MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 29TH JANUARY, 2015

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

Chairman: Councillor Helena Hart (Chairman),
Vice Chairman: Dr Debbie Frost (Vice-Chairman)

Members

Dr Charlotte Benjamin	Regina Shakespeare	Dawn Wakeling
Paul Bennett	Selina Rodrigues	Cllr Sachin Rajput
Dr Andrew Howe	Dr Clare Stephens	Chris Miller
Kate Kennally	Cllr Reuben Thompstone	

Substitute Members

Cllr David Longstaff	Nicola Francis	Maria O'Dwyer
Mathew Kendall	Dr Jeffrey Lake	Julie Pal
David Riddle	Cllr Wendy Prentice	

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

Andrew Charlwood – Head of Governance (Acting)

Governance Services contact: Salar Rida 020 8359 7113, salar.rida@barnet.gov.uk

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ASSURANCE GROUP

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3.	Declaration of Members' Interests	
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Minutes of the Health & Well-Being Board

13 November 2014

AGENDA ITEM 1

Board Members:-

*Cllr Helena Hart (Chairman)
*Dr Debbie Frost (Vice-Chairman)

* Dr Charlotte Benjamin	* Selina Rodrigues	* Dawn Wakeling
* Paul Bennett	* Dr Clare Stephens	* Cllr Sachin Rajput
* Dr Andrew Howe	* Cllr Reuben Thompstone	*Chris Miller
* Kate Kennally	* Peter Coles	

* denotes Board member Present

Also in attendance: Dr Jeff Lake
Sarah Pillai

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

The Chairman of the Health & Well-Being Board Councillor Helena Hart, welcomed the attendees to the meeting and thanked Claire Mundle, Policy and Commissioning Advisor, for all her contributions to the work of the Board.

The following corrections were noted – that Dr Jeff Lake and Julie Pal are listed as 'in attendance' on p1 of the agenda and on p8, for Dr Andrew Howe to receive an update on improved screening levels across London from the London Coverage Technical Group (NHS England).

RESOLVED that subject to the above corrections the minutes of the Health & Well-Being Board meeting held on 18 September be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from:

Maria O'Dwyer, Barnet Clinical Commissioning Group (Substitute)
Mathew Kendall, London Borough of Barnet (Substitute)

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

There were none.

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

None.

5. PUBLIC QUESTIONS AND COMMENTS (IF ANY) (Agenda Item 5):

None were submitted.

6. HEALTH & WELL-BEING STRATEGY YEAR 2 PERFORMANCE REPORT (Agenda Item 6):

The Chairman welcomed Dr Jeff Lake, Consultant in Public Health. Dr Lake introduced the item and referred to the performance indicators on pp 47-57 as an indication of how Barnet services are responding to local population need.

The Director for Public Health (Harrow and Barnet) informed the Board that the performance report will be presented to the Partnership Boards Autumn Catch-up on 20 November 2014 to ensure continued engagement with Partners in support of the delivery of the Barnet Health & Well-Being Strategy.

The Board noted the recommended priorities for Year 3 in light of the most recent performance data and achievements of the past 12 months. Dr Lake highlighted the challenges identified (p91) to ensure that the best possible health and well-being outcomes are achieved for the population of Barnet.

The Chairman noted that the wording of the third recommended priority for Year 3 (p.13) should include 'especially children in care' to read:
'3. That the Health and Well-Being Board partners work collectively and collaboratively to promote early intervention and prevention of mental health problems for children, especially children in care, working aged adults and older people and ensure robust local service provision.'

Dr Jeff Lake further noted the Partnership Boards progress reports in Appendix 1, highlighting the progress made by these Boards over the past 12 months in relation to the priority areas identified by the Board.

Action: Further discussion to be held between Barnet CCG, Primary Care and Public Health regarding an approach to drugs and alcohol.

Chris Miller, Independent Chairman of the Adults and Children's Safeguarding Boards welcomed the discussion and raised concerns in relation to the upward trend in higher risk alcohol consumption.

Dr Lake informed the Board of the health risks associated with excessive alcohol consumption. Furthermore, the Board heard about the importance of delivering information regarding units in different alcoholic beverages and the risks associated with drinking patterns in excess of the recommended daily limit.

Action: For the Board to give further consideration to effective ways of tackling excessive alcohol consumption across the Borough.

The Strategic Director for Communities, Kate Kennally commended the priorities identified in the report (p 13-14) and highlighted the importance of addressing social isolation and loneliness as part of priorities 9 and 10 (p14).

The Adults and Communities Director, Dawn Wakeling informed the Board that the Care Act 2014 places a duty on local authorities to provide information and advice relating to care and support locally. Ms Wakeling also noted the importance of linking the duties under the Care Act with the priority areas for Year 3.

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Selina Rodrigues, Head of Healthwatch emphasised that feedback from young people, teachers and youth workers suggested that there is an inconsistency in pathways experienced by young people accessing social and health support services.

RESOLVED that:

1. **The Health and Well-Being Board considers the second annual Health and Well-Being Strategy performance report and assesses the progress that has been made so far to meet the Strategy's objectives.**

2. **That the Board endorses the recommendations outlined in the final section of the performance report, and agrees to take these recommendations forward in Year 3.**

7. HEALTH AND WELLBEING PRIORITIES 2015-2020 (Agenda Item 7):

Dr Andrew Howe noted the proposed timeline to produce an updated Joint Health and Well-Being Strategy (HWBS) and a Joint Strategic Needs Assessment (JSNA) in 2015.

The Board noted the proposals to establish a task specific Steering Group to support the updates of the JSNA and HWBS. Dr Howe informed the Board that a Steering Group would be established to ensure that the delivery of the JSNA and HWBS is on track and the process is collaborative.

The Strategic Director for Communities commented that taking into account the comments and information gathered from various sources and stakeholders, the JSNA will be used to inform the future Joint HWBS which will in turn drive local commissioning decisions.

The Chairman stressed the importance of effective partnership working necessary to undertake a successful JSNA and HWBS and to engage with all Partnership Boards to improve health and well-being outcomes.

The Chairman, Councillor Reuben Thompstone and Councillor Sachin Rajput (Chairman of the Adults and Safeguarding Committee) noted that Council on 4 November 2014 had agreed the following motion:

"Council instructs the governance service, when scheduling the calendar of meetings for the next municipal year, to align the meetings of the Health and Well-Being Board and the Adults and Safeguarding Committee so that the meeting of the latter will have sight of the papers for the former and could, should the committee agree, make comments and suggestions to the Health and Well-being Board, through the Chairman of the Adults and Safeguarding Committee."

RESOLVED that:

1. **The Health and Well-Being Board approves the approach to updating the Joint Strategic Needs Assessment and Joint Health and Well-Being Strategy.**

2. **The Board approves the proposals to establish a Steering Group to oversee the JSNA/ HWBS updates. The Health and Well- Being Board**

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notes that this Steering Group has a distinct set of roles and responsibilities to the 3 standing sub-groups of the Board (set out in para 1.5)

3. **That the Board appoints membership to the JSNA and HWBS Steering Group.**

4. **That the Board approves the recommendations from the Health and Well-Being Board away day (set out in Section 1.10) and implements these recommendations immediately.**

8. PUBLIC HEALTH COMMISSIONING PLAN (Agenda Item 8):

The Director for Public Health (Harrow and Barnet) Dr Andrew Howe introduced the item and informed the Board that the Commissioning Plan is based on an assumption that spending on Public Health will be maintained at the present level through to the end of the decade.

The Commissioning Plan sets out the commissioning intentions and the revenue budgets and capital requirements for recommendation to the Policy and Resources Committee on 2 December 2014. It was noted that subsequent to agreement of the draft plan at the Policy & Resources Committee meeting in December 2014, public consultation will commence before the final Commissioning Plans are agreed in February 2015.

The Chairman noted that tackling obesity, particularly in children, by promoting physical activity and other measures is essential to increasing life expectancy and improving the quality of life. The Chairman requested that measures to tackle smoking in pregnancy and excess alcohol consumption should be included in the Public Health Commissioning Plan.

Dr Debbie Frost noted the importance for partners to share information and data to tackle obesity and promote physical activity with health visitors in Barnet with caseloads in London. Kate Kennally informed the Board that the Council will assume responsibility for the commissioning of Health Visiting services from October 2015.

Ms Kennally advised the Board that health visiting has historically been underinvested within the Borough. Dr Howe noted that action should be taken to work with other boroughs and the Department of Health to improve the health visiting work force in relation to the health visitor case load.

Paul Bennett expressed support for plans to work in close partnership with the Board to address the level of concern regarding the Health Visiting service levels, sufficient to allow for Barnet to deliver mandated HV services from October 2015.

RESOLVED that

1. **The Health & Well-Being Board approves the proposed Commissioning Plan (Appendix 1), subject to consultation.**

2. **The Board agrees to public consultation on the proposed Commissioning Plan commencing immediately following Policy and Resources Committee**

on 2nd December 2014, before final Commissioning Plans are agreed by Policy and Resources on 17 February 2015.

9. SEXUAL HEALTH STRATEGY (Agenda Item 9):

Dr Jeff Lake briefed the Board about the importance of expanding the provision of sexual health services in primary care, pharmacy and community settings to offer further accessible venues to the population in Barnet.

Chris Miller, Independent Chairman of the Adults and Children's Safeguarding Boards, queried the provision of services to support victims of sexual assault. Dr Lake stated that in light of a review of local mechanisms for onward referral, a local strategy is being developed for victims of sexual assault and Female Genital Mutilation (FGM).

Action: Public Health to develop and incorporate a local strategy for supporting victims of sexual assault and FGM as part of the Sexual Health Strategy.

Councillor Sachin Rajput asked what could be done to encourage a greater level of HIV testing among at risk population groups. Dr Lake noted that Public Health (Harrow and Barnet) will conduct an option appraisal for HIV testing for high risk populations in the Borough including the provision of home testing facilities.

Dr Debbie Frost advised that resources would need to be made available in order to shift provision in to Primary Care and Community Services.

The Chairman welcomed Lead Clinician, Sarah Pillai (CLCH) to join the discussion. Sarah Pillai expressed interest in working in partnership with the Public Health team to consider a broader range of interventions, such as social marketing to address concerns for young people and help develop a comprehensive strategy accordingly.

RESOLVED that

1. **The Health and Well-Being Board agrees that the Public Health team should participate in collaborative commissioning of Genitourinary Medicine (GUM) services.**

2. **The Board agrees the plans to expand the provision of sexual health and reproductive services in primary care and community settings, especially in 'hotspot' and deprived areas of the Borough to facilitate the shift from hospital based services.**

3. **The Board agrees the plans to review current services, increase the uptake of testing for HIV and Chlamydia among high risk groups and introduce an awareness and signposting campaign.**

4. **Additional recommendation: The Health and Well-Being Board agrees that the Sexual Health Strategy 2015-2020 should be aligned to addressing FGM and sexual exploitation with the Safer Communities Board and LSCB.**

10. PHARMACEUTICAL NEEDS ASSESSMENT UPDATE (Agenda Item 10):

The Director of Public Health (Harrow and Barnet) Dr Andrew Howe, introduced the report and identified the risk of a delay in data processes to the extent that it will not be possible to publish a final Pharmaceutical Needs Assessment (PNA) in Barnet prior to 1st April 2015.

Dr Howe noted the need for a pragmatic solution to meet the statutory duty under NHS Act 2006, as amended by the Health and Social Care Act 2012, to deliver a PNA before April 2015. Paul Bennett reported that the Board would receive an update in terms of meeting the deadline as set out in the paper.

Action: The Board to receive an update on the timeline for submission of the draft PNA

The Chairman noted that on p.162 of the Agenda, the wording 'sign of' in the first recommendation should be changed to 'sign off'.

RESOLVED:

1. **That authority to sign off the consultation draft of the PNA be delegated to the Director of Public Health in consultation with the Chairman of the Health and Well-being Board.**

2. **That Health and Wellbeing Board seeks assurance from NHSE that they accept responsibility for resolving the issues outlined in this paper by 17 November so that the PNA Consultation can begin on 16 December in order for Barnet to be compliant with the regulations by 1 April 2015.**

11. DISABLED CHILDREN'S CHARTER (Agenda Item 11):

The Chairman noted the evidence of the commitment and the work undertaken in Barnet to meet the commitments of the Charter over the last 12 months.

The Strategic Director for Communities, Kate Kennally informed the Board that Education, Health and Care plans will set clear outcome measures for children and young people with special educational needs, who will also be given the option to use a personal budget to meet the outcomes in their Education, Health and Care plans.

In light of the submission of evidence to EDCM, the Chairman noted the importance of ensuring on-going commitment to the Charter.

RESOLVED that

1. **The Health and Well-Being Board agrees that the content of this report provides sufficient evidence that Barnet has met the commitments of the Disabled Children's Charter.**

2. **The Board considers how they will continue to monitor implementation of the Charter's Commitments in future years.**

12. IMPLEMENTING THE DEMENTIA MANIFESTO (Agenda Item 12):

The Adults and Communities Director Dawn Wakeling introduced the item. Councillor Helena Hart welcomed Karen Ahmed, Later Life Lead Commissioner (LBB) to join the discussion. Karen Ahmed briefed the Board on the three key outcomes set out in the Dementia Manifesto.

It was noted that the Barnet diagnosis rate is already above the national average diagnosis rate but is working towards a target of 67% for 2015. Ms Ahmed further explained that LBB has begun to implement a 'dementia friendly community' approach in key areas to strengthen and main stream this approach through a dementia action alliance.

Peter Coles (Barnet CCG) noted the importance of a response to the Dementia Manifesto to ensure that the recommendation of the Manifesto has been addressed.

Dr Debbie Frost advised that Barnet CCG would like to support the Dementia Manifesto for London.

The Board noted that the position in Barnet has been to integrate the approach to dementia as part of on-going work in recognition of other needs that people with dementia and their carers often have.

RESOLVED that

1. **The Board notes the current work that is being carried out in Barnet which aligns with the Dementia Manifesto.**

2. **The Board considers whether any further action needs to be taken with respect to implementing the Dementia Manifesto.**

3. **Additional recommendation: The Board supports the achievement of the three key outcomes of the Dementia Manifesto in Barnet (p209)**

4. **Additional recommendation: The Board asks that officers bring back a further report setting out the implications of signing up to/ not signing up to the Dementia Manifesto for London**

13. MINUTES OF THE HEALTH AND WELL-BEING FINANCIAL PLANNING GROUP (Agenda Item 13):

Ms Kennally noted that the commissioned Task and Finish group will receive assurance of compliance with the Children and Families Act by December 2014.

RESOLVED that

1. **The Health and Well-Being Board notes the minutes of the Financial Planning Sub-Groups of 8th October 2014**

2. **The Board requests a verbal update on progress to develop the approach to risk pooling that will underpin delivery of the Better Care Fund from April 2015**

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3. **The Board agrees to receive the minutes of the Health and Social Care Integration Board as a standard item on the agenda, to ensure that adequate attention is given at Board level to the work that providers are doing to support delivery of Barnet's integrated care proposals.**

14. 12 MONTH FORWARD WORK PROGRAMME (Agenda Item 14):

Kate Kennally, the Strategic Director for Communities, informed that the forward work programme of the Health & Well-Being Board will be made available online and updated (where necessary) at the beginning of each calendar month.

RESOLVED that

1. **The Health and Well-Being Board proposes any necessary additions and amendments to the 12 month forward work programme (see Appendix 1).**

2. **The Board Members proposes updates to the forward work programme before the first day in each calendar month, so that the work programme can be published on the Council's website more efficiently, with the most up to date information available.**

3. **The Board aligns its work programme with the work programmes of the new Council Committees (namely the Adults and Safeguarding Committee, and the Children's, Education, Libraries and Safeguarding Committee), Health Overview and Scrutiny Committee, and Barnet CCG's Board.**

15. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 15):

There were none.

The meeting finished at 12.20 pm

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AGENDA ITEM 6

	Health and Well-Being Board 29 January 2015
Title	**Better Care Fund Update**
Report of	Adults and Health Commissioning Director CCG Director of Integrated Commissioning
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1 – Final BCF Plan Part 1 v1.1 (14 Jan 2015) Appendix 2 – Latest Work Plan BCF Pooled Budget
Officer Contact Details	Karen Spooner, Rodney D'Costa karen.spooner@barnetccg.nhs.uk / 0203 688 1836 rodney.dcosta@barnet.gov.uk / 0208 359 4304

Summary

This report presents the Final Better Care Fund (BCF) Plan submitted to NHS England on 9 January 2015 for ratification by the Health and Well-Being Board (HWBB). The plan was agreed by the Chairs of the Board and the Barnet Clinical Commissioning Group (CCG) along with the Chief Executive of the Council prior to submission. The previous version of the BCF Plan was presented to the Health and Well-Being Board on 18 September 2014 and submitted to NHS England on 19 September.

The Council and Barnet CCG have updated the BCF Plan following a request from NHS England to include more details of the schemes of work and their individual impact on reducing non-elective admissions. The additions include further financial and benefits modelling, an additional scheme of work for enabler services and tables that present the impact of the schemes and how each contributes towards achieving target changes in activity and financial benefits for the target cohort and the investment involved.

This report also updates the Board on delivery progress on integrated health and social care services for older people (as detailed in the Business Case for integration presented on 18 September 2014) and the work plan to set up the pooled budget required to determine and manage investment and spend to deliver the schemes of work in the Plan.

This includes an update on the Barnet Integrated Locality Teams project and Pilot Team in place. It also includes findings from a review of the Multi-Disciplinary Teams (MDT) and Care Navigation Service (CNS) elements of the Older People Integrated Care Project and new projects and developments in Tier 1 of our 5 Tier Integrated Care Model.

Recommendations

1) **That the Health and Well-Being Board (HWBB) ratifies the final BCF Plan submitted with the Chairman's agreement, along with the Chair of NHS Barnet CCG and the Council Chief Executive, to NHS England on 9 January 2015.**

2) **That the Health and Well-Being Board (HWBB) notes the next steps described here following approval of the Plan.**

3) **That the HWBB notes and comments on progress on delivering and embedding the 5 Tier Integrated Care Model for older people in Barnet.**

4) **That the HWBB comments on work to date to create a Pooled Budget for the delivery of services in the BCF Plan.**

5) **That the HWBB notes that final approval for the Pooled Budget will be given by the Council's Policy & Resources Committee and by the Barnet CCG Board.**

1. WHY THIS REPORT IS NEEDED

1.1 This report presents the Final Better Care Fund (BCF) Plan submitted to NHS England (NHSE) on 9 January 2015, following the previous Plan presented to HWBB on 18 September 2014 and submitted to NHSE on 19 September 2014.

1.2 This plan was given a rating of 'Approved Subject to Conditions' on 29 October 2014.

1.3 Only one of 11 potential conditions applied. This was a request for more details on how the BCF schemes would reduce Non-Elective Admissions (NEL) by the target of 1,025 between 01 April 2014 and 31 March 2016. Therefore we have updated the BCF Plan and submitted the final version to NHS England on 9 January as requested. Further details are below. Feedback from NHS England is anticipated in February (to be confirmed).

1.4 This report also updates the HWBB on progress to integrate health and social care services (as detailed in the Business Case for integration presented to HWBB on 18 September 2014) and the set up of the Pooled Budget required for implementing the schemes of work in the BCF Plan.

1.5 BCF Plan – NHS England Review

1.5.1 Barnet CCG and LBB Adults & Communities (A&C) met NHS England BCF Advisor Steven Bedser on 4 November 2014 to agree a plan of action for resubmission of the BCF Plan.

1.5.2 NHS England issued an assurance report, detailing the further information required and other updates for consistency and some minor technical corrections.

1.5.3 Barnet submitted an Action Plan to NHSE as required on 14 November 2014 as agreed, which NHS England approved by return.

1.5.4 Officers engaged with Steven by email and telephone regularly and met him again in December 2014 to update him on progress. Steven met the Chairman of the HWBB and Chair of the CCG Board for further discussions. He was fully informed of our work throughout.

1.5.5 Barnet CCG and LBB A&C made the following amendments to the BCF Plan document, listed in the Action Plan:

- Additional modelling of the impact of individual schemes for all metrics, i.e. NEL, reduced permanent admissions to residential and nursing care, increased effectiveness of reablement, reduced delayed transfers of care, increased patient experience and increased proportion of people using social care who receive self-directed support.
- Addition of a fourth scheme of work called Enablers, covering a range of successful operational services that support the other schemes to deliver the target BCF benefits and form part of the delivery of the different tiers in our integrated care model, e.g. later life planning, shared digital care records and other community health services.
- Further detail of the providers for services detailed within each scheme.
- Details of progress to date on establishing a pooled budget for delivering the schemes of work and for sharing any risk and the expected rewards (detailed below).
- Tables in Part 1 that present the impact of the schemes of work planned and how each scheme contributes towards achieving expected changes in activity and financial benefits derived for the level of risk for the target cohort and investment or cost involved, all referenced with Part 2.
- Quality assurance and further development of the care home admissions and patient experience targets.
- Enhanced descriptions of health and social care in Barnet today and the vision for 'Mr Colin Dale' and our integrated care model in future.
- Additional detail on how the Plan aligns with the Barnet Council Local Vision (from its Business Planning framework for 2015/16 to 2019/20).
- Technical assurance of the whole Plan and financial and benefits plans for consistency and extensive minor additions throughout.

