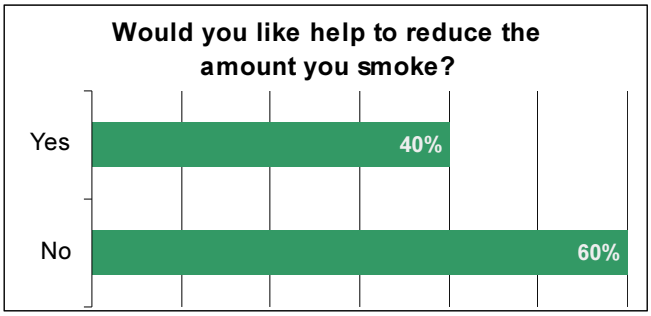
Similar proportions of residents would be prepared to eat more fruit and vegetables a day, take more exercise and check their blood pressure more regularly. Slightly less would be prepared to attend more invitations for screening and health checks. Overall only 29% said they would be prepared to raise more health issues at work, although this figure includes those who are not working. However, even after we exclude those that do not work, still less than half of respondents would be prepared to do this.



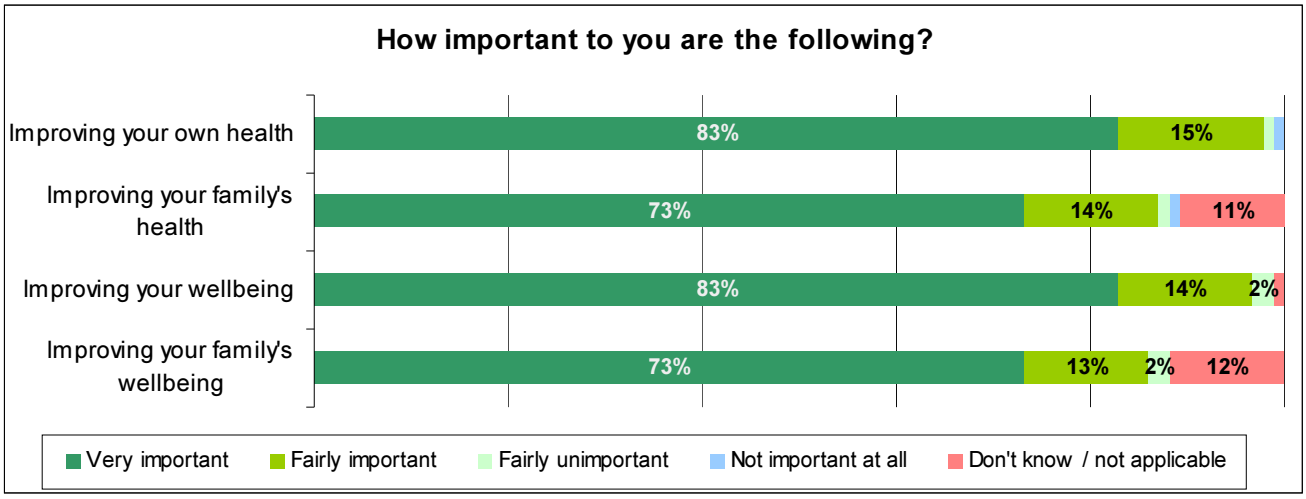
Only 5% of respondents currently smoke, with a further third having given up. 60% of respondents have never smoked. Of the five respondents that have smoked, none smoke more than ten a day and only two would like help to reduce the amount they smoke.





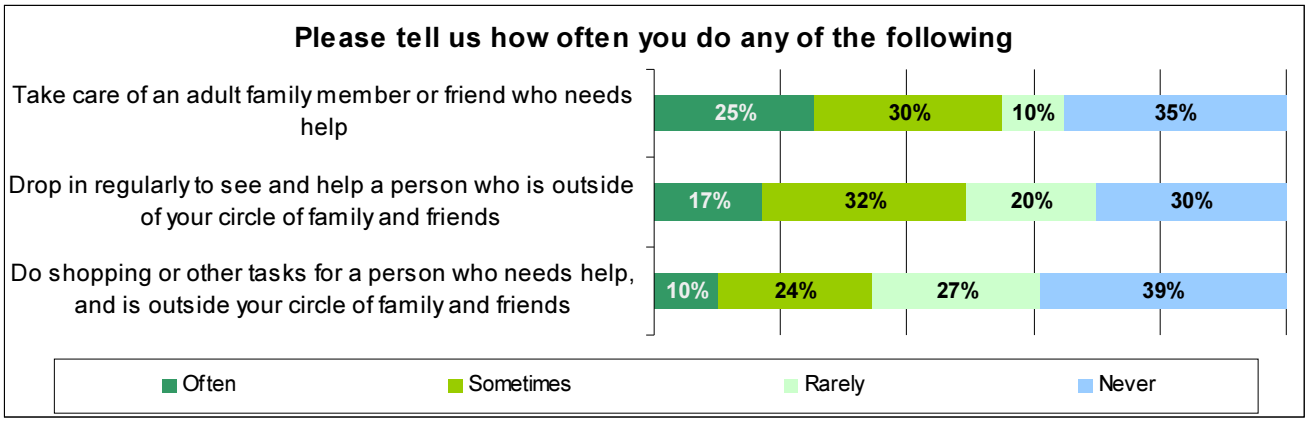


Respondents seem keen to improve both their own and their family's health and wellbeing, with large majorities rating it as very important. Improving their family's health and wellbeing might appear less important on the chart below, but this may be explained by respondents not having family members over which to take responsibility.

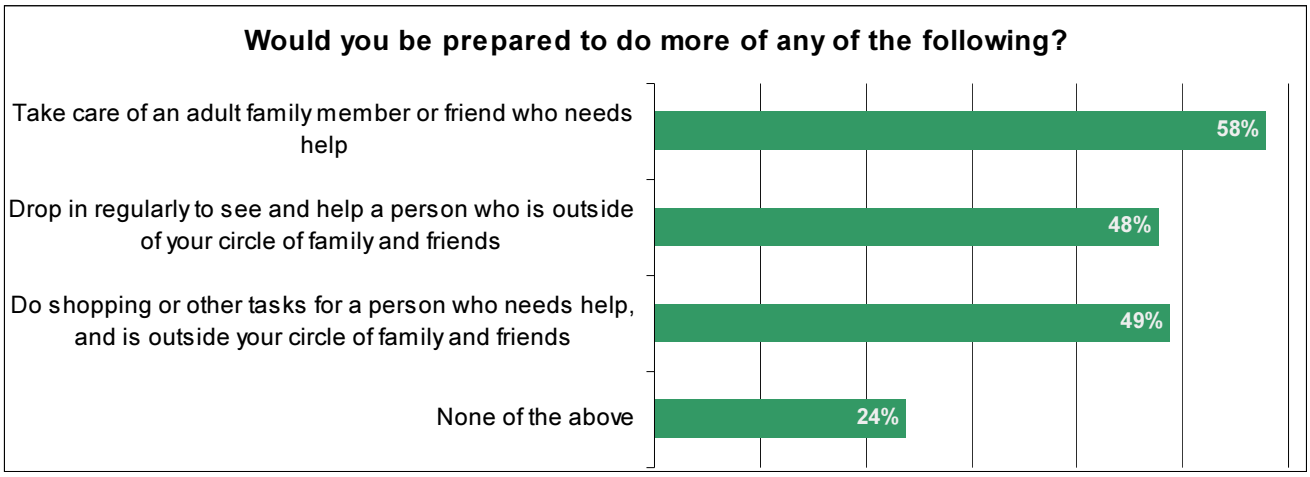


4.3 Keeping independent

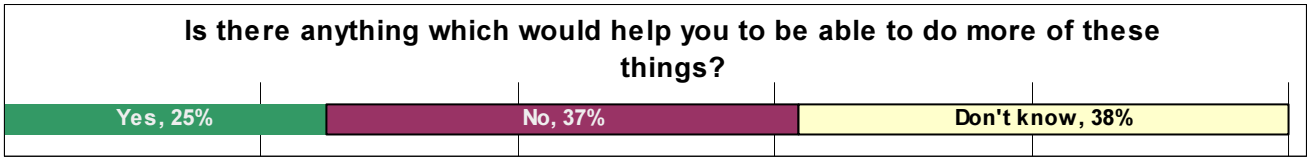
A quarter of respondents often take care of an adult family member or friend who needs help, with a further 30% doing so sometimes. 35% of respondents never take care of adult family members or friends. Respondents are more likely to drop in to see and help a person outside their family and friends but do so less regularly. In terms of helping out those outside their circle of family and friends with shopping or other tasks, 61% of respondents do so at some point, although only 10% do it on a regular basis.



Respondents appear keen to do more to help out others, particularly taking care of adult family members or friends who need help.

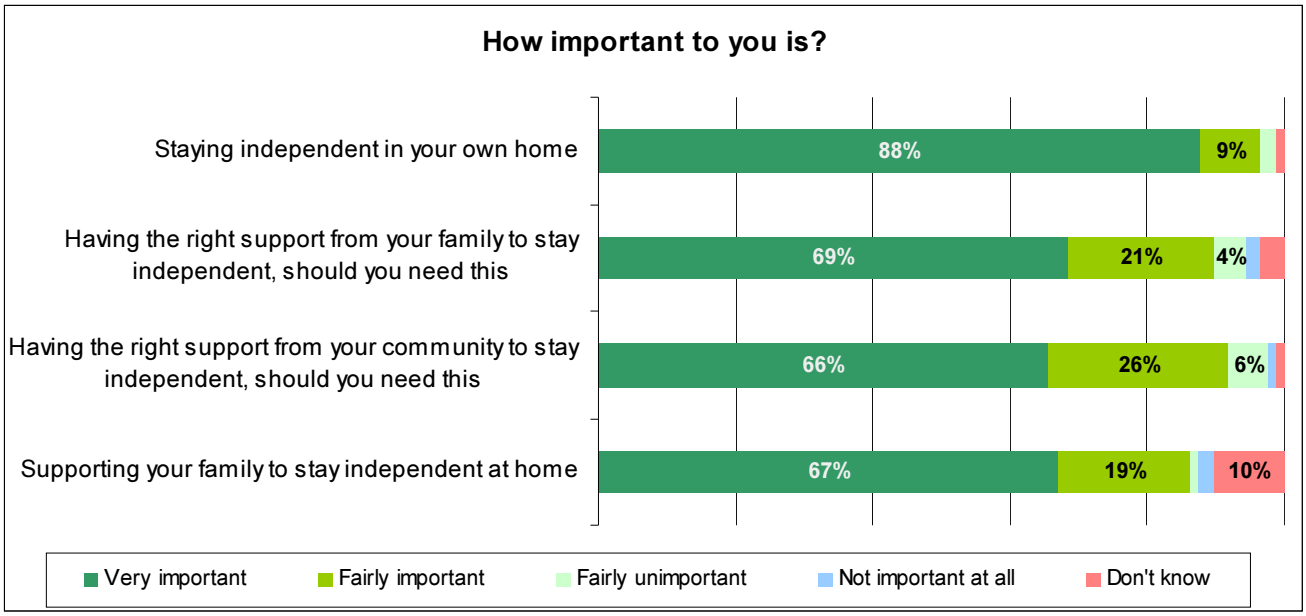


Only a quarter of respondents thought they definitely could do with help to do more of these things; a further 38% said they didn't know and 37% said there wasn't anything that would help. Suggestions for what might help included more time, transport provision, information and guidance, and signposting to those who need help.



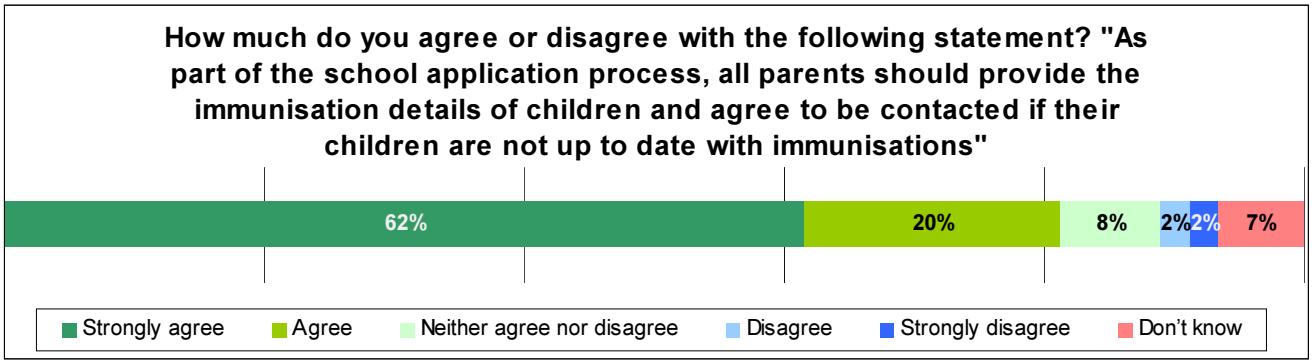
4.4 Improving independence

The vast majority of respondents (88%) say that staying independent in their own home is very important. Around two-thirds of respondents rate the following as very important also: having the right support from their family to stay independent, having the right support from the community to stay independent, and supporting their family to stay independent at home.

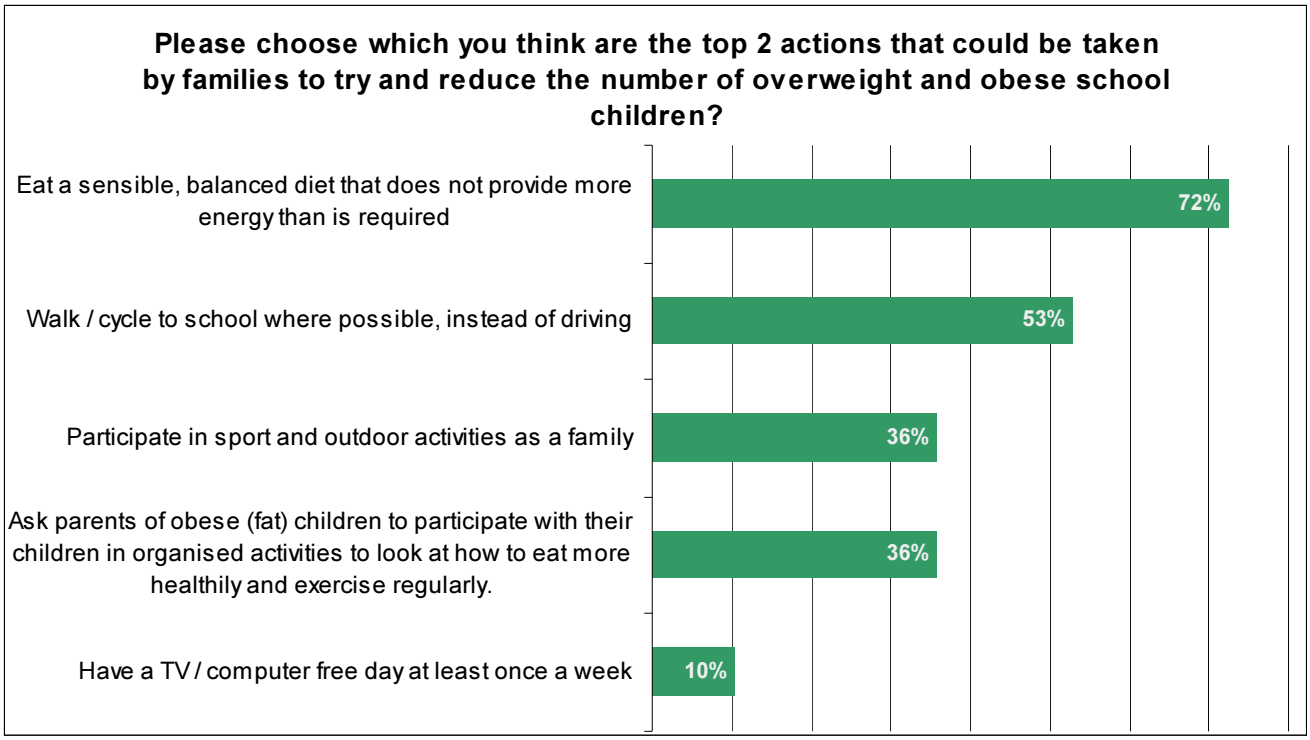


4.5 Preparing for a healthy life

Most respondents agreed that parents should provide the immunisation details of children and agree to be contacted if their children are not up to date with immunisations.



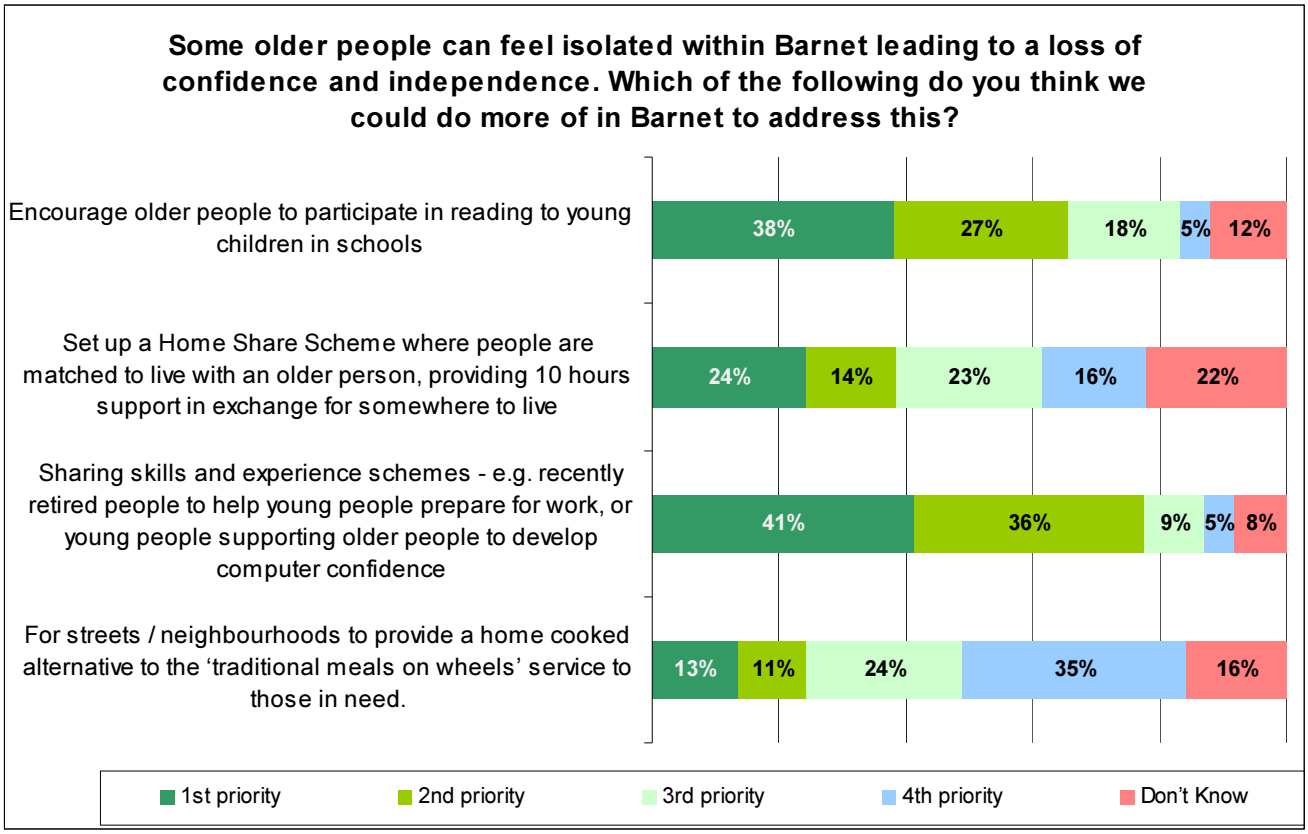
In terms of actions to reduce the number of overweight and obese school children, the most popular seem to be eating a sensible and balanced diet and to walk or cycle to school instead of driving.



Suggestions from survey respondents included parents setting a good example, normal mealtimes, restricting fast food, cookery classes and clubs and recipe ideas, educating parents and sharing ideas. There were also suggestions for cycle safety, meditation, more affordable sports facilities and outdoor activities and restrictions on advertising.

4.6 Wellbeing in the community

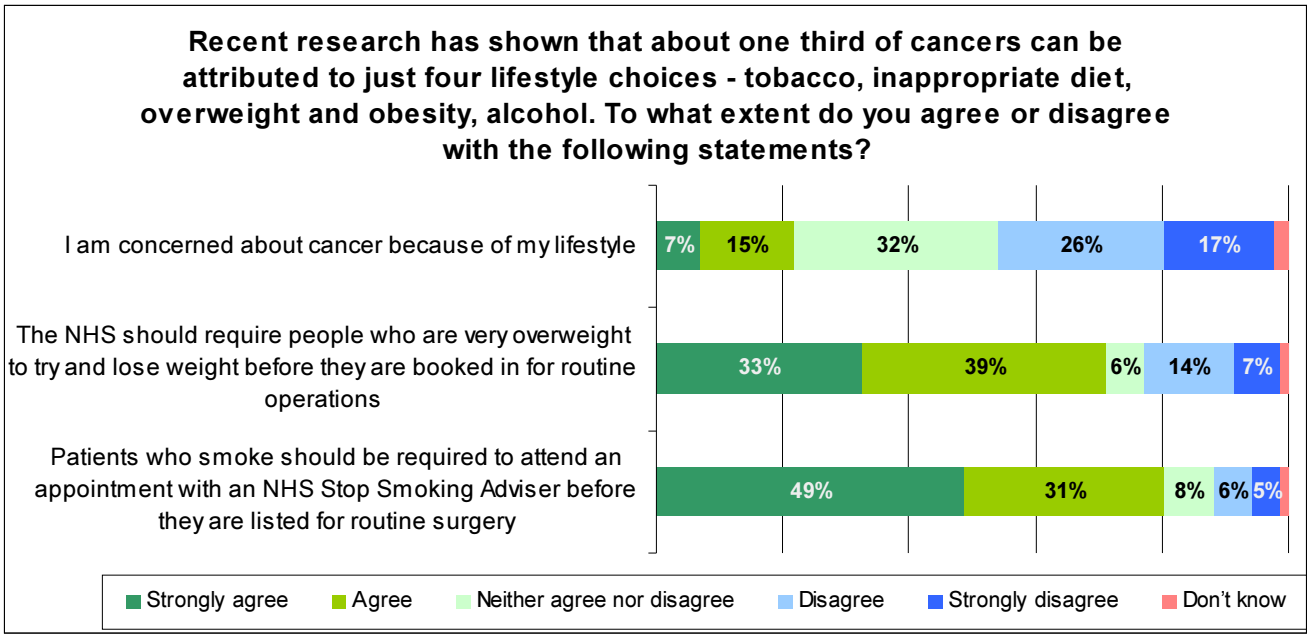
41% of respondents felt that sharing skills and experience schemes was the number one priority, and 38% felt that encouraging older people to participate in reading to young children in schools should be the top priority. Relatively few respondents thought that streets and neighbourhoods providing home cooked alternatives to traditional meals on wheels should be the top priority, and Home Share Schemes were seen as relatively less important also.



When asked what else could be done to reduce social isolation of older people, suggestions included home visits and phone calls, help for the elderly to get outdoors such as transport schemes and day trips, and community groups, day centres, and activities such as leisure walks.

4.7 How we live

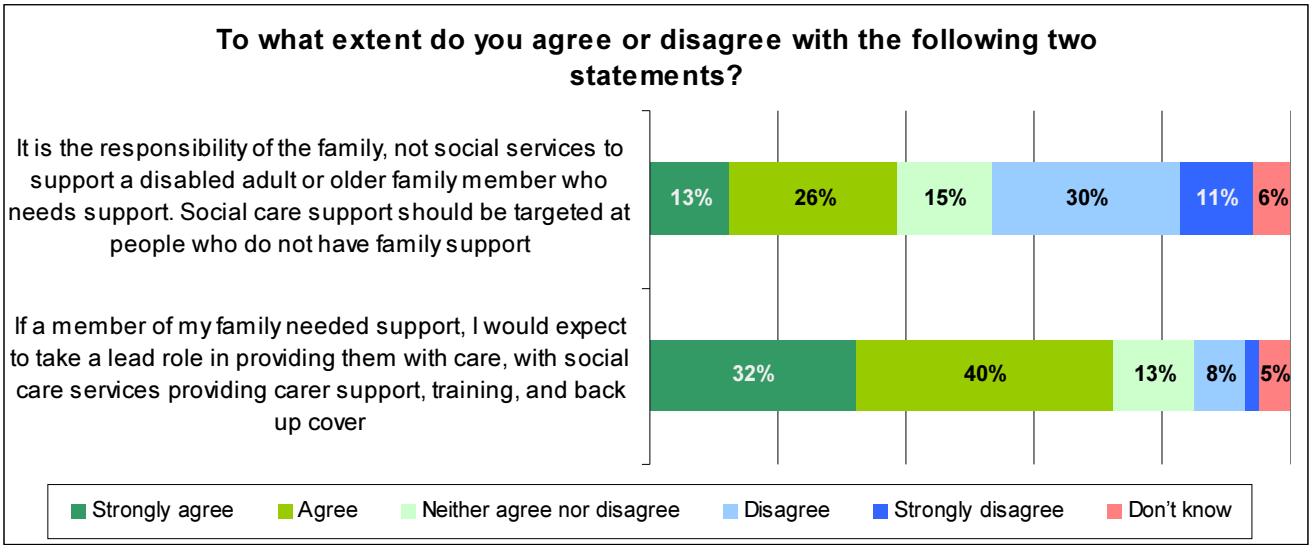
22% of respondents are concerned about cancer because of their lifestyle, with 43% unconcerned. Nearly three-quarters (72%) of respondents felt that people who are overweight should be required to try and lose weight before they are booked in for routine NHS operations. And 80% of respondents felt that smokers should be required to attend an appointment with an NHS Stop Smoking Adviser before being listed for routine surgery.



Of the five respondents who said that they smoked, three agreed or strongly agreed that smokers should be required to attend an appointment with an NHS Stop Smoking Adviser before they are listed for routine surgery, and only one smoker disagreed with this. Of those that have now given up smoking, 84% agreed with this policy.

4.8 Care when needed

There was a mixed opinion on whether social care support should be targeted at people who do not have family support - 39% agreed that it is the responsibility of the family to support a disabled adult or older family member, whereas 31% disagreed. There was much broader support for the notion that they would expect to take a lead role in providing family members with care if needed.



In terms of final comments, several respondents stated that many families were not in a position to take responsibility, or that some people did not have any family they could rely

on. There was also concern that there needed to be sufficient and effective support for family carers, and there was also a feeling that it is actually the role of the NHS and social services to support those in need.

5. Engagement Workshops

A number of meetings were held with the following groups to gather detailed feedback on the strategy:

- Experts by Experience group
- 55+ Forum
- Sheltered Housing Residents
- Barnet Voice for Mental Health
- Barnet Youth Board
- Community Barnet Providers Network
- Friern Barnet High School
- Holly Park Primary School
- Barnet Link Engagement Workshop

Meeting attendees were invited to express their views on all aspects of the Health & Wellbeing Strategy, were engaged in a general conversation about health and wellbeing, and were asked specifically how they thought the Council might implement the strategy.

The following are examples of the residents' views on the strategy, and how the strategy's proposals affect different groups, together with ideas on how the strategy's ambitions might be realised.