1.5.6 The final Plan was approved by the Chairman of the HWBB under delegated authority on 18 December. It was approved by the CCG Board Chair on 6 January 2015 and submitted 9 January 2015.

1.6 Integrated Care in Barnet (5 Tier Model) – Progress

1.6.1 We continue to make significant progress towards integrating health and social care services in Barnet. In place at the time of writing are the following:

- Joint Commissioning Unit for community health, social care, mental health, learning disability, older people and disability services is operational.
- Integrated Learning Disability and Mental Health care services in place.
- Substantial elements of the BCF / 5 Tier Model are in place for Community Based Intensive Services (Tiers 3 and 4) as follows:
- Multi-disciplinary case management system in place (MDT - acute care, mental health, social care, primary care, community health).

- Care Navigator service (CNS) to support people to get the care they need is now operational, with benefits being tracked.
- Risk Stratification is live in all GP practices, enabling them to proactively identify frail older people at high risk of deterioration.
- 7 day a week Rapid Care service in place to respond early to a crisis.
- 7 day a week social work services in place at Barnet General and Royal Free hospitals.
- Pilot Barnet Integrated Locality Team (BILT) in place.

Barnet Integrated Locality Teams

1.6.2 The BILT Pilot is based in the West locality working with seven GP practices that identified higher risk patients using the Risk Stratification tool. The Pilot Team also works with social care users with high packages of care. It comprises social workers, a telecare advisor, district nurses, occupational therapists and physiotherapists. We are also working to involve important roles such as community psychiatric nurses. The team will continue to grow as the Pilot learns from its early experiences and design of care pathways.

1.6.3 The Team is led by a Central London Community Hospitals (CLCH) Locality Manager and LBB Adult Social Care Service Manager. The Team is currently supporting 27 adults. Two have already been discharged following effective interventions. The number of adults supported will grow as the Team and pathways evolve. The Team has experienced positive engagement with third sector organisations, who we aim to include in the final model for wider roll out.

1.6.4 The Pilot runs through 2015, with a full evaluation starting in spring to determine the final design model for the Teams and scope of work. Work will also being to plan extend the approach across the rest of Barnet starting in the autumn. This includes plans to move services like CNS and MDT to be an integral function of the Team.

Evaluation

1.6.5 We recently reviewed the progress to date and outcomes and lessons learnt for two elements of the 5 tier model, namely Multi-Disciplinary Teams (MDT) and Care Navigation Service (CNS).

1.6.6 The review established there is a strong demand for MDT and CNS services. Initial findings indicate that their support can positively impact on spending on health services. Feedback from all MDT members indicated strong support for the value of integrated, collaborative working amongst professionals across different services.

1.6.7 Further analysis and data is required to establish the impact on spending on social care services. However, early analysis suggests that in some cases a reduction in costs may be possible or short to medium-term costs are either flat or do not increase significantly.

1.6.8 The review assessed 32 of the 107 cases supported by MDT in the six month pilot period. It considered the profile of health and social care provided before being the referral to MDT, the support provided as a result of the MDT review and the patient journey and care received for six months afterwards, to see if this contributed to improved outcomes.

1.6.9 The main findings from the review are:

- There were on average 3.5 A&E attendances and outpatient appointments per person in the period prior to the referral. The data shows a significant reduction of both in the six months post intervention. A&E attendances fell by 24% and outpatient appointments fell from 114 appointments in the six months before referral to 26 in the subsequent six months.
- One of the most expensive costs to health care budgets is the cost of days in hospital. Initial findings indicate that inputs from the MDT have resulted in the number of days spend in hospital falling from 571 days in the six months before referral to 128 days in the subsequent six months (a drop of 443 days).
- There were 54 fewer calls to London Ambulance Service in the 6 months after the referral. The number of conveyances to hospital after a 999 call in the six months before referral fell from 174, to 146 in the subsequent six months.
- 25 cases were identified from adult social care records as receiving care before and after support from MDT. Of this the total annual cost of care remained the same or decreased from 2013/14 to 2014/15 for 13 of the 25 people while 12 people experienced an increase in the annual cost for the same period. The average monthly cost of care did not change or decreased for 16 of the 25 people while it increased for the other 9.
- The MDT and CNS services support higher risk patients and six of the 32 individuals died in the pilot period. These factors affected the findings and further analysis of a larger number of patients covering more levels of risk is required to provide a clearer view of the impact. However the health and social circumstances of the other 26 patients did appear to stabilise or improve.

New Projects and Developments

1.6.10 Public Health and CCG are leading work to pilot and set up the new services planned for Tier 1. This includes:

- *Expert Patient Programme (EPP)* – Three courses are planned for early 2015, most likely in separate locations. Each course will have patients sourced from local GP Practices. A framework for evaluating the course based on levels of attendance at Practices and acute services before and after the course is in development.
- *Workforce Training / Development* – Implementation of a pilot scheme is underway based on an assessment of training needs for integrated care at GP Practices and service providers.
- *Healthy Living Pharmacy (HLP)* – Given the feedback on similar schemes in other London Boroughs the scale and ambition for the roll out of the pilot as detailed in the original Business Case has been increased to include all of Barnet rather than just two pharmacies initially. This is approximately 78 sites. Work to define this revised project and to gauge interest from these sites and model the potential impact is underway.

- *Health Champions* – Originally designed to be resourced from those who complete EPP, we are now considering options to include this as part of the wider HLP project outlined above. This will enable us to increase the number, breadth and depth of Health Champions across Barnet faster than waiting for resources to become available in stages, dependent on when and how frequently EPP runs.
- *Making Every Contact Count (MECC)* – We are developing a model that incorporates HLP, existing services such as NHS Health Checks and potential other new initiatives, including HLP. Work to define this project is underway and assumes a six month pilot to be evaluated to assess the cost effectiveness and other benefits of the approach.
- *Long-Term Conditions (LTCs)* –Barnet Community Health is on our behalf working to survey community and voluntary groups to assess the support they provide for managing LTCs, to assess if there are opportunities to put further resources or initiatives in place to delivery greater benefits.

1.6.11 We held a successful workshop on 31 October 2014 to discuss and develop initiatives in Tier 5 to reduce activity in this Tier and improve the quality of the care provided for those people for whom services in Tiers 1 to 4 cannot give the appropriate level of care needed.

1.6.12 Following the workshop we agreed with providers to combine ongoing work with the Barnet Integrated Care Strategy Steering Group, which directs work in Tiers 3 and 4. Many providers are involved across all Tiers, so this enables us to develop and embed system wide integration and change effectively with all the providers involved.

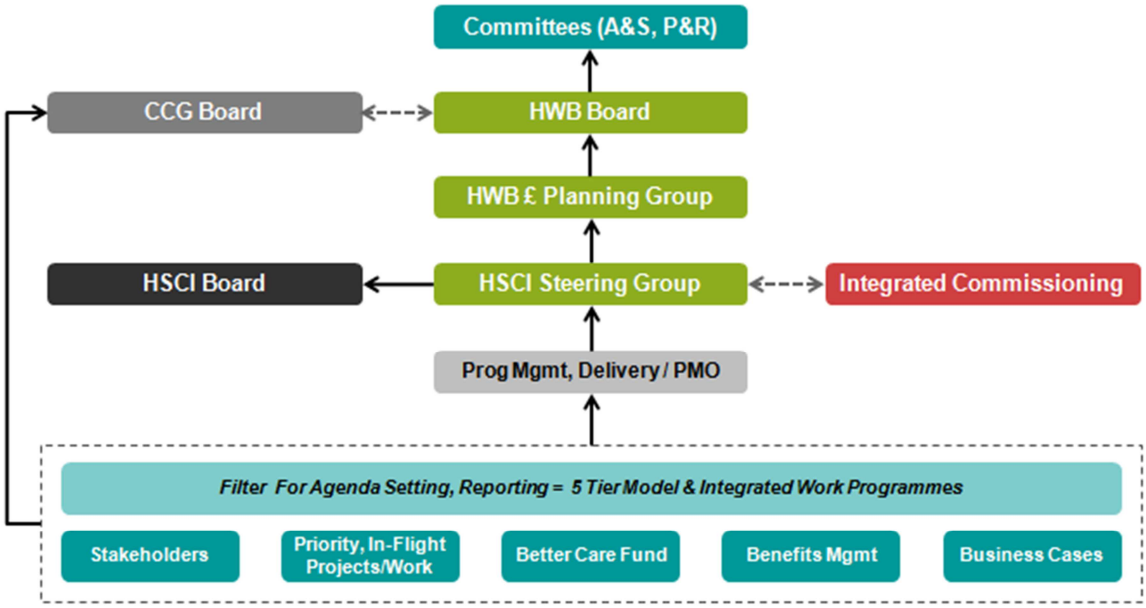
Governance and HSCI Board

1.6.13 The focus of our work is shifting from design and planning towards ongoing delivery of in-flight projects, benefits realisation and new projects or services.

1.6.14 We have updated the governance arrangements to create an HSCI Steering Group. It will direct work to meet joint aims and objectives to implement and embed the 5 Tier Model and BCF Plan. The Steering Group will:

- Monitor work to track and measure benefits realised against the targets in the BCF Plan and Business Case.
- Manage and quality assure delivery of the BCF Plan, internal or external reporting and performance of the Pooled Budget, offering challenge and scrutiny as necessary.
- Lead activities to facilitate the ongoing development and implementation of integrated services across all activities, e.g. stakeholder engagement or communications.
- Monitor progress and resolve exceptions in the delivery of priority and in-flight projects, offering guidance and support as required.
- Approve business cases for proposed new projects or work and to act as the change control authority.

1.6.15 The following diagram illustrates the current governance arrangements:



1.6.16 Our next HSCI Board meeting is set for 17 February 2015. This means we can continue to receive valuable feedback and strategic input into embedding the 5 Tier Model and system wide change and capture ideas for new services or developments.

1.6.17 Membership of the HSCI Board is comprehensive, including executives and Integration sponsors or leads from LBB, CCG and partner providers:

- Central London Community Health NHS Trust
- Royal Free London NHS Foundation Trust
- Barnet, Enfield and Haringey Mental Health Trust
- Housing 21
- Community Barnet
- MiHomeCare

1.7 Pooled Budgets – Status and Next Steps

1.7.1 BCF requires Local Areas to deliver integrated health and social care services through a pooled budget, for closer partnership working in the design and provision of such services. This underpins BCF as an enabler to take forward integration at scale and pace. Note: the BCF is not new or additional resources, rather the reallocation of existing service provision budgets to a pooled budget structure.

1.7.2 An important element of this pooled budget is the pay for performance (P4P) element for reducing NEL by our agreed target of 1,205 patients by 31 March 2016. This equates to an estimated benefit/risk of £2.054m and is the amount of the pooled budget therefore at risk depending on our performance on this target.

1.7.3 To deliver our vision for integration it is therefore necessary to establish a pooled budget compliant with BCF rules. In October NHS England advised Local Areas not yet fully approved that it would be unwise to enter into any formal pooled budget agreements until their plan was approved. This applies to Barnet.

1.7.4 Work is however underway to agree detailed principles and arrangements. A further schedule is to be added to the existing S75 Agreement for Integrated Care. To date we have identified or reached consensus on several key principles:

- The HWBB Finance Group should be considered to be the pool Executive with the HWBB to take and/or ratify decisions on the pool accordingly.
- The HWBB Finance Group will be responsible for monitoring all progress in delivering the target benefits and outcomes as detailed in the BCF Plan and Business Case, with ongoing oversight and sign off of work and spend.
- The HSCI Steering Group will deliver work and report progress to HWBB Finance Group and HWBB.
- We will review the pool every six months starting April 2015 (first review September 2015) to determine if there is a case to change the scope of it for the following year, to be decided by the following March.
- In principle LBB and CCG will monitor budgets for integrated care from the Business Case for Integration across health and social care via HWBB Finance Group, in order to track benefits realisation.

1.7.5 Work is ongoing to determine the best approach to including specific services and managing particular aspects or requirements of the pool, e.g.:

- Confirm the scope of services to include for the starting pool, taken from the schemes in the BCF Plan, to develop the Service Schedule to add to the S75 Agreement.
- Understand the impact on contracts for community health services and how and when the BCF services included them might be transferred to be managed though the pool.
- Define the most appropriate levels of benefits to track and the approach and process for recording benefits realised to help analyse progress and decide future direction and report internally and externally as required.
- How to mitigate against any loss in funding as a result of receiving only part of the 'at risk' funding of £2.054m for reducing NEL and develop a plan to manage this.
- Options to vary the amount and proportion of contributions each year, depending on policy direction, any changes to income and our agreed priorities for the future development of integrated care services against the benefits realised.

1.7.6 We will present the draft pool arrangements for contributions and sharing risk and reward to HWBB, prior to agreement by the Council Policy and Resources Committee and the CCG Board. The latest work plan for establishing the pool is attached (Appendix 2).

2. REASONS FOR RECOMMENDATIONS

2.1 The Final BCF Plan now includes significant additional detail to demonstrate the scale, quality and impact of the schemes of work planned to meet locally agreed targets for reducing NEL and other BCF benefits and outcomes.

2.2 It illustrates how each scheme contributes towards achieving the benefits and outcomes identified and the expected change in activity and financial benefit derived. This is given for how the schemes will support frail elderly people for the level of risk of admission to hospital or residential/nursing care (analysed via risk segmentation tools) and the level of investment or cost involved.

2.3 The Final Plan therefore underlines our ambitious plans for transforming and integrating health and social care in Barnet. The clear, analytically driven case for transforming care has been quality assured again and is now more robust.

2.4 BCF remains a key delivery vehicle for realising CCG QIPP plans and savings and Council Commissioning Plan priorities and savings. The Plan explains the work done and planned to maximise the chances of success in meeting these aims.

2.5 The BCF Plan has been subject to consultation and agreement with all key stakeholders in the Barnet health and social care economy. It demonstrates how we will use s256, CCG and LBB adult social care funding to invest to put in place new models of care.

2.6 The need to update the plan has diverted resources from the ongoing delivery of the schemes of work detailed. Ratifying the Plan and agreeing on progress to date and work to set up the required Pooled Budget for BCF will enable us to continue at pace to deliver the schemes of work and realise all the benefits and outcomes identified for 2014/15, 2015/16 and beyond.

2.7 Part 1 of the BCF Plan is attached (Appendix 1). There are no material changes to Part 2. Part 2 and the Action Plan are available for inspection on request from the Officers listed on the front page of this report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 n/a – All areas are required to submit a BCF Plan based on greater integration of health and social care.

4. POST DECISION IMPLEMENTATION

4.1 In anticipation of NHS England approval of the BCF Plan in January 2015, we will continue work to implement the schemes of work described and pooled budget, governance and benefits management arrangements, to evidence the successful delivery of the Plan and achieving the target benefits/outcomes.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The BCF Plan and Business Care align with the twin overarching aims of our Barnet Health and Well-Being Strategy 2012 to 2015 (October 2012), Keeping Well; and Keeping Independent. There are also clear links with the Barnet Council Corporate Plan, the Priorities and Spending Review, the outline aims of Council 5 year commissioning intentions for adult social care and Barnet CCG 2 and 5 year Strategic Plans. The London Borough of Barnet and Barnet CCG will lead delivery of the plan through the Joint Commissioning Unit (JCU) and with Public Health and partner service providers.

5.2 Resources (Finance and Value for Money, Procurement, Staffing, Property IT, Sustainability)

5.2.1 The BCF Plan and Business Case set out the overall investment required to implement the 5 Tier Model for integrated care and the links between it and published QIPP schemes and PSR proposals.

5.2.2 The BCF Plan details the financial LBB and CCG contributions which will likely comprise the pooled budget used to deliver integrated health and social care services to improved outcomes for patients and service users. Table 1 below provides a breakdown of this funding for 2015/16. Of this total the allocation for protecting social care is £4.20m (rounded). Most of the BCF is not new or additional resources, rather the reallocation of existing service provision budgets to a pooled budget structure. We will also where appropriate align budgets alongside the pool, including an agreed public heath contribution to deliver Tier 1 of the 5 Tier Model. Please note that existing s256 spending plans for 2014/15 (£6.634m) previously agreed by HWBB will continue in 2015/16.

Table 1 – 2015 /16 BCF

	£000
Adult Social Care Capital Grant	806
s256 Funding	6,634
Carers Breaks	806
Enablement	1,860
Disabled Facilities Grant (DFG)	1,066
NHS Funding *(Note - Includes £846K for Care Act Implementation)*	12,240
Total	**23,412**

5.3 **Legal and Constitutional References**

5.3.1 In 2015/16 BCF (the fund) will be allocated to Local Areas, placed into pooled budgets under joint governance arrangements detailed in S75 Agreements for Integrated Care between CCGs and councils (Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets).

5.3.2 A condition of accessing the fund is that CCGs and councils must jointly agree plans for how to invest the money, which must meet certain requirements. The fund will be routed through NHS England to protect the overall level of health spending and works coherently with wider NHS funding arrangements.

5.3.3 The Department of Health (DoH) will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to BCF and ensure it is deployed in specified amounts locally for CCGs and councils to use in pooled budgets.

5.3.4 Legislation is required to ring-fence NHS contributions to the fund at national and local level, to give NHS England powers to assure local plans and track performance and ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This ensures that the Disabled Facilities Grant (DFG) can be included in the Fund.

5.3.5 The DFG is included to incorporate the provision of adaptations into strategic considerations and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier local authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget so they can continue to meet their statutory duty to adapt the homes of disabled people, including for young people aged up to 17.

5.3.6 Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003). They will stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner so it can be spent in year. Further indicative minimum allocations for DFG will be provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the fund may decide additional funding is appropriate to top up the minimum DFG funding levels.

5.3.7 DoH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure DoH Adult Social Care capital grants (£134m) will reach local areas as part of the fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the fund.

5.3.8 The Health and Well-Being Board has the following responsibility within its Terms of Reference:

(*3); 'To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.'*

(9); Specific responsibility for:

- *Overseeing public health*
- *Developing further health and social care integration*

5.4 Risk Management

5.4.1 LBB / CCG projects are delivered using programme and project management methodologies and governance arrangements. This includes clear processes to identify, report and manage individual and aggregate risks through LBB and CCG Programme Management Offices and senior management teams in the CCG and LBB Adults & Communities.

5.4.2 Specific risks relating to BCF are included in the BCF Plan and Business Case with mitigating actions. These will be monitored regularly in accordance with the aforementioned governance process.

5.4.3 Strategically work has begun to assess over-arching governance arrangements for BCF in the context of a pooled budget and shared risk. This is essential to ensure robust management of the fund especially as the size and scope of the BCF and true pool will increase (subject to necessary due diligence).

5.5 Equalities and Diversity

5.5.1 It is mandatory to consider Equality and Diversity issues in decision-making in the Council, pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must have due regard to the equality duties when exercising a public function.

5.5.2 The broad purpose of this duty is to integrate considerations regarding equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

5.5.3 The specific duty set out in S149 of the Equality Act is to have due regard to need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.4 Relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.5.5 Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports. Proposals are therefore assessed for their impact on equality and diversity in line with the Barnet CCG Equality Delivery System. A requirement of the BCF is to guarantee that no community is left behind or disadvantaged – the commissioning system therefore needs to be focused on reducing health inequalities and advancing equality in its drive to improve outcomes for patients and service users.

5.6 **Consultation and Engagement**

5.6.1 The BCF Plan details the public engagement with patients and service users as well as with providers.

6. BACKGROUND PAPERS

6.1 The first draft of the BCF was presented to the HWBB on 23 January 2014. A revised draft was presented on 20 March 2014 and full Plan for submission on 18 September 2014. It was submitted to NHS England in accordance with the nationally mandated timescales on 4 April 2014.

6.2 In addition, HWBB meetings held on 19 September and 21 November 2013, discussed health and social care integration and Integration Transformation Fund (which then became the BCF). Closely linked are discussions at the 21 November 2013 meeting (Agenda Item 10) regarding NHS England's "Call to Action" Programme, part of a national engagement exercise designed to build public awareness of the challenges facing health and social care in order to create a platform for future transformational change. The BCF represents part of the government's response to this challenge.

6.3 There are no material changes to Part 2 of the Final BCF Plan submitted to NHSE (v1.1, 14 Jan 2015). Part 2 and the Barnet BCF Action Plan submitted to NHSE (v1.7 Final, 9 Jan 2015) are both available for inspection on request from the officers listed on the front page of this report.