5.1 The Strategy

In general, residents thought that the Strategy's ambitions were good, but that there was no real idea of how these ambitions would be achieved. Many thought that it was simply a wishlist, and they doubted that it would actually mean very much in practice.

There was a prevalent view that the Council, through the strategy, perceived the residents as being "social capital", who would "Do the council's work for them", and that this would inevitably lead to a cut in funding for voluntary groups, and day care and community centres. They wished that the council would provide more leadership, and continue to co-ordinate and organise these services, not leave it to the goodwill of residents.

Some criticisms of the Strategy were that it doesn't address mental health issues enough, it needs more work on the problems of the disabled, and that there is insufficient focus on reducing health inequalities

5.2 People with mental health problems

There was general agreement that prevention is better than cure, but concern that this is not happening, and that mental health problems are not getting spotted early enough. There needs to be earlier intervention, which will not only limit the impact of the mental health issue on the person's life and that of their family, but would also save money in the long-term.

The Mental Health Providers Network raised a concern that the strategy did not address how to deal effectively with mental health incidences and did not make enough reference to people's cultural needs more generally.

It was also mentioned that targets for the Improving Access to Psychological Therapies programme are currently not being achieved in the borough, and the network felt that providing welfare benefits advice for people with Mental Health problems should be included in the strategy.

As part of this consultation process, the Barnet Mental Health Partnership Board have put forward suggestions for how Mental Health issues can be addressed under each of the strategy's four priority areas (see Appendix C of this report).

5.3 Disabled residents

Disabled residents felt that the Council needs to be more responsive to their needs, and the particular challenges they face. They found lack of adequate housing to be a problem, with the Council and Barnet Homes needing to think more about disabled people's life changes, and how their housing needs to adapt to these changes.

They would also like to see more information made available to enable them to access parks and green spaces, and they are often unsure whether buildings and parks have facilities for them.

5.4 Older people

The problems of old age present a particular challenge to the council, with an increasing amount of people needing access to care and facilities such as sheltered housing. There was generally perceived to be a severe shortage of sheltered housing in the borough, and that which is available has been subject to cost-cutting with regard to maintenance and the provision of full time wardens. This often led to "fitter" residents doing jobs that should have been done by the council. Many sheltered housing residents weren't keen on tele-health and telecare equipment, valuing the care from an on-site warden, and feeling that having to wear gadgets, such as pendant alarms, would lead to them being spied upon.

Sheltered housing residents would also like more activities to be available to keep them physically, socially and mentally active, and stop them withdrawing from society and increasing the chances of them developing mental health problems, such as depression. Arts and crafts skills and gardening were mentioned as being beneficial.

Old people would also benefit from having more easily available transport, especially to and from day centres.

Many older people would welcome a befriending scheme, which would help alleviate social isolation, and which was especially important for those who were largely confined to the house through ill health or disability. Also, one suggestion was that the council could create a central register of old people who live alone.

5.5 Youth

There was general agreement that young people needed better education about health and wellbeing issues. Many do not necessarily understand why things such as drugs, alcohol, sexual health are important. Any education also needs to be re-inforced regularly throughout their time at school, as many felt that they had not really taken in the information at a younger age.

There was agreement that enforcing strict alcohol sales policies would simply drive drinking “underground”.

Concern was also expressed that teenagers were most vulnerable once they had left education, and were cut adrift from any support or guidance.

Young people would like to have access to stress counselling, especially during exam times, when they felt that their health was suffering, and they reported issues such as inability to sleep and binge eating. Anyone accessing counselling should be ensured anonymity, and the counsellor should not be a teacher at the school, but someone from outside.

There was also a curiosity as to why physical education was taught at school, but mental health issues were never mentioned.

5.6 Generational interaction

Young people reported that they would be happy to help out older people do things like cleaning and shopping, but that this would best be done through a more formal scheme. They suggested that the Council or the schools initiate such a scheme, with the possibility that they could receive some type of recognition – a certificate (“Something I can mention on my UCAS form.”)

Older people stated that they would welcome help from, and the chance to meet, young people, and would be keen for them to teach them how to use computers and access the internet.

5.7 Exercise and leisure

The council’s record was not thought to be good on these issues. Municipal leisure centres were considered too expensive, and that cheaper membership options or “pay as you go” tariffs should be available, especially to those with health problems. Prices were often confusing, and subject to sudden change, with discretionary rates not well advertised. Fixing simple matters like these would lead to much greater use of facilities by all residents, thus having a positive effect on health and wellbeing.

One respondent commented that it was only by being able to swim every day that she would be able to maintain her mental health, and not having affordable access to this would be detrimental to her health.

The lack of cycle lanes in the borough was also widely commented on, with many residents wondering why the Council was not considering these, if they were serious about wanting to improve peoples' general health and fitness.

Another activity that residents widely reported as being important to both their physical and mental health and wellbeing was gardening. Many wanted more allotments to be made available and/or an opportunity to help in the maintenance of parks. Allotments would also allow people to grow their own healthy food. There was considered to be a serious shortage of allotments, and a view that the Council largely neglected or underused its parks and green spaces.

Extra facilities that people would like to see in parks included tennis courts, cycle tracks and outdoor gym equipment. It was also widely felt that parks should be better maintained, and be made more family friendly, with park keepers or community officers looking after them – remote CCTV surveillance, however, was not popular. Young people suggested that schools might occasionally use parks as outdoor classrooms, and that dedicated spaces be made available for this.

5.8 Community amenities and services

Availability of community amenities, and the provision of services was seen as particularly important, and was considered essential for "social health and wellbeing", and particularly the wellbeing of older residents. These were essential support networks for local residents.

Residents were concerned that there had been too many closures of drop-in centres, day centres were too expensive, and there was a lack of transport to and from centres.

It was suggested that more meeting rooms be made available, and that schools could be used in the evenings, weekends and during holidays.

5.9 Environment

There was a general consensus that the built environment had a very important effect on health and wellbeing, with many believing that the aesthetic qualities of developments were not considered seriously enough. Council housing should be improved, and any future developments or regeneration schemes should be much more carefully planned.

Many suggested that unemployed residents might be offered the opportunity to help re-generate the housing estates by helping with things such as tidying up litter, painting, landscaping. There could be some sort of recognised training included in this or, for younger people, payment in the form of free leisure activities, gym memberships, etc.

Many residents wished to see cycle lanes and pedestrianised areas included in any new regeneration projects.

Poor housing was widely considered to be a negative factor in peoples' health and wellbeing, and it was something the Council urgently needed to address.

The borough also has to be more “green”, both in terms of its environmental policies, and literally “green” with the establishment of more parks and open spaces for leisure, and widespread planting of trees, to take the harsh edge off the built environment, and provide an atmosphere more conducive to wellbeing.

One contrary view was that regeneration was a very negative thing for the borough, as it invited more inward migration without the necessary infrastructure being present. There would be further pressure on already stretched resources (schools, roads, medical care) and would lead to a lower quality of life with a resulting negative effect on health and wellbeing.

5.10 Cultural and educational activities

The overwhelming feeling, amongst all groups, was that cultural facilities and activities needed improvement. Many pointed to the paring down of the library service as an example of what they thought the council was doing wrong, and that it seemed to be contradictory to many of the ambitions in the Health & Wellbeing Strategy.

Residents wanted more educational opportunities, with free or cheap courses in literacy or IT skills, which would help get them back into work, or in basic “living skills” for those who found it difficult to navigate our increasingly complex society – courses in managing money, recognising and coping with mental health issues, self-management, filling in official forms, or accessing benefits were mentioned.

There was also concern that such activities that do exist were not well advertised, and residents would like to see a comprehensive guide published online, and as a hard copy, perhaps in partnership with the local newspapers, or the establishment of some type of “one stop shop” for all community information, including a guide to all services that the council offer.

5.11 Implementation, updates and feedback

Voluntary groups and service providers would like representation on the Health and Wellbeing board, and residents were keen to receive regular feedback and updates on progress made on the Strategy’s implementation. A suggestion was that some sort of vehicle might be created by which residents’ proposals might be taken forward – possibly the formation of a committee including residents’ representation

Some residents proposed that a list of things which they would definitely want to see preserved should be drawn up, as there was the danger that when services are joined up some services would go.

Appendix A

Feedback from Barnet Link

The Council should use the voluntary sector more widely to disseminate information and to help co-ordinate activities. The Council should map existing services and providers and ensure that consistent messages are sent out through providers and that funding is in place to enable providers to tackle health problems.

The group were in agreement that people should not be denied health care on the basis of their existing health profile, such as obesity or smoking. Everyone should be entitled to health care in both primary and secondary settings (GPs, hospitals, access to drugs and operations). Some people are very vulnerable and if they are told that they have to meet certain conditions before they are treated, this might be intimidating to them and they then might avoid engaging with the health service altogether to the detriment of their health and well-being.

40% of those present said that the strategy is not perceived as a strategy as the 'how' is missing. It is a "wish list" of what could be done, but there is no detail or clarity on what will actually be implemented or how the services will be delivered. It did not seem that there would be an open opportunity for further discussion once feedback is received and the final strategy is published.

When the Council has made decisions, residents should also be consulted on which services will be delivered, how, by whom, when and where, before the decisions move to the implementation stage.

Real worry was expressed about the huge shift in placing greater responsibility on individuals and families for their own health and their lack of their involvement in shaping the strategy or defining its implementation. Much more effort should have been made to involve many more residents, for example, a leaflet should have been put through every letter box.

The emphasis on prevention is welcome but more is needed in terms of implementation. Importance of MOT yearly health check that will aid prevention of health matters deteriorating. Universal MOT health check should include Vitamin D deficiency, eye screening (for all ages).

Concern was expressed about the greater responsibilities being placed on families (caring, change of lifestyle, etc) associated with this document with no evidence of any involvement from families/ young people in the design of the consultation. Or have they?

Overall, the group concluded:
a. the strategy is packed with ideas but full of practical problems
b. promoting the document as a strategy could be disempowering, as a society we might not yet be ready

The four priorities:

1. Preparing for a healthy life
Children experience a range of influences, from their parents to television advertising. The Council should influence as many channels or providers as possible. This includes the provision of school dinners to supporting and promoting local suppliers on the high street to stock healthy produce.

Residents were concerned that some services were prioritised because there is funding attached. For example, immunisation is paid for by central government which is why it is included. In addition, some thought that parents and young people should have a choice as to whether to accept immunisations or not.

The loss of funding to children's centres and for health visitors and midwives, means that parents are not getting the essential information and support they need not only about healthy eating, but also about immunisations, and exercise for their children. Participants saw these cuts to services as a short term measure to save money now, whereas it would make better economic sense to continue to fund these services so that today's young people do not end up with avoidable health problems, needing NHS care, later in life.

Children should be encouraged to learn about how to grow and cook food in school. This could be done very cheaply and easily.

2. How we live
Volunteers can be used in some situations. For example, parents could take turns in walking a group of children to school rather than using the car. We know this already happens in some areas and consider it should be a scheme encouraged throughout the borough.

"Adult prescriptions" such as free access to swimming pools have been cut. In some cases, this was said to be because of low take-up, but it could be because of lack of awareness or lack of confidence.

Some of the green spaces run by the Council are attractive and well-used. There should be more adult playgrounds. Physical activity opportunities for adults should be much more widely promulgated and supported.

3. Wellbeing in the community
The strategy does not seem connected with wider strategies to empower residents to take a more active role in their health, particularly in relation to any employment.

Greater connection between social-health gradients and economic activity is needed if some of the ambitious proposals are to become a reality because improving lifestyle choices and wellbeing depends on the economic level of an individual (i.e. paying for exercise classes, buying better quality food, not having to work 45 hrs a week, and having the time and knowledge to cook properly).

A suggestion was made to suggest to families/individuals to save up for older age as its likely they will need care, including considering buying insurance.

No mention is made of problems associated with visual impairment;- 60% of people with a visual impairment have health conditions that are largely preventable, including depression, stroke, diabetes. Eye screening for all elderly people could be useful in the early detection of associated life-style diseases.

4. Care when needed

The group had concerns about the emphasis in the document on the shift in responsibility to individuals without information about the support/plan/clarity needed for individuals to take on this bigger role. Quote: *'This strategy is asking a mother to take a more active role, when they might already have a plate full of responsibilities and the new responsibilities are being dumped on her plate without her knowing!'* Furthermore, government/policy makers are assuming that within a family setting parents/carers could persuade lifestyle choices or wellbeing approaches: *" Within a family you can't always influence on health- I think my son is diabetic but he would not get tested".*

Yet another concern is about the greater responsibility within the family setting for caring, without evidence of any plans for proper support for carers. This will increase financial hardship and might trigger other health problems for these carers.

It was suggested that a proactive health check screening system, every 2/3 years, should be instituted to identify problems and encourage the necessary changes as early as possible. At present it was felt that there is a lack of consistency in screening across Primary Care/GPs.

Appendix B

Labour Group's Submission to 'Keeping Well, Keeping Independent' Consultation

Page 6

We agree that Barnet's flourishing Third Sector has a key role to play and consider this to be undermined by the continuing cuts that the Council has imposed on them. The need to grow social capital, especially in areas of disadvantage, is vital to the success of the strategy.[see page 10 2.2 Building effective community capacity to provide the right support when needed together with a focus on early intervention form the key priorities for this group(the retired)].

We agree that all Council services have a role to play in delivering the strategy - however, there seems to be no consideration of the effect of the move to a commissioning Council and the effect that will have on the ability and coherence of the different services, especially the regulatory services. The strategy states' All Council services have a role to play in promoting health and well-being and support delivery of this Strategy.' What about services that are to be outsourced - for a 3 year strategy this is a glaring ommission.

2.1
The fact that 18,195 children live in poverty and that this is a major determinant in health inequalities throughout their lifetime seems to be acknowledged[2.2, top of page 10]. The need for a proper and effective anti-child poverty strategy is not e.g. the importance of year round affordable childcare, the need to increase the availability of good quality social housing, etc.

2.3
Several comments on this section

- There needs to be a clearer acknowledgement on the need to intervene at the public as well as individual level; an example of this is the success of the smoking ban in public places - one cannot rely on the market to provide a healthier environment.
- The role of planning, regeneration, neighbourhood and town centre plans is mentioned. This is important to the strategy's success but does need to be pro-active e.g. looking at restricting the number of fast food outlets near secondary schools or in areas of high deprivation. This should be explicitly mentioned in the strategy.
- If these services become commissioned they need to sign up to the strategy and provide monitoring information that is open to scrutiny.
- 5 - "Developing greater local community capacity'...see comments above regarding the cuts to the very services that are to be developed.

3.1
Paragraph 2
This highlights the fact that inequalities begin pre-birth and again provides evidence of the need for a proper and effective strategy to attack child poverty. This is lacking in Barnet.
Last paragraph and several other places.
The need for effective partnership is vital. This needs to be built around a one public sector ethos that realises there are not market solutions to care - one cannot commercialise compassion.

4.1
We totally agree there is an important link between how places are planned and developed and the health of the communities who live in them. How will Barnet ensure that planning enhances a healthier built environment when it is a commissioned service? Similarly we agree with the link between unemployment and mental health is well documented - however the strategy does not comment on the cuts in public services that are adding to unemployment and the fact that this may increase demand on already stretched services.

4.2
We fully support bullet point one 'Use the Council's planning and licensing processes to create a built environment that is conducive to to healthy living choices such as walking and the accessibility of safe open spaces. However, we fear if these vital services are outsourced it will undermine the ability of the Strategy to deliver.

5.2
Last bullet point.
'Continue Trading Standards under-age alcohol sales test purchasing programme together with enforcement of Licensed premise licence conditions in relation to sales of alcohol to people who are already drunk.' As these do not bring in an income what is the incentive for a private company to prioritise these objectives?

6.3
The realignment of spending in both NHS and Social Care to provide a greater focus on prevention. This is to be welcomed, but the delay in dealing with long-term funding of social care, especially residential, will increasingly lead to greater costs to commissioners and the reversal of this move to prevention.

Cllr. Barry Rawlings on behalf of the Labour Group

Appendix C

Mental Health Partnership Board 19 April 2012

Feedback from Small Group Working

How would you see Mental Health (MH) fitting into the four themes?

1.1 Theme 1: Preparation for a healthy life – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development

- good sexual health and contraception strategies
- medication – stopping when pregnant
- maternity, post-partum psychosis
- post natal depression – early recognition - allied with medical conditions – risk factors - identification of pre-disposition
- ability to care for child
- planning with service users – care and support for mothers
- mothers getting early intervention:
  - substance misuse and mental health specialist midwifes
  - support around education
- access to MH services for children in a non-stigmatising way
- nurses in schools – awareness
- education
- in schools? 'Place 2 Be'. Partnership work with schools and young people
- advocacy
- investment in schools – Do they recognise child mental health? Very busy!
- teachers need a quick route to support them 'don't have time'
- non diagnosed children need input for prevention
- family work
- MH as part of safeguarding training
- adult service linking with children's services, specifically around services for adult MH
- CAMHS services – link with adult

1.2 Theme 2: Wellbeing in the community – that is creating circumstances that better enable people to be healthier and have greater life opportunities

- education
- not reinventing the wheel – using resources that are already out there – Time for Change campaign etc
- employment opportunity
- befriending – investment in services
- awareness of duty of care to self!
- social isolation

- social networks (includes online) / facilities, befriending, parks, libraries
- exercise, diet and mental health
- integrated provision
- housing
- anti-stigma
- awareness
- transport
- safety
- finance

1.3 Theme 3: How we live – that is enabling and encouraging healthier lifestyles

- education
- walking groups
- smoking cessation targeting MH
- link between substance misuse self medication / mental health

1.4 Theme 4: Care when needed – that is providing appropriate care and support to facilitate good outcomes

- education
- reducing isolation
- GPs (and all services and other groups) – need much better awareness of what's out there in the community
- provision of information / MH Guide
- communication about what is available and its limits
- access to IAPT (should be greater than 5%!)
- employers supporting employees
- personalisation
- dignity
- education
- choice
- service user support for carers

Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**Draft Integrated Prevention Plan**
Report of	Director for Public Health
Summary of item and decision being sought	This draft report sets out the proposed partnership approach to improve people's health and well-being through taking a variety of preventive actions to reduce the incidence of avoidable ill-health. Health and Well-being Board members are invited to comment on this report before it is finalised.

Officer Contributors	Dr Andrew Burnett
Reason for Report	Prevention is a key aspect of improving people's health and using scarce resources effectively and efficiently.
Partnership flexibility being exercised	N/A
Wards Affected	All wards

Contact for further information

Dr Andrew Burnett, Director for Public Health andrew.burnett@nclondon.nhs.uk

1. RECOMMENDATION

1.1 Health & Well-being Board members are asked to comment on this draft plan (as set out in Appendix A), with a view to approving it, to enable its finalisation and implementation

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well Being Board, 17 November 2011- item 5; developing the Health and Well-Being Strategy. This report agreed the proposed structure of the Health and Well-Being Strategy and delivery mechanisms including the integrated Prevention Plan.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 This draft plan focuses on preventing avoidable ill-health. There is considerable scope for partnership working and it is fully compatible with the draft Health and Well-being Strategy, the draft Integrated Commissioning Plan, the JSNA, and the annual report of the Director for Public Health, Barnet

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 This draft plan is based on assessed needs and implementing its recommendations can reasonably be expected, over time, to significantly contribute to reductions in health inequalities

5. RISK MANAGEMENT

5.1 Failure to address the 'causes of the causes' of avoidable ill-health and health inequality will lead to greater levels of ill-health, greater health and social care costs and widening health inequalities

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. Steps that may be taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the *prevention*, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities.

6.2 In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions.

6.3 Regulations setting out the detailed obligations are yet to be issued.

6.4 Proper consideration will need to be given to the duties arising from the Equality Act 2010 as mentioned above.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 Additional resources will be needed to implement some of the recommendations in this report: these will need to be prioritised from within existing NHS and local authority budget allocations. The ring fenced public health budget will be the main source for this, with resources prioritised against the public health commissioning intentions and the objectives for the new shared Barnet and Harrow public health function.

7.2 Every objective is accompanied by a commentary on likely resource implications, but it has not been possible to cost individual projects at present, This will be concluded when the operating model for the new shared public health service for Barnet and Harrow has been finalised, and will be included in future updates of performance against the Plan.

7.3 In summary, the financial status of each area of work in the Plan is as follows:

Staff time only required and other resources identified;

1.3.1 Non Cancer screening
1.3.2 Cancer Screening
1.3.3 Immunisation
1.3.4 Falls avoidance
1.3.5 Winter Well (maintenance of ongoing advice)
1.3.6 Smoking Cessation (current work)
1.4.2 Home learning Environment (Research)

Resourcing in process of being negotiated or bid for;

1.3.5 Winter Well- extension of work
1.4.1 Health Checks (to 31/3/13- after that date will require allocation from Public health budget)
1.4.2 Overweight and obesity –being explored at London-wide level
1.4.3 enabling physical activity (as part of sport and physical activity review)

No resources identified as yet:

1.3.6 Smoking cessation- enhanced levels
1.4.2 Home Learning Environment- projects arising from research
1.4.4 Prevention for people with physical health problems and unrecognised mental health problems
1.4.5 Prevention for people with mental; health problems and learning disability and unrecognised physical health problems

7.4 The recommendations have been shown by evidence based research to be cost-effective.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The development of the Prevention Plan has taken account of the substantial feedback received through the public consultation on the Health and Well-Being Strategy, particularly taking account of feedback from residents regarding lifestyle issues. Formal

engagement and communication with users and stakeholders for the integrated prevention plan will occur following approval by the Board..

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None yet for the reasons outlined in paragraph 8.

10. DETAILS

10.1 Preventing avoidable ill-health and disability is an important way of improving people's well-being, as well as releasing resources for use in other services. This draft plan sets out activities, some of which are currently undertaken and should be continued, others that are currently undertaken and should be developed to enable more people to benefit, and still other activities that are currently not undertaken and should be if we are to improve people's health in Barnet as best we can.

10.2 There are three types of prevention and all are relevant to improving the health and well-being of people in Barnet:

- primary – that is, trying to prevent something from happening in the first place, by, for example, hand washing; breast feeding; encouraging and enabling people not to start smoking, being immunised, eating healthily;
- secondary – that is, preventing the early phases of a condition from developing further, such as detecting and treating conditions (for example, high blood pressure, diabetes) at a sufficiently early stage so that they can be controlled before the onset of complications; and
- tertiary – which is aimed at minimising established effects and complications of established disease to reduce disability and restore functioning as far as possible.

10.3 This is referred to as an 'integrated' prevention plan because (i) activities need to be integrated with other organisations, and (ii) activities need to be integrated with policies and as part of everyday service provision. This is a significant component of what is meant by 'joined-up care'.

10.4 This plan is structured in the same way as the draft Health and Well-Being Strategy, that is:

- preparation for a healthy life – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
- wellbeing in the community – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
- how we live – that is enabling and encouraging healthier lifestyles; and
- care when needed – that is providing appropriate care and support to facilitate good outcomes.

10.5 The key prevention activities that need to be developed further in Barnet are:

- non-cancer screening;
- cancer screening;
- immunisation;
- falls avoidance;
- Winter-well programme; and
- smoking cessation.

10.6 The key prevention activities that need to be started in Barnet are:

- avoidance of overweight and obesity; reduction of existing overweight and obesity;
- improving the home learning environment for children living in poverty;
- enabling people to be more physically active;
- secondary and tertiary prevention for people with physical health problems and unrecognised mental health problems; and
- secondary and tertiary prevention for people with mental health problems and those with learning disability and unrecognised physical health problems

10.7 This draft Plan will inform the priorities for the shared Public Health function for Barnet and Harrow and the detailed Implementation Plan will be brought forward to the Health and Well-being Board by the Joint Director for Public Health in early 2013, once the resources for Public Health are clear and commissioning intentions have been consulted on.

11 BACKGROUND PAPERS

11.1 Joint Strategic Needs Assessment (2011-2015): http://www.barnet.gov.uk/downloads/download/356/joint_strategic_needs_assessment_2011-2015

11.2 Barnet Health & Well-being Strategy (elsewhere on this agenda)

11.3 Annual Report of the Barnet Director for Public Health: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=6565&Ver=4.

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Integrated prevention plan

1. Introduction

Preventing avoidable ill-health and disability is an important way of improving people's well-being, as well as releasing resources for use in other services. The purpose of an integrated prevention plan is to ensure that actions are taken across the public sector in all areas that Barnet Council and Barnet Clinical Commissioning Group influences through service commissioning and provision to improve people's well-being.

There are two, complementary, approaches to prevention and both are required in concert if we are to enable greater well-being in Barnet and make best use of our resources in so doing. The first might be thought of as the 'medical model' where, predominantly, clinicians identify issues affecting people's well-being and provide or recommend interventions at an individual level. The second might be considered as a 'social model', which involves intervening at a community (or population) level to create the circumstances in which people can live healthier lives. Neither approach alone will have sufficient impact to make a significantly large, long-lasting and borough-wide impact on people's well-being.

This plan sets out the key things that need to be done to help to deliver the intentions of the Barnet Health and Well-being Strategy, existing work, takes account of the focus on prevention in this year's annual report of the Barnet Director for Public Health and considers some of the implications of a recent report from the London School of Economics on the impact of untreated mental illness in people with physical health problems.

1.1. Context

The ambition articulated in the Barnet Health and Well-being Strategy is for all Barnet's residents will be able to live as healthily and as independently as possible by:

- being free of avoidable ill-health and disability;
- being able to take responsibility for their own and their family's health and wellbeing; and
- each being able to harness the support of their family and friends and the community.

Key to making this happen is preventing avoidable ill-health and disability. There are three types of prevention:

- primary – that is, trying to prevent something from happening in the first place, by, for example, hand washing; breast feeding; encouraging and enabling people not to start smoking, being immunised, eating healthily;
- secondary – that is, preventing the early phases of a condition from developing further, such as detecting and treating conditions (for example, high blood pressure, diabetes) at a sufficiently early stage so that they can be controlled before the onset of complications; and
- tertiary – which is aimed at minimising established effects and complications of established disease to reduce disability and restore functioning as far as possible.

The Barnet Health and Well-being Strategy has four overlapping (that is, not sequential) themes, which are:

1. **preparation for a healthy life** – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
2. **wellbeing in the community** – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
3. **how we live** – that is enabling and encouraging healthier lifestyles; and
4. **care when needed** – that is providing appropriate care and support to facilitate good outcomes.

1.2. What does 'integration' mean?

There are many determinants of health, including the pre-school home learning environment, educational achievement, employment status, income, housing, lifestyle, work environment, home environment, and health and social care. To improve the well-being of people as individuals and at a population level requires concerted action across many, if not all of these areas, and not just one of them.

Similarly, in terms of the provision of health and social care, especially as people live longer and do so with two or more long-term conditions (which will often include a mental health issue), they need concerted support from several agencies simultaneously. Yet the organisational arrangements of many such agencies often militate against this.

We therefore need to commission services as complete (and often complex) packages or pathways that involve more than one agency whereby teams of people with different areas of knowledge and expertise can be brought together to provide such care, including prevention services, for the benefit of both individuals and populations. No one organisation can alone provide what is needed other than in the most limited way.

Put another way, integrated care is approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs.[i] This is consistent with the Barnet Integrated Commissioning Plan's intentions that:

> "People and their carers at the heart of a joined-up health and social care system that is built around their individual needs, delivers the best outcomes, and provides the best value for public money. Integrated care will be commissioned by expert commissioners in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations."

Similarly, integrated prevention concerns incorporating various ill-health prevention and well being-promoting activities into services commissioned by one or more agencies from one or more providers such that all service provision includes significant prevention components at appropriate points in the patient/service user care pathway.

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i The King's Fund, Nuffield Trust. *A report to the Department of Health and the NHS Future Forum. Integrated care for patients and populations: improving outcomes by working together.* The King's Fund. London. 2012. http://www.kingsfund.org.uk/publications/future_forum_report.html (accessed 22 June 2012)

1.3. Key prevention activities that need to be developed further in Barnet

1.3.1 Non-cancer screening

The following non-cancer screening activities are undertaken and should be continued:

- diabetic retinopathy
- abdominal aortic aneurysm
- neonatal hearing
- neonatal blood spot for multiple congenital diseases

These are commissioned through the NHS but require public health support to ensure adequate take-up and to provide assurance.

Resource implications

Staff time is required for the commissioning aspects of these services, including monitoring and provider liaison.

1.3.2 Cancer screening

The following cancer screening programmes need to be developed to increase take-up:

- breast
- cervix
- rectum and colon

These are commissioned through the NHS but require public health support to ensure adequate take-up and to provide assurance.

Resource implications

Staff time is required for the commissioning aspects of these services, including monitoring and provider liaison. It is necessary to promote these services more and this will also require work with community groups.

1.3.3 Immunisation

This includes childhood immunisation, seasonal flu immunisation, additional immunisation, for example, with pneumococcal vaccine for certain at-risk people and prophylactic immunisation after exposure to people with certain infectious diseases.

We need to extend immunisation services to achieve 95% coverage not only in newly eligible people, but in children and adults who are beyond the routine age for particular immunisations but have missed them or have uncompleted courses.

Resource implications

Childhood immunisation will become the contractual responsibility of the National Commissioning Board (NCB) for the NHS. Assurance that adequate levels are being achieved will require local public health staff time to liaise with the NCB and, as may become necessary, with local gp practices and other providers.

1.3.4 Falls avoidance

Falls, especially in the elderly put people at high risk of fracture, especially of the hip, and premature death or prolonged high levels of dependency.

Extending awareness of falls risks amongst front line health and social care workers in primary, community, secondary, tertiary, social, independent and voluntary care sectors so that risk assessment and prevention advice can reach more people will reduce the risk of falls and reduce morbidity and, possibly, mortality.

Resource implications

Staff time is required to raise awareness of falls avoidance with service providers and community groups. Any contractual implications for NHS providers will need to be discussed with NHS Barnet CCG.

1.3.5 Winter-well programme

This is aimed at reducing excess Winter deaths through raising awareness of the need for adequate heating and adequate clothing when indoors and out during the colder months of the year.

Last year's mild Winter and record low seasonal flu rates should not lull us into a false sense of security. The preceding Winter was the coldest for 30 years. There is a direct relationship between cold weather and increased deaths and such deaths are avoidable.

Resource implications

Staff time is required to ensure that people's awareness is maintained of this issue. Barnet Council was successful in bidding for Department of Health funding for this initiative and there is an opportunity to do so again. If such a bid is successful it will be possible to extend work with third sector organisations and to enable wider provision of services.

1.3.6 Smoking cessation

This is the most significant secondary prevention activity we undertake and has probably played the largest part in closing the health inequality in cardiovascular disease deaths in Barnet over the last four consecutive years. Activity levels need to be significantly increased and bolstered with a tobacco control programme that targets school children.

Resource implications

Funding is currently in place and staff time is required for the commissioning aspects of these services, including monitoring and provider liaison. Increasing the number of people who quit smoking will require additional funding. There is no obvious source for this at present.

1.4. Key prevention activities that need to be started in Barnet

1.4.1 Health checks

Because of Barnet PCT's very challenged financial position, the board took a decision not to prioritise investment in a health checks programme on a temporary basis in order to ensure that other key services could be adequately supported. In deciding this, the board took into account the fact that Barnet already had a very high case ascertainment rate for diabetes (99.3% of the expected number vs. 88.3% nationally), that is, Barnet GPs were already very effective at identifying people with diabetes; and that performance in diagnosing high blood pressure and other key risk factors relevant to cardiovascular disease approximated to national medians. Barnet prescribing data also indicate high intensity treatment for these conditions.

In addition, Barnet GPs and community pharmacists and the Barnet Stop Smoking Service have consistently exceeded their targets since 2006 in enabling smokers to quit and have aimed such activities especially at people living in the more deprived areas of the borough. The impact of this is shown in the sustained closure of the health inequality gap for premature death (that is, under the age of 75 years) from heart attack and stroke in the borough for the last four consecutive years. This has been achieved

in the years preceding this closure by a faster lowering of death rates amongst people living in the most deprived parts of the borough. It is a significant health improvement achievement that can be attributed mainly to smoking cessation activity. It is discussed fully in the 2012/13 annual report of the Director for Public Health, Barnet (see http://barnet.moderngov.co.uk/documents/s4107/Appendix.pdf)

Now that Barnet PCT's financial situation is easing, it is putting together plans with NHS London to offer and undertake cardiovascular disease health checks again and expects to substantially increase its 2011/12 performance (2,288 offered, 1,209 taken up) by the end of March 2013. This should enable a sound platform for Barnet Council when it takes on responsibility for health checks in 2013.

The council is seeking approval through Cabinet Resources Committee on 18 October 2012 for a 'Later Life Planners' model which aims to provide a flexible 'one stop shop' for older people to help them to plan for their future and think about their next steps after retirement. The Later Life Planners will also be contributing to the NHS Health Checks initiative to ensure that an environment exists that includes health checks as a matter or priority to enable older people plan for their later life.

Resource implications

Funding is being negotiated with NHS London and NHS North Central London for health checks to 31 March 2013. Local authorities will be expected to fund health checks from their public health allocations from April 2013.

1.4.2 Avoidance of overweight and obesity; reduction of existing overweight and obesity

The importance of this in reducing morbidity and mortality in Barnet is second only to smoking cessation and tobacco control. Obesity, and its precursor overweight, significantly increases the risk of developing a number of conditions including some cancers, high blood pressure, and – most significantly – diabetes.

Resource implications

There has been no funding available for this work in the past and there is no obvious source at present. Nevertheless child obesity is one of the priority programmes of the London Health Improvement Board (LHIB), which is taking forward issues that can best be tackled at a pan-London level because it is a more efficient use of resources and can leverage additional resources, such as Transport for London, the third sector and business, thereby helping fulfil Borough obligations outlined in the Public Health Outcomes Framework. Discussion is ongoing through London Councils on how Boroughs might contribute towards the programme by passporting a small proportion of their ring fenced public health funding.

It would be possible to develop a scheme that involves signposting people to self-funding services. In addition, staff time would be required to raise awareness of the issue with front-line personnel and local community groups.

It is most important that initiatives to reduce overweight and obesity are linked with the developing sport and physical activity review.

Improving the home learning environment for children living in poverty

Educational attainment is a major determinant of people's health. Children living in poverty (as some 24% of Barnet's children do – that is, about 18,000 children) generally do less well at school and have statistically significant lower educational attainments. There is good evidence that enabling the parents of such children to support them more effectively, especially in terms of improving the home learning environment, significantly improves their attainment at school and can be related to improved health.

Resource implications

We are currently undertaking a research project into parental attitudes to the home learning environment in Barnet. This research is fully funded. Any proposals to help develop parental skills and the home learning will need to identify the resource implications as well as the benefits.

1.4.3 Enabling people to be more physically active

Increasing levels of physical activity reduces the risk of premature death and of developing overweight and obesity, dementia, cardiovascular disease, physical infirmity and falls. Nearly all of us can significantly increase our levels of physical activity simply by walking more, using stairs rather than lifts, walking up escalators, and taking up activities from gardening to cycling and from swimming to dancing.

People need to be helped to be aware of the benefits of being more physically active, and how to do this simply as part of everyday activities. But in addition, planners, nursery and pre-school groups, schools, higher education establishments, employers, voluntary organisations, community organisations and others need to create circumstances such that being more physically active is easier and something that needs to be actively opted-out from rather than something that has to be opted-in to.

Resource implications

This is being addressed through the developing sport and physical activity review being undertaken by Barnet Council.

1.4.4 Secondary and tertiary prevention for people with physical health problems and unrecognised mental health problems

There is evidence that many people in hospital (and elsewhere) who have long term physical health problems have unrecognised and thus untreated mental health problems which, in addition to reducing the quality of their lives, reduces the efficacy of their physical health treatment. Identifying and managing such mental health problems has been shown to reduce hospital length of stay and improve the quality of life.

Resource implications

There is evidence that such initiatives can save substantial sums of money. Any business case to address this issue needs to identify how such an initiative could recover sufficient funds in-year to cover costs. This would require co-operation between services commissioners and service providers.

1.4.5 Secondary and tertiary prevention for people with mental health problems and those with learning disability and unrecognised physical health problems

Many people with long-term mental health problems and many who have learning disability die prematurely from conditions that are amenable to preventive interventions and/or treatment. These physical health problems are often unrecognised and/or not managed appropriately. The same applies to lifestyle habits, especially smoking (in people with log-term mental health problems) and overweight and obesity in people with mental health problems and in people with learning disability.

Resource implications

There is evidence that such initiatives can save substantial sums of money. Any business case to address this issue needs to identify how such an initiative could recover sufficient funds in-year to cover costs. This would require co-operation between services commissioners and service providers.

This plan sets out the main ways in which the NHS and the local authority in Barnet intend to improve people's well-being through prevention in the context of these themes.

2. Preparation for a healthy life

Enabling the delivery of effective pre-natal advice and maternity care and early-years development.

Action	Potential activity areas	Success measure	Senior responsible owner
Providing women, and their partners where possible, with advice about being as healthy as possible before a planned pregnancy	■ family planning clinics and young people's sexual health services ■ GUM clinics ■ GP surgeries ■ youth services	■ contract monitoring of providers confirming advice given ■ uptake of leaflets	Assistant Director, Public Health
Early access to maternity care that is compliant with National Institute for Health and Clinical Excellence guidelines	■ GP surgeries ■ hospital-based maternity services	■ contract monitoring	Assistant Director, Public Health
Healthy early years	■ midwife interventions to promote an effective home learning environment ■ health visitor interventions to promote an effective home learning environment ■ GP interventions to promote an effective home learning environment ■ parenting classes ■ enablement of parental literacy ■ volunteer schemes providing reading to pre-school and to school children	■ contract monitoring ■ uptake of parenting classes ■ uptake of parental literacy classes ■ uptake of volunteer schemes providing reading to pre-school children and to school children	Assistant Director, Public Health
Substantially increasing the number of smoking quitters amongst pregnant women	■ antenatal clinics ■ specialist smoking cessation services ■ GP surgeries ■ community pharmacies	■ smoking quitter rates in pregnant women	Assistant Director, Public Health
Reducing the rate of overweight and obesity in reception and year-6 children	■ advice on improved maternal nutrition ■ 12-week assessment during pregnancy to target women who are overweight or obese	■ reductions in the number of women planning pregnancy and who are pregnant who are overweight or obese ■ increased breastfeeding rates at six	Assistant Director, Public Health

	■ encouragement of exclusive breastfeeding for six months ■ encouragement of higher levels of physical activity ■ promotion in GP surgeries ■ health visitor promotion ■ work with pre-school groups and Children's Centres	months ■ reductions in the proportions of children who are overweight and obesity in reception and year-6	
Reducing the number of children and young people who smoke and/or who misuse alcohol and drugs	■ promotion through schools, young people's community and youth groups ■ promotion in GP surgeries ■ promotion in children's and other hospital outpatient services and in A&E departments and walk-in centres ■ promotion in young people's sexual health services ■ promotion by personnel providing support services of all types to children and young people, including looked-after children	■ contract monitoring and other reporting	Assistant Director, Public Health
Increasing the uptake of all childhood immunisations	■ promotion in GP surgeries ■ promotion through midwifery services before and after delivery ■ health visitor promotion ■ work with pre-school groups and Children's Centres ■ promotion through schools ■ promotion by personnel providing support services of all types to children and young people, including looked-after children	■ increased uptake rates of all children's immunisation	Assistant Director, Public Health

3. Well-being in the community

Creating circumstances that better enable people to be healthier and have greater life opportunities

Action	Potential activity areas	Success measure	Senior responsible owner
Taking health and wellbeing considerations into account in council and health service policies and plans	■ enforcement of tobacco control regulations ■ involvement of schools in encouraging children not to start smoking (including avoidance of second-hand smoke) ■ all front line personnel trained in Level 1 smoking cessation service so that they can identify the issue effectively and signpost clients to smoking cessation services ■ enabling staff to attend smoking cessation services during work hours ■ pre-school groups and schools promoting and enabling childhood immunisation ■ front-line staff working with vulnerable people to be encouraged and enabled to have seasonal flu immunisation ■ active promotion of breast, bowel and cervical cancer screening in relevant contexts by trained front-line personnel ■ raising awareness of early signs and symptoms of different types of cancer and encouragement to seek early medical advice ■ active promotion of avoiding overweight, and seeking support to enable weight loss in people who are overweight or obese, in relevant contexts by trained front-line personnel ■ encouraging employers to support their	■ increased smoking quitter numbers ■ evidence of lower levels of starting smoking amongst schoolchildren ■ increased uptake of flu immunisation amongst people in at-risk groups ■ evidence of an increase in physical activity as part of everyday living	Assistant Directors, Public Health (each for different areas), working with Environmental Health

	staff who are overweight or obese to lose weight ■ encourage and enabling people to be more active in their everyday living activities by things such as using stairs rather than escalators and lifts, using public transport rather than driving		
Enabling people to have a greater sense of belonging to, and contributing to, the community in which they live to foster greater trust and mutual support	■ enabling and encouraging greater participation within communities in the borough such as – – voluntary activities – intergenerational activities – sharing skills and knowledge – home share – day opportunities – encouraging and enabling greater involvement in community group activities	■ implementation of the Ageing Well Strategy through identifiable, sustained projects in at least three wards	Joint Commissioner, Older Adults Assistant Director, Public Health

4. How we live

Enabling and encouraging healthier lifestyles

Tobacco control and smoking cessation	■ encourage and enable people, especially children, not to start smoking; ■ encourage and support people who do smoke to quit ■ focus especially on smokers who – – live in deprived areas – have chronic obstructive pulmonary disease – have diabetes or other cardiovascular risk factor, including overweight and obesity – have mental health problems	■ increased smoking quit rates ■ reduced smoking prevalence	Assistant Director, Public Health

	– have learning disability – are pregnant ■ enforce the law on smoking in public places ■ encourage employers to support their staff in quitting smoking, because a healthy workforce is a more productive one		
Reducing the prevalence of overweight and obesity	■ encourage and enable people, especially children, to eat sensibly and to take adequate exercise in order not to become overweight[ii] ■ encourage and enable people, especially children, who are overweight or obese to take adequate exercise in order to lose weight by at least 10% ■ encourage employers to support their staff who are overweight or obese to lose weight – which may be best achieved by encouraging and enabling all staff to to eat sensibly and to take exercise – because a healthy workforce is a more productive one ■ encourage people to be more active in their everyday living activities by things such as using stairs rather than escalators and lifts, using public transport rather than driving because this invariably involves some walking ■ work with parents and families, community groups, nurseries and pre-	■ a downward trend in overweight and obesity in reception class children in Barnet schools ■ a downward trend in overweight and obesity in year-6 children in Barnet schools ■ a reduction in the proportion of patients on GP registers who are overweight ■ a reduction in the proportion of patients on GP registers who are obese	Assistant Director, Public Health, working with the London Health Improvement Board

[ii] Everyone who is obese was, at one time, overweight. Body mass index (BMI) is calculated by dividing a person's weight (in kilograms) by the square of their height (in metres). A healthy BMI is between 18.5 and 24.9. A BMI of 25-29.9 defines a person as being overweight. A person with a BMI of 30 or more is obese

	school groups to encourage healthy eating and more physical exercise in children ■ work with schools to encourage healthy eating and more physical exercise in children		
Increasing people's opportunities to be physically active in everyday living activities, as well as through sports and leisure activities	■ using the planning process to enable and encourage to be more physically active in their everyday activities such that they need to consciously opt-out of such activities rather than consciously opt-in to them ■ encouraging the design of roads and walking areas to enable and encourage to be more physically active in their everyday activities such that they need to consciously opt-out of such activities rather than consciously opt-in to them ■ working with employers and service providers of all types to enable and encourage to be more physically active in their everyday activities such that they need to consciously opt-out of such activities rather than consciously opt-in to them (for example using stairs rather than lifts and escalators) ■ promoting easy financial and geographical access to culturally appropriate sporting and leisure activities of all types and for all ages	Clear programme of cross-council activity agreed through the Sport and Physical Activity Review	Assistant Director, Public Health
Enabling a reduction in the prevalence of potentially health-harming levels of alcohol consumption	■ working with front line health care workers to help to identify people consuming inappropriately high amounts of alcohol and to signpost them to appropriate services ■ working with front social care workers to help to identify people consuming	■ reductions in the rates of hospital admissions directly attributable to excessive alcohol consumption ■ reduction in crimes directly attributable to excessive alcohol consumption	Assistant Director, Public Health

	inappropriately high amounts of alcohol and to signpost them to appropriate services ■ working with the police and judicial system to help to identify people consuming inappropriately high amounts of alcohol and to signpost them to appropriate services ■ working with employers to help to identify employees consuming inappropriately high amounts of alcohol and to signpost them to appropriate services ■ working with community and social groups to help promote safe consumption of alcohol		
Reducing excess deaths in Winter	■ increasing awareness of excess Winter death risks amongst front line health, social care and other workers ■ increasing the uptake of seasonal flu immunisation in people in at-risk groups ■ increasing the number of homes that are adequately insulated and heated in Winter	■ increased referrals to council for Category 1 housing hazards ■ increasing seasonal flu immunisation rates	Assistant Director, Public Health, working with Environmental Health
Falls avoidance	■ increasing awareness of falls risks amongst front line health, social care and other workers ■ making referral to a falls service an acute hospital contractual requirement that is monitored ■ identifying and managing falls risks through review and assessment of, for example (but not limited to) – – repeat medication reviews – visual assessments – referral for management of conditions that increase falls risk, including	■ reduction in the incidence of wrist and hip fractures in people aged 65 years and over ■ increased referral rates for assessments to falls services	Assistant Director, Public Health Joint Commissioner, Older People

	vascular insufficiency, cardiac rhythm abnormalities, past fall ■ increasing the uptake of activities that improve balance and truncal stability		
Improving the home learning environment for children living in poverty	■ increasing awareness of home learning environment issues amongst front line health, social care and other workers ■ developing services, especially involving intergenerational work and volunteer involvement, to improve, at a significant scale amongst families living in poverty with pre-school children – – parenting skills – parent literacy and numeracy skills – reading to and reading with children	■ increased parental involvement in such initiatives	Assistant Director, Public Health

5. Care when needed

Providing appropriate care and support to facilitate good outcomes

Ensuring a greater emphasis on ill-health and disability prevention in all health and social care service provision	■ promotion of re-ablement in all contacts with patients and clients to foster greater independence and reduced reliance on carers and professional services ■ encouraging and enabling front line health and social care staff to promote smoking cessation with their patients/clients, especially those who are - – due to undergo elective surgery[iii] – in-patients in hospital[iv]		

iii There is unequivocal evidence that quitting smoking some 8-10 weeks before surgery reduces the risk of a wide range of post-operative complications and the need for prolonged in-patient stays (including admission to intensive care)

iv Stopping smoking will help to improve the health of everyone except those who are terminally ill (that is, expected to die within three months). Enabling hospital in-patients to quit smoking is especially important as smoking affects wound healing, bone healing and the way a wide variety of drugs work in the body, in addition to increasing the risk of acute respiratory tract infection and increasing the risk of a plethora of other conditions

	■ encouraging people to eat sensibly and to take adequate exercise in order not to become overweight[v] ■ encouraging people who are overweight or obese to take adequate exercise in order to lose weight by at least 10% ■ identifying people who are consuming inappropriately high amounts of alcohol and signposting them to appropriate services		
Secondary and tertiary prevention for people with physical health problems and unrecognised mental health problems	■ developing integrated care between both acute and community services and mental health services, following the RAID (Rapid Assessment Integration Discharge) model to identify people with unrecognised mental health issues and to provide appropriate care	■ increased referrals to community-based psychiatric services from primary, community, acute, tertiary and other care services ■ reduced lengths of stay in acute and in community hospitals ■ improved outcomes for physical health issues amongst people identified with unrecognised mental health issues	Assistant Director, Public Health
Secondary and tertiary prevention for people with mental health problems and those with learning disability and unrecognised physical health problems	■ developing integrated care between both acute and community services and mental health services, to identify people with unrecognised physical health issues and to provide appropriate care	■ an increased number of people receiving care of all types for mental health problems and learning disability receiving care for physical health problems from appropriate practitioners ■ reduced incidence of acute illness/exacerbation of physical health problems in people with mental health problems or learning disability	Assistant Director, Public Health
Non-cancer screening	For – diabetic retinopathy – abdominal aortic aneurysm	■ increased uptake of screening	Assistant Director, Public Health

v Everyone who is obese was, at one time, overweight. Body mass index (BMI) is calculated by dividing a person's weight (in kilograms) by the square of their height (in metres). A healthy BMI is between 18.5 and 24.9. A BMI of 25-29.9 defines a person as being overweight. A person with a BMI of 30 or more is obese

	– neonatal hearing – neonatal blood spot for multiple congenital diseases to: ■ encourage and enable front line health and social care staff to promote the uptake of non-cancer screening ■ work with community and social groups to help promote the uptake of non-cancer screening ■ promote the uptake of non-cancer screening through commissioned providers		
Cancer screening	For – breast cancer – cervical cancer – rectal and colon cancer to: ■ encourage and enable front line health and social care staff to promote the uptake of cancer screening ■ work with community and social groups to help promote the uptake of cancer screening ■ promote the uptake of cancer screening through commissioned providers	■ increased uptake of screening	Assistant Director, Public Health

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AGENDA ITEM 7

Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**Barnet, Enfield and Haringey Clinical Strategy (BEH) – Programme Update- Presentation**
Report of	BEH Clinical Strategy Programme Director
Summary of item and decision being sought	To make a presentation on progress in the delivery of the Barnet Enfield and Haringey Clinical Strategy programme

Officer Contributors	Chair, Barnet Clinical Commissioning Group NHS North Central London, Acting Borough Barnet Director
Reason for Report	To provide the Health and Well-Being Board with an update on the Barnet Enfield and Haringey Clinical Strategy
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Varuna Balmogim, BEH Clinical Strategy Programme Manager Varuna.Balmogim@nclondon.nhs.uk

1. RECOMMENDATION

1.1 The Health and Wellbeing Board note the content of the presentation that provides an update on the Barnet, Enfield and Haringey Clinical Strategy

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The Barnet, Enfield and Haringey Clinical Strategy programme update has been provided to the Barnet Health Overview and Scrutiny Committee in September 2012.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1. The BEH Clinical Strategy will work closely with key stakeholders to ensure links with community and primary care within the context of the Barnet Health and Well-being Strategy and other commissioning documents.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 A full Equalities Impact Assessment has been carried out for the Barnet, Enfield and Haringey Clinical Strategy.

5. RISK MANAGEMENT

5.1 The BEH Clinical Strategy Programme risk governance is managed by the BEH Clinical Strategy Programme Board and escalated to the Joint Trust Board where necessary.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. Steps that may be taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the prevention, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities. In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions. Regulations setting out the detailed obligations are yet to be issued. Proper consideration will also need to be given to the duties arising from the Equality Act 2010 as mentioned above.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 In April 2012 NHS London approved the Barnet and Chase Farm Outline Business Case (OBC) for capital investment of £17.4 million into Barnet Hospital and £11.8 million into Chase Farm Hospital.

7.2 In April 2012 NHS London approved the North Middlesex University Hospital Outline Business Case (OBC) for capital investment of £80 million[1].

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Communication and engagement is a key part of the programme and there is a Communication and Engagement strategy and plan

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The BEH Clinical strategy engages with key providers and stakeholders.

10. DETAILS

10.1 Included in the attached presentation

11 BACKGROUND PAPERS

11.1 No additional papers

Legal – HP
CFO – JH

[1] Source: NHS London

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Healthcare changes across Barnet, Enfield and Haringey

Purpose: To provide an update on the changes that will be implemented across Barnet, Enfield and Haringey from autumn 2013

Audience: **Barnet HWB**

Date: 4 October 2012

NHS

North Central London

BEH Clinical Strategy links with Primary Care and Community Services

The BEH Clinical Strategy is part of a whole system improvement process that is aimed at improving quality of care delivered in North Central London.

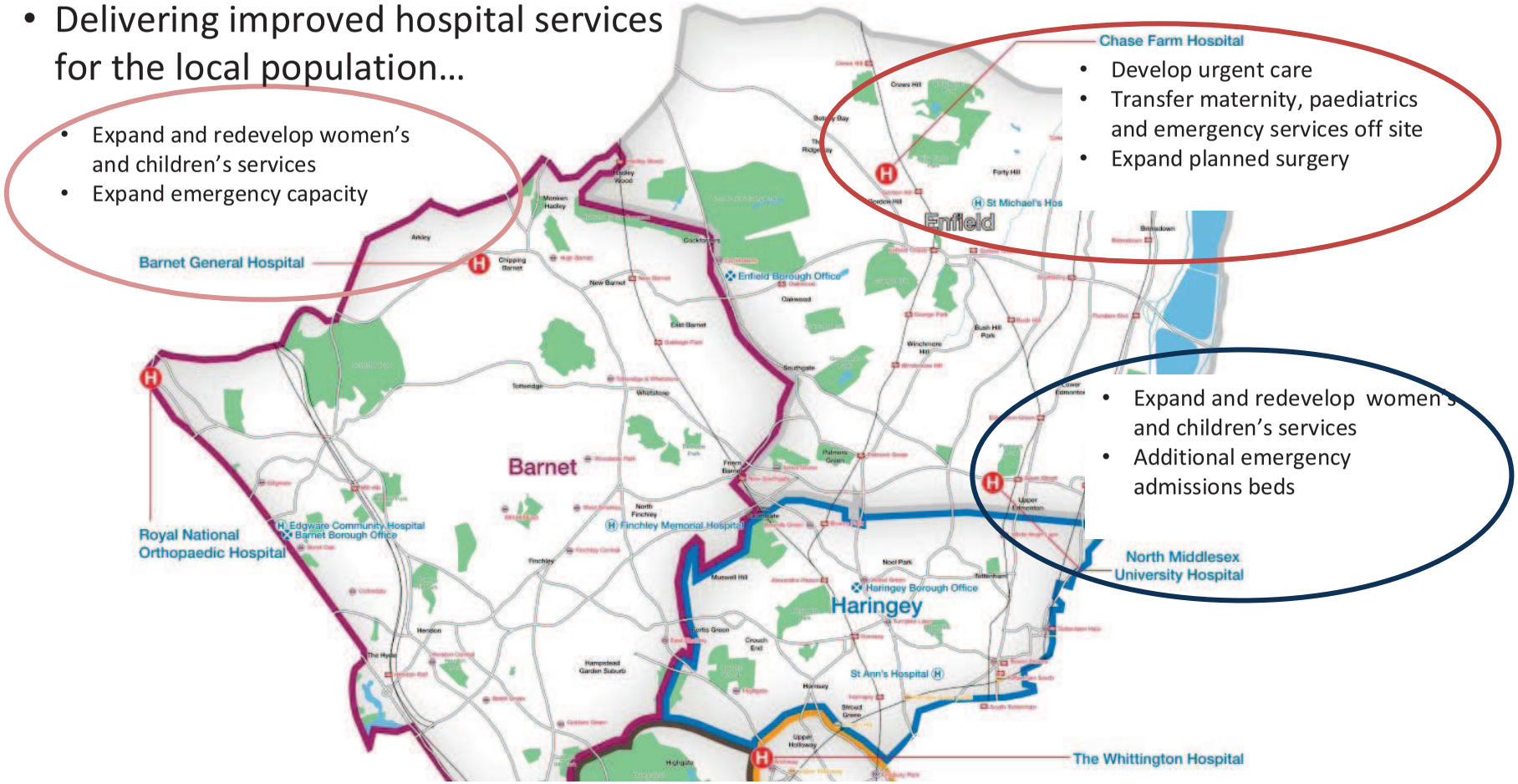
Clinical service changes across BEH

- The Barnet, Enfield and Haringey (BEH) Clinical Strategy Programme is responsible for delivering the changes agreed in 2007, to provide safer, closer, better healthcare for the populations of Barnet, Enfield and Haringey.