6.4 BCF Guidance and Planning is provided in a letter dated 25 July 2014, *NHS England Publications Gateway Ref No. 01977.*

Updated July 2014 (Plan Submitted 15/09/14 & 09/01/15)

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014 (final submission no later than 12 noon 9th January 2015). Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

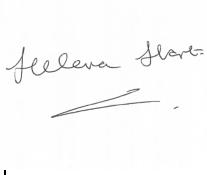
a) Summary of Plan

Local Authority	**Barnet Council**
Clinical Commissioning Groups	**Barnet Clinical Commissioning Group**
Boundary Differences	**Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients.**
Date agreed at Health and Well-Being Board:	**18.09.2014**
Date submitted:	**19.09.2014 & 09.01.2015**
Minimum required value of BCF pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**
Total agreed value of pooled budget: 2014/15	**£6,634,000**
2015/16	**£23,412,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	09.01.2015

Signed on behalf of the Council	
By	Andrew Travers
Position	Chief Executive
Date	09.01.2015

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	09.01.2015

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Selected Links
Barnet Health and Social Care Concordat Barnet Integrated Health and Social Care Model 2013 Barnet Health and Well-Being Strategy Barnet Council Corporate Plan 2013 Barnet Council Priority & Spending Review 2014 Barnet CCG 2 Year Operational and 5 Year Strategic Plan Barnet Joint Strategic Needs Assessment (JSNA) 2011 - 2015 Health and Social Care Integration Board Terms of Reference Health and Social Care Integration Board Programme Governance Barnet, Enfield & Haringey Clinical Strategy Health and Social Care Integration Business Base (Sept 2014)	HSCIB concordat signed.pdf Barnet Health Social Care Integrati Barnet Health Social Care Integrati Barnet Health & Social Care Program HSCI Business Case Update Oct 014 v0.9 Others available upon request

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20.

The Vision for integrated care in Barnet is articulated in the Health and Social Care Integration Concordat and states:

Care integration in Barnet will place 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 experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.

In **3 to 5 years' time,** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

- Delivers on expected patient outcomes; meeting the changing needs of the people of Barnet.
- Enables people to have greater choice and autonomy on where and how care is provided.
- Empowers the population to access and maximise effective preventative and self-management approaches which support their own health and wellbeing.
- Creates a sustainable health and social care environment, which enables organisations to work productively within resource limits.
- Reduces overall pressures in hospital and health budgets as we shift from high-cost reactive to lower cost prevention and self-management services.
- Listens and acts upon the view of residents and providers to make continued improvement to services.

Our plans are informed by the **Barnet Joint Strategic Needs Assessment** (JSNA) 2011 to 2015 (July 2011). This provides a framework for informed **commissioning and the prioritisation of need and demand management based upon on local evidence.** We will focus on tackling the areas of inequality and highest impact, which include:

- An increasing ageing population, with growing numbers of people with long-term conditions as a result of an above average growth rate (5.5%) in the elderly population: 3,250 more residents aged over 65 (+7.4%) and 783 more aged over 85 (+11.3%). In addition to the other, more traditional, health risks associated with old age, long-term conditions such as dementia are a particular issue that we expect to become more prevalent as people live into old age. For example, prevalence rates for dementia as calculated by the London School of Economics and King's College for the Alzheimer's Society predict that dementia will affect 8% of people aged 65 years and over in Barnet and 24% of people aged over 85 years. Whilst the number of people in Barnet aged over 65 with dementia in 2010 was estimated to be 3,778, this is predicted to rise to 4,744 by 2020. This is an increase of 26% over 10 years, compared to only 17% across London.

- Specific health trends: While many people in Barnet experience good health, some issues remain significant obstacles. This includes cancers where although mortality associated with cancers remains relatively low, an improved take-up of screening could ensure earlier identification and treatment. This increases the likelihood of survival and decreases the need for more radical treatment. Death rates for chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD) are falling; however we recognise that early identification of undiagnosed COPD remains a priority, as does smoking cessation to prevent CVD. Also of significance is the "obesity epidemic". Almost 25,000 residents of Barnet aged over 18 years are obese. While this represents a lower prevalence than the national average (15.4% versus 24.5%), it is still a significant number, especially considering that those who are obese are at greater risk of premature death and a number of health complications including diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases and infertility and respiratory disorders.
- **Improving independence:** With increased demand pressures from a growing population and reduced financial resources, it will be essential that we enable more people to take personal responsibly for their own health and wellbeing through particularly through prevention schemes.

Our **Barnet Health and Well-Being Strategy** 2012 to 2015 (October 2012) centres on reducing such health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent':

- **Keeping Well:** focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.
- **Keeping Independent:** when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet quickly, supported by health and social care services working together.

The strategy recognises that we can only achieve this through a partnership between residents and public services.

The views of patients, service users and carers are integral to the vision for integrated care in Barnet, with extensive involvement of a wide range of individuals and organisations including Healthwatch Barnet, Older Adults Partnership Board, Age UK (Barnet) and the Alzheimer's Society. The role of public and patient engagement is outlined in more detail in Section 8a below.

Taking into account the call from local residents to increase co-ordinated care to enable them to live better for longer we have created our Barnet integrated care Vision around Mr Colin Dale, a fictitious representative user of health and social care services in Barnet. Central to success is the development of a model that will mean that Mr Dale has coordinated care around him including:

- A single point of contact for all their care needs
- Quick and responsive services
- Professionals and care services that talk to each other **and**
- For Mr Dale to only need to tell his story once (Diagram 1)

Diagram 1 – Barnet Vision for Colin Dale

We have a shared 'model' approach to delivering integrated care across Barnet and we have made significant progress so far. For example, both the Care Navigation Service (CNS - a team that supports the delivery of integrated care plans for people with frailty and long term conditions) and Multi-Disciplinary Team (MDTs - to plan and manage the delivery of the most complex care including GPs, acute consultants, social care, specialist mental health, community health) case conferences started in July 2013. We launched the Rapid Response service in August 2013 and the Community Point of Access (CPA) in April 2014. The Risk Stratification Tool (IT based case finding tool) is now in use in all GP Practices and our Integrated Locality Team pilot (a fully integrated, co-located team of community health and social care professionals, linked to 7 GP practices) became operational in August 2014. Our Care Homes Locally Commissioned Service, operational since September 2014, is improving the quality and level of care provided in care homes throughout Barnet. This scheme is enhancing relationships between GPs and care homes, offering a more holistic medical to care homes for more proactive and preventative care to anticipate when issues may arise and to prevent crisis and avoidable emergency admissions. Distinct services from GPs include fortnightly ward rounds, six monthly reviews and post-admission and medication reviews over and above services commissioned through current GP GMS and PMS contracts.

All these new services are beginning to demonstrate improved outcomes for frail elderly people and those with long-term conditions, alongside returning financial benefits.

As the number of frail elderly people requiring health and social care support increases, it is essential that they are offered services that help them to remain independent and live healthily in their own homes for as long as possible. They need timely access to crisis response services to prevent unplanned hospital admissions and dedicated support to recover quickly from illness and prevent future deterioration.

Current health and care services in Barnet do not always fulfil these objectives and as result there is an over-reliance on hospital services and residential care. There are local examples of good practice, especially in our new services described above, but some health and social care services for frail elderly people are still delivered separately from

individual teams. This can result in a disjointed response or service which fails to meet the health and social care needs of individuals holistically.

For Mr Colin Date, this means that in the current system, he receives separate assessments and has to tell his story a number of times. In an average month (without an emergency visit) he may see approximately 10 different professionals from across health and social care, each of whom delivers a specific but isolated task. The number of visits typically increases during and after each exacerbation in one of his conditions. Although Mr Dale and his family recognise that each intervention helps, they often find themselves spending a lot of time waiting for someone to come and deliver the different elements of his care.

Each intervention adds some value to Mr Dale's life, but because the interventions are not integrated to focus on the person and their long-term needs, each intervention does not link with the next to multiply value. The lack of a strong "chain" of support to help maintain health, wellbeing and independence means that the value added by the individual interventions evaporates over time.

In our current system, we find that people sometimes have to re-tell their story to each care or health service provider that they use. They sometimes don't get the support they need because the different services don't share relevant information. Older people can be discharged from hospital to homes not wholly suitable to their needs, so they deteriorate or fall and return to A&E. Health or care workers sometimes make home visits at times that do not fit in with the needs of the person receiving care. Finally, some patients may face longer waits in hospital before being discharged, because hospital and social care staff are unable to coordinate next steps.

We realise that although we have made progress with our integrated care services, there remains much to do to improve services across the whole system in Barnet. Our work to date has focused on developing intensive support and admission avoidance services which address pressures on acute hospital services. The benefits realised so far reflect this, starting to show a reduction in unplanned emergency admissions to hospital and an increase in people enabled to remain independent and well at home.

We now need to maximise the benefits of our new service model, ensuring that all people in Barnet who could benefit, are supported with fully integrated care, thereby achieving better health outcomes for people and increased financial benefits for the health and social care system. We need to do more work to understand the long-term impact of integrated care services on adult social care. We need to ensure that our proposed model will deliver benefits to ensure sustainable, local adult social care services.

Another priority is to increase self-management and prevention in our integrated care model, providing access to an appropriate range of information, services, care and long term self-management solutions for all who could benefit. This should reduce stress, isolation and possible person and/or carer breakdown, thereby reducing demand on health and social care services and ensuring services can provide the right level of care at the right time across the whole system in Barnet.

The London Borough of Barnet (LBB) and Barnet Clinical Commissioning Group (BCCG) have worked for many months on our jointly agreed integrated care model.

The Better Care Fund (BCF) plan has its foundations in the **Barnet Health and Social Care Concordat** (included in Section 1c above). Our Concordant is a clearly articulated vision for integrated care co-designed and agreed by all parties of the **Barnet Health and Social Care Integration Board (HSCIB)**.This integrated care model is the foundation of our future transformation:

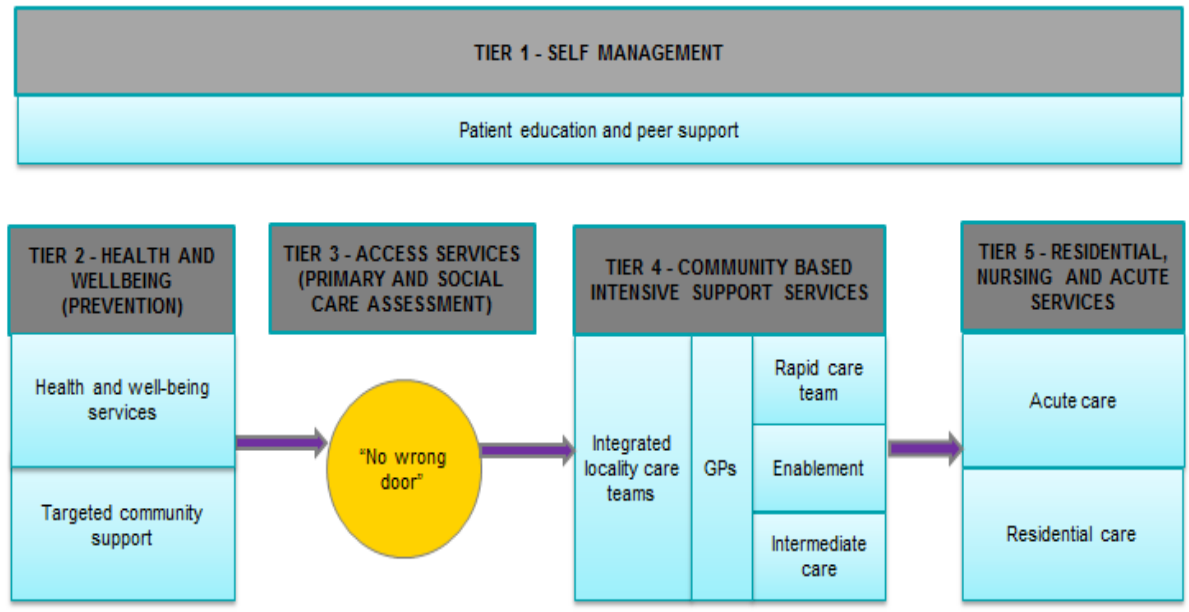


Diagram 2 – Overview of the Barnet Integrated Care Model

The BCF will be an important enabler for us to implement our vision at scale and pace.

The integrated care model consists of five tiers of integrated health and social care services, all designed with the aim of providing people with the right care, in the right place, at the right time, through a significant expansion of care in community settings and championing of prevention and self-management. Our schemes of work for BCF therefore comprise:

- **Scheme 1: Self-Management and Health and Wellbeing Services (Tier 1):** This reflects Tier 1, i.e. people and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible.
- **Scheme 2: Access services including primary and social care assessment:** identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises Mr Dale's skills, increases his quality of life and prevents deterioration.
- **Scheme 3: Community based intensive services (Tiers 3 and 4):** Intensive community based support services are readily accessible and react quickly to need.
- **Scheme 4:** Enablers: supports the delivery of the three schemes above and consists of a range of successful operational services, including planning for later life (a team of advisors that help people prepare for their old age), shared digital care records (to enable all professionals and teams to work together to

deliver care and support to Mr Dale) and other community health services. These services do not directly deliver the 6 core BCF targets but support their achievement through other indirect benefits and underpin the delivery of the different tiers in our integrated care model.

We realise that implementing our vision for the BCF will be challenging, especially in the context of the required 3.5% reduction in non-elective emergency admissions (NEL) and both a Clinical Commissioning Group and Local Authority facing severe financial challenges, including the financial pressures associated with the implementation of the Care Act in social care.

Local demographic and infrastructure challenges, including re-configuration of acute services and a relatively high number of residential and nursing homes create local pressures for Barnet, which must be addressed. There is also the local recognition that much of the BCF funding will come with services already provided.

However, we believe this plan is a significant, proactive step towards dealing with these challenges successfully. Our BCF plan is aligned to the NHS BCCG Draft Delivery Plan, presented to the BCCG Board on 28 August 2014 and remains part of the overall aim to manage demand pressures and improve long-term sustainability.

b) What difference will this make to patient and service user outcomes?

Our BCF schemes of work will significantly contribute to improved patient, service user and carer experience, better quality outcomes and financial benefits through identified service efficiencies and productivity. The BCF translates these top level outcomes into measurable whole system targets with agreed, shared accountability across all of our providers and commissioning organisations.

Table 1 below shows to which core target or outcome each scheme contributes:

Scheme	Scheme description	Benefits					
		NEL	Residential & Nursing Adm	Reablement Effectiveness	DTOC	Patient Satisfaction	Self Dir. Support
1	Expert Patient Programme	✓				✓	✓
2a	Long-term conditions (dementia, stroke, falls, pall. care)	✓	✓		✓	✓	
2b	Older People Integrated Care (OPIC)	✓	✓	✓		✓	✓
2c	Care Homes	✓				✓	
3a	Rapid Care	✓		✓	✓	✓	
4	Enablers					✓	✓

Table 1 – Overview of Scheme Contributions to BCF Benefits and Outcomes

Table 2 overleaf details our current and target performance against the set baseline for each of those quantifiable targets and measures:

	Current Level	Target Next Year	Benchmark (ONS Peer Group)	Comment
Non-elective admissions	29,094 80 per 1,000 population	28,069 3.5% reduction	64 per 1,000 population	• Barnet is already in the top quartile on non-elective admissions performance • Improvement from reducing GP variation and increased use of risk stratification
Care homes	487	405	410.9 (for current level and based on LBB comparator group)	• Aim for top quartile performance
At home after 91 days	71.9%	81.5%	85%	• Move from bottom quartile to second
Delayed transfer of care	7 per 100,000 population	6 per 100,000 population	6 per 100,000 population	• Move from second quartile to top quartile
Patient experience	0.87	0.92	0.869 (based on CIPFA comparator group; data is currently restricted and is owned by the NHS Information Centre)	• The metric is based on the Annual Social Care User Survey (2013/14), Question 1: Overall how satisfied or dissatisfied are you with the support or services you have received from social services in the last 12 months?
Self Directed Support	1 (2,701 people)	1 (2,718 people)		The metric is from the adult social care outcomes framework, long term support indicator. Percentage of people with self-directed support, expressed as a percentage of all eligible social care service users.

Table 2 – Current and Target Performance for BCF Benefits and Outcomes

<u>Improved Outcomes</u>

Better patient and carer experience:

- The provision of a local, high quality service that targets those most at need. In addition, it will enable people to remain at home, where essential care can be delivered and monitored.
- Reduction of duplication in assessment and provision of care through use of an integrated locality team approach to case management.
- "No wrong door" for frail, older people and those with long-term conditions.

- Increase in the number of people who have early interventions and proactive care to manage their health and wellbeing.

Improved older adult outcomes (health and social care):

- Ensuring quality long-term care is provided in the most appropriate setting by a workforce with the right skills.
- Pro-active care to ensure that long-term conditions do not deteriorate, leading to reductions in the need for acute or long-term residential care, and reducing the demand for repeat interventions and crisis services such as emergency departments.
- Increased use of health and social care preventative programmes that maintain people's health and wellbeing, and improved practice in use of medication leading to a reduction in unplanned and emergency admissions to hospital and A&E.

Lower cost, better productivity - achieved through the ability to improve future resource planning and needs by way of:

- Utilising risk stratification to manage the care of those individuals most at risk of an escalation in their health and social care needs.
- Utilising a joint approach to care will ensure a better customer journey and led to better management of resources providing the services.
- Increased information and signposting to ensure preventative services are fully utilized.
- Supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health and wellbeing, which in turn will help reduce or delay the rising admissions to residential care.

c) What changes will have been delivered in the pattern and configuration of services over the next five years and how will BCF funded work contribute to this?

There will be significant changes to the delivery of services over the next 5 years.

Section 2a above outlines the five tiers that form the foundations of our integrated care model. Transforming services through integrated care will ensure that we are improving outcomes for patients and service users, gaining the best value for money in services and are maximising opportunities arising from joint commissioning. This section outlines the operating arrangements for each of the tiers of the integrated care model.

Diagram 3 below illustrates our approach for how the design and structure of services will evolve significantly to reflect each tier of our integrated care model:

Diagram 3 – Evolution of Services for Mr Colin Dale

The diagram shows four of the five tiers, namely 1) Self-Management, 2) Prevention (i.e. Health and Wellbeing), 3) (A single point of) Access to Assessment and Care Planning and 4) Community Based Intensive Support Services. Tier 5 is not shown in this diagram because it shows the key changes we aim to make through our integrated care vision. We aim to reduce demand for tier 5 services through the support we provide in tiers 1-4. The following paragraphs describe each tier.

Tier 1: Self-Management – Shifting the focus of health and social care delivery away from formal care and institutions and developing the individual's resilience to seek their own solutions and manage circumstances:

- All individuals with a recognised long-term condition (such as diabetes or heart disease) will be offered self-management education, training and support.
- Up-skilling people and improving their health literacy so that they are more confident about looking after their own health.
- Access to support from a long-term condition Mentor or Health Champion, or access to online support forums tools.
- Development of Healthy Living Pharmacies, to review medication, access community based preventive services and to work with a health champion to adopt healthier behaviours.
- Training for health and social care professionals to enable them to support and empower people to manage their long-term conditions independently.

Tier 2: Health and wellbeing – Preventing the onset of ill health and improving people's social well-being:

- Targeted primary and secondary prevention to reduce health inequalities.
- Encouraging healthy lifestyles and lending support to families, friends and carers who provide informal care.
- Strong Information and Advice offer, with branding and in a format that will make these services publically recognisable, readily available, understandable and easy to access. Increased use of social media, mobile and internet technology to support delivery.
- Early contact made with people identified as at risk of needing Tier 3 and 4 services, to link with advice and support to help keep them well. Examples include the Falls Clinic, Dementia Hub, Dementia Cafes, Dementia Advisors, Day Care and Stroke Support Services.
- Health education package for carers, which supports safe caring, promoted by GPs, LBB, carer's services and hospitals. Dedicated carer's centres.
- Implementation of the Ageing Well Programme (user, carer and community led prevention and social inclusion activities), including greater investment in volunteering to support people in the community.
- GP network led Wellbeing service piloting community navigation to health, social care and voluntary sector services.
- Evidence base of what works at a system and individual level will be developed to inform future commissioning.

Tier 3: Access services – Primary and social care assessment for people with a long-term condition, aimed at preventing emergency and unnecessary admissions:

- **Identification of at risk Older Adults through risk stratification:** population profiling; predictive modelling of high-risk patients; disease profiling to enable early identification and navigation to the appropriate prevention services.
- **Community Point of Access:** single point of access to provide advice and support for older adults and those with long-term conditions, signposting them quickly and efficiently to the correct services and provide a timely and direct referral route to existing community health services.
- **Shared Care Record:** An information repository providing a single, holistic view of an individual's health and social care needs that will be accessible 24/7 from any location and wherever staff are working. This is a key system enabler.

Tier 4: Intensive Community Support – Services to increase independence and provide health and care support to manage people in the community e.g. at home.

- **Care Co-ordination and Case Management:** Delivered through Integrated Locality Teams in partnership with GPs (including social care, mental health and community healthcare), to support and manage care from self-management through periods of crisis, into end of life pathways where necessary. They will review and assess complex patients living with multi-morbidity and long-term conditions at risk of admission to introduce care plans and link to services to keep them at home. Building from an initial framework of a team based with each of the 3 localities, they will move resources around

flexibly to avoid crises and maintain people in their homes or in other care settings.

- **Weekly Multi-disciplinary Team (MDT) meetings** will provide a more intensive and coordinated approach to managing the most complex cases by planning individualised care packages across multiple providers.
- **Care Navigators** supporting these groups with implementation and delivery of care plans through care co-ordination and signposting.
- **Rapid Care service** that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.
- **Enablement services,** working closely and effectively with facilitated discharge to provide holistic care packages seamlessly with other care providers.