- Over the next 18 months there will be:
  - expansion and redevelopment of emergency services at Barnet Hospital and North Middlesex University Hospital (NMUH)
  - expansion and redevelopment of maternity and neonatal services at Barnet and NMUH
  - development of urgent care services at Chase Farm Hospital, including assessment centres for children and older people
  - expansion and redevelopment of planned surgery at Chase Farm Hospital
  - improvements to local primary care and community services

The changes include:

- Delivering improved hospital services for the local population…



… as well as improved primary care and community services across the three boroughs.

Where services will be in the future

Once Option 1 has been implemented the following services will be available:

	Chase Farm Hospital	Barnet Hospital	North Middlesex Hospital
Accident and Emergency with GP service	Urgent Care Centre	***Yes and Urgent Care Centre***	***Yes and Urgent Care Centre***
Emergency activity	Minor illness/injury only	***Yes***	***Yes***
Intensive Therapy Unit	No	***Yes***	***Yes***
Routine inpatient surgery	***Yes***	No	Some
Full maternity services	Future decision regarding midwife-led unit	***Yes***	***Yes***
Full paediatric services	Paediatric Assessment Unit	***Yes***	***Yes***
Day surgery	Yes	Yes	Yes
Outpatients	Yes	Yes	Yes
Diagnostic services	Yes	Yes	Yes

Key: Service change | ***Increased capacity***

Barnet and Chase Farm

In April 2012 NHS London approved the BCF Outline Business Case(OBC) for capital investment:

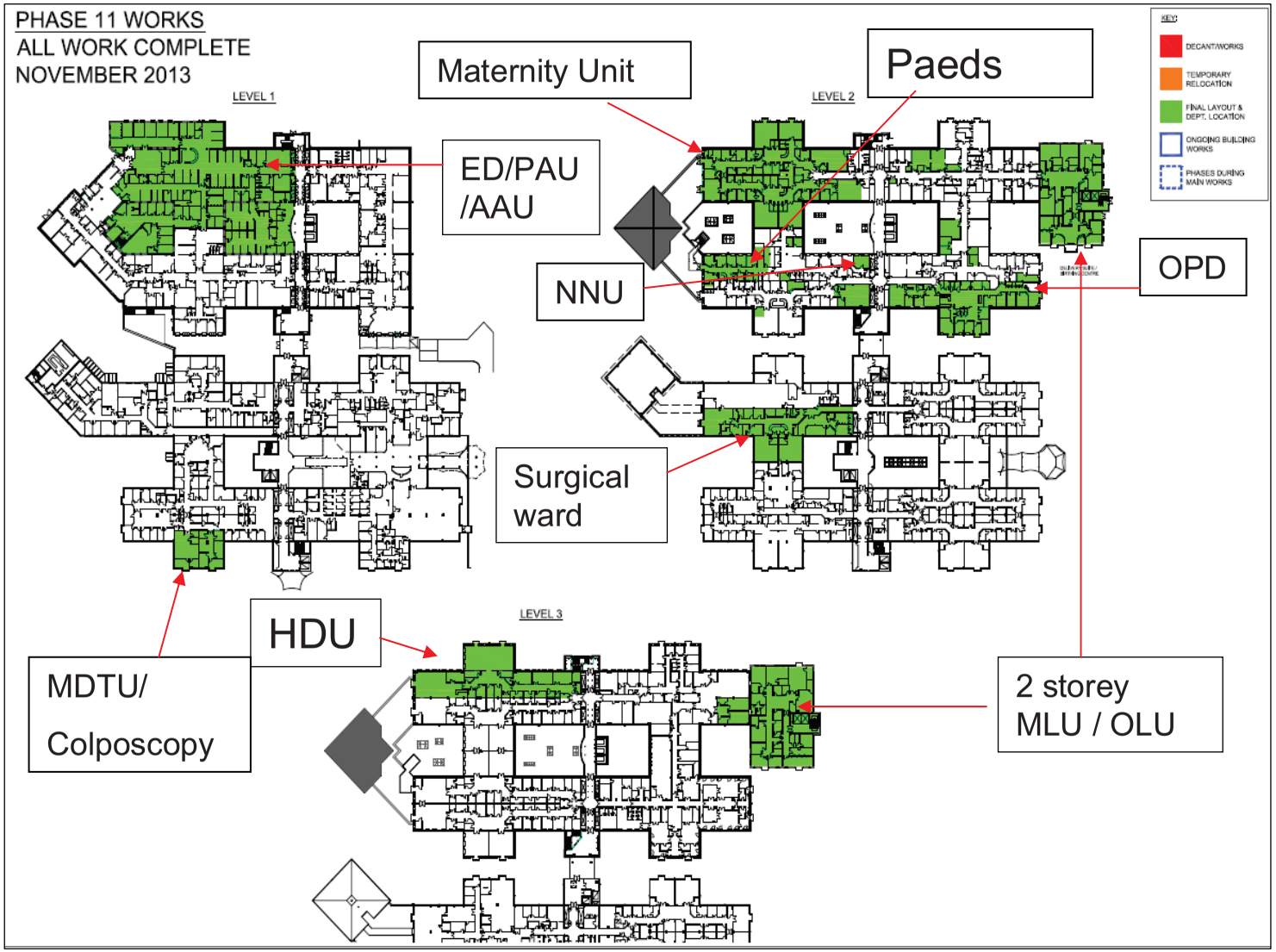
Barnet Hospital: £17.4m

- Relocation of Genito-Urinary Medicine for ward use
- Develop A&E to include sufficient resuscitation and paediatric facilities
- Develop an Urgent Care Centre
- Expansion of ITU/HDU capacity
- Increase in single room accommodation
- Additional CT scanner
- Changes to paediatric in- and out-patient areas
- Remodelling of women's outpatients
- New and remodelled maternity and neonatal facilities
- Additional car parking

Chase Farm Hospital: £11.8m

- Develop existing A&E into Urgent Care Centre (including paediatric UCC and Paediatric Assessment Unit)
- Creation of Older People's Assessment Unit within Highlands Wing
- Consolidation of beds onto Highlands Wing
- Refurbishment of maternity building for outpatients
- Conversion of ITU/HDU to an enhanced recovery area

Barnet Hospital Layout
Post BEH Clinical Strategy



NHS
North Central London

Chase Farm Hospital Layout
Post BEH Clinical Strategy

Services available at Chase Farm Hospital

1. OUTPATIENTS
2. PLANNED SURGERY
3. REHABILITATION
4. URGENT CARE CENTRE
5. PAEDIATRIC ASSESSMENT UNIT (PAU)
6. OLDER PEOPLE'S ASSESSMENT UNIT
7. WOMEN'S DIAGNOSTICS
8. PAEDIATRIC OUTPATIENT SERVICES
9. GYNAECOLOGY OUTPATIENT SERVICES
10. MIDWIFERY-LED AND OBSTETRIC ANTENATAL SERVICES
11. MATERNITY DAY UNITS

North Middlesex University Hospital

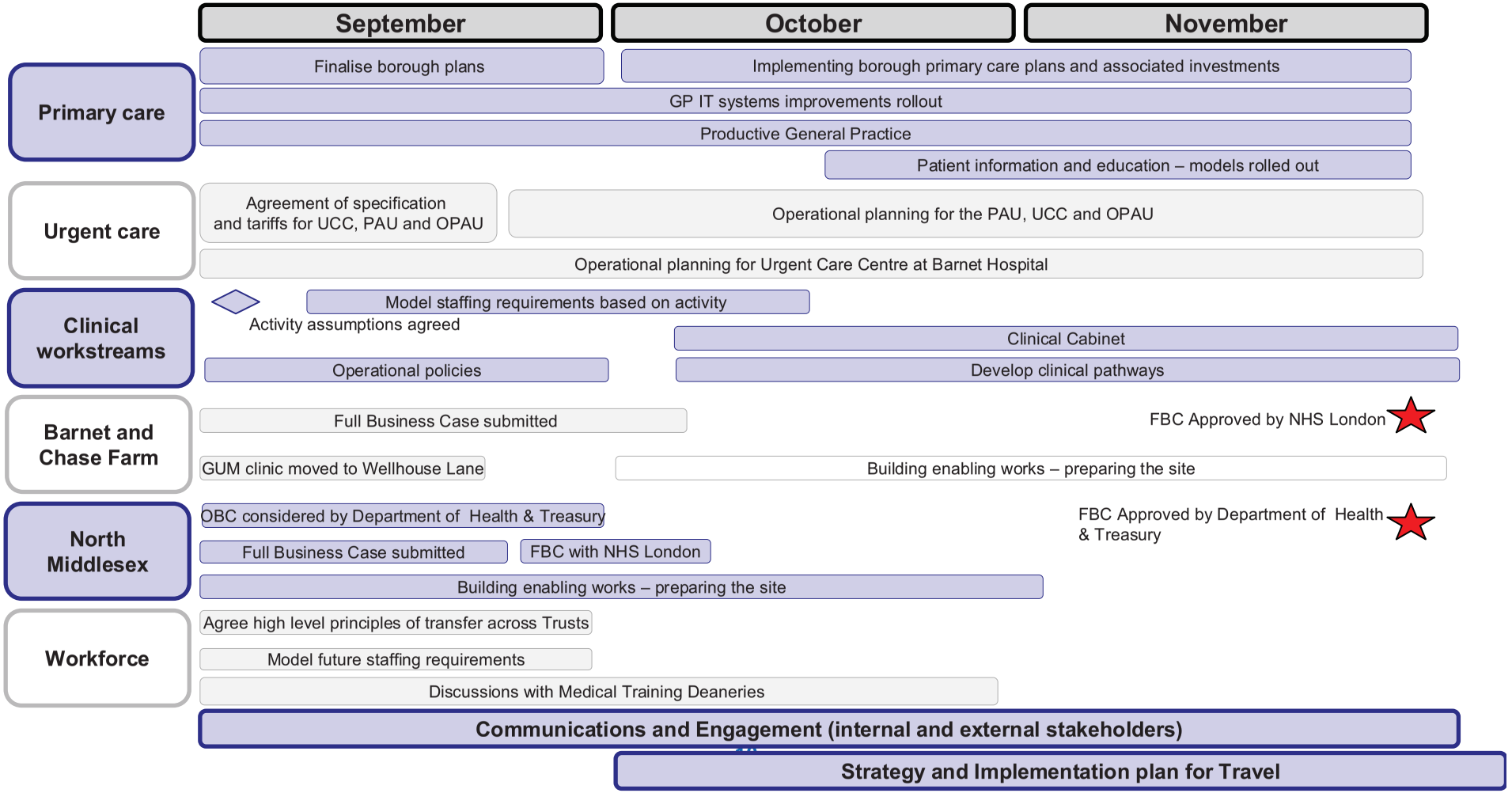
In April 2012 NHS London approved the NMUH Outline Business Case for capital investment:

North Middlesex University Hospital: £80m

- Reconfiguration and expansion of women's & children's services, including:
  - additional paediatric, maternity and neonatal beds
  - triage and related assessment facilities
  - a new midwife-led maternity unit and expansion of consultant-led birthing centre including 2 new theatres.
- Expansion and improvement of outpatient facilities for women's services
- Expansion of general and acute bed capacity to cater for the increase in emergency inpatients
- An improvement of both clinical and functional adjacencies to allow the new service to be delivered efficiently
- Provision of sufficient administration space
- Additional car parking

The next three months

Detailed plans are being drawn up across the programme to support the Full Business Case (FBC) and provide clarity on tasks to deliver the changes



Finchley Memorial Hospital & Edgware Community Hospital

- Will significant increase the community capacity and will support the shift of acute care and the implementation of the BEH Clinical Strategy

	Finchley Memorial Hospital	Edgware Community Hospital
BEH Clinical Strategy	• Hospital outpatients • Avoid hospital admissions • Diagnostics • X-rays and Ultrasounds	•Hospital outpatients •Diagnostics •Day Surgery
Primary Care	• Walk in centre • Pharmacy • GP Practices	• Walk in centre • Pharmacy
Integrated Care	• All providers work together • Beds for rehabilitation • Musculoskeletal services	• All providers work together • Beds for rehabilitation

Finchley Memorial Hospital

Edgware Community Hospital

Edgware Community Hospital

Edgware Community Hospital

AGENDA ITEM 8

Meeting	Health and Well-Being Board
Date	4th October 2012
Subject	**Barnet and Chase Farm NHS Trust – Progression to achieving Foundation Trust Status**
Report of	Interim Chief Officer – NHS Barnet
Summary of item	The Health and Well-being Board are asked to comment on the options that are being explored by Barnet and Chase Farm NHS Trust regarding the selection of a partner to support the Trust acquire Foundation Trust status.

Officer Contributors	Ceri Jacob, Interim Chief Officer
Reason for Report	The Health and Well-Being Board has a role in overseeing the health and social care system to encourage integrated services and ensure they are properly joined up around the needs of patients. Any mergers or changes to major providers should be considered by the Health and Well-being Board to consider the implications for the delivery of integrated services in Barnet
Partnership flexibility being exercised	None
Wards Affected	All
Appendices	None

Contact for further information: Ceri Jacob, Interim Chief Officer, NHS Barnet, 020 8937 7632

1. RECOMMENDATION

1.1 For the Chairman of the Barnet Health and Well-being Board to prepare a written position for consideration by Barnet and Chase Farm NHS Trust Board and the Royal Free Foundation Trust Board in October 2012 regarding the potential partnership between the two organisations.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 None

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 Any partnership between NHS organisations needs to have regard to the local NHS Quality, Innovation, Productivity and Prevention Plan (QIPP) for Barnet and the Barnet, Enfield and Haringey Clinical Strategy. The achievement of the clinical strategy has been set as a key success criteria in the evaluation framework.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Any new organisation will need to consider how it will respond to the needs of the residents and patients that it serves. An equalities impact assessment will be included as part of the work to develop the strategic outline case referred to in paragraph 9.6 below.

5. RISK MANAGEMENT

5.1 There is a risk that failure to align financial strategies across health and social care, financial and service improvements will not be realised and or there will be cost shunting across the health and social care boundary. The financial planning group has identified this as a key priority risk and is being mitigated by work to align timescales and leadership of improvement plans which affect both health and social care through the HWBB.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Wellbeing Board must be mindful of the broad statutory target duty in section 2B of the NHS Act 2006 imposed on the local authority by s12 of the Health and Social Care Act 2012. The duty is owed to the population at large and the local authority must act reasonably at all times in the exercise of those functions. Regulations setting out the details are yet to be issued by the Government. Consideration will need to be given as to how the potential partnership between Barnet and Chase Farm NHS Trust Board and the Royal Free Foundation Trust Board will facilitate the discharge of the local authority's functions.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The evaluation criteria specifically includes a section on financial benefits. Given the challenged financial position of the Barnet health economy, it is essential that any new Foundation Trust has sufficient critical mass to support a shift in activity away from hospital based care to community based care without affecting the organisation's overall financial viability.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Cabinet Member for Public Health and the Director of Adult Social Care and Interim Director of Children's Services have been advised of the plans and invited to comment on the evaluation criteria.

8.2 The Barnet LINk has observer status as part of the evaluation process ensuring that patients views are fed into the evaluation process.

9 DETAILS

9.1 At the July Meeting of the Barnet and Chase Farm Hospitals NHS Trust, the Trust agreed that it was not possible to bring together a credible financial case given expected pressures in the next few years and that in order to maintain progress on implementation of the BEH Clinical Strategy and the focus on quality and access, it would be more appropriate to seek an organisation to partner with. . The Trust Board confirmed that it wished to seek expressions of interest from NHS organisations which it could partner with to become a viable and successful Foundation Trust into the future.

9.2 On 17th August 2012 the Trust issued an "Invitation to Apply" letter, final draft Questionnaire, Information Memorandum and draft Heads of Terms to the three organisations that had expressed an interest. Organisations had until 31 August to formally confirm their intention to submit.

9.3 The Royal Free Foundation Trust was the only organisation who formally confirmed their intention to submit a proposal and work has been undertaken during September between both organisations to explore whether a viable larger Foundation Trust can be created from bringing together the two organisations, in order to achieve patient, staff and financial benefits.

9.4 Despite the Royal Free Foundation Trust being the only organisation to express an interest, the Trust in conjunction with NHS London has required that a full evaluation is undertaken and clinicians and managers from both organisations have been working closely during September to develop the evidence of the patient, staff and financial benefits that could arise through such a partnership.

9.5 The Royal Free Foundation Trust was required to submit a detailed response to the evaluation questionnaire which would form the basis of formal evaluation, by an evaluation panel involving Barnet CCG with Barnet LINk as an observer. The evaluation panel will meet on the 28th of September 2012 and will produce a report setting out the recommendations regarding the way forward for consideration by Barnet and Chase Farm Trust Board on the 12th of October 2012 and the Royal Free Foundation Trust Board on the 19th of October 2012.

9.6 If both Boards are in agreement that this partnership will deliver the patient, staff and financial benefits anticipated, then a strategic outline case will be prepared for consideration by the Trust Boards and NHS London.

9.7 Changes to management arrangements will not affect the BEH clinical strategy, which will be taking place over this period

10. BACKGROUND PAPERS

10.1 Barnet and Chase Farm NHS Trust Board Papers – 13th July 2012 and 14th September 2012. These are available online - www.bcf.nhs.uk/about_us/trust_board_meetings/meeting

Legal - HP
CFO – JH/MC

Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**NHS Barnet Clinical Commissioning Group- Authorisation Process**
Report of	Chair NHS Barnet Clinical Commissioning Group
Summary of item and decision being sought	NHS Barnet CCG are working towards key milestones to achieve wave 3 authorisation submission. This formal process commences on the 1st October 2012. In accordance with the timeline highlighted, they have to ensure completion of a number of key outputs before this October deadline. This report updates the Board on the steps undertaken to achieve these milestones as well as outlining other key developments for NHS Barnet CCG

Officer Contributors	Deputy Director of Clinical Commissioning, NHS Barnet CCG (NHS NCL)
Reason for Report	To update the Board on progress with the development of local clinical commissioning arrangements and provide an opportunity to discuss the authorisation process.
Partnership flexibility being exercised	None applicable.
Wards Affected	All

Contact for further information

Lucy Botting, Deputy Director of Clinical Commissioning NHS Barnet CCG (NHS NCL)

Lucy.botting@nclondon.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board note progress on developing the Barnet Clinical Commissioning Group and comment on the way in which the Board can support the authorisation process in Barnet.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Discussions have taken place at monthly CCG Board meetings as well as internal NHS events. In addition progress is regularly monitored via NHS North Central London.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 From 1 April 2013 the CCG will have responsibility for local NHS commissioning (acute, mental health and community services), a budget of over £450 million. An effective CCG is essential to the development and implementation of commissioning strategies across health and social care in support of the Health and Well-Being Strategy.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The CCG views the Joint Strategic Needs Assessment as the document which sets out health needs and from which to develop strategic priorities

5. RISK MANAGEMENT

5.1 A high level local risk assessment has been undertaken as part of planning for local development of the CCG. Initial risks have been identified as:

- That GPs and member practices may not all engage with the development of the CCG and the implementation of the commissioning plans. This risk is being mitigated through a focus on engagement of GPs in the development of the CCG via localities particularly;

- That the CCG does not have effective commissioning arrangements in place to support its development. Work is underway on developing effective support as set out in Section 10;

- That the CCG does not have the partnership arrangements and relationships in place to work effectively across the health and social care system. The CCG has developed a communications plan and is an integral part of the health and Well-being Board.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Bill was given Royal Assent on 27 March 2012. The Act provides for the abolition of Primary Care Trusts and Strategic Health Authorities and the establishment of the NHS Commissioning Board (NCB) and Clinical Commissioning Groups. This means that on 1 April 2013, the commissioning functions of NHS North Central London will pass to a number of organisations, primarily, Clinical Commissioning Groups (CCG), the NHS Commissioning Board, Local Authorities and NHS Property Services Ltd. The CCG will take responsibility for securing continuous improvements in the quality of services commissioned, reducing inequalities, enabling choice and

promoting patient involvement, securing integration and promoting innovation and research

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The Barnet Primary Care Trust budgets will be divided across the following organisations from April 2013 as follows[1]:

CCG	£457 million (to commission acute, mental health and community services)
NHS Commissioning Board	£122 million
Local authority (public health)	£12 million
Public Health England	£0.5 million
NHS Property Services	£0.5 million
TOTAL	£592 million

7.2 These are very top level estimates and subject to change following detailed work by NHS North Central London which is currently under way.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Communications arrangements for the CCG are set out in section 10.

8.2 A Local Involvement Network (LINK) member and the local authority Director of Adult Social Care and Health are observers with speaking rights on the CCG Board.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Engagement events with local providers have been undertaken and more are planned.

10. DETAILS

Authorisation process

Evidence Collation

10.1 Work continues on the collation of evidence which is required by the NHS NCB as part of the authorisation assessment process. Specific evidence required within each of the six domains is clearly documented within the CCG Draft Guide for Applicants (NHS NCBA April 2012). The latest document from the NHS NCBA Clinical Commissioning Authorisation: Draft Guide for Assessors Undertaking Desk Top Review (June 2012) outlines the thresholds that the CCG have to achieve. Evidence consists of strategic documents such as the NHS Barnet Constitution, Strategic Commissioning Plan 2013/14 (ISOP) as well as Terms of reference for the main committees and minutes of relevant meetings.

10.2 Work also includes the development of 5 clinical case studies to inform the achievements made by the CCG in the first year and 8 factual accounts of the commissioning arrangements that the CCG have in place in accordance with the commissioning outcomes framework. Commissioning arrangements also highlight those contracts provided in collaboration with partners i.e. the local authority and neighbouring CCG's.

[1] Source: NHS London

Specific areas include Barnet, Enfield and Haringey Clinical Strategy, frail elderly commissioning.

10.3 Once approved by the CCG governing body all these documents will be uploaded onto a NHS NCB site (KLM) where they will be stored and used by the assessors to formulated Key Lines of Enquiry (KLOE). These key lines are used for CCG Board scrutiny by the NHS NCB on the pre arranged site visit on November 27th 2012.

10.4 NHS Barnet CCG are on track to complete this action by the 28th September 2012.

NHS Barnet CCG Constitution

10.5 The draft constitution based on the NHS NCB model constitution and, in accordance with Local Medical Committee (LMC) guidance has now been developed

10.6 This legal document is a series of regulations and orders which confer specific legal powers to an organisation and will depict how NHS Barnet CCG formally operates as an organisation. It can therefore be assumed that this is one of the most important documents in the authorisation process.

10.7 The LMC have been involved in the process and in collaboration with NHS Barnet CCG hosted an evening event for primary care on the 22nd August 2012 to discuss the detail of the constitution. Following the event the constitution was made available to all GP's for comment using an on line secure site. Consultation closed on the 7th September, some 21 days later. A short on line questionnaire enabled GP's to be guided to specific sections which were of particular relevance. All comments were amalgamated and the constitution amended accordingly. This has subsequently been approved by the LMC on the 10th September and has been adopted by NHS Barnet CCG.

10.8 The constitution will be taken to the CCG Board in October 2012 for formal adoption.

CCG member engagement, empowerment and enablement

10.9 In accordance with the Health and Social Care Act 2012 clinical commissioning groups are membership organisations. Therefore NHS Barnet CCG will need to work closely with primary care colleagues (CCG members) to ensure that commissioning processes are transparent and members have an opportunity to be part of and engaged in the decision making process of the CCG. This includes ensuring that CCG members are satisfied with and approve the 2013/14 strategic commissioning plan (which also needs to be approved by the Health and Wellbeing Board pre adoption).

10.10 An engagement plan (October- March 2013) for member practices led by the vice chair of the CCG Board with support from the senior management team is in development (in alignment with work on the primary care strategy and practice provider status). This will explore locality structures, systems and process to ensure that the link between the governing body and member practices is explicit and members are fully engaged in the decision making of the organisation. This will include an emphasis on patient engagement as well as partner collaboration.

10.11 The plan will be presented to the organisational development committee for NHS Barnet CCG in September 2012 and will commence in October.

Strategic Commissioning Plan 2013/14 (ISOP)

10.12 The CCG governing body held two development days in July and August 2012 to begin to prioritise NHS Barnet CCG's commissioning intentions for 2013/14 based on the Joint Strategic Needs Assessment (JSNA) and in alignment with the NHS North Central London Strategic Commissioning Plan, Health and Wellbeing Strategy (HWBS) and Integrated Commissioning Plan .

10.13 Following these two days there will be a third day- a provider marketplace event, which will explore NHS Barnet CCG's commissioning priorities with key provider stakeholders. This event scheduled for the 19th September 2012 will build on previous CCG governing body sessions and begin to explore commissioning through collaboration.

10.14 Once developed the strategic commissioning plan for 2013/14 will be shared with CCG member practices for approval and with the Health and Well being Board for final approval in accordance with the Health and Social Care Act.

Quality and Patient Safety (inclusive of child and adult safeguarding)

10.15 As per the Health and Social Care Act (2012) the CCG are formally required to put in place structures that support the governance around quality, clinical risk and patient safety.

10.16 Work is currently underway to develop NHS Barnet CCG's strategic vision for Quality as well as to define the terms of reference for the quality and clinical risk committee (sub committee of the CCG governing body) who will formally take over statutory quality and governance functions from NHS North Central London and Barnet Professional Executive Committee (PEC-Barnet PCT) from April 2013. NHS Barnet CCG will be working with NHS North Central London (to be called Commissioning Support Unit (CSU)) from October 2012 to ensure a smooth and safe transition to formal hand over of these functions.

10.17 The strategic vision for quality for NHS Barnet CCG will be taken to the CCG Board in November for approval and adoption.

NHS Barnet CCG public facing website

10.18 The CCG external facing website is being developed with support from NHS North Central London. The timeframe for go live is the end of September 2012.