Tier 5: Reduce demand for residential, nursing and acute services.

Residential, nursing home and hospital inpatient services support intensive care where individuals cannot live happily, healthily and independently at home. The aim is for these services to be accessed only when other community based services available cannot provide the correct level of care or an appropriate environment for the patient or service user.

The focus of our integrated care model is to shift activity to Tiers 1 – 4 and to reduce demand for acute hospital and residential care (Tier 5). Within Tier 5, we are developing several initiatives to reduce demand for acute hospital care, including reducing the risk of people in nursing or residential care being admitted to hospital.

Both acute hospital sites serving Barnet operate admission prevention services (TREAT) and early supported discharge schemes (PACE). 7 day a week social worker services operate in both hospital sites.

Our leadership and thinking and working with stakeholders are integrated across aligned activities. The Chair of BCCG also chairs our local System Resilience Group (SRG) to set and implement plans across the whole health and social care system to manage patient flow and demand and capacity management driven by winter pressure and other identified risks to public health. In December 2014 we hosted an A & E Summit to bring together all major stakeholders for urgent care in Barnet to agree how we can work better for patients to reduce admissions and help them leave hospital and return home faster. This included social workers, BCCG, the London Ambulance Service (LAS) and the Royal Free NHS Foundation Trust.

In Scheme 2 we have a dedicated set of initiatives which target care homes, working with locally commissioned services to improve staff skills and quality of care in care homes. Our aim is to support the care homes themselves to appropriately respond to patients requiring intensive support, preventing hospital admission with the deployment of additional support from the integrated care model. Dedicated GP support has been enhanced, for example with fortnightly ward rounds and six monthly holistic reviews and post-admission and medication reviews (over and above the services commissioned under GP GMS and PMS contracts). We have a dedicated improvement team for Care and Nursing Homes (IQICH, recognised for its good practice in the Skills for Care Accolade awards). All this work is further improving the relationship between the care home and GP, increasing levels of proactive and preventative care given to anticipate

potential issues and prevent crisis and avoidable emergency admissions. We are also supporting people's preference of place of death through advanced end of life care planning, with a Barnet GP acting as dedicated 'End of Life Champion'. The scheme is providing education and training to care home staff and managers to empower them to improve the quality of care and build networks between care homes to facilitate shared learning and best practice.

Scheme 4 (Enablers) includes improvements to hospice services, to provide a more appropriate environment than acute hospital for people if their health deteriorates and they require palliative care.

Tables 3 and 4 overleaf list the schemes of work for each Tier for the next two years. They show the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below) and their contribution to reducing non-elective admissions. The savings are based on a £2,004 average unit cost per admission, as used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 3 and 4 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016.

More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving the effectiveness of reablement and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 3 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 4 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The delivery of our BCF plan will occur in the context of a challenging health and social care environment:

- Barnet Clinical Commissioning Group (BCCG) has an inherited debt of £34.1m. The Revenue Resource Limits (RRL) in place for 2014/15 and 2015/16 continue to disadvantage BCCG by providing funding below the 'fair share' target. Significant ongoing QIPP challenges will continue for BCCG in to the foreseeable future.
- The Barnet Council (LBB) Priorities and Spending Review (PSR) forecast a gap in the Council's finances of £72m between 2016 and 2020. It has identified a package of options for LBB to save money and raise revenue, with a potential to provide a financial benefit of approximately £51m. Adults & Communities share of the PSR package of savings is £12.6m. This includes proposals for improving organisational efficiency, reducing demand and promoting independence and service re-design.
- In addition to the £72m gap, the Council must meet the challenge of providing the new statutory duties of the Care Act, including for the 32,000 informal carers across Barnet.
- Significant change in the landscape for the provision of hospital services as a result of strategic change and re-configuration.
- Barnet has more than 100 care homes, with the highest number of residential care beds in London, leading to a significant net import of residents with health needs moving here from other areas.

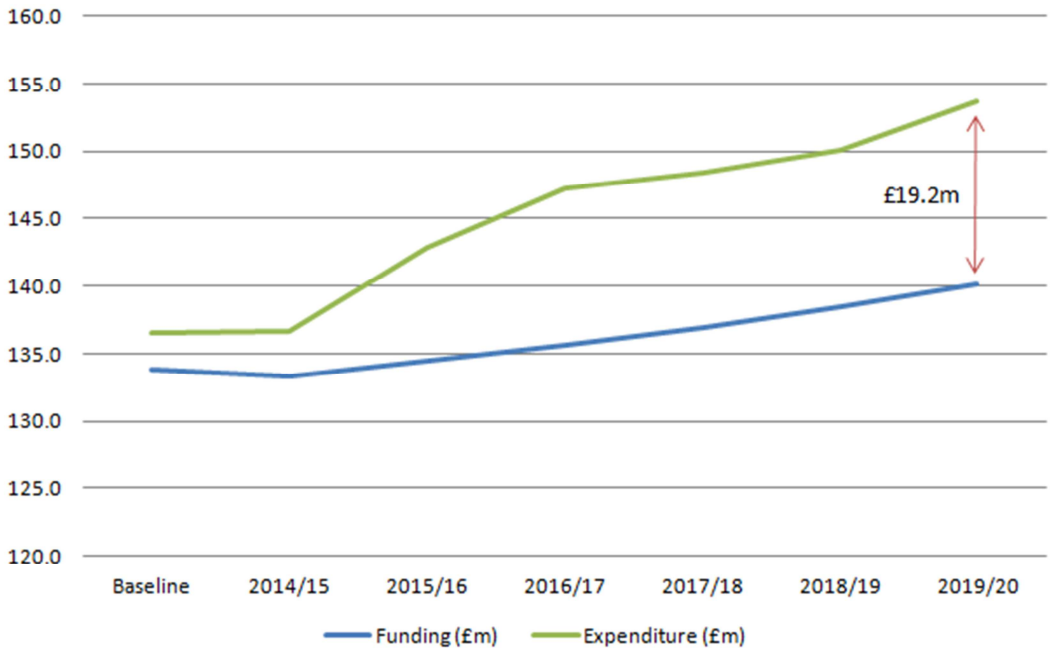
Our case for change centres on five issues:

1. **A challenging financial environment with significant uncertainty**
2. **An ageing population with a growing burden of disease**
3. **High levels of variation in primary care**
4. **Outcomes which are not as good as we aspire to**
5. **Insufficient spend on areas that support integrated care**

We have undertaken a **financial analysis of the affordability and deliverability of our integrated care model** to address the critical question for the Barnet economy of how we can achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way.

Our Business Case for integrating health and social care services includes our BCF Plan and shows that the combined effect of likely reduced funding and our forecast increases in expenditure may create a significant financial gap over the next six years **if we do not change our current care model**. Based on the scope of services at the time of developing the business case, our baseline for the first year of the business case modelling period (2013/14) was a budget of £133.8m with a forecast expenditure of £136.5m. This leaves a funding gap of £2.7m. Diagram 4 below illustrates our analysis of

the costs involved, which give us an indicative view of the possible longer term forecast funding gap relevant to older people (in scope) from 2014 to 2020. **This demonstrates the need for change to our model of care.**



Data source: LBB & BCCG Business Case for Integration of Services September 2014.

Diagram 4 – Graph of Forecast Funding Gap for Services 2014 – 2020

Our strategy for embedding integrated care will enable us to implement ambitious change in the scale and scope of services to close any potential funding gap. Our BCF plan is our first significant step to embed fully integrated care for the whole health and social care system in Barnet.

We have taken a conservative approach to financial modelling, which provides a solid baseline on which to expand initiatives and increase the scope of future projects. This will enable us to identify and realise additional benefits going forward and to factor in the impact of other local or national changes that will influence our model for integration, e.g. the Care Act.

There has also been significant change in the local provider landscape following implementation of the Barnet, Enfield & Haringey Clinical Strategy. This has created shifts in capacity and demand throughout the local system that continues to have knock-on impacts. Some implications are clearly visible and are being managed e.g. demand pressures on community beds, whilst others continue to emerge. Until the local health economy settles down following this change it will be difficult to gain a true understanding of the new baseline for Barnet. Similarly, the recent acquisition of **Barnet & Chase Farm hospital by the Royal Free NHS Foundation Trust** has changed operational practice and subsequent service demand models. The impact of this is only just starting to be manifested in the system but is likely to impact over the next 12 months and beyond.

The population cohort most likely to represent a pressure on the system is growing. The population of Barnet is expected to increase by nearly 5% over the next 5 years (an increase of 17,308), **with disproportionate growth in both the young and old cohorts**. The effects of an ageing population will become most acute, with the over-65 population forecast to grow by 10.4% over the next 5 years and 24% over the next decade, placing increased pressure on social services and health budgets.

Barnet will have one of the largest increases in elderly residents out of all the London boroughs over the next five to ten years. There are currently 52,000 people in Barnet over the age of 65, and this will increase to 59,800 by 2020. We also have more than 100 care homes in the borough, disproportionately high compared to other London boroughs. Barnet's Health and Wellbeing Strategy 2012 to 2015 (October 2012) sets out our ambition to make Barnet '*a place in which all people can age well*'. The challenge is to make this a reality in the context of such rising demand and need for rising health and social care among older people, and ongoing and resulting financial pressures facing the NHS and Council.

Table 5 overleaf shows that segmentation of the Barnet population identifies that £95.5m per annum is spent on 21,900 people aged 70 or over with one or more long-term conditions or dementia. In addition £114.3m is spent on 46,600 adults with one or more long-term conditions. There are today more than 1,600 people over 65 with long-term conditions or physical frailty receiving community based care services in their home through Adult Social Care.

These figures form a natural starting point for identifying and defining specific cohorts of people in our community around which we are developing the integrated care model.

Our approach for determining the scope of the first schemes of work detailed in Annex 1 was to refine these cohorts as our target users for the services, using risk stratification. This gave us a specific view of the number and profile of those most at risk of an unplanned admission to hospital.

This approach confirmed the three main cohorts for the Plan as detailed below. Section 7d[i] sets out in more detail our approach to risk stratification and how it might evolve in line with future opportunities for detailed, parallel segmentation of the population to identify the need for new services.

Source: McKinsey Integrated Care Model

Table 5 – Population Segmentation For Barnet Population 2012 – 2013

Closing current variations in primary care and improving performance represents a significant opportunity for Barnet. Benchmarking shows that Barnet currently performs poorly against peers in terms of experience of and access to primary care:

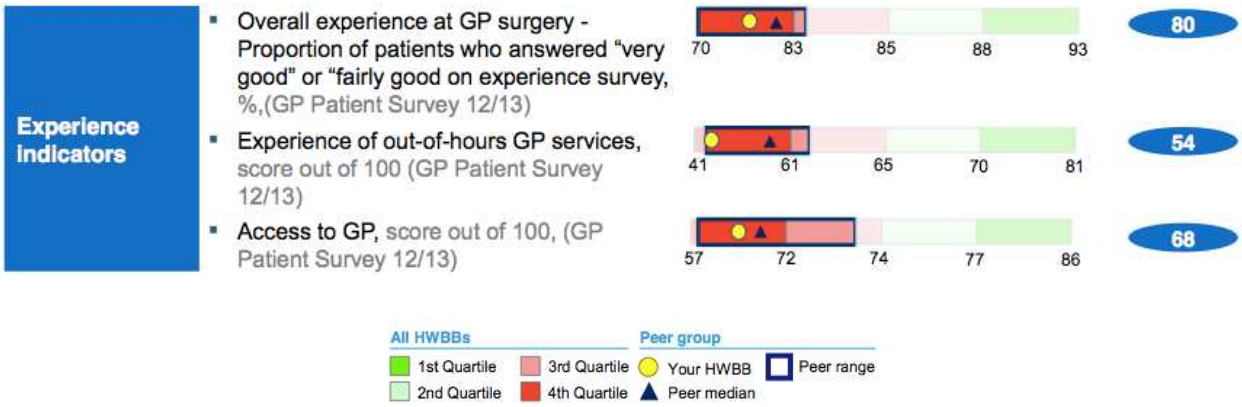


Table 6 – Access to and Experience of Primary Care: Barnet Performance Relative to Other Local Areas 2012 – 2013

In addition there is a **wide variation across the borough's GP practices in terms of non-elective admissions performance** as can be seen below. Closing these gaps represents a strong opportunity to meet challenging NEL reduction targets:

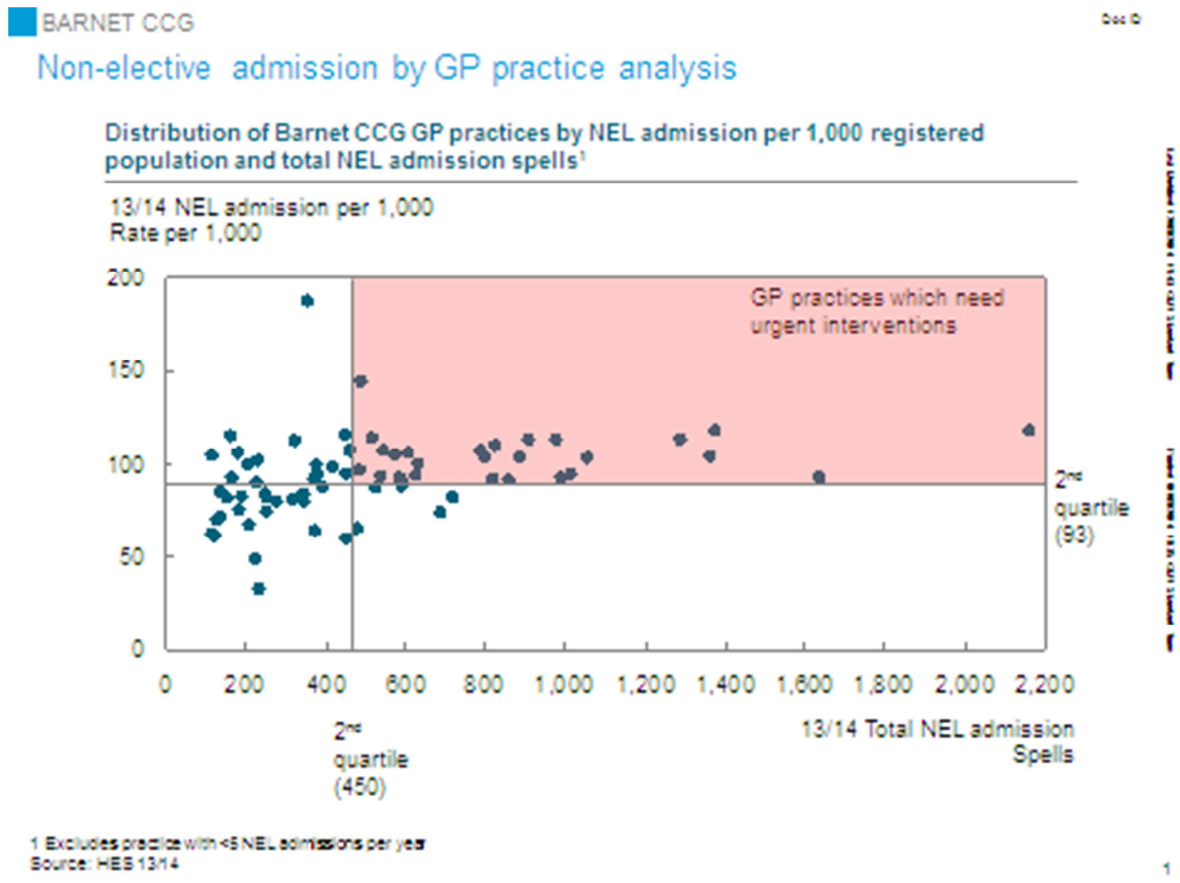


Diagram 5 – BCCG NEL Admissions By GP Practice 2013 – 2014

There are further opportunities to improve BCF metrics and to improve outcomes.

Barnet has made progress in reducing non-elective admissions over recent years with a 2.2% decrease between 2009/10 and 2013/14. This has been reinforced in the BCF Health and Wellbeing Board (HWB) Fact Pack and baseline data. It states that "Barnet performs significantly better than peers and most of England on non-elective admission rates and that activity growth is significantly better than peers and top quartile for England as a whole".

Non-elective performance	Non-elective hospital admission rate per 1,000 population (MAR 13/14)	193	109	95	84	60

Table 7 – Barnet NEL Admission Rate per 1,000 Population 2013 – 2014

While this is encouraging, it should be noted that the reduction is not consistent and reflects unusual trends in provider activity for specific periods in 2013/14. We therefore need to be cautious in our assumptions on how this reduction can be sustained and increased going forward.

When considering benchmarking and target setting, it can be noted that the BCF HWB Fact Pack identified a limited opportunity for reducing non-elective admissions for Barnet compared to ONS and peer group data, which put Barnet non-elective activity in the top decile (all HWB). However, international scientific evidence and case examples for fully

operational best-practice integrated care suggests that full delivery of the four key components of integrated care outlined in Table 8 below could impact as a reduction of up to 37% in hospitalisations. Taking into account population growth and current performance, it is suggested that this represents a potential opportunity for Barnet of a **10 - 19% reduction in non-elective admissions over 3 to 5 years**.

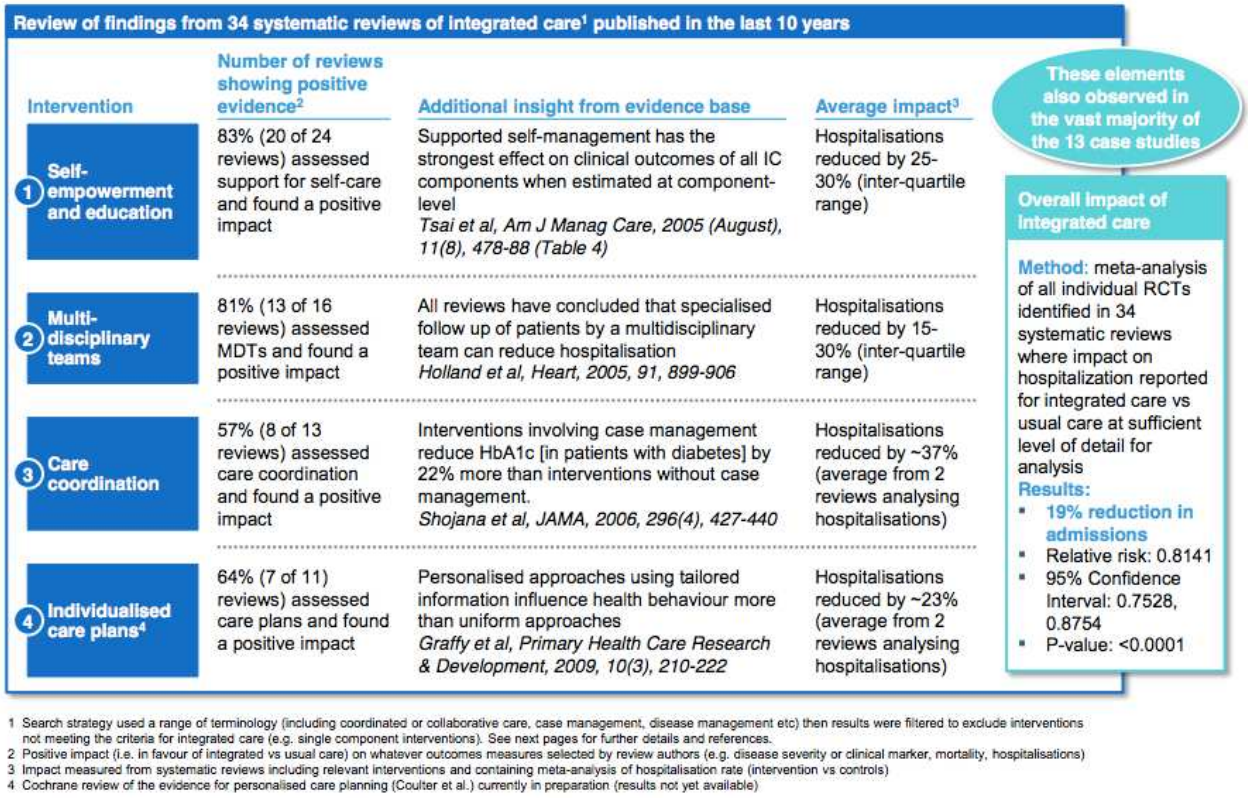


Table 8 – Review of Best Practice Integrated Care Systems 2004 - 2014

Compared to peers Barnet has the scope to improve **delayed transfers of care** to move into the top quartile (all HWB); and to increase the proportion of elderly people aged 65 or over who were still at home 91 days after discharge from hospital into **rehabilitation** or **reablement** services:

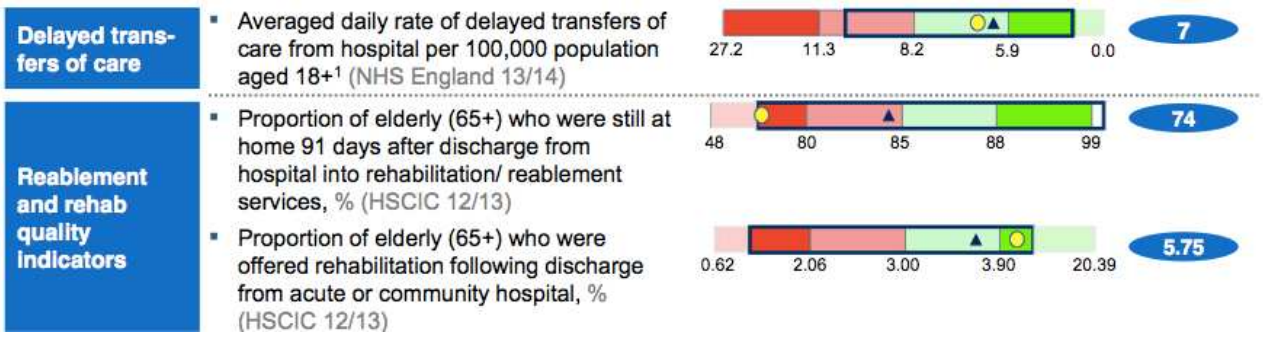


Table 9 – Barnet DTOC and Reablement Performance 2012 - 2014

It is recognised locally that the resource in the current system is not sufficiently weighted towards key services to achieve this. Of the total £133m resource envelope over 61% is

spent on acute and residential care services. Less than 3% is currently spent on self-management and health and wellbeing services, with the remainder spent in the other two tiers.

The BCF provides an opportunity to target investment in a more holistic, integrated model and accelerate the process of whole system reconfiguration.

Barnet will address the challenges set out in this case for change by moving to an integrated care model, investing in lower level, preventative and community based support, through shifting the balance of care and activity over time from hospital and longer term residential care. It will focus on the following groups of people:

1. **Frail elderly people:** people aged 65 or over who suffer from at least three of the 19 recognised Ambulatory Care Sensitive (ACS) conditions.
2. **People with long-term conditions**: those aged 55 to 65 with one or more long-term conditions.
3. People living with **Dementia**.

The target for the BCF pay for performance element is set at 3.5% (equivalent to 1,025 less non-elective admissions) in 2015 to 16. This supports a longer term plan to deliver a continued downward trend in non-elective admissions at a controlled and sustainable pace as indicated in the 5 year strategic plans.

There remains a focus on initiatives that are designed to support people to remain as independent as possible, for as long as possible; meeting statutory social care needs whilst still delivering the efficiencies required by LBB. This includes a requirement to ensure that more people can stay in their own homes with the support of enablement services and a reduction in their need for statutory care services.

Our Health and Social Care Integration (HSCI) Programme will continue as planned and through the extensive capacity and demand modelling we will re-assess how we can deliver fully on this trajectory. We also understand that there is still work to do particularly in relation to improving the patient experience to primary care and access to a GP that will directly impact on successful delivery of the Programme.

We have planned our BCF to deliver the model within limited financial resources. Given the funding allocations of BCCG and LBB, there may a requirement for additional investment into Barnet to deliver the maximum benefit from the model identified.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

A phased approach is being taken to service development over the next 5 years. The core services are those that we will be re-designing for integration, investing and re-allocating resources as necessary. These include residential care, community healthcare, homecare, and self-management or preventative services.

The accelerated programme of work will create efficiencies and financial benefits for health and social care through a reduction in non-elective admissions and length of stay for the frail and elderly population. It will achieve a step change in care delivery over a period of 2 to 5 years, leading to fewer crises, and more planned care for the frail elderly, encompassing a number of services now designated under the BCF scheme of work.

The key milestones are outlined below:

Tiers	Progress to date	2014/15	2015/16
Overall	Full Business Case approved and further validated in the context of separate modelling to support BCCG QIPP and the payment for performance element of the BCF. BCCG has analysed in detail its current and planned spend on non-elective admissions. Development of the programme of work and PMO function Governance arrangements in place	Develop Business Case to support integrated care model and strategic approach to future commissioning /contracting for approval Co-design detailed operational delivery models including phasing of delivery, funding streams, future capacity and workforce requirements. Determine outcome measures and regular monitoring mechanism with assurance Test current governance arrangements for BCF particularly in relation to agreement and monitoring of risks and benefits Agree shared PMO arrangements to support delivery programme Develop a communications strategy, including a mechanism to capture user views to effectively feed in user perspective to inform progress and continued improvement.	Test outputs of current service delivery and scope further plans Fully functional benefits tracking and financial monitoring model in place Implement communications strategy Establish and monitor financial flows to and from the pooled budget including those contributed from parties outside health and social care Develop feedback mechanism to interested parties to promote success and share learning.
1	Expert Patient Programmes planned for Autumn 2014 Telehealth pilot underway as part of Rapid Care Project Engagement with range of stakeholders including voluntary sector in development of tier specification	Deliver project plans in line with tier specifications: priority focus on self-management, e.g. defined roles of health champions and long-term condition Mentors; and healthy living pharmacy Design and deliver carers support programmes Design and implement structured education offer Pilot programmes for Telecare and Telehealth	Deliver project plans in line with tier specifications: priority focus on self-management Mainstream programmes for Telecare and Telehealth if appropriate
2	Ageing Well project operational in 3 areas	Implement early phase plan: Ageing Well	Develop an evaluation model to support development of a local

	Clear links established between HSCI/BCF Programme and public health Carers service re-design being taken forward in the context of the BCF	Design Health education package for carers Design preventative services and develop the market/ strategic partnerships in voluntary and commercial sectors to deliver. Link into Public Health team initiatives (e.g. NHS Healthchecks, healthy eating and physical activity promotions, smoking cessation) Link into "universal offer" to older people through preventative services Link into LBB carer support services	evidence base to support future commissioning Unified branding for prevention tier Use learning from care pathways re-design for Stroke, Dementia and Falls to scope, design and extend wider Tier 2 – 4 end-to-end services, in line with work programme.
3	Community Point of Access (CPA) opened April 2014 Risk Stratification Tool live in all GP Practices.	Phased roll out of Community Point of Access. Embed use of the risk stratification model as the default method for design and delivery of services for targeted cohorts, in stages by level of risk. Develop early phase plan: Shared Care Record (Business Case to be signed off)	Develop a single assessment process, using findings from the Risk Stratification Tool and other projects. Incorporate service re-design projects: dementia and end of life pathways. Implementation of the Shared Care Record
4	Integrated locality Teams trail-blazer team mobilised in August 2014 The Care Navigation Service (CNS) and Multi-Disciplinary Team (MDTs) case conferences started in July 2013. Expanded Rapid Care service in August 2013, now available 7a.m to 10p.m 7 days a week	Implement and monitor early phase plan: Rapid Care Finalise the design and delivery model of borough wide Integrated Locality Teams. Extend the scale and operations of Multi Disciplinary Teams, including assessment of higher risk individuals and planned co-ordination of care. Implement Care Homes LIS for GPs and monitor outcomes.	Rapid Care pathway development linked to PACE. TREAT and other front door services in acute settings. Embed Integrated Locality Team model expanding across service areas as required Explore role of existing Older Peoples Assessment Unit (OPAU) to offer increased clinical capacity and expertise. Develop Enablement, Intermediate and Respite Care offer to meet need.

Table 10 – Milestones for Integrating Health and Social Care Services in Barnet

Interdependencies and existing programme alignment:

- Establishment of aligned budgets for BCCG, LBB and other parties, e.g. public health, into our integrated care model to influence delivery of the BCF.
- At a North Central London (NCL) CCG level, the establishment of Integrated Provider Units (IPUs) and value based commissioning.
- Integration with new and re-designed LBB systems and services designed to meet the requirements of the Care Act, including LBB first point of contact and assessment services, information and advice offer, enablement services and new, upgraded case management and other ICT systems.
- Link into further development of 'Integrated Quality in Care Homes' team to improve standards of care and co-ordination between health professionals and care homes, especially with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes.

b) Please articulate the overarching governance arrangements for integrated care locally

Diagram 6 below illustrates the governance and board structure for the Health and Social Care Integration (HSCI) Programme.

Initial governance arrangements were put in place in April 2013. This included gateway review and approval processes for projects and work, project and programme reporting, roles and responsibilities, the Programme Management Office (PMO), risk, change and issue management processes, information governance (IG) and terms of reference.

Governance structures have been regularly reviewed as the programme has evolved and this will continue as required. The current governance and board structure is below.

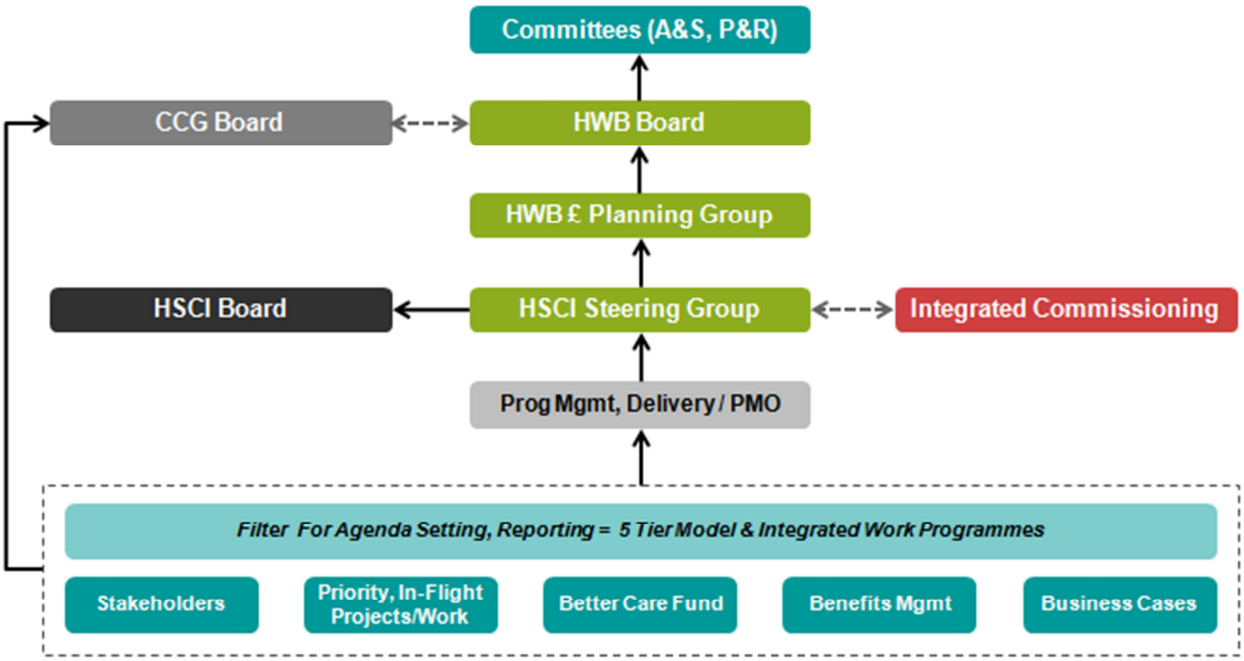


Diagram 6 – Barnet HSCI/BCF Governance Arrangements 2014

The LBB Director of Adults & Communities and BCCG Chief Operating Officer act as joint sponsors for BCF. The LBB Assistant Director of Adults & Communities and BCCG Director of Integrated Commissioning act as joint Programme Directors and Project or Tier Sponsors.

Each tier has a dedicated lead and subject matter expert. Each project has a project manager and prioritised work plan, aligned to Programme aims and objectives and agreed benefits and outcomes. Tier leads work in partnership to define strategies for delivering end-to-end services.

All Programme and project work uses approved programme and project management methodologies. Work is grouped and delivered in tranches based on priority (e.g. by its contribution to desired benefits or outcomes and how achievable the work is against other competing demands for resources).

We will deliver and manage work and define, validate and track the realisation of desired benefits using our programme, project and benefits management methodologies and tools.

This will enable an objective and independent scrutiny and assurance of work done, with scheduled reporting and reviews to monitor outputs and to retain tight management and financial control of Programme spend and delivery.

Proposed new projects must have a viable Business Case that clearly states the strategic fit to the BCF, and financial and non-financial benefits of putting in place the changes described.

The Programme Board (Steering Group) will consider the Business Case and approve or reject it against agreed evaluation criteria, e.g. whether it meets the vision, aims and objectives of the 5 tier model, meets one of the six core BCF target benefits and outcomes, improves on the quality of services and commissioning for outcomes, or meets commercial criteria such as lower costs (i.e. reduced duplication or acute activity). If accepted the Programme will deliver the project, tracking progress and outputs against similar quality assurance criteria.

The Health and Wellbeing Board (HWB) Finance Group, a formal sub-committee of our HWB, is responsible for setting and controlling expenditure for budgets for Better Care Fund and for wider work to integrate care services, e.g. with Public Health to deliver services for Tier 1 of our integrated care model. The HWB Finance Group also monitors progress in delivering BCF services and tracking benefits realisation against these budgets, reporting back to HWB accordingly.

LBB and BCCG already have a Section 75 Agreement for integrated care in place. This started in August 2013, for an initial three year period. The agreement will be extended beyond this date by both parties to support the long-term delivery of BCF and integrated care services.

Our S75 Agreement states the aims of both parties and our statutory responsibilities for integrated care. It also contains baseline arrangements for creating and managing pooled budgets, including the role and responsibilities of the nominated Lead Party and annual accounting, auditing and reporting cycles.

We have already aligned our Section 256 and some social care and community contract budgets to design and deliver the integrated services described in this BCF plan, e.g. Integrated Locality Care Teams and Rapid Response and stroke support services.

We are now working to formalise these arrangements under a pooled budget as required for BCF. We have set up a Working Group, containing executive or lead representatives from our finance, governance and legal functions to develop and implement the pooled budget, e.g. scope and level of contributions and how this is reviewed and increased over time, risk and reward share arrangements (see Section 5b below) and operational requirements, e.g. the timing of and information required for accounting and reporting cycles.

We have already agreed a number of core principles. For example, the pool will start with the £23.4m BCF fund and increase over time to include core LBB and BCCG budgets for

relevant care services. Until these budgets are transferred into the pool, we will manage them on an open book basis. The Pool will be reviewed every year in September, to define the pooled budget for the following financial year.

Work is ongoing with meetings set through December and early January, to finalise the draft arrangements as a Schedule to the S75 Agreement. This includes confirming the Lead Party and testing scenarios for annual contributions to the Pool and tolerances for managing risk and reward sharing (see Section 5b below).

Final approval of the detailed principles and arrangements for the Pool will be an agenda item for HWB, BCCG and LBB Adults & Safeguarding Committee (A&SC) meetings scheduled from January to March 2015. This is in line with advice from NHS England to sign the pooled budget and risk and reward share arrangements once our BCF Plan is approved. Our intention is to implement the pooled budget from April 2015 subject to the BCF plan receiving full approval.

A copy of our latest work plan for establishing the Pool is below.

HSCI BCF Pooled Budget Work Plan MS

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

A programme approach is in place to support planning and delivery of the Health and Social Care Integration (HSCI) Programme and BCF Schemes of work. The figure below illustrates the current and proposed scope:

Projects comprise a defined change (output) for one or more tiers, e.g. the Shared Care Record to implement a new IT system for sharing information about the care people receive, or a suite of defined changes by theme or condition, e.g. Stroke, to deliver end-to-end integrated services.

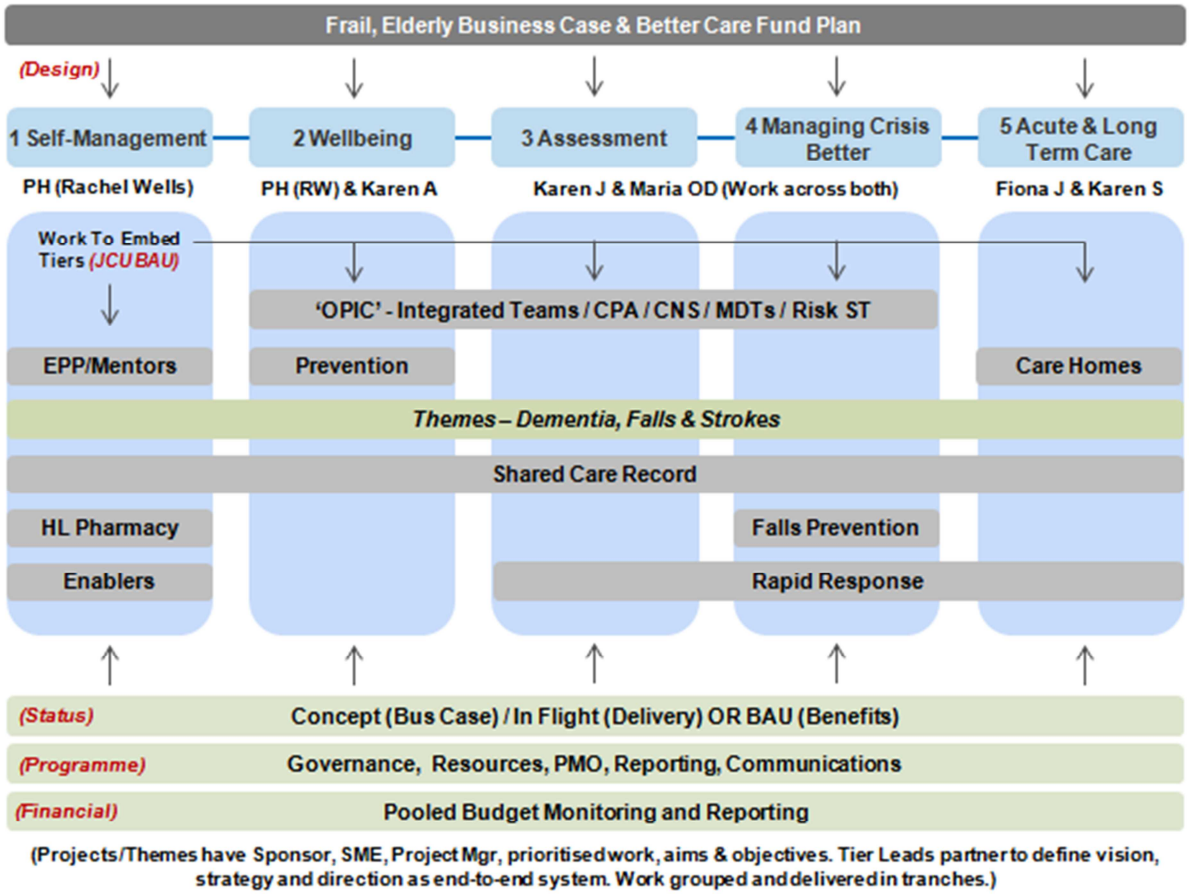


Diagram 7 – Barnet HSCI/BCF Programme Scope and Structure 2014

A Programme Management Office (PMO) will coordinate and manage Programme work and operations. This will include governance, administration, project/work delivery and reporting, benefits realisation, documentation, information control and communications and engagement with stakeholders. Governance will complement wider arrangements in place as appropriate, e.g. where decision making is to be escalated to or made directly by HWB.

As indicated above the HSCI Steering Group oversees operational implementation of the BCF. It meets monthly and has terms of reference set to flex meet the emerging needs of this BCF plan. Members include BCCG and LBB director level roles, Joint Commissioning staff, tier leads, finance and PMO.