10.19 The CCG lead for communications is leading this work with support from the communication officers in Barnet.

360 degree stakeholder survey

10.20 The 360° stakeholder survey closed on the 24th August 2012. This survey (undertaken through IPSOS MORI) was sent to all NHS Barnet CCG key stakeholders inclusive of primary care.

10.21 NHS Barnet CCG had a response rate of 54%, ranked as average by IPSOS MORI and in keeping with the majority of other CCG's across England. IPSOS MORI will be summarising responses and sending this report to NHS Barnet CCG for comment.

10.22 This process informs stage 1 of the authorisation process.

Authorisation Process: next stage

Application Phase.

10.23 The wave 3 application phase commences on the 1st October 2012 with a signed certification from the Chair and Chief Officer. This will certify that the CCG is ready, willing and able and has plans in place to discharge its duties and responsibilities in key areas. This self certification forms part of the evidence collection discussed in sections 10.1-10.4.

Board to Board Challenge from NHS London

10.24 In preparation for Wave 3, NHS London will be hosting a mock board to board challenge for NHS Barnet CCG on the 18th October 2012. This will simulate the event to be held by the NHS NCBA in November and provide the CCG with recommendations for preparedness.

10.25 As part of the preparation for this assessment and subsequent assessor site visits NHS Barnet CCG will develop a readiness plan which will ensure that development sessions and preparation for these events commences from September 2012. These development sessions will include key partners and stakeholders who will inform the process such as the local authority and acute trusts.

Board to Board Challenge with the NHS NCB

10.26 November 27th 2012 is the date which has been approved by the NHS NCB for the assessor site visit to NHS Barnet CCG. As mentioned above preparation is under way.

Commissioning Support Unit Development

10.27 Barnet CCG is in the process of determining its commissioning support arrangements in discussion with the North Central East London Commissioning Support Service (NCEL CSU).

10.28 Following further discussion the CCG will be asked to sign a detailed service level agreement. In the meantime a high level memorandum of understanding has been agreed which indicates that NCEL CSU and the CCG have worked together to agree which core commissioning support services the CCG will require, how these should be delivered locally and what the price will be.

10.29 NCL CSU will begin full service delivery in October 2012, in accordance with the National Commissioning Board timeframes.

10.30 Between October 2012 and April 2013 the CCG and NCEL CSS will agree Key Performance Indicator (KPI) targets, having agreed metrics.

Key CCG governing body appointments

10.31 NHS Barnet CCG have appointed John Morton to the role of Chief Officer. John Morton, currently a Director of Partnerships in Bournemouth and Poole PCT cluster will take up this post in November 2012.

10.32 The Chief Financial Officer post is currently out to national advert. During this critical period an Interim Chief Financial Officer has been appointed who will take up this post in October.

11 BACKGROUND PAPERS

11.1 None

Legal – HP
CFO – JH

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AGENDA ITEM 10

Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**Approach to developing the Barnet Clinical Commissioning Group (CCG) Commissioning Plan**
Report of	Acting Borough Director: Barnet
Summary of item and decision being sought	This paper sets out the approach being taken to development of the 2013/4 – 2015/16 Commissioning Plan by Barnet CCG.

Officer Contributors	Ceri Jacob: Acting Borough Director
Reason for Report	To inform the Health and Wellbeing Board of the approach being undertaken in the development of the CCG's commissioning plan and to invite comment.
Partnership flexibility being exercised	NA
Wards Affected	All

Contact for further information:

Beverley Wilding: Head of Service Transformation and Commissioning NHS North Central London

Tel: 020 8732 6234

Email: Beverley.wilding@nclondon.nhs.uk

1. RECOMMENDATION

1.1 The Board is asked to note and comment on the approach taken to development of the Barnet CCG Commissioning Plan.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Wellbeing Board – 26 May 2011. Integrated Health and Wellbeing Commissioning Strategy scoping document approved.

2.2 Health and Wellbeing Board – 27 July 2011. Integrated Commissioning: Progress report for the Health and Wellbeing Board noted.

2.3 Health and Wellbeing Board – 22 September 2011. NHS NCL Commissioning Strategic Plan 2012/13-2014/15 noted.

2.4 Health and Wellbeing Board- 31 May 2012. Item 9- Barnet Clinical Commissioning Group- update

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Barnet CCG plan supports implementation of the Joint Health and Wellbeing Strategy and encompasses priorities set out in the Joint Integrated Commissioning Plan and Joint Prevention plan.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Commissioning Plan is based upon the needs of the population as set out in the Barnet Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. As such the plan will directly address health needs of the Barnet GP registered population and unregistered Barnet resident population.

4.2 A full Equalities Impact Assessment will be carried out as part of development of the plan in accordance with the CCG Equalities and Diversity Strategy.

5. RISK MANAGEMENT

5.1 There is a risk that implementation of the plan could be undermined by capacity within the CCG team. This risk is mitigated through the commissioning of a Commissioning Support Service by the CCG and a collaborative approach to certain key initiatives, such as services for the frail elderly with the local authority and / or other local CCGs.

5.2 Further, the CCG has recently reinstated its local Programme Management Office (PMO) to support implementation of the Barnet QIPP (Quality, Innovation, Prevention and Productivity) programme and other major programmes of work.

5.3 Current financial constraints nationally within the public sector and locally within health may pose a risk to the ability of the CCG to invest in the desired system and service changes that will be set out in the commissioning plan. This is mitigated through the use of robust, evidence based business cases with an invest to save approach.

6. LEGAL POWERS AND IMPLICATIONS

6.1 CCGs are required to develop and publish commissioning plans annually as set out in the Health and Social Care Act 2012. Commissioning plans must be submitted to the NHS Commissioning Board and the local Health and Wellbeing Board.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 Development of the plan will require input from a range of clinicians, CCG Board members, CCG and NHS NCL managers.

7.2 Financial implications of the Commissioning Plan will be understood and set out as part of the plan development process.

7.3 Resource implications will be contained within the health budgets.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Workshops with service users and carers were carried out in relation to development of the draft integrated commissioning plan. This plan is reflected within the CCG Commissioning Plan.

8.2 As the plan is developed a range of engagement activities will be undertaken. These will include but may not be restricted to engagement with the Barnet LINk, Practice Patient Groups, existing fora such as the Barnet Older People's Assembly and the Partnership Boards.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 A workshop with key health providers is planned for October 2012. Providers will be invited to work together to propose solutions to challenges and / or system changes set out in the draft commissioning plan.

9.2 Providers are also engaged n the development of key work streams within the Commissioning Plan.

9.3 The CCG will issue outline commissioning intentions to providers by the end of September 2012.

10. DETAILS

10.1 The Barnet CCG Commissioning Plan is based on the needs of the local population. It takes account of the local context and collaborative working with partner organisations such as the Local Authority and other CCGs. It is the key planning document and a tool for communicating the scale of the CCG's vision for health care in Barnet.

10.2 There will be a focus on supporting people to remain healthy and independent for as long as possible. Where people have long term ill health or care needs there will be a focus on supporting them to manage their care needs as independently as possible whilst ensuring there are high quality and effective services available when needed.

10.3 Integral to the Commissioning Plan will be the Barnet QIPP plan which is designed to drive innovation, quality improvements and financial sustainability. The QIPP plan will reflect the same 3 year timescale as the commissioning plan.

10.4 Health and Wellbeing Boards are required to approve CCG Commissioning Plans. The draft Commissioning Plan will be discussed in detail with the HWBB at the 29 November Board workshop and will be submitted for final approval in February 2013 prior to submission to the NHS Commissioning Board.

11 BACKGROUND PAPERS

11.1 N/A

Legal – HP
CFO – JH/MC

Meeting	Health and Well Being Board
Date	04 October 2012
Subject	**Health and Social Care Integration programme update**
Report of	Deputy Director, Health and Adult Social Care, London Borough of Barnet
Summary of item and decision being sought	This report provides an update on progress to implement the Health and Social Care Integration work programme and delivery governance proposal that was endorsed by the Health and Wellbeing Board at its meeting on the 31 May 2012. The report includes a summary of the agreed actions from the Health and Social Care Integration Summit meeting held on the 27 July which includes the following: • A strong commitment from all commissioning and providers organisations present to support the delivery of a single coordinated health and social care integration programme • Endorsement of the programme delivery governance structure approved by the Health and Wellbeing Board at the meeting on the 31 May 2012 • Establishment of a Health and Social Care Integration Programme Delivery Board to lead the implementation of a programme of spearhead health and social care integration projects that will deliver whole system benefits The Health and Wellbeing Board is requested to note the report.

Officer Contributors	Rohan Wardena, Programme Lead, Adult Social Care and Health, LBB
Reason for Report	Update Board Members on progress to implement the Health and Social Care Integration work programme
Partnership flexibility being exercised	None apply to the proposals in this report. However, the programme will seek to develop business cases for integration projects that will benefit partners and these

	may include use of the flexibilities available under section 75 of the National Health Service Act 2006.
Wards Affected	All

Contact for further information: Rohan Wardena, ☎ 020 8359 3877; email rohan.wardena@barnet.gov.uk

1. RECOMMENDATIONS

1.1 That the Board notes the Health and Social Care integration Programme update on progress.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The agreement of the Health and Wellbeing Strategy and integrated commissioning strategy scoping document by the Board on 26 May 2011 proposed that integration in commissioning and / or service delivery should be considered in any area where health and social care overlap or are interdependent. This proposal was accepted by the Council, the Barnet Clinical Commissioning Group and NHS North Central London. The draft Health and Wellbeing Strategy was subsequently endorsed by the Board on the 22 March 2012. The Health and Social Care Integration Strategic Outline Case was endorsed by the Board on the 31 May 2012.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELLBEING STRATEGY; COMMISSIONING STRATEGIES)

3.1 Links To Sustainable Community Strategy

3.1.1 The Sustainable Community Strategy 2010-2020 is committed to achieving its objectives through working *"together to draw out efficiencies, provide seamless customer services; and develop a shared insight into needs and priorities, driving the commissioning of services and making difficult choices about where to prioritise them."* The integration of health and Social care services embodies this approach to partnership working.

3.1.2 Successful integration of health and social care services should promote the Sustainable Community Strategy priority of *"healthy and independent living".*

3.2 Links To Health And Wellbeing Strategy

3.2.1 The Health and Wellbeing Strategy sets out the aspirations of the Health and Wellbeing Board and its member organisations. The Health and Wellbeing Board is responsible for promoting greater coordination of planning across health, public health and social care. This is recognised in the Health and Wellbeing Strategy and the linked draft Integrated Commissioning Plan.

3.3 Links To Commissioning Strategies

3.3.1 As noted above, a draft Integrated Commissioning Strategy is being developed as one of two delivery vehicles for the Health and Wellbeing Strategy. This commissioning plan will form part of the Barnet Clinical Commissioning Group's overall commissioning plans for 2012/13.

3.3.2 The delivery of an integrated frail elderly community based service is included in the draft NHS NCL Commissioning Strategic Plan and associated QIPP (Quality, Innovation, Productivity and Prevention) plan.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Needs Assessment Implications

4.1.1 Any integration of health and social care services needs to be done where this is the most appropriate option to improve outcomes and the customer experience and where there is firm evidence that this will benefit people using care in Barnet. The available research does not support a view that integration is always beneficial, but rather that it provides positive results for certain groups within society, such as those with multiple or long term conditions and complex care needs.

4.1.2 All identified opportunities for the integration of health and social care services in Barnet will be informed by an analysis of local and national data and evidence of what has been proven to work elsewhere. It will ensure that any subsequent work on integration is informed by the local population needs identified in the Joint Strategic Needs Assessment and the priorities for health improvement and wellbeing set out in the Health and Wellbeing Strategy.

4.1.3 The benefits from the proposed programme of integration initiatives should enable partner organisations to identify more effective ways of meeting some of the future demographic challenges that are facing the commissioning and delivery of health and social care services in Barnet, such as the aging population and substantial growth in the numbers of frail older people.

4.2 Equalities Implications

4.2.1 The integration of local health and social care services could have a disproportionate impact on different groups and communities in Barnet. This could include people within the protected characteristics of age, disability and gender as defined by the Equality Act 2010, such as older people and carers of older people or disabled people. An Equalities Impact Assessment will be conducted for each health and social care integration initiative to determine its impact and the requirement for any reasonable adjustment.

4.2.2 The integration of health and social care services may also have a disproportionate impact on staff with protected characteristics. An Equalities Impact Assessment will be conducted for each health and social care integration initiative to determine its impact on staff and the requirement for any reasonable adjustment.

5. RISK MANAGEMENT

5.1 The Health and Social Care Integration Programme includes an initial risk register. This will be reviewed as a regular agenda item at each Integration Programme Delivery Board meeting.

5.2 Resourcing constraints are expected to impact local NHS organisations that are undergoing major transitions during the next 12 months. This is partially mitigated through the commitment of NHS organisations and Barnet Council

to provide resources to support the delivery of social care and health integration initiatives and the investment of Section 256 monies.

5.3 There is little documented evidence that demonstrates the measurable return on investment for social care integration and the timescale for benefit realisation. This risk is mitigated by building local insight through the piloting and evaluation of integration initiatives prior to a large scale commitment or long-term investment decision. Insight building and the definition of benefits measurement is an essential component of integration project development and delivery.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. Steps that may be taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the prevention, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities.

6.2 In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions.

6.3 Regulations setting out the detailed obligations are yet to be issued.

6.4 Proper consideration will need to be given to the duties arising from the Equality Act 2010 as mentioned above.

6.5 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006. The provision of health and social care services takes place within a complex regulatory environment and the potential impact of this on any integration proposals arising from this outline business case will be explored as part of the development of specific proposals. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 Financial Implications

7.1.1 Integration has the potential to increase value for money of health and social care and enable public funds to meet increases in health and social care demand by:

- Improving outcomes for people who use care, reducing demand for repeat interventions and crisis services such as emergency departments
- Increasing the opportunities for whole system efficiencies
- Reduction of duplication in assessment and provision
- Preventing demand for more intensive and high cost services such as acute hospital and residential care, through coordinated use of prevention and early intervention services

7.1.2 The strategic outline business case identifies that health and social care integration initiatives will contribute £4.2m savings in adult social care expenditure over three years and will contribute towards the local health economies £30m recurrent integrated care Quality, Innovation, Productivity and Prevention (QIPP) 2012/13 savings requirements. This represents the minimum expected savings that will be delivered by integration initiatives. Full business case development and benefits modelling will be conducted for each health and social care integration project as part of the initiation and assurance phase.

7.2 **Investment Commitments**

7.2.1 The London Borough of Barnet is committing to provide £1.1m for health and social care integration in 2012/13 through its One Barnet Programme which has been agreed by the Cabinet Resources Committee. This will be in addition to the Section 256 funding for social care integration investment which has already been endorsed by the Health and Wellbeing Board.

7.2.2 Some of the £1m One Barnet funding will be used to provide resources to establish an Integration Delivery Programme Management Office to support the operation of the Integration Programme Delivery Board and management. This will be dependent on the governance support requirements and scale of the programme management function agreed by the Integration Programme Delivery Board.

7.3 **Staffing Implications**

7.3.1 It is expected that the integration of health and social care services will impact staff currently working for the Local Authority and NHS organisations. This will be defined as part of the development of specific project business cases and through the equalities impact assessment process described in. section 4.2.2 above.

7.3.2 Recruitment of a programme manager and programme management office administrative officer to support the operation of the Integration Programme Board and programme management office. This will be subject to approval of a resource plan by the Integration Programme Delivery Board and One Barnet Programme Board.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A list of key stakeholders involved in the development of a shared position statement on health and social care integration is included in the strategic outline case. This work recognises that stakeholders have different strategic requirements and this is reflected in the shared position described in the outline business case.

8.2 Service users, carers and key stakeholders have been involved in the development of the integrated commissioning plan through a series of engagement events. Local service user and voluntary groups will be included in the membership of programme and project delivery boards and will provide input and assurance on all health and social care integration projects.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Provider organisations have been involved in the development of both the strategic outline case and integrated commissioning plans and are represented on the Integration Programme Delivery Board.

10. PROGRESS UPDATE

10.1 The first phase of the project has been successfully completed with the delivery of the Health and Social Care Integration Summit on the 27 July. One of the key outcomes from the Summit was a unanimous agreement from health and social care Commissioning and Provider organisations to proceed and establish a Health and Social Care Integration Programme Delivery Board. It was agreed that the Board would only include senior leaders in its membership who have a clear mandate to make decisions and commit resources on behalf of their Organisations.

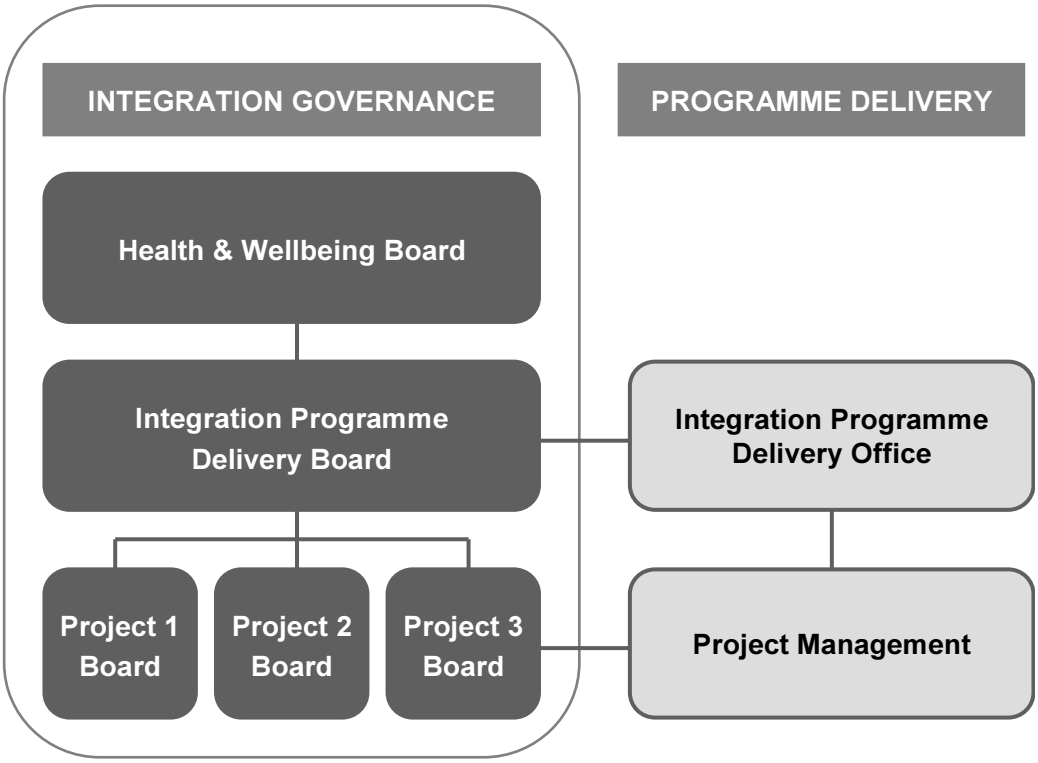
10.2 The first Integration Programme Delivery Board meeting is scheduled for the 17 October and will then meet at least quarterly to ensure projects are being delivered to plan and the expected programme benefits are on track to be fully realised.

10.3 The proposed list of integration opportunities that was prioritised by the Health and Wellbeing Board was also endorsed at the Summit and it was agreed that a small number of projects should be selected to spearhead delivery of the Health and Social Care Programme. Work is underway to review the status of each initiative to determine which projects have the necessary coverage and benefits potential to be selected as spearhead projects.

10.4 Barnet Council has agreed to provide Programme Management resources to assist in the operation of Integration Programme Delivery Board and establishment of a Programme Management Office to oversee delivery of the work programme. This function is expected to have the mandate from Integration Delivery Board members to support and work across multiple organisations involved in the delivery of the integration programme.

11. INTEGRATION PROGRAMME GOVERNANCE AND DELIVERY

11.1 The following Integration Programme Governance and delivery structures have been endorsed by the Membership of the Integration Programme Delivery Board:



11.2 The Integration Programme Delivery Board membership will include executive and director level representation from the following organisations:

- Barnet and Chase Farm Hospitals NHS Trust
- Barnet Clinical Commissioning Group
- Barnet Council
- Central London Community Health NHS Trust
- Community Barnet
- Enara
- Housing 21
- NHS NCL Barnet
- Personnel and Care Bank
- Royal Free London NHS Foundation Trust

11.3 The Programme Delivery Office will initially be resourced by Barnet Council with appropriate support and input from the Integration Delivery Board member organisations. This will be reviewed and adjusted to reflect the scope and programme management support requirements for the spearhead work programme once this has been agreed.

12. KEY PROGRAMME STAGE PLAN MILESTONES

12.1 The current phase of the project is focused on establishing the Integration Programme Delivery Board and the Programme Management Office to support the delivery of the programme plan. The key milestones that will be completed during this phase of the programme are summarised below and the full Integration Programme Milestone Plan is provided in Section 14 of this report:

High-level Milestone Description	Delivery Date	Status Commentary
Health and Social Care Integration Leadership Summit held	27 JUL 12	Completed
Establishment of an Integration Programme Delivery Board agreed	27 JUL 12	Completed
Health and Social Care Integration One Barnet WAVE 2 Member engagement event held	01 AUG 12	Completed
Internal integration project assurance Gate Review conducted and overview and recommendations report for initiatives to spearhead programme delivery produced	24 SEP 12	Project Gate Reviews Confirmed and will be held on the 24th September.
Draft Integration Programme Delivery Board Concordat produced for sign-off at the first Programme Delivery Board meeting	28 SEP 12	On track to be completed by the original plan date.
Health and Social Care Integration Programme Delivery Board meeting arranged and held	17 OCT 12	Scheduling the meeting has taken longer than expected due to the limited availability of CEO and lead Director level representation from Integration Programme Delivery Board membership.
Spearhead initiatives prioritised and resources assigned by the Integration Programme Delivery Board	31 OCT 12	On track to be completed by the original plan date
Programme Governance and Delivery workstream plan completed	31 OCT 12	On track to be completed by the original plan date

High-level Milestone Description	Delivery Date	Status Commentary
Programme Concept and Definition Phase completed.	31 JAN 13	Dependent on the decision on spearhead projects and outcomes from the Integration Programme Delivery Board meeting.

13.LIST OF BACKGROUND PAPERS

None

Legal: HP
Finance: JH

APPENDIX 1

1. HEALTH AND SOCIAL CARE INTEGRATION SUMMIT OUTCOMES

1.1 Summary of Decisions

- Integration Initiatives - All organisations represented at the Summit Meeting agreed the proposed integration programme initiatives and provided an overwhelming commitment from their organisations to provide the necessary leadership and support to deliver this.

- Governance and delivery structures - All representatives agreed the proposed governance structure to oversee the delivery of system-wide integration initiatives, including the establishment of a single Integration Programme Delivery Board. It was agreed that the governance arrangements should be proportionate to the level of investment and complexity of the work programme being delivered and should promote rather than hinder delivery of initiatives and benefits realisation.

- Investment In Integration - Barnet Council has confirmed that it is prepared to commit £1m to invest in funding care integration initiatives that will deliver tangible system-wide benefits.

1.2 Agreed Actions

Key Action	Supporting Actions & Information
1. Arrange and hold first Integration Programme Delivery Board Meeting	Barnet Council will liaise with each organisation to identify a date in late August/early September and will arrange the first Programme Delivery Board meeting. Organisations will nominate a director level representative to attend the Integration Programme Delivery Board meeting, with the appropriate mandate to make decisions on behalf of their respective organisations.
2. First Integration Programme Delivery Board Meeting Agenda	Meeting agenda to include: • Agreement of a partnership concordat and principles for engagement • A review and agreement of work programme delivery priorities and next steps
3. Produce Draft Care Integration Programme Concordat	NHS NCL Barnet and Barnet Council will prepare and circulate a draft Integration Programme Partnership Concordat for review and comment by each commissioning and provider organisation. The draft will be produced and circulated for review in August. It will then be formally agreed at the first Integration Programme Delivery Board meeting. The Concordat will also clearly describe a personalised vision for integration from the perspective of a

Key Action	Supporting Actions & Information
	person and carer who uses health and social care services in Barnet using a similar approach like Torbay's Mrs Smith.
4. Identify and prioritise Spearhead Initiatives	Integration initiatives to quickly build momentum and spearhead delivery of the integration programme will be prioritised and agreed at the first Integration Programme Delivery board meeting.
5. Spread the word and build support for the integration programme within each organisation	Each organisation representative will take responsibility for communicating the output from the Summit meeting and building support for the programme of initiatives within their respective organisations.

1.3 Summary Points From Discussion Threads

- Building trusted and equal relationships is vitally important to the success of integrated working.
- We need to create the right environment for our staff and partners to be able constructively challenge established ways of doing things and professional and organisational boundaries.
- The vision for integration needs to clearly describe what improvements integration will make to patients, carers and people who use care services in language that is meaningful.
- Care organisation leaders need to make it easier for their staff to collaborate, innovate and to be able to quickly drive integration initiatives from the front line where this makes sense.
- We need to identify more opportunities for staff from different care organisations to have contact through co-location of teams and establishing co-location or contact hubs – There maybe opportunities for this at the new Finchley Memorial development.
- Move to an outcomes based model for contracting health and social care services which promotes the right behaviours and creates the space for people on the front line to collaborate.
- Share information to identify high risk groups (e.g. troubled families) and concentrate integrated and coordinated services around particular groups and places.