A key role of this group will be to monitor delivery including early identification of risks and issues. If plans go off track, project leads will be expected to work with the PMO to assess the scale of any problem and to develop a remedial plan, where necessary, to re-align service delivery. If the project requires a revised approach this will be managed via a formal change request agreed with the PMO and the operational group. Direct linkages with the over-arching governance structure through senior management will facilitate this mechanism as required.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Tier 1 & 2. Self-management and prevention a. Expert Patient Programme & Long-Term Condition Mentors
2	Tier 3 & 4. Assessment & Care Planning a. Long-term conditions (dementia, stroke, falls and palliative care) b. Older People Integrated Care (OPIC) c. Care Homes
3	Tier 4. Community Intensive Support a. Rapid Care b. Seven Day Working
4	Enablers a. Service enablers b. Administrative enablers

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
3.5% reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance	4	4	16	• Routine monitoring of activity shifts and remedial action as required • Continued analysis of interdependencies to fully understand impact and consequences • Regular updates to management teams • Governance arrangements to include risk and benefits share
Shifting resources to fund new joint interventions and schemes could de-stabilise current service providers and create financial and operational pressures.	2	2	4	• Impact assessment of integrated care model to allow for greater understanding of the wider impact across the health economy • Ongoing stakeholder engagement including co-design and transitional planning with providers • Ongoing review of impact
The recent acquisition of Barnet and Chase Farm hospital by Royal Free and subsequent change in the NHS provider landscape could impact the implementation of BCF services	2	3	6	• Provider engagement • Robust commissioning plans with contingency arrangements
Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda	4	3	12	• Increased focus on workforce development and organisational development with all providers • Front line/ clinical staff engagement and input in developing integrated care model and plans • Communications strategy with staff across the system • Incentivise provider to develop workforce models
The capacity within commissioning and provider organisations to deliver changes is limited and prevents progress	3	3	9	• Develop the Business Case to include resource to deliver the BCF plan. This could include BCCG and LBB initialisation resources to support delivery and implementation of schemes/work streams.
The baseline data used to inform financial model is incorrect and thus the performance and financial targets are unrealistic/unachievable	4	3	12	• Validation of assumptions and savings target with respective finance departments • Close monitoring and contingency planning • Define any detailed mapping and consolidation of opportunities and costs

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				to validate plans. • Develop strong patient and service user engagement plans to ensure current information so as to flex and tailor plans to meet needs
Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years	5	2	10	• Assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative • Use 2014/15 to test and refine assumptions with a focus on developing more financially robust Business Cases.
The local authority's financial position is challenging and significant savings from all service areas are needed to deliver cost savings and realise benefits within the planned timeline	4	3	12	• Managed and phased approach to spend and save model • Robust governance in place to support risk and benefits share • Clear identification and monitoring of saving opportunities • BCF could be the catalyst to savings in other areas of LBB spending, i.e. Adult Social Care.
The Care Act will increase costs from April 2015 and again from April 2016 resulting in increased cost pressures to local authorities and CCGs	4	4	16	• Undertake an initial impact assessment with a view to refining assumptions. • Explore and develop opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. • Define the impact of the Care Act and the potential pressures on LBB and BCCG budgets as a result. • Ensure appropriate utilisation of allocated funds within BCF to meet need
An underlying deficit in the health economy impacts on service delivery and/or investment	4	4	16	• Develop a managed and phased approach to spend and save model • Ensure robust governance is in place to support risk and benefits share
Social care is not adequately protected due to increased pressure impacting the delivery of services	4	3	12	• Work with partners on developing plan for protection of services
Resources cannot be shifted from the acute sector due to members of the public presenting themselves to A&E directly or requiring emergency admissions (through pressures in other parts of the health economy) resulting in no overall shift in numbers	4	4	16	• Engage with colleagues in adjust HWB to determine their strategic changes and how it will impact Barnet • Discussions with key stakeholders including acute sector, social care community care, etc. to explore linkages and why shift is not taking place • Invest in re-educating public on use of acute sector. • Public communications strategy,

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
				including targeting primary care settings
Population characteristics and demographics adversely impact on deliverability of the model (e.g. population growth and continued net importation of over 75s into care homes from other areas)	3	3	9	• Focus on high impact project to target populations • Factor growth into planning assumptions and monitor trends
Differing discharge arrangements between Barnet and surrounding Trusts means patients receive and inconsistent service	2	2	4	• Stakeholder engagement with surrounding Trusts and GP networks • Consider working with neighbouring trusts to develop common discharge plans in line with borough specifications • MDT to monitor eligibility for services and ensure appropriate referrals
Acceptability of 7 day services impacting on integrated care model	2	2	4	• Stakeholder engagement on 7 day working • Cross system sharing of good practice

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of targets related to reducing in non-elective emergency admissions. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care and will manifest itself as cost pressures within organisations and potential reduced services.

Section 4b above details our plans for establishing a pooled budget to manage the funds allocated for BCF and the corresponding risk and reward share arrangements to deal with the issues.

The amount of BCF pooled funding at risk is £2,054,100. This equates to 3.5% reduction in non-elective admissions and has been calculated with the support of informatics and finance using agreed methodologies. It builds on existing BCCG QIPP plans, particularly related to Integrated Care and Ambulatory care and reflects a 2 year plan (2014 - 16) with increasing ambition for 15 - 16. It also builds on our Business Case for Integration included here in Section 1c above. We have recently modelled 2015 – 16 following the recognised Newham/Tower Hamlets methodology.

Tables 11 and 12 overleaf list our BCF schemes that directly support achievement of this target for the next two years. They include the total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget and their contribution to the target. The savings are based on a £2,004 average unit cost per admission used in our Business Case for Integration (included in Section 1c above) and our financial model in Part 2 (spreadsheet) of our Plan.

The estimated reduction in non-elective admissions (NEL) in Tables 11 and 12 reflects the figures in Tab 4, HWB Benefits Plan of Part 2 of this submission, covering two full years (eight quarters) from 1 April 2014 to 31 March 2016. More details of each Scheme are included in Annex 1. This includes the:

- Impact of schemes on reducing nursing and residential care home admissions, improving reablement effectiveness and reducing delayed transfers of care.
- Evidence base and assumptions used to analyse the costs and benefits and their specific contribution to our target benefit and outcome measures detailed in Part 2 of this submission.

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*35,000 (Not BCF pool)*	n/a	23	46,092	3.62
3, 4	2	Assessment & Care Planning a. Long-term conditions	267,357	4.03	15	30,060	2.36
		b. Older People Integrated Care	1,057,451	15.94	155	310,620	24.41
		c. Care Home – LCS	231,000	3.49	29	58,116	4.57
4	3	Community Intensive Support a. Rapid Care	636,171	9.59	413	827,652	65.04
		b. 7 Day Social Work & Enablement	300,000	4.52			
All	4	Enablers a. Services	862,021	12.99			
		b. Administrative	3,280,000	49.44			
		Total:	**6,634,000 (BCF Pool)**	**100**	**635**	**1,272,540**	**100**

Table 11 – Cost and Impact of Schemes on NEL Admissions April 2014 – March 2015

Tier	Sch Ref no.	Scheme	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	Saving (£)	% Change NEL Adm.
1, 2	1	Self-management and prevention a. Expert Patient Programme & long-term condition Mentors	*87,120 (Not BCF pool)*	n/a	119	238,476	11.66
3, 4	2	Assessment & Care Planning a. Long-term conditions	2,722,921	11.63	110	220,440	10.77
		b. Older People Integrated Care	1,292,026	5.53	331	663,324	32.42
		c. Care Home – LCS	1,146,000	4.89	10	20,040	0.98
4	3	Community Intensive Support a. Rapid Care	1,316,464	5.62	451	903,804	44.17
		b. 7 Day Social Work & Enablement	300,000	1.28			
All	4	Enablers a. Services	10,636,589	45.43			
		b. Administrative	5,998,000	25.62			
		Total:	**23,412,000 (BCF Pool)**	**100**	**1,021**	**2,046,084**	**100**

Table 12 – Cost and Impact of Schemes on NEL Admissions April 2015 – March 2016

Part of the ongoing strategic approach to establishing the BCF pooled budget will be to ensure sustainability in the key services that will deliver the target for NEL that we require. This will involve continual monitoring and review of all services being funded under these arrangements linked to robust commissioning decisions based on evidence.

Outline priority investments are already agreed for 2015/16 and mobilisation plans will reflect availability of funding. This is supported by demand and capacity modelling in the Full Business Case. The risk of not-achieving targets will be mitigated where possible through contractual arrangements and we will work closely with providers to deliver in line with expectations. Where appropriate, contingencies to mitigate any at risk BCF funding (arising from non- or below target achievement of the NEL target) will be identified from the pool itself or other organisational funds. This could include the use of pooled budget under spend, other reserves or re-prioritisation of forward spend. BCCG and LBB corporate risk registers already reflect the risks, aims, and scope of the BCF.

Section 4b above describes our approach and work plan for our HWB and HWB Finance Group to establish a pooled budget to manage all the funds allocated for BCF and the corresponding risk and reward sharing arrangements.

Our work to finalise the pooled budget includes developing detailed arrangements for the proportion of contributions as a basis for sharing risk and reward and mechanisms to deal with:

- The impact on the Pool as a result of receiving only part of the 'at risk' funding of £2,054,000 for reducing non-elective admissions and how to offset any loss in funding, e.g. through establishing contingency funds, increasing contributions or adjusting the scope and benefits of the Pool accordingly.
- Varying the level and proportion of contributions each year, depending on policy direction, any changes to income and our agreed priorities for the future development and delivery of integrated care against Pool performance and benefits realised.
- Potential overspend and under spend of budgets and how future contributions or the level of risk and reward taken on by each Party is adjusted to reflect this and return the Pool to the level required to deliver the benefits identified.

Our Section 75 Agreement provides baseline arrangements for decision making and the risk share approach for the Pool. We will develop more detailed arrangements for HWB, BCCG and LBB Council approval for the end of March 2015 as described in Section 4b above.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

BCF is integral the delivery of our integrated care model. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future. The Better Care Fund is also aligned to the following initiatives and is a critical element of both BCCG and LBB longer term strategic plans (CCG 2 and 5 year plan; LBB Medium Term Financial Strategy 2015/16 and Priorities and Spending Review (PSR) 2016 - 2020:

Initiative	Dependency
Clinical service re-design particularly in relation to urgent care and long-term conditions pathways	• An enabler to shifting settings of care and improving integration between care settings
Changes to social care statutory responsibilities and service delivery. For example, increased Care Act duties and the re-modelling of the 'first contact for social care of LBB to increase the capacity to manage demand	• Demand manage new statutory responsibilities of LBB • Impact on BCF metrics and spend • New flow of users resulting in change of legislation
System-wide operations resilience planning and delivery	• Impact on non-elective activity • Manage seasonal demand and surges in line with BCF strategy • Cross-system stakeholder understand of issues and solutions
Acute service reconfiguration particularly the continuing implications of the Barnet, Enfield & Haringey Clinical Strategy and the recent acquisition of Barnet & Chase Farm Hospital by the Royal Free NHS Trust	• Impact on non-elective activity • New flow of patients resulting in shifts in capacity and demand throughout the local system • Other implications such as demand pressures on community beds
Refresh of the Joint Strategic Needs Assessment	• Identification of new demand for services in future and alignment of our plans to meet this need
Value based commissioning approach	• Identification and exploration of alternative contracting models
HSCI Full Business Case	• Critical enablers for demand and capacity modelling for delivery and future investment • Corporate sponsorship of HSCI/BCF Programme of work

The dependencies and alignment of these related initiatives will be managed through HWB and the HSCI Board and the governance arrangements described in Section 4.

Local interest in the BCF is high and as plans develop in related areas consideration will be given to how best to strategically link where necessary. This is anticipated over the next few months in relation to user engagement/ voluntary sector services and telecare. Additional work is required to align plans with Housing strategy.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF vision for delivering integrated care aligns fully with **BCCG 2 year operating plans and 5 year strategic plans**. They are built around the same **vision** for services with over-arching values and a set of **strategic goals**:

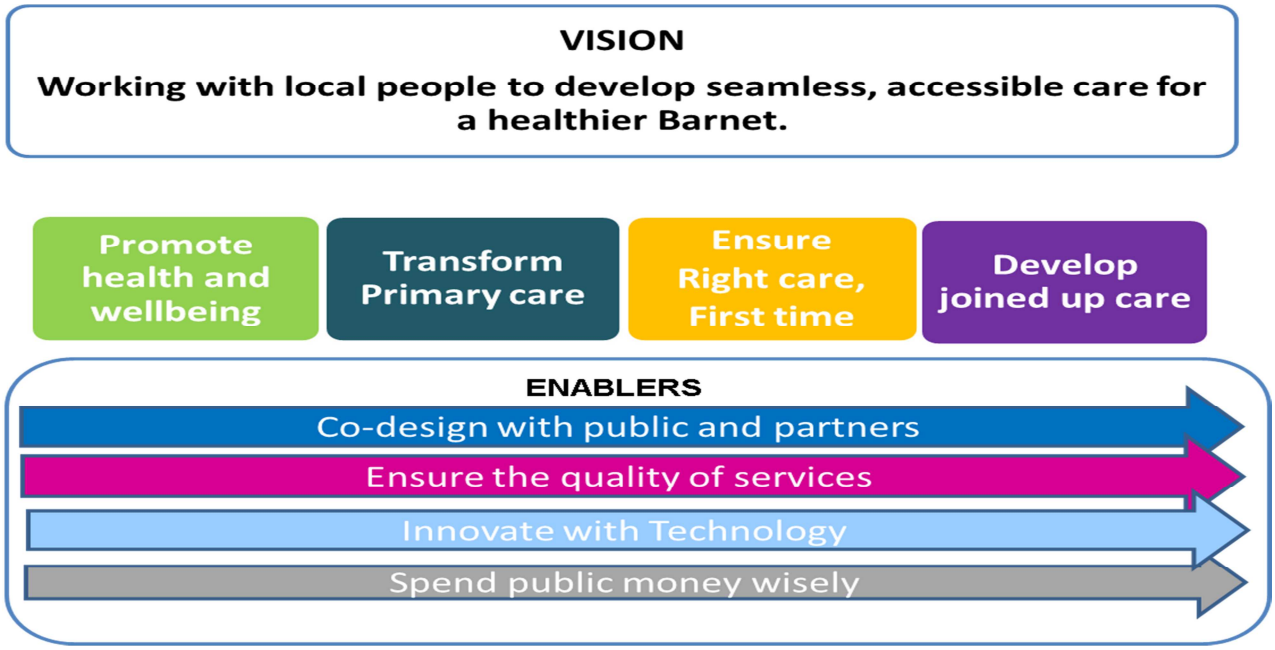


Diagram 8 – BCCG Vision for Barnet and Better Care Fund

These strategic goals set the direction of travel for BCCG whilst providing a framework, which is flexible enough to encompass new local and national priorities. They also focus on the organisational development that needs to take place to engage our stakeholders, strengthen our governance and financial management to deliver our challenging agenda. Our delivery of BCF lies in the 'Joined Up Care' Strategic Transformation Programme and encompasses a key set of priorities for 2015/16 focussed on:

- Implementation of our 5 tier integrated care model by maximising our existing resources including the Better Care Fund.
- Roll out of Multi-disciplinary teams across Primary Care.
- Roll out of Risk Stratification Tool to support Primary Care.
- Partnership working with Voluntary and Community based organisations.
- Improve care in the community for over 75 with complex needs.

The Barnet Council Local Vision is set out in its Business Planning framework for 2015/16 to 2019/20 (LBB Policy & Resources Committee, 02/12/14), specifically the LBB Corporate Plan and the Adults & Safeguarding Committee (A&SC) Commissioning Plan 2015 – 2020 which encompasses our Better Care Fund plan.

The LBB Corporate Plan contains 3 core principles – Fairness, Responsibility and Opportunity – all of which are embedded in the A&SC Commissioning Plan. This outlines how LBB will manage the key changes required by the Care Act and BCF at a time of rising demand, increased expectations and shrinking resources. The commissioning intentions support the overall vision of the Council that:

"All adults will be given the opportunity to live well, age well and stay well. This means that all adults will feel safe and be safe in their environment. Financial constraints should not hinder the delivery of good outcomes for all but to achieve this Barnet's community will need to continue to play an important part, creating responsive and responsible neighbourhoods and communities in which vulnerable adults can live well and with personal autonomy, meeting principles of fairness through a targeting of resources on those that need it most. In order to support our growing and ageing population we will need a stronger focus on prevention and early intervention with a reshaped specialist care offer for those that need it".

The proposals for implementing the 5 tier integrated care model align with the Local Vision of both BCCG and LBB. Both demonstrate a commitment to work in partnership on:

- **Alternative ways to deliver services in partnership with residents and other organisations** – for example, integrating care and health services where this delivers the best outcomes; and stronger integration with customer services and public health to help people better self-manage and plan to age well.
- **Implementing the Care Act** – for example, improved advice and advocacy and information services with a greater availability of helpful information to support ageing well.
- **Going further with personalisation by developing creative approaches to meeting care needs** – for example a shift from specialist segregated services to community settings; support to remain at home for longer and greater use of direct payments and personalised health budgets.
- **Focus on efficiency, effectiveness and impact** – for example, through the integration of services explore alternative delivery models for health and adult social care to maximise BCCG and LBB's chance of mitigating the impacts of rising demand, increasing expectations and shrinking resources.

The BCF plan is crucial in supporting the delivery of the long-term strategic, operating and financial plans for the health and social care economy through the re-design of core services to develop a sustainable local care model.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

As a member of the North Central London (NCL) CCG group, BCCG has submitted an expression of interest for primary co-commissioning to NHS England. After NHS England confirmed receipt the NCL CCG group met the NHSE NCL Area team Assistant Head of Primary Care and are pursuing further development of the plan.

The plans for the development of primary care complement the BCF plan by:

- Recognising and supporting the critical link with general practice in delivering integrated care, designing and delivering services around patients and service users.
- Enhancing the ability to commission integrated services along whole pathways, supporting in particular Tiers 3 and 4.
- Providing a platform for innovation, improvement and investment in primary care, particularly in the development of GP networks.
- Focussing on improving prevention of illness and the prevention of morbidity (or delay in onset) in clients with long-term conditions, through improving the level and range of preventative interventions within health and social care, and improving support for self-management by clients will be delivered in primary care settings.
- Developing and supporting services that deliver on the BCF metrics such as the specific local service specification for GP practices to support improved care within care homes.
- Feeding in programmes of work linked to delivery of the London Primary Care Strategic Commissioning Framework (formerly the London GP Development Standards) relating to delivering within primary care: accessible care – better access to routine and urgent care from primary care professionals, at a time convenient and with a professional of choice; coordinated care – greater continuity of care between NHS and social care services, named clinicians, and more time with patients who need it; Proactive care – more health prevention by working in partnerships with other health and social care service providers to reduce morbidity, premature mortality, health inequalities.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) **Protecting social care services**
i) Please outline your agreed local definition of protecting adult social care services (not spending)

In Barnet, protecting social care services means:

- Maintaining current FACs eligibility of substantial and critical for adult social care, and enabling the authority to meet new national eligibility criteria from April 2015.
- Ensuring that additional demand for Social Care Services which supports the delivery of the integrated care model and which delivers whole system benefits and savings will be funded.

It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds. LBB and BCCG agree to plan and review on an annual basis the allocation of the BCF to these priorities.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care.

The BCF includes identified funds to support the implementation of new statutory requirements contained within the Care Act. The Barnet BCF allocation includes specific funding to cover aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers. Whilst this funding will not cover all the demands arising from the Act, it will be used as part of our local work to ensure that we are prepared for the implementation of the Act in April 2015.

There is a clear synergy between better access, improved care planning and community support for frail older people contained within our BCF integrated care model and the enhanced duties on local authorities in relation to supporting people to plan how to meet their care needs early on through enhanced advice, information and prevention. Barnet has a Care Act preparation programme in place and the dependencies between this and the BCF plan are being scoped.

The principles for protecting local social care services will be delivered through:

- Strategic direction for BCF to take into account existing and future commissioning plans of BCCG and LBB and to have due regard to the Joint Strategic Needs Assessment (JSNA).
- An agreed shared governance framework for spend and management of the BCF with membership from health and social care. To include an approval process for services with appropriate input from relevant parties. Oversight and governance provide by HWB.

- Services delivered through a jointly owned integrated care model with emphasis on maintaining people with health and social care needs in the community. Modelling to measure impact upon and reflect changes in demand to social care services e.g. enablement with a view to maintaining or increasing where necessary.
- Maintaining and developing services for carers.
- Maintaining current FACs eligibility of substantial and critical, and through meeting needs of national eligibility criteria from April 2015.
- Where possible move to joint commissioning of services via an agreed framework e.g. care home beds, enablement.
- Working with LBB and providers to manage demand to ensure optimal usage of social care service provision.
- Embed social care services within integrated delivery models to flex operational efficiencies and build services with greatest impact on people utilising the most appropriate care choice. Example would be delivery of enablement services through locality based integrated care teams.
- Ensuring that additional demands for social care attributable to increased out of hospital healthcare are considered for funding as part of the pooled budgets.
- By ensuring that personalisation and self-directed support continue in integrated arrangements through selecting this as our local performance indicator.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total set aside for the protection of social care is £4,141,357.

In addition we have identified a further £846,000 which represents Barnet's proportion of the £135m for the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Barnet has a clear and mutually agreed definition on what constitutes "protecting adult social care services". It is recognised that the priorities for spending against the BCF are likely to be greater than the available BCF funds, in the context of on-going austerity in the public sector and demographic change. However, to date the plans delivered and the work between health and social care support this approach.

Barnet has a Care Act Implementation Project Board which oversees work relating to the national and local requirements and to assess the impact of the Care Act reforms on Adult Social Care services in Barnet. The implementation of our 5 tier integrated care model will underpin LBB's ability to fulfil its statutory responsibilities, in particular in relation to prevention, assessment, care planning and carers.

The work of the Project Board is focused on seven work streams, each with a dedicated lead manager and implementation plan, as follows:

1. **Demand Analysis and Modelling:** delivering a picture of what the total impact of the Care Act on LBB's finance and resources will be;
2. **Prevention, Information and Advice:** refreshing and updating prevention, information and advice initiatives and catalogues;
3. **Carers:** ensuring that LBB carer's services comply with Care Act regulations;
4. **First Contact, Eligibility, Assessment and Support Planning:** ensuring readiness for national eligibility criteria, developing and implementing new approaches to assessment and support planning, ensuring sufficient capacity and effective risk mitigation arising from the likely increased take up of assessment due to the funding reforms and creating a first contact service that is able to manage demand efficiently and effectively and enable costs to be reduced;
5. **Finance:** delivering a universal deferred payment offering and making any necessary changes to charging and debt collection processes.
6. **Marketplace:** updating existing and developing new policies and processes related to market shaping and provider failure;
7. **Communications, Workforce Development and Governance:** developing and delivering internal and external communications related to the Care Act, delivering a comprehensive workforce development plan and staff training to prepare the social care workforce and co-ordinating public consultation and corporate decision making

v) Please specify the level of resource that will be dedicated to carer-specific support

The level of resource associated with carer-specific support in the BCF is:

Carers breaks	£846,000
Carers services (S256)	£300,000
Total	£1,146,000

Our integrated care model includes other elements of carer support in addition to the above funding. For example, the dementia cafes and the dementia advisor provide support to carers. However, for the purposes of this section, only funding that provides **support to carers alone** has been included in the table.