1.4 Organisations Represented At The Health and Social Care Integration Summit Meeting

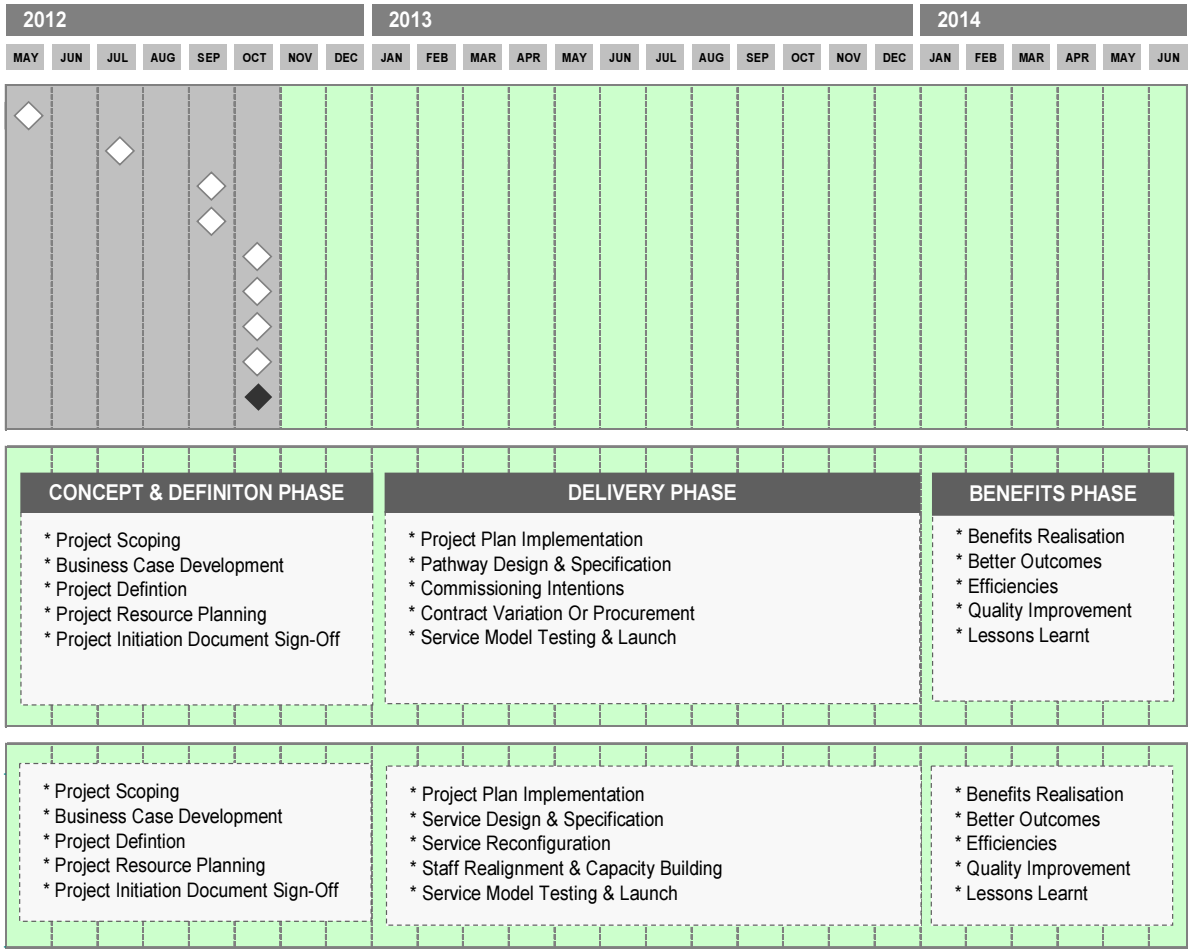
Representatives from the following organisations attended the Barnet Health and Social Care Integration Summit Meeting on the 27th July 2012:

Organisation	Representative	Role
Barnet Clinical Commissioning Group	Dr Sue Sumners Dr Clare Stephens	Chair, Barnet Clinical Commissioning Group Board Member
Barnet, Enfield, Haringey Mental Health Trust (BEH)	Maria Kane	CEO
NHS NCL Barnet	Ceri Jacob	Acting Borough Director
Central London Community Health NHS Trust (CLCH)	James Reilly Howard Perry Murray Keith	CEO Interim Executive Director of Operations Executive Director of Strategy & Business Development
Royal Free London NHS Foundation Trust	Katie Donlevy	Director of Integrated Care
Personnel & Care Bank	Debbie Beavis	Project Director
Enara	Dr Andy Dun	CEO
Community Barnet	Yessica Alverez-Manzano	Head of Engagement and Barnet LINk
Barnet Council	Kate Kennally Dawn Wakeling	Director of Adult Social Care and Interim Director of Children's Services Deputy Director, Adult Social Care and Health

APPENDIX 2 - HEALTH AND SOCIAL CARE INTEGRATION PROGRAMME MILESTONE PLAN

The current programme milestone plan assumes that the concept and definition phase for all agreed spearhead projects will have been completed by December 2012 and the delivery phase will have been completed by December 2013. The expectation is that project benefits will start to be realised from January 2014 at the latest.

WORKSTREAM	KEY MILESTONES	TARGET DATE
PROGRAMME GOVERNANCE & DELIVERY	Health & Wellbeing Board Sign-Off HSCI Programme	31 MAY 12
	Health & Social Care Integration Summit Held	27 JUL 12
	Preliminary Project Assurance Gate Review Held	24 SEP 12
	Integration Programme Delivery Board Concordat Produced	28 SEP 12
	Health & Wellbeing Board HSCI Programme Update	04 OCT 12
	Integration Programme Delivery Board Meeting Held	17 OCT 12
	Spearhead Integration Projects & Resources Approved	17 OCT 12
	HSCI Programme Delivery Office Set Up	OCT 12
	HSCI Programme Stage Completed	OCT 12
ADULT SERVICE INTEGRATED COMMISSIONING	Frail Elderly Commissioning Project Completed	JAN 13
	Dementia Care Commissioing Project Completed	
	Stroke Care Commissioning Project Completed	
	Primary & Community Mental Health Project Completed	
	Mental Health Dual Diagnosis Project Completed	
	Learning Disabilities & PSI Commissioning Project Completed	
	Continuing Care Commissioning Project Completed	
	Telehealth & Telecare Commissioning Project Completed	
INTEGRATED SERVICE DELIVERY	Childrens Services Multi-Agency Delivery Model Project Completed	OCT 12
	Inegrated Primary Care Delivery Model Project Completed	OCT 12
	Learning Disabilities Services Project Completed	OCT 12
	Data Sharing Project Project Completed	JAN 13
	Health & Social Care Service Co-Location Project Completed	MAR 13



Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**Update on cancer prevention work and North Central London cancer network**
Report of	Director for Public Health
Summary of item and decision being sought	Members of the Board are asked to note this report

Officer Contributors	Dr Andrew Burnett, Director of Public Health, Barnet
Reason for Report	This report summarises work on cancer prevention across north central London, including Barnet. The responsibility for raising the public's awareness of cancer issues and for its prevention passes to local authorities in April 2013
Partnership flexibility being exercised	N/A
Wards Affected	All wards

Contact for further information

Dr Andrew Burnett, Director for Public Health, andrew.burnett@nclondon.nhs.uk

1. RECOMMENDATION

1.1 That the Health & Well-being Board note the report attached at Appendix 'A', especially the need for the development of links between the council's public health team and the North Central and North East London Commissioning Support Unit's cancer support team, and liaison with the North Central and North East London Cancer System.

1.2 To note that the responsibility for raising the public's awareness of cancer, a key factor in increasing one-year survival, passes to local authorities in April 2013.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 This report has not previously been presented to Barnet Council but it has been discussed by the NHS North Central London Directors for Public Health

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 This links with the Barnet Health & Well-being Strategy and draft Integrated Prevention Plan.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Most cancers occur more commonly in people living in more deprived areas, especially lung cancer. Survival rates tend to be higher for all cancers amongst people living in more affluent areas.

5. RISK MANAGEMENT

5.1 As the population ages and, literally, as people become less likely to die from other things, the likelihood of developing a malignancy increases. Cancer is becoming more common for this reason but death rates are falling. Key to reducing death rates and making cancer a 'long term condition', that is one that people live *with* and die with but are less likely to die *from*, is increasing the public's awareness of causative factors and enabling them to avoid these, and increasing awareness of early symptoms and the importance of seeking medical advice sooner rather than later. This includes, but is not restricted to, participating in national screening programmes.

6. LEGAL POWERS AND IMPLICATIONS

6.1 N/A Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. Steps that may be taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the *prevention*, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities.

6.2 In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions.

6.3 Regulations setting out the detailed obligations are yet to be issued.

6.4 Proper consideration will need to be given to the duties arising from the Equality Act 2010 as mentioned above.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The Department of Health has yet to clarify either the funding regime or the levels of funding available for local authorities for the new responsibility of increasing the public's awareness of issues concerning cancer. It is anticipated that any work on cancer awareness will be delivered through a partnership between the local NHS, local authority and the London Health Improvement Board.

7.2 Should no additional funding be earmarked as a result from the Department of Health, then any projects not currently funded will need to be supported from existing budgets from public health, the NHS or social care. These will need to be included within a process of prioritising allocation of these budgets against the outcomes set out in the Health and Wellbeing Strategy and the Integrated Prevention Plan.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 There has not been any formal engagement or communication with users and stakeholders for the cancer prevention plan which will occur following the Health and Well-being Board's comments on the draft documents.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None yet for the same reasons as in 8 above.

10. DETAILS

10.1 The former North Central London Cancer Network supporting activities in Barnet has now merged with the North East London Cancer Network to mirror the boroughs covered by the future North Central and North East London Commissioning Support Unit (CSU) and will become a 'cancer support team' within this new body. It is likely that the CSU will seek healthcare public health support from local authority public health teams as part of the support that they are required to give to clinical commissioning groups.

10.2 'Integrated cancer systems' are being developed in London, bringing together various NHS providers to better co-ordinate cancer prevention and care services. These integrated cancer systems will also mirror the commissioning support unit areas, so Barnet will be covered by the north central and north east London one, which will also cover west Essex and include all of the main NHS trusts currently serving Barnet residents.

10.3 Table 1 below summarises the main features of three key cancers in Barnet. More detail can be found in the main report. Overall, mortality and one-year survival rates are improving. The key reason for low one-year survival rates is late presentation and thus the key way to address this is through increasing the public's awareness of relevant symptoms and what to do. Of course, encouraging lifestyles that themselves reduce the risk of cancers of various types is vital, especially as about one third of all cancers are caused by tobacco consumption, inappropriate diet, overweight and obesity, and excess alcohol consumption.

10.4 Table 1 - Summary of the Main Features of Key Cancers in Barnet

Cancer	Barnet incidence	Barnet mortality	Barnet one-year survival
Breast	Below national average	Lowest in north central London but above the London and England averages	Similar to those in the other north central London boroughs
Cervix	Below national average	Below London and national averages	Similar to London average
Colon and rectum	Similar to London average	Similar to national average	Similar to national average

10.5 The responsibility for promoting cancer awareness and prevention transfers to local authorities in April 2013. Funding for NAEDI (the National Awareness and Early Diagnosis Initiative) is held within cancer commissioning teams and it is not yet clear whether this will be passed to local authorities, whether it needs to be bid for or whether local authorities will need to work with local cancer networks to undertake this work.

10.6 There are various cancer awareness initiatives currently in place, including:

- a GP leadership project
- NAEDI cancer networks supporting primary care local improvement initiatives
- achieving earlier presentation in lung cancer through targeted community awareness

10.7 Full details are included in the update '**Cancer Prevention work and NCL Cancer Network'** prepared by Rachel Wells from the Public Health team which is attached at Appendix 'A'.

11 BACKGROUND PAPERS

11.1 Joint Strategic Needs Assessment (2011-2015): http://www.barnet.gov.uk/downloads/download/356/joint_strategic_needs_assessment_2011-2015

11.2 Barnet Health & Wellbeing Strategy (elsewhere on this agenda)

11.3 Annual Report of the Barnet Director for Public Health: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=6565&Ver=4

Legal – HP
CFO – JH/MGC

APPENDIX A

Title	**Update on Cancer Prevention work and NCL Cancer Network**
Audience	**NCL Directors of Public Health**
Date	**August 2012**
Author	**Rachel Wells** **NHS NCL/London Borough of Barnet**

1. Background

The landscape for cancer prevention and early diagnosis is changing in London. This paper sets out the current picture for cancer for the boroughs in NCL and identifies some of the challenges for the near future which should be taken into account when planning how cancer prevention, early diagnosis, treatment and public health will operate in any new structures.

2. Present and future structures

2.1 The NCL Cancer Network has merged with the NEL Cancer Network and jointly these are now known as the NCLNEL Cancer Commissioning Network, in which there is currently one day of public health support offered by NCL and a part time consultant attached to NEL. The structure mirrors that of the Commissioning Support Organisation and once staff consultation and re-organisation is complete the cancer network will transform to become a team with the new CSS known the Cancer Commissioning Team. It is not clear at present whether this will include any public health support within the team and neither of the current consultants will be available from Aug 2012. If public health does not exist in the team there may be an intention for public health support for come from within the boroughs, though there has been limited discussion on this to date as structures in general are still being clarified.

2.2 Alongside the development of the cancer commissioning team within the CSS is the establishment of the Integrated Cancer System. This has taken place only in London at present and brings together providers to integrate and co-ordinate the care that is provided to cancer patients, though the ICS that covers NCL/NEL is also keen to be involved in prevention and early diagnosis and is working hard to engage GPS and CCGs.

3. London Cancer, Integrated Cancer System

3.1 London Cancer is an Integrated Cancer System for North Central & North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the patients and populations.

3.2 In April 2011, responding to London's cancer challenge to improve survival and patients' experience of care, the Model of Care for Cancer (NHS London, 2010) noted that cancer services can only be substantially improved if care is provided through co-ordinated networks taking collective responsibility for whole pathways of care rather than individual NHS

organisations. Services would be built around the needs of cancer patients, rather than patients and their carers having to navigate the different approaches of individual NHS organisations. As such, it proposes a fundamental system shift with the creation of Integrated Cancer Systems (ICS) as provider collaborations to improve the delivery of cancer care.

3.3 The following provider organisations have co-created London Cancer:

•Barnet and Chase Farm Hospitals NHS Trust •Barts Health NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free Hampstead NHS Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whittington Health.

3.4 London Cancer is the smaller of the two London ICS, the other one, known as London Cancer Alliance covers the rest of London. However UCLP is the key driver in London Cancer and the best contact details for information is:

Charlotte Williams, Director of Integrated Cancer, UCLPartners, 170 Tottenham Court Road, London W1T 7HA, T: +44 (0) 2031082346; M: +44 (0) 7703319213, E: charlotte.williams@uclpartners.com

4.0 Incidence, Mortality and One year Survival Current for Breast, Bowel and Cervical Cancers

The overall picture for cancer in NCL has improved since the last report from the National Cancer Action Team which identified several key issues with one year survival and mortality across the cluster. However we cannot be sure that these trends are likely to continue, and should continue to refresh the LAEDI baseline as a sense check for trends in mortality, incidence, one and five year survival and stage of diagnosis. This paper updates on mortality, incidence and one year survival.

4.1 Breast Cancer:

Incidence

Other than for Islington the incidence of breast cancer across NCL is lower than the England average for the rest of NCL boroughs, with Barnet and Enfield below the London average, See Appendix 1, figure 1.

Mortality

Mortality for all ages is lowest in Barnet and above the England and London average in the rest of the NCL boroughs see Appendix 1 figure 2.

One year survival

One year survival has been an area of concern recently though latest data suggests that differences in one year survival have evened out across NCL, see Appendix 1, figure 3.

4.2 Cervical Cancer

Incidence

With the exception of Islington rates are lower than the England and London average across the cluster, see Appendix 1, figure 4

Mortality – Cervical Cancer

Mortality from cervical cancer is low, however when comparing rates across the cluster Islington and Enfield have higher rates than London and England, and the rest of the cluster. Camden, Haringey and Barnet have rates below those of both England and London, see appendix 1, figure 5

One year survival – Cervical Cancer

One year survival for cervical cancer is around the 83% for 2002-2006 rolling average for NCL, there is no significant difference between the London rate and the NCL rate for cervical survival.

4.3 Colorectal Cancer
Incidence

The incidence for colorectal cancer is above the national and London averages for Islington, and just about on the national average for Haringey. Camden, Barnet and Enfield sit on or just below the London average. However there are pockets in each borough where rates will be higher depending on particular populations, and factors which increase the potential for incidence to increase, these include gender, ethnicity and lifestyle factors**,** see Appendix 1, figure 6.

Mortality

Mortality for under 75s is above the England and London average in Haringey and Islington and sitting on average for Barnet and Enfield, whilst Camden sits just under these averages - see appendix 1, figure 7. Mortality is much higher in men than in women, reflecting the national and London picture.

One year survival

On year survival for colorectal cancer has been compared to Sweden and Norway, both countries offer a good comparison has they have similar levels of cancer registration as England. When comparing one year survival, Camden has the highest rate in the cluster, which is just above the England rate, with Islington and Barnet meeting the England average. Haringey and Enfield sit below the England average and NCL also sits below this. This

means that one year survival for colorectal cancer is poorer across NCL and below the best comparison in Europe, see appendix 1, figure 8.

5. What work is taking place on Cancer Awareness and Prevention?

5.1 The responsibility for cancer awareness and prevention transfers to local authorities in March 2013, though many NCL boroughs have been prioritising this work already. The Cancer Commissioning Network Team have also been the driver for much of the NAEDI (National Awareness and Early Diagnosis Initiative) work since funding for this has been awarded to Cancer Networks in the past, and not directly to boroughs or PCTs. It is not clear as yet how this might change but it may be significant if the competition to bid for NAEDI funds increases to a wider audience in future. It is likely that it would be expected that consortia would come together for this purpose but the configuration of these is unknown.

5.2 There are several initiaitives being conducted across the cluster led by the Cancer Commissioning Network Team, with contributions from local PCCLs and public health.

- GP Leadership Project – see Appendix 2
- NAEDI Cancer Networks Supporting Primary Care: Local Improvement Initiatives & GP Leadership (Wave 2) – see Appendix 3
- Achieving earlier presentation in lung cancer through targeted community awareness (Wave 3) – see Appendix 4

In addition to work being undertaken there are 2 expressions of interest awaiting news of funding:

- Expression of Interest – Promoting Earlier Diagnosis of Cancer 2012/13, funding for local activity on constellation of cancer symptoms North East London Cancer Network and North Central London Cancer Network, working with London Cancer
- Expression of Interest – Promoting Earlier Diagnosis of Cancer 2012/13, funding for local activity to run local stretch engagement activity for bowel cancer across the North East London Cancer Network (NELCN) and North Central London and West Essex Cancer Commissioning Network (NCL&WECCN), covering 13 PCT areas(coterminous with 13 Local Authority areas), representing a population of over 3million, and including; City and Hackney, Tower Hamlets, Newham, Waltham Forest, Redbridge, Barking and Dagenham, Havering, Enfield, Camden, Barnet, Haringey, Islington and West Essex.

The development of a new CSS covering both NCL and NEL means that any new NAEDI work will need additional public health support from boroughs in order to be successful and to build on local priorities. The relationships with the Cancer Commissioning Team and the CCGS are being well established

but the development of these with local authorities and public health vary at this time.

6. The role of the public health lead for the NCL/NEL Cancer Commissioning Network Team

This role has been primarily to support the development of public health relationships, and advise of the collection and interpretation of data. I have led on the information section of the Cancer Commissioning Strategy and interpreted the LAEDI baseline and the more recent LAEDI refresh for the purposes of providing public health information and data for NAEDI bids. I have advised on data interpretation and looked at detail at particular areas where queries have arisen.

I have also held the lead on inequalities for the network and undertaken the audit of inequalities in cancer work across the sector and convened a learning set to devise a forward plan for this. I co-chair the Primary Care and Prevention Board for the network which is the key driver for NAEDI and sit on the Cancer Commissioning Strategy Board and have held a role on several of the project teams.

The future of this role is uncertain and dependant on the Cancer Commissioning Team new structure.

7. Summary

- Progress on prevention and awareness work across the cluster has been led by the Cancer Network Commissioning Team with support from public health.
- The structure and relationship with this team is changing and arrangements for public health are uncertain.
- No announcement has yet been made about how funding for NAEDI funds will be accessed in future.
- The enlargement of the CSS to cover NCL and NEL means that relationships with local authorities, public health and CCGs need to be development to get the best from future funding and co-ordination over the larger area.
- The establishment of the ICS, London Cancer, is significant for commissioning but also prevention and awareness work.
- Mortality and one year survival concerns have improved though these maybe down the an additional period of data and a further refresh would be useful.

Appendix 1 Figure 1

Note that the contents of this appendix are not currently available

Appendix 2: GP Leadership Project

The project

In 2009/2010 all Cancer Networks received funding for the GP Leadership Project. The Project Initiation Document/ Service Level Agreement described the key outcomes – identification of practices of interest on the basis of the GP Practice Profiles; visits to an agreed number of practices to review the information and offer support, including funding for the Primary Care Audit; and implementation of an action plan. Funding was given for GP sessions (8 per borough) and the targeted use of the primary care audit. Since the start of the project, NCIN (National Cancer Intelligence Network) have updated the GP practice profiles and work continues in terms of promoting the use of the data to inform and improve practice.

Initial funding: Total budget £24k; £10k for the Practice visits, £14k for the RCGP audit.

1.0 Progress through life of project

How practice profiles have been distributed

- Commencing with receiving the Data Access Forms and distributing case by case
- Promoted the PPs at events and through the PCCLs
- The profiles were arranged in categories: 'more of a need' and 'maybe a need' individually with the PCCLs and from the 'first cut' list, 8-10 practices for each PCT were then selected for a potential visit following a second stage review, which involved clinical oversight and review by each PCCL.
- PCCLs contacted practices individually to offer the PP and a visit & RCGP audit.
- Received confirmation that PPs could be sent out to individual practices
- Compiled a GP database ensuring we had all correct GP email addresses
- Individually sent an email explaining the profiles, with profile and supporting documentation attached, an offer for PCCL to meet regarding the profile and a survey to gather thoughts
- Events used to 'promote' and distribute the profiles

Communications with GPs

- The Cancer Network have produced a number of communications in order to promote the use of practice profiles; through emails promoting the work, through inclusion in GP bulletins, personal emails as well as mentioning the project in communications relating to other projects.

- GP practice profiles (2009/10 QOF data) posted to all GP practices with the Bowel Cancer Awareness pack (posted July 2011) as well as the refreshed GP practice profiles (2010/11 QOF data) as part of the Lung Cancer Awareness pack (posted February 2012).

- GP practice profiles (2009/10 QOF data) posted to all GP practices as part of the two national campaigns, Bowel Cancer (posted January 2011) as well as the refreshed GP practice profiles (2010/11 QOF data) for the Lung Cancer campaign (posted April 2012).

- All GPs were emailed (using the dedicated primarycarecancer@nclondon.nhs.uk address) the refreshed GP practice profiles in May 2012.

The role of the Primary Care Cancer Lead

- Primary Care Cancer Leads have been promoting profiles at every opportunity within their patch; at meetings, through informal communications, through emailing personally to GPs in the area and through telephone conversations.

- The structure in the network is that of a devolved model where each PCCL conducted 8 or more visits for their PCT population; the lead GP has overall responsibility for the work and has regular input at the Primary Care & Prevention Board meetings and close liaison with the Senior Management and Quality Innovation team of the Cancer Commissioning Network.

Camden – Dr Lucia Grun (new in post) Islington - Dr Karen Sennett Barnet– Dr Clare Stephens	West Essex - Dr Christine Moss Enfield - Dr Mike Gocman Haringey– Dr Toni Hazel - Dr Kate Rees covering maternity leave (until March ’13)

Summary of achievements by PCCLs:

- Total visits to practices = 35
  Total RCGP audits completed = 10

- **How have the GP practice profiles informed strategy**

- The profile data is used to inform a number of projects in the Network as well as being discussed at Primary Care and Prevention Board and NAEDI programme board. The data will be used as a baseline for improvement work, for example, data around 2WW referral patterns can inform work around the

interface between primary and secondary care in the NAEDI and GP focussed programmes of work. In addition, the data will feed into our overall commissioning intelligence picture.

- A summary of the profiles is as below:

- **Responses from GPs**

- A survey was used to gather responses: https://www.surveymonkey.com/s/GP_PracticeProfiles - the results are in the document below.

- Overall, GPs and GP practices have found the information to be useful, there is definitely an appetite for this kind of information and when presented to GPs in a appropriate format (A3)/forum (GP event) then the profiles are welcomed.

- **2.0 Next steps:**

- **PCCLs**

    - Continue with GP leadership work in each borough.

Network

- Continue to progress GP leadership work through the NAEDI programme.

- Explore interdependencies with additional programmes of work; GP education (series of education sessions being planned) and GP engagement work (Cancer Research UK) as well as London Cancer and the Primary and Community Care Engagement Project

- Explore opportunities with CCGs and use of practice profiles; produce a usable dashboard for example.

- End of life profiles: http://www.endoflifecareforadults.nhs.uk/news/all/new-end-of-life-care-primary-care-trust-profiles are now available and can be used to inform future strategy.

Appendix 3: NAEDI Cancer Networks Supporting Primary Care: Local Improvement Initiatives & GP Leadership (Wave 2)

Introduction

Following the development of a successful bid during July 2011, the NCL &WECCN were awarded National Funding in September 2011 as part of the NAEDI programme Cancer Networks Supporting Primary Care.

There are 2 parts, or work streams within the programme;

- Part one; strengthening GP leadership within the network
- Part two; the development of local initiatives to promote earlier diagnosis for Lung and Oesophageal cancers.

The programme will run from September 2011 to March 2012 (final evaluation due). Reports due in September (completed) and March 2012.

Outcomes

To increase the reach of NAEDI to our local GPs and their practices
To ensure appropriate treatment at an earlier stage
To improve 1 & 5 year Survival
To increase % of diagnosis via 2WW
To reduce % of diagnoses via emergency presentation
To reduce the proportion of late stage presentation
To increase the proportion of early stage diagnosis
To increase uptake of thoracic surgery (lung)
To increase access and timeliness feedback to straight to test (chest x ray for suspected lung cancer)
To improve referral interface between primary and secondary care
To promote engagement / communication between primary and secondary care
To increase the number of GP's that are aware of the importance of early diagnosis
To develop practice and learning through reflective practice
To share learning, innovation, best practice and evidence
To improve GP confidence and ability to recognise signs and symptoms of cancer

(NB The national team are advising regarding collection of pre and post project evaluation metrics)

Progress to date

- NAEDI Programme board meeting continues to meet monthly
- Weekly project team meetings continue
- TCR / ECRIC / data analysis /segmentation completed
- Detailed project plan developed
- Project running to plan, please contact Emma if you would like a copy.

4. **Progress since last reporting period**

GP Leadership

The team met with Brondesbury GP practice to discuss the practice profiles and cancer more generally; this proved to be a useful meeting and additional meetings could be set up.

Next steps: Strategic GP meeting to take place under the GP leadership programme of work rather than Wave 2. West Essex event to be scheduled for the summer period.

Lung Cancer

Next steps: As part of the the GP education work conduct sessions for GPs focusing on lung cancer.

OG Cancer

Next steps: sign off the new 2WW form and urgent endoscopy form and implement across the network. This is being led by London Cancer.

Overall next steps:

- Evaluation interviews run by Durham University are taking place in July.
- Developing the NAEDI presence with the NCL web manager on the NCL website.
- All 2WW forms to be uploaded on the Cancer Network website and the changes communicated through the relevant GP IT leads by *London Cancer.*
- Final 'wrap up' event is planned for September – agenda to be agreed with Primary Care and Prevention Board.

- Pan London specification around chest x-rays being produced; once this has been produced a local decision can be made as to future improvement in this area.

- Tumour site evaluation to take place (ie. Lung Cancer) in order to establish impact of the programmes of work in totality.

5. Risks and Issues

Ref	Risk	Mitigating Factor
1	**Increased Referral Demand** - planned interventions could increase the number of inappropriate referrals, which has the potential to compromise the delivery of acute sector services.	Mitigated by measuring data from Providers monthly, having a central point of contact in case of difficulty, communicating with Providers & Tumour Board Chairs to ensure that they are aware of the interventions and their likely impact and have developed capacity plans based on planned scenarios, i.e., x% increase in appropriate referrals and x% decrease in inappropriate referrals.
2	**Timing** - risk that as the Programme is very tightly packed that not all aspects of it will be completed on-time.	Mitigated by robust performance management. As soon as funding is confirmed the programme governance structure will be established and performance management will begin on a weekly basis. All non-compliance will be escalated to project management group in the first instance and Programme Board should the issue fail to be resolved.
3	**Changing NHS Landscape -** risk that stakeholders are distracted by the structural reforms taking place currently and fail to deliver Programme objectives, in addition there is a risk that during this time key staff will leave.	Mitigated by being clear what the Programme objectives are and the strategy that we are deploying to deliver the end results. Positive communication of the benefits to all stakeholders of improved 1 year survival. Programme Manager will need to ensure that all members of the programme team know what is expected of them and develop succession plans should they leave during the Programme.
4	**Sustainability -** risk that as the NHS landscape evolves the impact of this intervention will lessen.	Mitigated by ensuring that within each work stream sustainability is a key deliverable and that attention is paid to ensuring that structural changes are made to enable improvement work to continue, i.e., addressing gaps in processes to routinely collect staging data within MDTs.