Carers are critically important in Barnet. The borough has over 32,000 carers with over 6000 providing over 50 hours of care a week. This is the second highest number of carers in the London region. As part of the modelling work for Care Act Implementation (see Section 7a[iv]) Barnet has estimated that the financial cost for carrying out additional carers assessments (including the cost of related support) would cost a projected £962k - £1.44m, against a backdrop of a financial challenge for BCCG and LBB.

Our priorities for carers are:

- Early recognition and support for carers
- Information and advice offer for carers
- Supporting carers to fulfil their employment potential
- Carers as expert partners in care

We are developing a suite of performance and monitoring tools and reports to improve our infrastructure, capacity to track contracts and performance activity in Adult Social Care and key partners relating specifically to carers. This will help us deliver improved insight and analysis about what works best, highlight risks, and inform how we optimise allocation of our BCF resources going forward.

We have reviewed our Carers Strategy Partnership Board arrangements strengthening the carer's voice in service development and commissioning, and we plan to further strengthen the role of health here working closely with the Joint Commissioning Unit.

All of the above work is coordinated through a project dedicated to Carers as part of the Care Act Implementation Project Board (see Section 7a[iv]). It highlights dependencies too, which include HSCI and Family Services (Children and Families Act requirements around young carers and transition).

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Overall the impact has not changed significantly compared to original submission (the Barnet BCF allocation includes approximately £1.206m to cover some aspects of the increased demand relating to new eligibility regulations and new duties in relation to safeguarding, wellbeing, prevention and carers).

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We have already made reasonable progress to establish 7 day working in Barnet but we recognise the need to enhance further the scope and reach of services already in place.

We have engaged with a variety of stakeholders to get agreement and commitment to seven day service delivery particularly during the design phase of our integrated care model through:

- Co-design working sessions for integrated care in 2013/14. These sessions included patients, LBB, GPs and Acute and Community Service providers as outlined in Section 8.
- NCL wide sessions to share development plans, ideas and best practice

We are working towards implementing the national standards for 7 day services in urgent and emergency care within the next three years. Our intention is to develop a programme across three years to embed seven day services into core contracts for services and the intention is for all of the clinical standards to be incorporated into the national quality requirements section of the NHS Standard Contract for Barnet's provider services.

High level delivery plan associated with the move to 7 day services:

Priority action	**Milestone**
Acute services	
Extension of hours of tracker nurse provision to support identification of those who could be discharged	Nov 13
Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID to extend over 7 days.	Ongoing
Operational resilience plans agreed to test some 7 day delivery. Outputs to be evaluated to inform future planning. Examples include occupational therapy and access to pharmacy.	Awaiting plan sign off
Undertake action in service development and improvement plan identifies 7 day working to assess current position and develop forward plan for delivery for national seven day standards	2014/15 onwards
Community & Primary Care services	
Extension of 7 day provision of core community services to 7 days – district nursing, intermediate care and Rapid Care. To include night sitting where required	Nov 13
Links established between services above and current providers of seven day services (e.g. out of hours GPs and London Ambulance Service (LAS))	May 14
Barnet Community Point of Access is operational providing an effective and safe referral point to facilitate access to rapid response/nursing teams over 7 days.	April 14

Refresh of current alternative care pathways with LAS to facilitate avoided admissions.	Ongoing
Social Care	
Social work and Occupational Therapy teams operational 7 days per week within A&E departments at both main Acute hospitals to support care planning for transfer home	Jan 14
Access to new and amended packages of care throughout the weekend	Jan 14
Other	
Ongoing managed system for Delayed Transfers of Care involving all providers facilitating and unblocking reasons for delay and allowing for transfer throughout the 7 days period.	Ongoing
A communication strategy with over-arching view of the services available and to stream-line referrals and transitions across interfaces.	tbc

Table 13 – Barnet Milestones for the Roll Out of 7 Day Working

Collectively, this delivery plan will result in:

- A consistency of service delivery over 7 days that will even out pressure points and lead to reduced non-elective admissions including at weekends
- More integrated approach to individual care with clear pathways from assessment to care planning and delivery
- Increased discharges over the weekend with confidence of appropriate support

The key risk associated with delivery of 7 day services will be implementation of the clinical standards for 7 day services by acute providers, acceptability amongst staff and population demographics related to acuity.

c) **Data sharing**
i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Locally we recognise the importance of joint working across all health and social care services. The NHS Number will be used as the primary identifier for integrated case management, data exchange and care reviews. It is already used as the unique identifier for most NHS organisations across Barnet.

Social Care includes the NHS Number with some client records; however, this is not currently required for all client information. Adult Social Care is in the process of procuring a new case management system, which will be implemented by April 2015 and will result in the recording of the NHS Number for all social care clients from this point forwards.

To further support this integrated care, we are implementing the Barnet Shared Care Record. This project, which has been agreed and approved by HWB and overseen by the Health and Social Care Steering Group will be a key enabler for sharing information between care providers:

- The Barnet Shared Care Record Project will first implement the service in 2015.
- It will not replace local systems, but will provide a single view of an individual's care by combining information from all the care providers in the Barnet area.
- It will use the NHS Number as the unique identifier to combine data about individuals and data submitted to the Shared Care Record must use it this way.
- Initial data providers have been identified as those that will already have the NHS Number included in their records (e.g. GP Records, Community Health).
- Change in business processes will reinforce the use of the NHS Number as the primary method for identifying individuals alongside the roll out of the Shared Care Record in early 2015.

Following initial roll out of the service, the project will work to increase the data in the Shared Care Record and to improve the process of sharing. The project plan outlines an approach to work with these care organisations during 2015/16 to where the NHS Number is not currently in use to undertake the preparatory work required to move to routine use of the NHS number as the primary identifier in the process of information sharing.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The use of Open Standards and Open APIs is a principle that is adopted and built in to the procurement of any new system (e.g. the recent Adult Social Care procurement of a new case management system includes the requirement to use Open APIs and Open Standards (e.g. ITK) both in the mechanisms used to connect to local systems and the method for interfacing with external systems).

Requirements also include the adoption of common formats for information/data (e.g. CDA). From a technical perspective a system that securely uses Open Standards and/or Interfaces will be prioritised over an identical system that does not.

Where existing systems are required to be enhanced or changed specifications always include the use of Open Standards and non-bespoke development whenever possible. Where new development is required (e.g. new messaging interfaces) LBB will always seek to publish these and have them approved.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

LBB / BCCG operate within an established information governance (IG) framework, including compliance with IG Toolkit requirements and the seven principles in Caldicott 2.

The contract documents used by BCCG to commission clinical services conform to the NHS standard contract requirements for IG and IG Toolkit Requirement 132.

BCCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies.

IG arrangements and the IG Framework conform to IG Toolkit requirements in Version 11 of the Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

In addition to maintaining a current PSN Code of Connection, LBB is working towards compliance with the latest NHS IGT V12 which will be completed by the start of 2015. All new projects / business process changes complete an IG Impact Assessment prior to initial approval and activity is routinely reported to Information Management and Governance Groups.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

For the target cohorts of people listed in Section 3, risk stratification has given us a specific view of the proportion, number, profile and characteristics of those people most at risk of unplanned admissions to hospital.

This approach has identified 1,975 adults in the highest risk cohort and 17,463 adults in the next. The data also indicates that PbR costs associated with people in classification levels 2 and 3 are £85m, representing approximately 52.4% of total spend.

The latest view of the level of risk for the BCCG population is as follows:

Risk Level	Population Percentile	Number of Patients	Risk Ratio Range	Ave Risk Ratio	Average In Patient Admission (planned same day care)	Average Unplanned In Patient Admission	Average Unplanned Chronic In Patient Admission
3	0% to 0.5%	1,975	25.925- 40.226	32.230	11.51	3.99	2.77
2	> 0.5% to 5%	17,463	4.785- 25.914	10.216	2.03	0.77	0.36
1	> 5% to 25%	77,463	0.783- 7.785	1.806	0.34	0.09	0.02
0	> 25% to 100%	297,226	0.05- 0.783	0.304	0.08	0.01	0.00
Total Population		394,127		1.198	0.274	0.105	0.044

Table 14 – Risk Classifications for the Barnet Population December 2014

This underpins the scope of services offered in Tiers 3 and 4 which in turn is the basis for partnering with GPs to proactively engage with these people to offer the services.

Approach

BCCG uses a recognised risk stratification tool and in August 2014 we completed an accelerated programme to implement the tool in GP practices and train practices to use it. All GP Practices now have and use the tool to identify patients at risk of a future unplanned hospitalisation within the next 12 months due to chronic conditions. It predicts future health risk based on recent patient activity using predictive models. The following data sets are used to determine the relative risk of patients within a given population:

- Primary Care (GP Registry, GP Medication and GP Activity Data) and
- Secondary Care (SUS PbR/SEM datasets including in-patient, out-patient and A&E activities)

The data links to the Kaiser Long-term Conditions triangle by classifying patients into 3 levels and then assigns the RISC level of a patient following a scoring process:

Total Population Level	RISC % Range	RISC % of total population	LTC Triangle population (top 26% of total PCT Population)	LTC Triangle % of total population
3	0% to 1/2%	1/2%	5%	1.3%
2	>1/2% to 5%	4-1/2%	15%	3.9%
1	>5% to 25%	20%	80%	20.8%
0	>25% to 100%	75%	Not Included in LTC Triangle	74%

Table 15 – Barnet Risk Stratification Tool Classifications

The following diagram shows which elements for the Schemes described in Section 2 above are designed for and impact on each risk category (grouping):

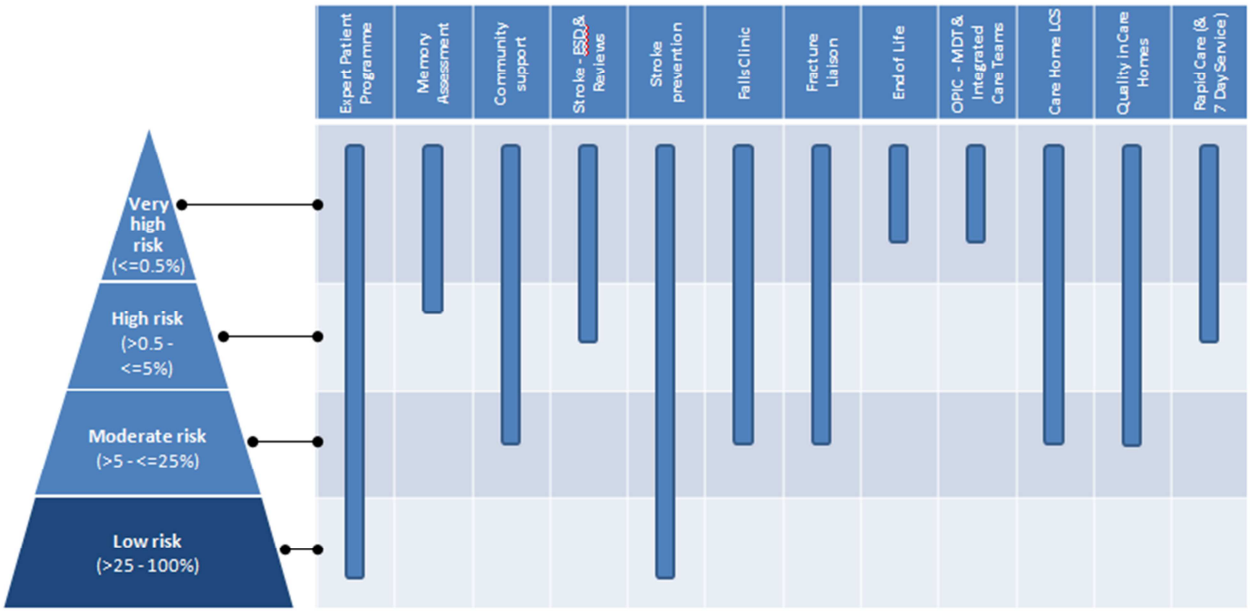
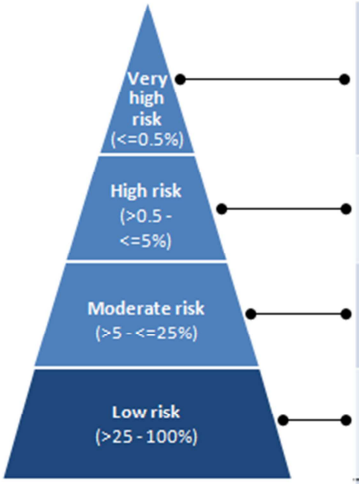


Diagram 9 – Risk Classifications Targeted By BCF Scheme Elements

For the population cohorts (by risk level) listed above the following table details the costs of the schemes and their impact on reducing non-elective admissions for each initiative:



	Pop (All)	Pop (65+)	NEL Adm (65+)	Cost (£m)	Scheme	Cost (£m) *	NEL Adm Impact	% NEL Target
Very high risk (<=0.5%)	1,975	1,617	4,045	21.75	2b 2c 3a	2.34 1.37 1.95	9 4 87	0.54 0.24 5.25
High risk (>0.5 - <=5%)	17,463	13,718	3,292	42.58	2a 2b 2c 3a	2.99 2.34 1.37 1.95	23 88 35 779	1.39 5.32 2.11 47.04
Moderate risk (>5 - <=25%)	77,463	36,010	104	11.05	1 2a 2b	0.19 2.99 2.34	112 100 389	6.76 6.04 23.50
Low risk (>25 - 100%)	297,226	745	0	8.60	1	0.19	30	1.81
Total:	**394,127**	**52,090**	**7,441**	**83.98**	**n/a**	**8.84 ****	**1,654**	**100**

* Total cost of project over two years, shown for reference purposes only. Schemes 3b, 4 do not contribute direct benefits in reduced admissions and so are not included.
** Total cost of individual schemes 1, 2a to c and 3a, not the total of the individual costs listed.

Diagram 10 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

Our approach to using risk stratification to implement this first tranche of our integrated care model will include:

- Supporting GP practices to use the tool regularly to inform care planning and case management in line with the GP Admissions avoidance DES from NHS England as part of the GMS contract for 2014/15.
- Embedding use of the tool as a partnership approach with the Integrated Locality Teams to put in place a framework for integrated joint assessments and the role of the accountable lead professional.
- To link risk stratification to current service provision, and where necessary, re-align to target those patients identified through the risk stratification model to maximise clinical and financial impact.
- Agreeing an approach for risk stratification in future to ensure continuity.

Over the longer-term, we will work with all stakeholders to assess opportunities to move to commissioning of services through risk stratification or detailed segmentation of the population. We expect our BCF plans to evolve as implementation continues and we are able to measure the impact of changes made.

At the same time the technology and breadth, depth of data used in risk stratification will continue to evolve, increasing the value of the insights provided.

As a result risk stratification may be better utilised for niche cohorts or the planning and the delivery of individual scheme elements, working together with parallel segmentation techniques. Or segmentation may emerge as the best approach for Barnet overall.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

A number of existing and planned models will ensure that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Key elements include:

- Use of risk stratification in primary care (as above) to identify those most at risk of admission to ensure that they are actively case managed.
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- A care navigation service that provides a care co-ordination role following MDT assessment.
- Admissions avoidance DES as per GP contracts for 2014/15 where new responsibilities for the management of complex health and care needs for those who may be at high risk of unplanned admission to hospital have been introduced. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.
- Planned introduction of Integrated Locality Teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long-term condition approach which will enable early identification and care planning for future management of exacerbations.
- An enhanced GP service focussed on care homes to provide a much more holistic management approach to supporting homes to reduce admissions.

Barnet has an agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. To date this has been a paper-based approach operated on a small scale led by the MDT. It has fed directly from risk stratification that was, until recently, being undertaken manually by GP.

With the roll-out of the risk stratification tool and the introduction of the Integrated Locality Team trailblazer during the summer of 2014 we have an increased ability to target those most at risk of admission and so see a shift in approach and activity.

A key principle of using the bottom-up build operational model is to provide the freedom and the permission for partners, including GP practices, to work together to develop and agree a robust framework for joint assessment and care planning.

To remove potential barriers to success we have focussed the work around the needs of the patient and, in particular, are advocating an outcomes based approach to make the benefits tangible to those delivering care. We have also created an environment that supports innovation and ownership of the model with the commissioner only providing

high level outlines of requirements to allow for innovation and advocating a hands off commissioner position to allow for problem solving and planning by the teams themselves. Development of a risk and issues log will identify clearly the possible barriers to implementation of the model on a longer term or wider basis that can then be addressed as part of ongoing implementation. It is intended that this work taken forward will include:

- Working directly with GP practices to assess risk stratification data together to determine how best to prioritise the numbers of people who need care planning and case management to address those most at need and high climbers (those with a significant change in risk score over a short period of time).
- Agreeing an ongoing outcomes-based mechanism to allocating of accountable lead professional across a range of providers and clinicians. This is envisaged as the single contact point for the patient and other professionals in relation to the ongoing care plan for an individual. They may not be fully responsible for the delivery of all care to that patient but will have an overview of what the care plan encompasses, what next steps may be required for the patients and can support timely decision making.
- Developing a fit for purpose joint assessment framework that can be utilised and is accepted across the system.
- Developing and introducing a standard care plan.
- Assessing and evaluating the inter-dependency between the team and the Admissions Avoidance DES to ensure that GPs are supported in being accountable for co-ordinating patient centred care.
- Identify any gaps in service, including evaluating whether current systems accommodate to the needs of those with dementia and mental health problems adequately.
- Active consideration and challenge to crossing boundaries of care to reduce the numbers of people working directly with the patients and to explore possible opportunities and efficiencies.
- Evaluating the need for keeping a ‘watching brief’ approach for a proportion of the population.
- Outlining how often patients should have their care plan re-evaluated and hence could move within the framework.

Utilisation of an exemplar framework as overleaf may be beneficial.

	Requires Care Plan?	Joint assessment	Active Management & accountable lead professional (ALP)
Very High Risk	Yes – Plan may include action points to be picked up by community, social or specialist services.	Yes for some.	Yes for some. ALP agreed as part of assessment and care planning. May be allocated via MDT approach across GP, community services, social or specialist services
High Risk	Possibly – particularly for 'high climbers' with identified significant change in risk score	Possibly high climbers	Possibly high climbers. ALP – generally GP with some managed under MDT
Medium Risk	Not generally	No	No ALP - GP
Low risk	Not required. Patient may benefit from information via navigation services	No	No ALP - GP

Table 16 – Cost and Impact of BCF Scheme Elements for Barnet by Risk Level

The pilot team will work with 7 GP practices in one locality. This will be followed by a planned roll out across the area over the next year.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

From July 2013 to July 2014 233 people were managed via the MDT and all had a jointly agreed care plan. These figures are expected to increase as detailed above.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A range of individuals and organisations have been involved in developing the constituent services within the BCF plan, and the over-arching plan itself, making patient and service user views integral to the Vision for Integrated Care in Barnet.

The patient engagement and service user groups we approached to shape our vision were **Healthwatch Barnet, Barnet Older Adults Partnership Board** (a resident and service user engagement group)**, Barnet Older Adults Assembly** (a large user and carer forum), **Age UK (Barnet), Alzheimer's Society** and others.

We also drew on experiences and feedback gained at **Council** and **BCCG public engagement** events and in broader project-based consultation exercises such as **Guiding Wisdom for Older People**.

Our care model incorporates universal preventative and self-management services, such as the **Barnet Ageing Well** project. This initiative was developed in response to needs identified by the community.

The **integrated care model** was developed from feedback from local residents. Ongoing involvement and oversight by the co-chair of the Older Adults Partnership Board keep the strategy grounded and progressive.

We have not only used requirements feedback from engagement groups to inform strategy but also used groups to test the practical implementation of that model. Workshops were held with Older Adults Partnership Board members, Older Adults Assembly meetings and public forums. These were facilitated by Healthwatch, and enriched with interviews and surveys.

Feedback from patients and service users was key in helping us develop our vision in particular:

- Meeting the changing needs of the people.
- Allowing for greater choice on where and how care is provided.
- Promoting individual health and wellbeing to be managed by that person.
- Listening to and acting upon the views of residents and providers to improve patient experience and care.

Further under-pinning this, and picking up the work of National Voices, BCCG is participating in a **value-based outcomes commissioning programme** with other NCL CCGs. Patient and service users have been involved from the outset through multi-disciplinary workshops to develop an agreed outcomes hierarchy and as part of expert reference groups to test and validate the findings. The continuing work with Camden CCG, focussing on frail and elderly populations, will equip health commissioners to change the way in which they do business to achieve patient-centred goals.