6.0 Costing

Delivery of the project is currently within agreed budget.

7.0 Conclusion

The project is currently in the wrap up and evaluation stage, with completion of outputs by April and evaluation completed by July 2012. In order to sustain the work, some outputs will continue to run over the summer, 2012.

Appendix 4: Achieving earlier presentation in lung cancer through targeted community awareness (Wave 3) – see Appendix 3

1. **Introduction**

Following the development of a successful bid during August 2011, the NCL&WECCN, were awarded funding from the promoting earlier diagnosis of cancer investment programme 2011/12. The Project will run from September 2011 – May 2012.

The aim of the project is to work with and through a range of existing community networks including traditionally hard to reach communities, to reach those population groups where lung cancer incidence, smoking rates and / or late presentation are known to be a particular issue across the Network.

The project is based on a review of the available evidence into community outreach, faith groups, lay health workers, peer educators, peer support and other forms of community engagement in health promotion/improvement, as well as learning from what has been shown to work both locally and in other NAEDI funded projects, to develop a community-focused project to promote earlier presentation for individuals with signs and symptoms of lung cancer.

The project aims to raise awareness of lung cancer and deliver the positive message that cases are treatable if diagnosed at the early stages. By drawing upon the knowledge and energy of local communities, the project will seek to ensure messages are tailored and delivered in a way that reaches those most at risk.

2.0 Outcomes

- *To improve 1 & 5 year relative survival from lung cancer*
- *To increase % conversion rates of diagnosis via 2WW*
- *To reduce % of diagnoses via emergency presentation*
- *To reduce the proportion of late stage presentation*
- *To increase the proportion of early stage diagnosis*
- *To raise awareness of early signs and symptoms of lung cancer*

(NB awaiting DH input re exact metrics to be collected)

8. **Progress in this period**

- Phase 1 project work complete
- Phase 1 evaluation complete
- The 4 Community Organisations: Haringey Life Savers, Tottenham Hotspur Foundation, Arab Advice Bureau and Bangladeshi Association have commenced phase 2 work (June-August 2012) in the community delivering health events and the Lung cancer messages.

- Contracts and project plans have been developed, agreed and signed off by the project teams.

- Event evaluation and Lung CAMs are being submitted by the organisations and are being analysed by the Islington Public Health team.

- The project manager has been meeting with each organisation to ensure the project is on track and any issues are picked up as well as attending community events.

2. **Next Steps**

- Community organisations to deliver Phase 2 three month campaign and awareness raising and submit evaluation for the period before the end of August.

- Central evaluation carried out by the community organisations of interventions will be collated by 27th September.

- Additional feedback/presentation session for the community teams to be held in August '12 for teams to present progress so far and learn from each other.

- Final event to be held at 24th of September to feedback to stakeholders.

4.0 Risks and Issues

5.0 Costing

Delivery of the project is currently within agreed budget.

3. **Conclusion**

Project in delivery phase; interventions to be delivered by community partners June-August with final conclusion of phase 1 of the project by the end of September.

Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**A review of strategic partnerships with customers, carers and communities**
Report of	Director of Adult Social Care and Health
Summary of item and decision being sought	This report presents the conclusions of a wide-ranging review of engagement and co-production across ASCH and concentrates on the role of Partnership Boards in the context of strategic partnerships and collaboration.

Officer Contributors	Mathew Kendall, Interim Associate Director, Joint Commissioning Stephen Craker, Co-production and Ageing Well Interim Programme Manager
Reason for Report	It is a principle of good governance to review partnership structures regularly. Given that the partnership board structures have not been reviewed for some time and that the Health and Wellbeing Board is still relatively new it is particularly important to review whether the partnership structures that report to it are working effectively as the Board prepares to take on its statutory responsibilities from 1 April 2013. To note and comment on the thirty recommendations (section 2.3 of the attached paper) for action that have been set out to build on existing good practice and strengthen existing partnership work.
Partnership flexibility being exercised	Health and social care are required, under Section 82 of the NHS Act 1986, to co-operate to secure and advance the health and well being of the local population.
Wards Affected	All

Contact for further information

Stephen Craker, Co-production and Ageing Well Interim Programme Manager Stephen.craker@barnet.gov.uk 020 8359 4762

1. RECOMMENDATION

1.1 To note and comment on the thirty recommendations (section 2.3 of the attached paper) for action that have been set out to build on existing good practice and strengthen existing partnership work.

1.2 To approve the establishment of a Health and Wellbeing Partnership Summit (recommendation 22, under section 2.3 of the attached paper) for the Partnership Boards and the Health & Wellbeing Board to meet twice a year.

1.3 That the draft Implementation Plan (section 4 of the attached paper) be implemented and the Board review progress at future meetings.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board, 26 May 2011, item 2, Governance and Membership. This report agreed relationship with Partnership Boards, including an annual report from each Board setting out achievements for the year and forward work programme for the year ahead; the ability for Partnership Board chairs to propose items for the forward plan; and a twice yearly meeting between the Chairman of the Board and Partnership Board chairs.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The work of the Partnership Boards actively support the implementation of the Barnet Sustainable Community Strategy 2010 – 2020 priority objectives of '*promoting choice and maximising independence for those needing greatest support*' and ensuring '*better health, healthy lives for all*'.

3.2 The Partnership Boards have a clear role in monitoring commissioning plans for specific client groups and ensuring that they are shaped by the needs of service users and their families and carers. This report relates to the collective ability of the Boards to function effectively and therefore lead the development of the strategies the Boards are responsible for, which sit underneath the overarching Health and Well-being Strategy.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Partnership Boards involve people with learning disabilities; mental health issues; carers; older people; and people with a physical and/or sensory impairment. Their work is therefore intrinsically linked with ensuring that the needs of specific groups covered by equalities legislation are considered.

5. RISK MANAGEMENT

5.1 There is a risk that the document will not be adopted fully and in a meaningful fashion across the Council, NHS, wider community partners and with families and communities. This risk is mitigated through undertaking an extensive consultation process that included engagement across Adult Social Care and Health; Barnet Clinical Commissioning Group (CCG); NHS commissioners and providers; the Local Involvement Network (LINK), third sector networks and other stakeholders

6. LEGAL POWERS AND IMPLICATIONS

6.1 In exercising their respective functions, NHS bodies and local authorities are required, under section 82 of the NHS Act 1986, to co-operate with one another in order to secure and advance the health and well being of the local population.

6.2 Both the NHS and the local authority must be mindful of their statutory duties pursuant to the Equality Act 2010. The equality duties are a mandatory relevant consideration in decision-making which means that equality issues should form a central part of decision makers' consideration when formulating policies and proposals.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 None specifically arising from the report. Implementation of the strategy will be led by the Assistant Director for Adult Social Care & Health. A separate document has been produced that sets out the resources required for a consistent approach to co-production across ASCH in Barnet.

7.2 Two posts will be transferred from the Strategic Commissioning Team in ASCH to the ASCH Customer Care and Business Team. In addition, as the User, Engagement and Co-production plan and the recommendations from the Partnership Board review are implemented, there will be the need for additional administrative support. There is currently a part-time temporary Business Support officer based in the Strategic Commissioning Team. The current contract for the existing temporary Business Support Officer is due to end in late September so there will be the need to recruit a Business Support Officer for a period of 6 months. Funding for this has been identified from Section 256 monies for 12/13.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each of the Partnership Boards provides an opportunity for service users and their representative groups to advise on their experience of service delivery and for commissioners and providers to work constructively with them to address their needs. Each board is co-chaired by a service user, a carer, or an advocate of service users and carers.

8.2 The proposal has been developed in partnership with partnership boards as detailed in Section 10 below.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Voluntary/community sector providers are represented on each of the partnership Boards and were involved in this review.

10. DETAILS

10.1 There are a number of Partnership Boards that sit below the Health and Well-Being Board, which oversee services for a number of specific groups. They are: Learning Disabilities; Carers; Mental Health; Physical and Sensory Impairment; and Older Adults. Each is co-chaired by a senior manager from the NHS or the local authority and a service user.

10.2 In March 2012, the Senior Management Team of Adult Social Care and Health (ASCH) commissioned a Consultant to review the departments work on Involvement,

Engagement and Co-production. Involvement, Engagement and Co-production (IECP) is an approach that recognises the value of partnership between users of public services and public authorities in developing services, policies and strategies.

10.3 Over 70 people were interviewed, individually or in groups, ranging from customers (people who use services) and carers to commissioners and partner organisations. A comprehensive review of current national thinking and duties also took place and is brought to bear appropriately.

10.4 Following discussions with members and co-chairs of each of the existing Boards, a number of changes and improvements are proposed. These will enable a better alignment between the partnership structures and supporting collaborative arrangements, whilst getting greatest impact from partnership activity. The proposed changes will also ensure a focus on co-production and more direct accountability to customers, carers and the local community.

10.5 The Health and Well-Being Board has agreed the importance of ensuring that the experience of users of health and care services was placed at the heart of the Board's work. Members of the Partnership Boards were keen to ensure that the Health and Well-Being Board had opportunities to be involved with the work of the partnership Boards. The review therefore includes a recommendation to establish a Health and Wellbeing Partnership Summit for the Partnership Boards and the Health & Wellbeing Board to work together to develop a coherent view of future priorities of work; celebrate progress made by both the Partnership Boards and the HWBB, share any lessons learned; and develop a set of key messages to deliver to the community. This is in addition to receiving an annual report from each of the Boards.

11 BACKGROUND PAPERS

11.1 None

Legal – HP
CFO – JH/MGC

Barnet Council

Adult Social Care and Health

A review of strategic partnerships with customers, carers and communities

"Working together to involve and share responsibility with people, including people who use services and carers, in the design, commissioning and provision of support and services to meet people's needs"

Version 1.5

10 September 2012

Prepared by Stephen Craker, Kazou Consultancy Ltd

North Central London

1.0 Executive Summary

This review was commissioned by Barnet Council Adult Social Care and Health (ASCH) in March 2012 in order to ensure that customers, carers and communities are engaged in a meaningful, transparent, consistent and efficient way.

This report is the result of one consultant's wide-ranging review of engagement and co-production across ASCH and concentrates on the role of Partnership Boards in the context of strategic partnerships and collaboration. Over 70 people were interviewed, individually or in groups, ranging from customers (people who use services) and carers to commissioners and partner organisations. A comprehensive review of current national thinking and duties also took place and is brought to bear appropriately.

It is clear that there is considerable potential for work in co-production through involving customers, carers and communities in improving services through commissioning and service development.

Members of the Barnet Council's ASCH's Senior Management Team (SMT) have expressed a desire to see how services can move towards co-production with customers, carers and communities. Co-production is about building relationships between different groups in order to share information, knowledge and experience, and come to consensus decisions on service development.

Following discussions with members and co-chairs of each of the existing Boards, a number of changes and improvements are proposed. These will enable a better alignment between the partnership structures and supporting collaborative arrangements, whilst getting greatest impact from partnership activity. The proposed changes will also ensure a focus on co-production and more direct accountability to customers, carers and the local community.

1.1 Background

Barnet Council ASCH has a track record of partnership working through the various Partnership Boards. The Partnership Boards have provided Barnet Council ASCH an effective forum to share its plans and seek views in setting out priorities and aspirations. Nevertheless, the current arrangements do not fully support the development of new models of care and the changing relationship that ASCH has with its customers, carers, communities and their representatives to help ensure local resources are directed at local needs.

Each of the major customer group areas has a partnership board, which enables Barnet Council ASCH, and other organisations to work together to improve services. There are the following partnership boards:

- Learning Disability Partnership Board
- Older Adults Partnership Board
- Mental Health Partnership Board
- Physical and Sensory Impairment Partnership Board

- Carers Strategy Partnership Board

Key developments and aims and targets from these Boards are reported annually to the Health and Wellbeing Board.

Each Board approaches involvement in a different way, with mechanisms in place to assist wider accountability. Reflecting on these differences may enhance the engagement with the Partnership Boards and with people who use services.

1.2 Findings

There are several fundamental and interlinked factors which have influenced the findings which include the department and culture of Adult Social Care and Health and its officers and managers. The views, skills and needs of individuals, customers and carers, the community and voluntary sector and partner agencies, the wider council and the political, legal and financial context have also been taken into account.

The departmental intention to inclusively engage people is clear and officers are getting a good mix of ideas, challenge, information and feedback about the services they deliver and commission. The majority of people interviewed are clear that Adult Social Care and Health staff are really engaging with people and that there are a variety of ways to get involved.

In the main, individuals and staff are impressed with the leadership and engagement of senior officers of the Department. There is excellent practice apparent in different areas and there are many very committed and skilled officers. This good practice should be celebrated.

Some individuals and groups are having a direct influence over development and strategy, for example the improvement of accessible toilets at Finchley Memorial Hospital and the review of library services. Individuals across all areas are involved in different types of decision-making, for example the Ageing Well project and Right to Control programme. Recently established groups, for example the Older People's Assembly and the Learning Disability Parliament are already demonstrating good practice. There are also examples of different and creative approaches to engagement such as the open membership approach within the Mental Health Partnership Board.

Engagement work has developed in different ways across different partnership boards responding to the needs of different client groups and communities. This inevitably means there are opportunities and gaps along with good practice. Although there is clearly a lot of good will and intention to engage individuals, for a variety of reasons this is not consistently translated into good practice. Along with all the compliments, some individuals and groups expressed concerns. This was sometimes for very obvious practical reasons, such as feedback not always being given.

Individuals and officers have a range of motivations for getting involved or carrying out engagement work. Some of these are shared, such as a personal drive, a determination to make changes or wanting to gain a deeper understanding of others or of a situation. Skills inevitably vary amongst individuals and staff and therefore training, in a variety of themes such

as inclusivity or representation can be productive.
It is important to note that there are inevitably different and sometimes conflicting opinions about engagement, which is a very complex issue and a huge challenge for the different people involved. There is also often increased controversy and concern within periods of change and at times of difficult decisions. This is not unique to Adult Social Care or to Barnet.

In summary, the strengths and opportunities identified can be described as:

Strengths:

- the long standing relationship members of the partnership boards have with ASCH officers
- well established service user and carer involvement officer and partnerships officer within ASCH
- development and use of innovative approaches to involvement with the Learning Disability Parliament, the Older People's Assembly and the Carers Forum
- a highly committed group of customers, campaigning for the development of a Centre for Independent Living;
- some examples of joint work with local NHS organisations.
- Newly developed and approved policy on payment for customers and a budget to support involvement costs including transport

Areas for improvement:

- further development in the publication of a newsletter to maintain contact with people involved and to encourage people to become involved
- increasing the numbers of customers and carers involved
- development of a cross-partnership theme approach
- further develop involvement to ensure a co-creation and co-production approach.

A number of issues have been identified in terms of this involvement:

- how customers/carers are supported to participate fully
- how customers/carers are accountable to the larger user group and where this interfaces with the LINk / HealthWatch
- how succession of customers/carers is achieved
- how a wider cohort of customers and carers can be involved
- the capacity for development and co-ordination has been limited due to the volume of work

A full SWOT (strengths, weaknesses, opportunities and threats) analysis has been included in appendix 1.

2.0 The way forward - A fresh approach to Partnership Boards: Making a Breakthrough in Strategic Collaboration

2.1 Introduction

This paper provides an overview of the work undertaken during spring/summer 2012 when Adult Social Care and Health commissioned a strategic review of engagement by an independent consultant. This element of the review concentrates on the role of partnership boards and will show how customers, carers and communities were being engaged and suggests how to build on the good inclusive practice that was evidenced. It then goes on to provide a suggested framework for delivering involvement, collaboration and partnership working within the partnership board arena so that it is efficient, effective and sustainable[1].

The main purpose of engaging and involving customers, carers and the community is to maintain and improve services through commissioning and service development. It is vital to commission good quality services that are value for money and are meeting people's needs. This means individuals must be at the heart of the commissioning process by analysing what is needed; planning and designing services and then monitoring and reviewing them.

Members of the Barnet Council's ASCH's Senior Management Team (SMT) have expressed a desire to see how services can move towards co-production with customers, carers and communities. Co-production is about building relationships between different groups in order to share information, knowledge and experience, and come to consensus decisions on service development.

The approach of engagement and co-production can be summarised as:

- a method of working together from the outset, to achieve an agreed outcome
- everyone involved is valued as an equal
- where the 'trading' of skills, experience and knowledge is respected and employed to its maximum, in all directions
- positioning the perception and aspirations of the end-user as the main driver.

Comments made during the interviews and focus groups indicate that future strategic partnership working across ASCH in Barnet must be focussed and purposeful. This collaboration must be characterised by commitment, action and leadership.

There are no immediate financial implications to the report, however bringing about the change in relationship may identify pressures which will need SMT discussions.

[1] See the Barnet Council ASCH's Engagement and Co-Production strategy, which outlines how we propose to involve residents, customers, carers and partners in local issues

2.2 What people have been telling us?

People have told us where there are overlaps and where we could work with partners more closely, what works well and some ideas of how to improve. Below are a selection of comments and views that have been expressed.

- *Community members on Partnership Boards are most effective when they represent a range of views and people.*
- *Partnership Boards could be more inclusive and less formal.*
- *We need to be clearer on what outcomes we want from the engagement and what has been achieved as a result of the work.*
- *We do a lot of good work with working groups and forums but need an over-arching approach to ensure consistency and continuity.*
- *We should have an evidence-based approach to engagement and make better use of the information ASCH hold and what we hear from partnership boards.*
- *Engagement and involvement activities aren't always aligned with commissioning intentions and procurement. There needs to be a closer link between the two.*
- *Designing strategies and services together works well if people are involved from the very start.*
- *We need to engage with customers on their experiences of support planning and personalised services and involve people in new developments.*
- *Some new user-led forums are emerging - they should be supported to be able to be involved with Adult Social Care*
- *We do a lot of work around involving people but they are often the same people who work with us. We should recruit people on a regular basis and also reach more minority ethnic and other seldom heard people.*
- *We might be losing out as not everyone wants to engage with us in the traditional way by attending formal meetings.*
- *Creating a climate where everyone can be candid about their views and differences in opinion can be explored leading to breakthroughs in thinking.*
- *Ensuring that it is clear who takes decisions and how decisions are made, how information is collected from the range of people and how decisions are communicated so that they result in action and change on the ground.*
- *It is critical that new working arrangements are flexible, eliminate duplication of activity and ensure involvement is efficient and effective.*
- *Communications and activities should always be accessible and inclusive.*
- *Service user and carer involvement in re-commissioning ensures quality and relevance.*
- *There is not always enough evidence that results of stakeholder feedback went into the planning, delivery and monitoring of services.*
- *It was emphasised that the council should attempt to always feedback to people who have been involved on what has happened or changed.*

2.3 Recommendations

Thirty recommendations for action have been set out to build on existing good practice and strengthen existing partnership work. They cover four specific areas:

- Strategy and outcomes
- Accessibility and standards
- Skills and partnerships
- Form and function

All of these recommendations are intended to fit with and complement the broader context of Barnet Council ASCH's Engagement and Co-production Plan and supporting framework.

Strategy and outcomes

1 Where possible, build a three year framework that sets out an annual published timetable showing which key decisions are to be made and what consultation and engagement processes are taking place to complement them
2 Be creative in encouraging further co-production and devolution of responsibilities. For example, enable groups and individuals to take on key roles
3 Where possible, establish further opportunities for theme based cross-partnership work.
4 Recognise, celebrate, publicise and promote good practice and innovation in engagement to improve service design, development and delivery
5 Ensure the contribution of Partnership volunteers is recognised by the council, by highlighting their achievements in press releases and articles and through recognition certificates and events
6 Across all partnership boards draw up a set of agreed possible outcomes that can effectively demonstrate the impact of engagement. Ensure that these are monitored. Where possible, include them in service contracts for providers
7 Draw up an annual public statement of achieved engagement outcomes and publish widely
8 Carry out a 'one more time / clean slate' review of recurring issues. Review all feedback and see what issues continue to arise. Ask of staff, individuals and voluntary sector organisations, 'what are you continually saying that we have not responded to?' Do a no-holds-barred report, clear up issues and move on.

Accessibility and standards

9 Ensure all standards are consistently implemented, particularly those which address equality and diversity, accessibility, facilitation, communication and information so that customers, carers and communities can choose to become involved in mainstream engagement processes
10 Ensure aims are clear in each complex or contentious engagement process and review these periodically.
11 Ensure clear and consistent standards for engagement for individuals and voluntary sector representatives and that these standards form part of the induction process for new and existing members
12 Publicise existing engagement mechanisms alongside each other

Skills and partnerships

13 Establish a training programme for staff, customers and carers including; representation, participation, co-production, facilitation, meeting skills, inclusion, conflict management, the community and voluntary sector in the borough and where to turn for information
14 Encourage and support customers and carers to assist in delivering the training
15 Ensure joint policies (for example the Reward and Recognition Policy) are implemented in a consistent manner by staff at Barnet Council ASCH and the Clinical Commissioning Group
16 Explore further joint working with the voluntary sector, CCG, and provider organisations, particularly in training, skills-sharing and measuring outcomes
17 Co-Chairs, with support from the Partnerships and Governance Officer work to proactively recruit new members
18 Consider the recommendations within this report internally within the department, within existing engagement mechanisms and with the voluntary sector
19 Run a “Festival of Ideas” workshop to bring providers, commissioners, care managers, users and their carers together to increase knowledge and understanding of collaboration, co-design and co-production.

Form and function

20 Develop a new flexible way of working that provides the opportunity for all interested parties to engage. As far as possible, reduce the rigid formal ways of working and embrace a more collaborative approach that encourages creativity, innovation and radical action
21 Strengthen membership representation from customers, carers and the voluntary sector
22 Establish a Health and Wellbeing Partnership Summit for the Partnerships and the Health & Wellbeing Board to work together in developing a coherent view of future priorities of work; celebrate progress made by both the Partnership Boards and the HWBB, share any lessons learned; and develop a set of key messages to deliver to the community
23 Establish two joint-sub groups, one for Autism, which reports to both the Learning Disability and the Mental Health Partnership Boards and the other for Older Adults Mental Health reporting to the Older Adults and the Mental Health Partnership Boards
24 The Mental Health Partnership to consider developing arrangements with equivalent bodies in Enfield and Haringey to focus on common services across all three Boroughs
25 Keep Partnership membership under review to ensure it reflects the changing delivery arrangements across the public sector
26 Provide continued support to strengthen and develop networks such as the Older People’s Assembly, the Learning Disability Parliament and the Carers Forum in order to support a collaborative approach
27 Introduce and use ‘Action Logs’ for each Partnership to help ensure actions are not lost and report back where agreed actions, or actions were not followed up and reasons why.
28 Each Partnership and the Health & Wellbeing Board to share the 3 or 4 key points from each of their meetings with other Partnerships/Health & Wellbeing Board
29 Communicate the new working arrangement to all partners
30 Review the impact of the proposed working arrangements at the end of the initial twelve-months to determine the precise value of their activity and, if impact is evident, to determine ways of improving future collaboration.

3.0 Future Form: From partnership working to collaboration and co-production

This review has shown that generally those involved are not wedded to any particular structure or process but that they wish to engage in the most appropriate way. In other words, we should strive to create a flexible way of working that builds on goodwill and commitment by 'bringing the right people, to the right table, at the right time, to look at the right issues'.

The feedback has indicated a number of areas that are important to customers, carers and communities in making strategic partnerships work:

1. An inclusive approach; the partnership boards must reach out to those who use services including those in care homes, people who are housebound and those whose language or culture may make it difficult to engage
2. An increase in the number of individuals, who need to be drawn from across service areas, to ensure diversity of perspective
3. Development of existing structures to bring together customers, carers and representatives with the commissioners to focus on outcomes for customers and carers
4. Adopt a 'task & finish' approach wherever possible

To strengthen strategic collaboration in Barnet it is recommended that new working arrangements are put in place that include establishing an inclusive overarching Barnet Health and Wellbeing Partnership Summit that will represent the views of the variety of people and organisations involved and associated with Health and Wellbeing.

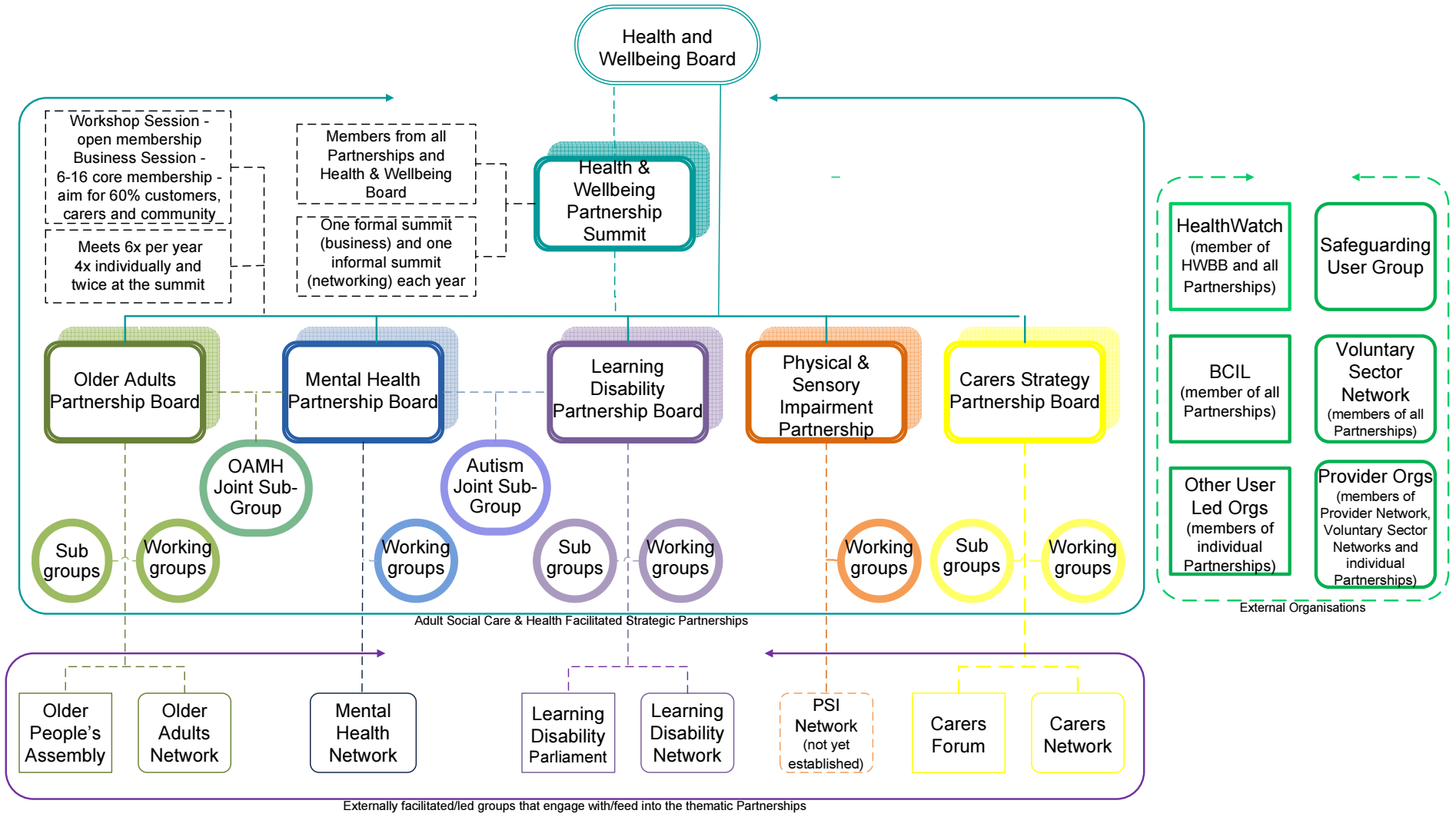
3.1 Partnership Boards

Partnership Boards will need to ensure that the added-value benefits of sustained collaborative working are maximised; leading to improved quality of life outcomes. To support the workshop approach, they will seek the involvement of local people in identifying and delivering value for money solutions and quality of life improvements for customers, carers and potential users of services. They will be able to facilitate a culture that encourages creativity, innovation and radical action to keep the adult social care and health agendas moving forward. In addition, they will be able to respond to cross-agency / cross-partnership efficiency and business transformation reviews in order to maximise effectiveness and value for money. The business sessions will call upon users, providers, commissioners, communities and other stakeholders to ensure that the recommendations around commissioning are well-informed and, that, once they have been made, services are successfully designed and delivered.

3.2 The Barnet Health and Wellbeing Partnership Summit

Members of all the Partnership Boards, together with members of the Health & Wellbeing Board will meet twice a year. One full-day business summit to co-develop future priorities of work, review and celebrate progress made over the previous year, share lessons that have been learned and to co-develop a set of messages to deliver to the community. The Barnet Health and Wellbeing Partnership Summit will represent the views of the variety of people and organisations associated with Health and Wellbeing. A second shorter, more informal summit to be held once a year for networking.

3.3 Future structure of strategic collaboration and partnership in Barnet



3.4 HealthWatch, Barnet Centre for Independent Living and User Led Organisations

The Government's *HealthWatch Transition Plan* states that HealthWatch is being created as a consumer champion to gather and represent the views of the public at both national and local levels. HealthWatch will have a duty to assist local health and social care commissioners and providers, and other community stakeholders by providing feedback, research and information on local people's views and experiences of health and social care, to improve services.

Barnet HealthWatch will therefore have a central role going forward in making sure that the views of the public and people who use services are taken into account. They will represent the views of people who use services, carers and the public on the Barnet Health and Wellbeing board and will have a seat on each of the Partnership Boards.

Barnet's Centre for Independent Living is a user-led organisation that brings together a range of community organisations, service users and carers to offer services that are based on the social model of disability and aimed at promoting independence, social inclusion and equality. Barnet Centre for Independent Living will have a seat on each of the Partnership Boards.

Other user-led and provider organisations may also have a seat on individual Partnership Boards relating to their area of expertise, for example Barnet Mencap could have a seat on the Learning Disability Partnership Board.

3.5 Voluntary Sector Networks

The Voluntary Sector Networks are independently hosted by Community Barnet. Community Barnet facilitate seven networks which meet on a regular basis to discuss shared interests and concerns and engage with local partnerships at a strategic level. Each network is chaired by an elected representative from a local voluntary and community organisation. The networks include: Adult Health and Social Care Providers Network; Carers Support Organisations Network; Children, Young People and Families Network; Learning Disabilities Network; Mental Health Network; Multicultural Network, Older Adults Network and a Small Organisation Network. Community Barnet are also working on developing a Refugee Network and a Physical and Sensory Impairment Network.

The networks represent the views of local voluntary and community organisations who have a relationship with Adult Social Care and Health and will have a seat on each of the Partnership Boards.

3.6 Barnet ASCH Provider Forum

Adult Social Care and Health host a forum for existing and potential new providers. The purpose of this forum is to facilitate good communication and focus strategic planning activity between existing and potential new providers and commissioners.

The Provider Forum allows the council to demonstrate greater transparency, inclusivity and strategic connection with providers. It helps to make sure that provider organisations are better informed about and able to respond to current local and national developments affecting their work.

3.7 Suggested framework for the Barnet Health & Wellbeing Partnership Summit

Purpose
To ensure that local priorities are addressed through stronger partnerships with customers, carers, voluntary and community sector, statutory organisations and other key partners, for example police, planning, job centre, road safety.

Aim
To bring together people with experience of, and responsibility for, adult social care and health in Barnet into a strategic network with a particularly focus on helping those with a strategic responsibility for funding, commissioning and facilitating the design and delivery of a more sustainable health and social care system.

Key Objectives
- To enable clear communication and flow of information between the Partnership Boards and the Health & Wellbeing Board
- To provide a forum in which members can develop co-ordinated, collaborative thinking and action for the wellbeing of individuals and communities
- To detect emerging and cross-Group issues
- To develop a coherent view of future priorities of work and a set of messages to deliver to the community
- To help take forward the borough-wide vision that will enable individuals 'to live as healthily and as independently as possible', with strong underpinning values that are firmly driven by the needs of the borough, in which all members have a commitment of collaboration.

Operational Arrangements
The summit will meet twice a year and will involve members of the Health & Wellbeing Board and Partnership Board members. The Summit does not exist to operate in its own right but acts under delegated powers from the constituent Partnership Boards as well as the Health & Wellbeing Board.

The programme of the full-day business summit can be divided into three sessions:
- Review of previous year's work, including a celebration of successes and lessons learned
- Workshop Sessions on cross-partnership Themes
- Forward Planning discussions to agree possible areas of future priority

The Chair of the Health & Wellbeing Board, together with the Director for Adult Social Care & Health will co-chair the business Summit.

The format of the networking summit will need to encourage lively, open discussions in a positive and supportive environment. The summit will create opportunities for dialogue and reflection so that a plethora of ideas can be shared. Participants will be able to participate in various small group breakout sessions focusing on a specific area of benefit or needed improvement. It is anticipated that the networking summit would last around three hours.

3.8 Suggested framework for the Partnership Boards

Vision
To promote, provide and enable partnership, collaboration and co-production to ensure that the added-value benefits of sustained collaborative working are maximised; leading to improved services and quality of life outcomes.

Purpose
To undertake strategic partnership working between the key public, voluntary and community organisations including service users, carers and the wider public to secure better health and wellbeing outcomes for the whole population, better quality of care, and better value for the taxpayer.

Aim
The Partnership Boards aim to promote a clear and co-ordinated approach to the co-development and co-delivery of programmes and initiatives that will provide the basis of a transformation in the effectiveness of adult social care and health services for the residents of Barnet.

Key Objectives

- To ensure services and strategic plans meet the needs of our local communities and communities are involved in the planning, design and delivery of actions, including the development and implementation of the Barnet health and wellbeing strategy and supporting commissioning strategies

- To co-produce where possible, finding new ways of doing things and how services are run and developed.

- To establish common priorities and targets, agreed actions and milestones that drive and lead to demonstrable, positive and sustainable change

- To ensure relevant communication channels with existing partnerships in the community and at Borough level that have a significant impact on the social and economic wellbeing of the Borough.

- To promote improved health and well being for people within their client group

In addition, members of the Partnership Boards will be encouraged to have a focus on;

- ***Solutions*** and
- ***Value for money*** – enabling others to save public money by doing things more efficiently.

Roles and Responsibilities

- To follow a co-productive model where staff, service users and their carers work together as equal partners on time limited and some ongoing projects using a user focused methodology.

- To establish permanent and/or “task and finish” sub-groups as required to undertake specific activities, receive reports from the sub-groups and monitor progress with activities

- Members to keep their own organisations / networks and other partnerships informed about progress and communicate effectively and accurately the outcome of Partnership Board meetings

- To promote and actively engage with local citizens and communities in the planning and delivery of local priorities

- To be part of the Barnet Health and Wellbeing Partnership Summit to widen local debate and discussion on achievements and future priorities

Principles

Each Partnership Board, Joint Sub-Groups and Sub Groups will:

- Take account of equality and diversity, promote inclusion and take responsibility for serving the best interest of service users and their carers

- Operate in a collaborative, open and effective way that views each member as an equal partner and values their contribution

- Conduct all business in a climate that seeks to find effective and realistic solutions

- Foster an ethos of success and achievement across partners with statutory and non-statutory responsibilities and the wider community

- Support the sharing of good practice, expertise and resources for the benefit of all

Operational Arrangements

The Partnership Board will meet every three months, however additional meetings may be arranged as and when necessary.

Members will be willing to raise and champion issues identified by the Partnership Board within their own organisations / networks to influence outcomes and delivery.

The meetings are divided into two sessions:

- ***Workshop sessions*** - an open session to co-produce new ways of doing things and how services are run and developed

- ***Business sessions*** - to ensure projects will be taken forward by a smaller membership group, comprised largely of the project leaders for the different projects, (including 60% service user, carers and voluntary sector membership) whose role is to:-
    - ensure that projects are kept on track
    - ensure that appropriate linkages are maintained between different elements
    - organise the delivery of reports to enable the Partnership Boards to exercise its function

Membership
Form should follow function. In order to deliver the purpose outlined above the following principles have underpinned the decisions about membership:-

- in keeping with the central theme about hearing the voice of users of services, their carers and representatives and supporting them to make a positive contribution 60% of the membership consists of service user / voluntary and community organisation representatives and family carers

- representation from statutory bodies needs to be sufficiently senior to achieve the required accountability and influence over resources

- there needs to be representation from the wide spectrum of services which are important to the lives of those people affected

- For the business sessions, a quorum to comprise a minimum of six members (with a suggested maximum of 16) provided this consists of one co-Chair and at least one representative of the Council, NHS Barnet, the voluntary sector, a service user and a carer.

Reporting Responsibilities
The Partnership Boards continue to report annually to the Health & Wellbeing Board

It is important to ensure that strong links are maintained with the Lead Member for Adult Social Care and Health, and with Members of the Health & Wellbeing Board. A twice-yearly summit will be held with all members of the Partnership Boards and Health & Wellbeing Board.

The Partnership Boards and Joint Sub-Groups may also establish sub groups as required to assist its core purpose provided these report promptly back. Some may be temporary task and finish groups, and others may have a longer term role.

As a point of principle, all projects overseen by the Partnership Boards will involve services users, their carers and representatives in their delivery – from project initiation to completion. The exact nature and extent of this involvement in each project should be decided by the Partnership Boards on a case by case basis.

4.0 Implementation

Implementation of the strategy should adopt the co-production approach and milestones will therefore need to be collectively agreed. It is important to remember that:

- Co-production may challenge existing frameworks of service provision
- Co-productive schemes require sustained, secure funding and organisational support but also need to be independent
- Co-production requires support for customers, carers, communities and staff - there is a need for training to support co-productive approaches.

The arrangements for strategic collaboration need to be established in as simple a way as possible in the first six months, demonstrating significant 'early wins' and establishing the quality of relationships necessary to produce consistent and high impact results. The following next steps are therefore proposed;

Co-chairs meeting
Arrange a meeting of co-chairs of existing partnership board to discuss approach for implementation.

Establish the Barnet Health & Wellbeing Partnership Summit to develop future priorities of work and a set of messages to deliver to the community. It is suggested the summit should involve all members from all Partnerships, the Health & Wellbeing Board as well as senior ASCH and NHS Managers.

Carry out a 'clean slate' review of recurring issues to see what issues continue to arise. Publish a no-holds-barred report to clear up these issues and foster a culture of openness and the principle of equal partnership.

Restructure existing Partnership Boards
Introduce workshop sessions into all Partnership Board meetings so that coproduction becomes the core business of the meetings. Encourage as many individuals as possible to become actively involved in these workshops so that services, strategies and development plans can be co-produced from the planning and design stage onwards.

The following list sets out suggested membership types of the Partnership Boards;

- Joint Strategic Commissioner
- Health / CCG representative
- Customers
- Carers
- Voluntary Sector Network Chair
- Voluntary Organisations
- A representative from LINks/Healthwatch
- A representative from BCIL

Communicate the new working arrangement to all partners.
Prepare and circulate a '500 word narrative' for the new working arrangements. It has been suggested that the Groups produce a concise quarterly report that can be widely shared.

Develop Action Plan
An action plan will need to be developed to deliver the thirty recommendations within section 2. Implementation of the action plan will be overseen by the Assistant Director for Adult Social Care & Health.

Monitor implementation
The Partnership Boards will produce annual reports that reflect on the progress made towards goals from the perspective of customers/carers and any other relevant matters to put before the Barnet Social Care & Health Summit and Health & Wellbeing Board.

Ongoing Communications
The Partnership Boards newsletters "Peoples Voice" and "Your Life" will continue to be produced at least six-monthly to inform all customers and carers about how involvement is influencing outcomes for customers and carers.

More regular e-bulletins will be produced for distribution. Both Peoples Voice and Your Life newsletters to be more widely circulated than previously to encourage customers and carers to become involved. Staff will be informed of activities through the quarterly departmental email newsletter. A web page will be further developed on ASCH's website about how to become involved and will include the strategy. The LINk will be consulted about maintaining good communication.

Training Programme
Establish a training programme for staff, customers, carers and representatives, including representation, participation, co-production, facilitation, meeting skills, inclusion, conflict management, the community and voluntary sector in the borough and where to turn for information

Resources
Implementation of the strategy will be led by the Assistant Director for Adult Social Care & Health. A separate document has been produced that sets out the resources required for a consistent approach to co-production across ASCH in Barnet. Sufficient resources will need to be made available to ensure implementation of the strategy.

Appendix 1: Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

Strengths	Weaknesses
• Generally good personal relationships • Civic leadership • Good public sector joint working with senior level buy-in across partners • Clarity about identifying success • Growing appreciation of what partnership work can deliver • Strong infrastructure and networks - family of partnerships' approach • Innovative approaches • Strong desire to do well	• Lack of awareness of what Partnership Boards are and what they are not. Clarity of purpose • Not outcome focused across all partnership boards • Frustrations due to bureaucracy • Duplication of effort • Balance of agendas / reports / actions falling to the council and to partners generally doesn't demonstrate a sharing of burden
Opportunities	**Threats**
• A one team ethos to keep ASCH moving forward with a clear sense of direction and shared priorities • Combining all the thematic partnership plans into a single annual rolling Barnet Partnership Plan with connectivity to partner business plans • Production of an annual 'state of the ASCH' report to drive the annual work programme of partnership groups • Strong focus on value for money, efficiencies and asset maximisation • Understanding of the total resource (budgets, people, asset etc) across all partners that can be deployed potentially leading to new ways of working / transformation. • Strong focus on action / delivery / outcomes and not on process • Nimble and flexible ways of working - bring the right people together, at the right time, to address the right priority • Significantly reducing the bureaucratic burden • Demonstrating the shared burden approach	• Budget restrictions leading to key partners focusing solely on core activities and not the value added partnership activities • Partner retrenchment leading back to organisational silos. • Cross partnership issues that do not get tackled. • Relationships between key individuals and key agencies / organisations breakdown • The goodwill and partnership working ethos built up through the partnership boards is lost. • ASCH sends out mixed messages, rather than a unified message to all parties involved.

Appendix 2: Who we talked to

- Allan Johnson, Barnet Multi-lingual Wellbeing Service
- Andrew Cowen, Barnet LINKs
- Andrew Cox, Middlesex Association for the Blind (PSIPB)
- Anela Shah, Barnet Elderly Asians Group (OAPB)
- Ann Burgess, Carer Representative (CSPB)
- Anthony Nicholson, Carers rep for (LDPB) and (CSPB)
- Benji Lanzkron, Parliament Officer, Barnet People's Choice
- Bernice Davis, Chief Executive, Norwood (LDPB)
- Caroline Chant, OA/PSI Joint Strategic Commissioner, LBB/NHS (OAPB and PSIPB)
- Caroline Collier, Barnet Centre for Independent Living
- Caroline Powls, Service User Involvement Officer, LBB (CSPB)
- Caroline Rossi, Support Worker, Barnet People's Choice
- Ceri Jacob, Joint AD for Joint Commissioning, LBB/NHS (MHPB)
- Cllr Alison Cornelius, Chair of Health Overview and Scrutiny Committee, Barnet Council
- Cllr Graham Old, Ageing Well Champion, Barnet Council
- Cllr Sachin Rajput, Cabinet Member - Adult Social Care, Barnet Council
- David Morris, Carer Representative (MHPB)
- Dawn Rowe, Communications Manager
- Dawn Wakeling, Deputy Director Care Services, LBB (LDPB)
- Deborah Robinson, ASCH Transformation Manager, LBB
- Denise Murphy, Chief Executive, CommUNITY Barnet
- Diane Williams, Barnet Carers Centre (OAPB)
- Elsie Lyons, Barnet Voice for Mental Health (MHPB)
- Emily Bowler, Customer Care Manager. LBB
- Fiona Jones, Barnet Carers Centre (CSPB)
- Foizul Islam, Project Manager - Social Care Transformation, LBB
- Heather Bates, ASCH Commissioning Manager, LBB
- Helen Coombes, ASCH Head of Transformation, LBB
- Henk Vermeulen, Barnet, Enfield and Haringey Mental Health Trust
- James Hulme, Communications Manager, Metropolitan Police - Barnet Borough
- Jasvinder Kaur Perihar, Carers Strategic and Commissioning Lead, LBB (CSPB)
- Jennifer Watson-Roberts, Complaints Manager, LBB
- Julie Pal, Strategic Equalities Officer, LBB
- Karina Vidler, Partnerships and Governance Officer, LBB/NHS (OAPB, PSIPB, MHPB, LDPB)
- Kim Sherwood, BCIL, Barnet Voice, Depression Alliance (MHPB)
- Mahmuda Minhaz, Chief Executive, People's Choice (LDPB)
- Manik Bapat, OT Manager, Adult Social Services, LBB
- Margaret Nolan Carer Rep (PSIPB)
- Marie Bailey, Head of Service (PSI), LBB (PSIPB)
- Marie Donaway, Graduate Trainee, LBB

- Mark Robinson, Age UK Barnet (OAPB)
- Marshall Taylor, Project Manager, LBB
- Mathew Kendall, AD Transformation and Resources, LBB (OAPB)
- Michael Nolan Service User Rep (PSIPB)
- Michael Nolan, Barnet Centre for Independent Living (PSIPB)
- Mike Fahey, Barnet Libraries Service (PSIPB)
- Nila Patel, Chair, Multicultural Health & Social Care Network (OAPB)
- Peter Cragg, 55+ Forum and Older People's Assembly (OAPB)
- Rachel Williamson, ASCH Commissioning Manager, LBB
- Ray Booth, Chief Executive, Barnet Mencap (LDPB)
- Richard Harris, Barnet People's Choice (LDPB)
- Rodney D'Costa, Head of Performance, LBB
- Rosie Evangelou, Consultation Manager, LBB
- Ruth Mulandi, Previous Chief Executive, CommUNITY Barnet
- Sarah Thomas, Right to Control Project Manager, LBB
- Selina Rodrigues, CommUNITY Barnet, Community Voluntary Sector Network
- Shailja Kumar, Stroke Association
- Shelley Gibbons, Community Projects for Barnet Mencap (LDPB)
- Shirley Rodwell, Carer Representative (CSPB)
- Stan Davison, 55+ Forum and Older People's Assembly (OAPB)
- Stella Henriques, Carers rep for (PSIPB) and (CSPB)
- Sue Smith, Safeguarding Adults Manager, LBB (Safeguarding Adults Board)
- Temmy Fasegha, MH / LD Joint Strategic Commissioner, LBB/NHS (MHPB) and (LDPB)
- Val Humbles, Multi-disciplinary Team Manager, Right to Control, LBB
- Virginia Wood, GP Practice Manager Rep (PSIPB)
- Yessica Alvarez-Manzano, Barnet LINk Manager, CommUNITY Barnet

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Meeting	Health and Well-Being Board
Date	4 October 2012
Subject	**Forward Work Programme**
Report of	Director of Adult Social Care and Health
Summary of item and decision being sought	To present an updated work programme of items for the Health and Well Being Board for 2012/13

Officer Contributors	Andrew Nathan- Chief Executive's Service
Reason for Report	To allow the Board to schedule a programme of agenda items that will fulfil its remit
Partnership flexibility being exercised	The items contained in the work programme will individually take forward partnership flexibilities including the powers Health and Well-Being Boards will assume under the Health and Social Care Act 2012.
Wards affected	All
Contact for further information	Andrew Nathan 020 8359 7029

1. RECOMMENDATION

1.1 To note and comment on the draft forward work programme attached at Appendix 'A'.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Shadow Health and Well Being Board – 26 May 2011- agenda item 9

2.2 Shadow Health and Well-Being Board- 19 January 2012- agenda item 11

2.3 Shadow Health and Well-Being Board- 22 March 2012- agenda item 2

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; JOINT HWB STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Work Plan has been designed to cover both the statutory responsibilities of health and well-being Boards and key projects that have been identified as priorities by the Board at its various meetings and development sessions.

3.2 Approval and performance management of the Health and Well-Being Strategy has been included within the work plan and, when adopted, the Strategy will be the most significant determinant of future work programmes.

4. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 None specifically arising from this report- but all items listed will demonstrate how the needs analysis contained in the Joint Strategic Needs Assessment (JSNA) has influenced the options chosen, including differential outcomes between different communities.

5. RISK MANAGEMENT

5.1 A forward work programme reduces the risks that the Health and Well-Being Board acts as a talking shop for the rubber stamping of decisions made elsewhere, or does not focus on priorities. It ensures that all decisions formally within the Board's statutory duties, Terms of Reference and other key issues relating to local health and care services are considered.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The forward work programme has been devised to incorporate the legal responsibilities contained in the Health and Social Care Act 2012. The HWBB has been operating in shadow form in readiness for the legislative changes.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 None specifically arising from the report. The programme is co-ordinated and monitored by the Chief Executive's Service as part of their support to the Board.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The programme has been devised through consultation with Council and NHS managers, but the Barnet LINk through their membership of the Board have the opportunity to refer matters or suggest agenda items. The same will be true of the Healthwatch representative.

8.2 In addition, the Chairman of the HWBB periodically meets with the Co-Chairs of the Partnership Boards which report into the HWBB, and this provides an opportunity to discuss the forward plan of the HWBB.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None at this stage, although feedback from providers should guide the choice of future agenda items.

10. DETAILS

10.1 At its meeting on 22 March 2012, the Board considered a forward work programme for the whole of 2012/13, with items reflecting the Board's future statutory responsibilities; key strategies and projects currently in progress; and the precedents set during the HWBB's first year in operation.

10.2 It was also agreed that future meetings should be divided into two parts, the first, as now, a public meeting which considers formal written reports for information and decision; and the second informal workshop style sessions between Board members which would take place on the conclusion of the formal meeting and not by themselves take any executive decisions. The work plan therefore marks with a 'B' items to be handled as formal business, and with a 'W' those which are discussion items to be handled through informal workshops at this stage.

10.3 An updated work programme is attached at Appendix 'A' for the Board's comments.

10.4 There is a key role for the LINk representative in pressing for the forward plan to take into account issues of community concern, as well as any specific LINk reports or requests for information.

11 BACKGROUND PAPERS

None

Legal – HP
CFO-JH –

APPENDIX A
CURRENT SCHEDULE OF HEALTH AND WELL BEING BOARD BUSINESS 2012/13 (agreed at 22/3/12 HWBB and revised)

item	29 November 2012	31 January 2013	4 April 2013	Notes
STANDING OR GOVERNANCE ITEMS				
Financial Planning Group minutes	B	B	B	
HWB Implementation Group- minutes	B	B	B	
Governance arrangements, ie review Terms Ref Membership etc			B	4/4/13 will approve conversion from shadow to full statutory status
Development of HWBB			W	

	29 November 2012	**31 January 2013**	**4 Apr 13**	**Notes**
JSNA, HWBS AND RELATED STRATEGIES				
Joint Strategic Needs Assessment- update/review/refresh	B?			Not sure what requirement is to refresh. Might benefit from a more discursive workshop format.
Integrated Commissioning Plan	B			Deferred from July and October
Substance Misuse Plan	B			Deferred from July and October
Performance Report against HWBS targets	B?		B?	
In depth report on one issue in DPH's Annual Report	B	B	B	
NEW PRIMARY CARE COMMISSIONING ARRANGEMENTS				
Clinical Commissioning Group- update on organisational progress			B	
Clinical Commissioning Group- sign off of commissioning plans etc for 13/14	W	B		29 Nov workshop to discuss draft CCG Commissioning Plan
Commissioning Support Organisation- update on proposals				

	29 Nov 12	31 Jan 13	4 Apr 13	Notes
PUBLIC HEALTH/ DETERMINANTS/ PREVENTION MATTERS				
Leisure Services- Strategic Review	B			
Early Intervention and Prevention- strategic review	B			Requested by Linda Spiers. Essential to taking forward Marmot actions and the HWB Strategy
Annual Report of Director of Public Health			B	
Other Children's issues				
H and SC- contribution to economic well being		W ?		A possible idea, as high priority for council and partners in next year- how can the health and care system make its own maximum contribution to ensure people well enough and supported enough to retain or gain employment? The prevention plan will set out much of this but could benefit from a discussion of its own.
WORK WITH VOLUNTARY AND COMMUNITY SECTOR/ REPORTS OF PARTNERSHIP BOARDS				
Chair's meeting with Partnership Board chairs- minutes			B	
Discussion on how to work with and develop the voluntary sector (following the recent financial reductions)	W?			

	29 Nov 12	31 Jan 13	4 Apr 13	Notes
SAFEGUARDING/QUALITY AND SAFETY ISSUES				
Safeguarding Adults Board- Annual Report				Annual Report
Safeguarding Children Board- Annual Report				Annual Report

Quality and Safety Matters in NCL		B		To be provided 6 monthly
Whole system working to reduce pressure ulcers	B			(identified in quality and safety discussion at Jan HWBB)- might be workshop format depending on complexity of issue/which providers need to be involved? Deferred from July 2012
Care Homes- joint quality spec/principles for whole system working		B		Identified at HWBB 26 July during Quality and Safety discussion
USER AND CARER ENGAGEMENT				
Local HealthWatch- spec and tender process		B		report of new contractor how service planned to be delivered
LINK- Annual Report			B	12/13 reports as part of LINK/LHW handover
HEALTH AND CARE INTEGRATION				
HSC Integration Scoping project	B	B	B	Workshop was held Mar 2012.
HSC Integration- specific projects that result				
Ageing Well	B			
New or amended Section 75 agreements				As identified through the Financial Planning Group
System Risk Assessment- MTFS and QIPP	B			
Allocation of Section 256 funds	B ?	B ?		Will we still be getting these on an annual basis?
Mental Health- plan for better joining up across system		B?	B?	Need for this agreed at our workshop on 26 July- should come back in due course

OTHER HEALTH ECONOMY	**29 Nov 12**	**31 Jan 13**	**4 Apr 13**	**Notes**
Barnet Chase Farm Update on foundation status				
Barnet, Enfield and Haringey Clinical Strategy- Next steps/ Investment Plans				

HWBB will exercise statutory functions from 4 April 2013 meeting.