Continued patient, service user, carer and public engagement are essential to bring momentum to the implementation of the **integrated care model.** Moving forward, we will continue to use the existing **Older Adults Partnership Board** framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and the voluntary sector. We will develop an engagement strategy with this forum at the core that will allow us to ensure in-depth engagement, and involvement in planning and monitoring, from residents as we implement the model. This will include:

- Tier specific workshops.
- Engagement with experience panel or reference groups, the Barnet Seniors' Assembly, a group of over 150 older local residents supported by LBB.
- Engagement with other partnership boards, e.g. carers.
- Membership of relevant steering groups.
- Links with other organisations communications strategies e.g. BCCG and Age UK.
- Engagement with voluntary sector and existing services (e.g. Neighbourhood model) to engage hard to reach communities.
- Co-production approaches to new specifications.

External scrutiny has been given to the over-arching plans for Integrated Care through presentation at BCCG public board meetings and through an elected member scrutiny exercise at LBB Council.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Key NHS partners include **Royal Free NHS Foundation Trust** (following the recent merger with Barnet & Chase Farm NHS Trust), **Barnet, Enfield and Haringey Mental Health Trust**, our community health services provider, **Central London Community Healthcare NHS Trust**, hospices and **London Ambulance Service**.

Our BCF plan has its foundations in the **Barnet Health and Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners.

The concordat was co-designed by the partner members of the **Health and Social Care Integration Board (HSCIB)**. It provides the over-arching strategy for delivery endorsed fully by service provider recognition and support. The integrated care model has been formally supported by providers as above as key members of the HSCIB and is embedded within organisational plans.

The plan brings together work in progress in individual organisations (health, social care and voluntary sector), joint work being undertaken through the work programme of the HSCIB and emerging priorities as identified in a newly developed 5 tier integrated care model co-produced with partners.

For key schemes already underway, such as Older People Integrated Care and Rapid Care, service providers are active participants in existing frameworks and work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery. We have taken this further with development of locality based integrated care teams (July 2014) through a bottom-up build approach via a shared trail-blazer team.

Service provider involvement in the integrated care model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This continues with providers being actively involved in developing the plans for implementation including acting as tier sponsors in relevant areas. A key development has been the establishment of the bi-weekly Barnet Integrated Care Strategy steering group. This is co-chaired by the sponsors for tiers 3 and 4 and encompasses projects being delivered in tiers 3 to 5. It provides the forum to influence operational delivery and explore the implications of the BCF, in detail, beyond the high level principles and financial models that are embedded within existing operational plans.

Our **Clinical Commissioning Programme for Integrated Care** gives us a joint forum for commissioners and providers. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With HSCIB running alongside, our plan embeds service provider engagement at both operational and strategic levels.

ii) Primary care providers

The primary care infrastructure in Barnet includes 67 GP practices, our out-of-hours provider Barndoc and 77 community pharmacies. GP practices are structured in localities with designated BCCG Board member and management leads. In additional to practices operating individually we are seeing an increasing shift towards network development resulting in increased service delivery on this basis. This will be explored further in terms of a future delivery model.

GPs were involved in the development of our 5 tier integrated care model with a number providing input and challenge to the OBC process. These included BCCG Board member GPs and others with a specific interest in older adults. We also value the support of GP clinical leads to provide expertise and clinical advice in relation to service re-design and operational plans.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC. There is an ongoing programme of communications and engagement underway with events targeting the Integrated Locality Teams and the introduction of the Care Homes Locally Commissioned Service. GP leads have been identified for key services to ensure that their views are integral to operational standards and fit for purpose.

We recognise that extensive engagement is essential to implement integrated care and will develop a primary care facing plan on a broader basis over the next few months.

iii) Social care and providers from the voluntary and community sector

Current plans have been jointly developed with anticipated delivery largely expected through Joint Commissioning.

Strong working partnerships exist between commissioners and provider side teams within LBB (e.g. social work) with sponsorship of key projects and with an established co-production approach. This is now most visibly seen within the bottom-up build Integrated Locality team where a number of staff are central to leading the change management process. In terms of service re-design they are active stakeholders in informing direction of travel and providing feedback on suitability.

The ongoing work has also supported a facilitative approach to building key stakeholder partnerships across the system, particularly between social care and community services, and collectively we are now working collaboratively to understand respective organisational perspectives, concerns and issues. By fostering joint ownership of the model and centring the work on the needs of Barnet patients and service users we aim to adopt a shared approach to innovation and problem solving.

Other key partners have been in included in developing integrated health and social care services, such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK and the Alzheimer's Society and British red Cross). There is very much a growing interest in this area from partners and we are harnessing the energy, enthusiasm and skill by inclusion in steering groups and experts by experience panels as appropriate.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Our main acute provider is now Royal Free NHS Foundation Trust working through 2 key sites in Hampstead and Barnet. Extensive re-configuration of local infrastructure and service provision has recently be completed with changes to the Chase Farm hospital site, as outlined in the Barnet, Enfield & Haringey Clinical Strategy, and the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital. This has resulted in shifts in demand and activity through 2013/14 which will impact for this year and beyond.

The ongoing financial position of BCCG is well known by acute partners including a recognition that extensive service re-design and a robust QIPP programme is required to deliver a stable system in financial balance. Therefore we have a very strong focus on:

- Transformational change of the health system by providing integrated care for patients with complex needs as defined in this plan. With proactive identification, care planning and integrated management of care for such patients we will seek

to avert crises, thus reducing the unplanned use of acute care;
- Reducing elective acute care through the robust management of referrals and the re-design of care pathways to provide upstream early intervention, a greater range of care in primary care settings and community based alternative care.

Relationships with providers of acute services are proactive and constructive and they actively demonstrate support for our over-arching strategy behind BCF and its aims.

The current BCCG QIPP plans for Integrated Care (2014/16) represented savings of approximately £3.1m as outlined in contract negotiations and agreed plans. The revised BCF guidance (July 2014) requires greater ambition in terms of movement of costs and services away from acute, primarily in the form of emergency admissions, and hence the savings methodology and projections for the second year of this plan have been scaled up. It has also used information from the 'Appropriate Place of Care Audit' and the modelling associated with the full Business Case to understand the numbers of non-elective patients who are receiving care in an inappropriate location, and the capacity and demand limits of current provision.

Revised savings equate to 1,025 less non-elective admissions in 2015 to 16 with a relative estimated impact on the acute sector as outlined in Table 17 below. This reflects the 3.5% ambition in line with the BCF but should be noted as being a significant challenge in light of the wider financial, demographic and environmental issues in Barnet. The numbers below are based on a different costing model to above (as derived from BCF guidance) and simply represent indicative workings that require further validation.

	Estimated Activity Reduction 15/16	Estimated impact at £2,004 (amended to reflect local cost with MFF)
Royal Free (Barnet site)	656	1,314,626
Royal Free (Hampstead site)	307	616,230
Other	62	123,244
Total	**1025**	**2,054,100**

Table 17 – Estimated Impact of BCF Plan on Acute Service Providers 2015 to 2016

With current BCCG contractual arrangements funding will follow the patient, therefore any additional acute activity resulting from non-delivery of the target will be reimbursed in accordance with agreed tariffs. This will mitigate the risk somewhat for providers although it is recognised that deviation from plan could create operational issues. Current systems will continue in terms of demand management and urgent planning and these will directly support reductions in emergency admissions and capacity and surge management.

ANNEX 1 – Detailed Scheme Descriptions

Scheme ref no.
1a.
Scheme name
Expert Patient Programme
Scheme description
Pilot scheme and roll out of generic and disease-specific Expert Patient Programmes – organised by individuals who have existing long-term conditions.
What is the strategic objective of this scheme?
The objectives of this scheme are to: • Empower patients to self-care and manage their condition. • Optimise individual patient's health status. • Increase knowledge, understanding of long-term conditions and lifestyle/behavioural influences. • Improve the patient's experience, and • Mitigate for unnecessary A&E attendances and unplanned hospital admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will enable community social care professionals (health and primary care) to refer older people who have just been diagnosed with a long-term condition, into the Expert Patient Programme. The scheme will be organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, these trainers will have the ability to signpost the patient to other local support services such as long-term conditions Mentors. The primary objectives of the projects in this tier are to up-skill people and improve health literacy. This will make individuals with long-term conditions more confident about looking after their health. Structured patient education programmes based on specific long-term conditions will also be introduced alongside the generic Expert Patient Programme. The content and structure of these courses will be determined by a systematic review of needs evidence and service piloting results. The outcome of this analysis will highlight which course subjects will have the biggest impact on particular cohorts within Barnet. It is envisioned that the disease specific pilots will focus on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression. The generic and disease specific programmes will be launched (staggered) as follows: • Pilot of generic programme: January 2015 • Pilot of disease specific programme: April 2015 Evaluation of the various pilots will help to determine an optimum programme for Barnet's residents. The generic programme, the disease-specific programme, or a combination of both will be rolled out to up to 5% of the eligible population of older people with long-term conditions should the pilots prove to be successful (currently 1,975 older people with long-term conditions).
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project lead: Steve Buck/Lisa Jacob Project plan in place to deliver phase 1 from January 2015. This will be provided by **SM:UK** and will be delivered through 3 cohorts of 16 people each based in community venues in each of the 3 localities.

Phase 1 is being sponsored by Public Health and commissioned in partnership. The initial programme is partly funded on the basis of a successful BCCG bid last year and identified Public Health sitting alongside the core BCF pool. Costs will therefore be excluded from the part 2 submission.

Plans for April 2015 are in development and we are currently exploring links with existing structured education programmes in Barnet. Current plans make provision for roll out to 240 people in 2014/15.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Research into the success of expert patient programmes has produced mixed results. For example, a number of papers have suggested that further analysis and a review of comparator schemes is necessary before the full effectiveness of such programmes can be gauged. However, despite some criticism, there exists a general consensus that these programmes reduce both costs and service utilisation e.g. GP's.

Background paper on the Expert Patient Programme for NICE Expert Testimony (A. Rogers) – This expert paper reviews the effectiveness of this Expert Patient Programme launched by the Department of Health in 2001. Although the results are very mixed, it is reported that there was a moderate increase in self-efficacy amongst the patients who joined the programme. In addition, overnight hospital stays reduced across the target cohort, and there was an overall reduction in service utilisation. These factors are likely to offset the costs of intervention, making the programme a cost effective alternative to usual care for long-term conditions. To summarise, the paper states that any expert patient programme should be able to meet a wide range of needs for patients with long-term conditions, rather than focusing on one course.

In addition, the HWB Fund Fact Pack highlights the importance of self-empowerment and education to a successful integrated care system. Significantly, the average impact of support for self care was estimated at 25 - 30% reduction in hospitalisation (impact measured from systematic reviews).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment – the costs of the projects for 2014-15 are estimated at £122,120. However this currently sits outside the proposed main BCF pooled budget and so is not included in Part 2 of this submission.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

The evidence base suggests that savings of between £452 (DoH) and £987 (SM:UK) can be expected per person with respect to reduced admissions. Using these assumptions the impact is estimated at 142 (23 + 119) reduced non-elective admissions over the BCF period as indicated above.

Key assumptions in the financial model:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Roll out of programme to 5% of population aged over 65 with long-term conditions over 5 years. Cohort size for 2015-16 is 240 people
- Benefit based on £987 saving per person risk adjusted to reflect:
    - 95% attendance rate - based on national data and local knowledge of Barnet residents
    - Time lag in benefit gain

To ensure the Expert Patient Programme is fulfilling its primary objectives, we have planned for an evaluation of the first cohort. This will assess local impact/programme outcomes and will be measured against key success criteria and performance indicators. It is intended that the results of this review will inform future commissioning. As a result we may need to re-plan the level and timing for realising the

benefits identified in this plan
Assumed Benefit Map – Expert Patient Programme:

Benefits Map 1 - Expert Patient Progra

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use "Benefit Cards", an important control document containing all the information for all agreed benefits for each scheme, which enables us to monitor and measure the delivery of scheme outcomes and benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Clear programme of structure education linked to benefits
- Structured education supported by relationships between primary care, specialists, carers and patients
- Professional development and support from long-term conditions specialists.
- Acceptability and utilisation of programme by population

Scheme ref no.
2a.
Scheme name
Long-term Health Conditions (dementia, stroke, falls and palliative care)
Scheme description
Increase the scale of services to support people with long-term conditions.
What is the strategic objective of this scheme?
The objectives of this pilot scheme are to: • Improve clinical outcomes across the cohort of individuals with the specific long-term conditions identified. • Invest in community and other services to provide better care for patients with long-term conditions, keeping them out of hospital and creating financial benefits. • Reduce the number of emergency admissions for people with long-term conditions. • Provide patients with services closer to home. • Facilitate advanced care planning to support end of life care in the patients preferred place of death.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme forms part of Tier 3 and 4 (assessment and care planning) and represents a family of services targeted at long-term conditions – primarily dementia, stroke and falls. It also encompasses end of life care with the recognition that this needs to fit seamlessly into pathways for the management of long-term conditions. **<u>01 Dementia Services</u>**: Two key service developments are being taken forward in relation to dementia at this stage. 1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service to meet the Memory Service National Accreditation Programme (MSNAP) and National Dementia Strategy standards. 2. Development of a **community support offer for people with dementia and their carers**. To include dementia hub with resource centre, dementia advisors and dementia cafes. Dementia Friendly Communities Project. **<u>02 Stroke Services:</u>** Suite of three services to focus on prevention of stroke, and improved outcomes post-stroke through early supported discharge (with appropriate rehabilitation at home) and robust review. 1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's home by increasing early supported discharge capacity, reducing the length of stay in hospital and acute activity and freeing up resources. 2. **Stroke reviews** - to establish a formal stroke review service: every stroke survivor in Barnet to receive a 6 month review using the GM-SAT tool to prevent further strokes which will result in better outcomes for patients. 3. **Stroke prevention** - to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool. This is a preventative measure that will reduce the number of people having a stroke and avoiding admissions etc.

03 Falls Service:

The Falls Service will focus on preventing falls in the community by indentifying susceptible patients and facilitating education, exercise and fall recovery. Furthermore, it will work with/offer treatment from the multi-disciplinary teams to ensure a holistic approach to preventing further falls.

1. **Falls Clinic** – re-configured clinic modelled to best practice standards focussing on therapy led interventions (with medical support) to provide a seamless patient-centred, integrated and comprehensive service. Targeted to those who have fallen or those at risk of falling. To act as a the central hub for a co-ordinated falls offer in Barnet linked to primary care, falls co-ordinator and fracture liaison service. To establish clear pathways into ongoing voluntary sector strength and balance classes.
2. **Fracture Liaison Service** - aims to identify people who may be at risk of further falls or fractures in acute settings, providing comprehensive assessment and specific treatment recommendations.
3. **Falls co-ordinator** - To support the development of an integrated falls system in across Barnet and promote this across the whole health and social care economy linking voluntary sector, health and social care sector falls prevention initiatives

04 Palliative / End of Life Care:

Service re-design is currently underway in relation to end of life care through a comprehensive mapping exercise and review of the current pathway in partnership with multiple stakeholders. The over-arching aim would be to update the pathway to reflect a more integrated approach with clear pathways into and out of other supporting pathways including those managing long-term conditions. Focus will be retained on quality of care, advanced care planning and preferred place of death. The two key in-scope services in relation to the Better Care Fund are:

1. **Home based palliative care service** providing a key link between district nursing and hospice / acute service to support patients and carers in the last few weeks of life. The service offers additional resource at this time, tailored to identified needs, aimed specifically to enable people to die at home if this is their preferred choice.
2. **Palliative care provided through hospices**. This includes access to in-patient beds, out-patients consultant and nurse-led clinics, home visits and counselling/bereavement services.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the work plan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
Dementia – Memory assessment service	Caroline Chant	**Barnet. Enfield & Haringey MHT**	Operational to new spec from May 2014
Dementia - community support service	Caroline Chant	**Alzheimer's Society**	Operational. Re-procurement planned
Stroke – Early Stroke Discharge	Caroline Chant	**Central London Community Health**	Operational to new spec from April 2014
Stroke – Reviews	Caroline Chant	**Central London Community Health/ Stroke Association**	Operational since Summer 2013. Ramping up activity
Stroke – Prevention	Caroline Chant	**Primary Care**	Ongoing

	Falls – Falls clinic	Ette Chiwaka	**Central London Community Health/ Age UK (Barnet)**	New service expected Dec 2014
	Falls – Fracture Liaison Service	Ette Chiwaka	**Royal Free NHS Trust**	Operational since July 2013
	Falls – Falls Co-ordinator	Ette Chiwaka	**London Borough of Barnet**	Recruitment completed October 2014
	Home-based palliative care	Ette Chiwaka	**Central London Community Health/ North London Hospice**	Ongoing
	Palliative Care	Ette Chiwaka	**North London Hospice/ Marie Curie Hospice**	Ongoing

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. At present, there is estimated to be 23,355 people aged 65 or over in Barnet with a limiting, long-term illness.

01 Dementia service – The elderly cohort is expected to increase by more than 20% over the next ten years. The chances of developing dementia are significantly increased in old age. Barnet will experience an increase in the volume of dementia cases reported, because the life expectancy of its residents is continually increasing. In 2012, Barnet had a higher population of adults with dementia than any other London Borough (the 2012 percentage was also significantly higher than national averages). In 2014, there was estimated to be 4,000 people living in Barnet with dementia. This number is rapidly increasing (1.5 times faster than other London locations) making this a key challenge for health and social care.

02 Stroke service - There are approximately 400 strokes per year in Barnet with an estimated health cost of £5,743 per patient (2011-12). In 2013 we identified that although mortality rates is good compared to England and London averages, hospital admission rates were significantly higher than the national average and in addition Barnet patients were significantly more likely to be readmitted to hospital within 28 days of discharge. Evidence suggests that an appropriately resourced Early Supported Discharge service provided to a selective group of stroke patients can reduce long-term dependency and institutional care (Langhorne, P. 2005; 2007) as well as being cost effective (Beech et al 1999). Alignment with the National Stroke Strategy would also require all stroke survivors and their carers to receive regular reviews of their health and social care needs.

In relation to stroke prevention the Barnet Joint Strategic Needs Assessment (JSNA) states that "unless we take steps 16% more people will suffer from strokes by 2020". This links to a growing and ageing population. In Barnet there were 4,168 cases of AF on QOF registers in Barnet (2010/11), this gives Barnet an AF prevalence of 1.1% (370,335-total list size). The national average is 1.43% and hence identifies an opportunity to close the gap. Evidence suggests that optimal management of AF in the population could reduce overall risk of stroke by 10%i.

03 Falls service - Falls and the related injuries are amongst the most common medical problems experienced by older adults. Around 30% of over 65s living at home experience at least one fall a year,

rising to 50% of adults over 80, who are living at home, or in residential care. The burden of falls is equally felt in both the acute and social care setting as it involves LAS, A&E, primary care, urgent care providers, community services, local authority and third sector. Barnet identified a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. This is illustrated in the table below, which shows the spend on falls related activity by age group and provider in Barnet ,2011/12:

	Fractured neck of femur		Other codes related to Falls		Total	
Age Band	**No of Patients**	**Cost**	**No of Patients**	**Cost**	**No of Patients**	**Cost**
65-69	8	£46,621	62	£144,273	70	£187,894
70-74	15	£114,902	57	£126,242	72	£244,143
75-120	203	£1,333,940	757	£1,543,352	960	£2,877,292
Total	**226**	**£1,462,463**	**876**	**£1,816,867**	**1102**	**£3,309,330**

Due to the preventable nature of falls, it is felt that this is an area where cost savings can be made by ensuring that there is a focus on preventing and managing falls, as well as having a seamless pathway that can deliver appropriate care to our population closer to their homes.

04 Palliative / End of Life Care - In Barnet the current expected death rate is 486 per 100,000 (JSNA); with a higher rates in the older population. In 2011 non-cancer related deaths accounted for over 70% of deaths in Barnet.

The End of Life profile published in 2014 and recent work with stakeholders has highlighted a number of areas for development in Barnet namely:

- Preferred place of death. Most deaths in Barnet occurred in hospitals 1285 (54%) and only 434 (18%) occurred in the home with an additional 18% in care homes. This falls far below the aspirational levels of patients which indicate that 63% want to die at home.
- Care homes. Although the rate of deaths in care homes in Barnet is lower than England Average there is still room for improvement towards the England Lowest rate.
- Cost of admission. Evidence suggests that the estimated average cost of an admission is £2,506 and approximately 15% of admissions ending in death have a stay of more than 21 days. More importantly, they are likely to be poor care experiences for the person, and their relatives and carers. Expert opinion suggests that such long stays are often the result of gaps in services and an inability to discharge.
- Traditionally palliative care services have been oriented towards cancer care. As indicated above 70% of deaths are non-cancer related and hence could be linked to long-term conditions such as respiratory and neurological disorders and dementia.

Noting these themes, our BCF schemes recognise the importance of end of life care particularly in terms of embedding it within integrated care pathways both for a planned response (with advanced care planning) and to react quickly to sudden changes in medical status. Through 2015-16 our re-design of care pathways will continue to develop an integrated approach linked to GPs, Integrated Locality Teams, Rapid Response and carers support.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment – Outlined in the tables below. Breakdown:

- Dementia services are £395,632.
- Stroke Service is £487,868
- Falls services is £539,691
- Palliative Care services is £1,300,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
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3a	636,171	9.59	413	65.04		10		865,962
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	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

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2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Falls	Estimated relative impacts of 10%, 25% and 35% related to reduced admissions for falls and fractured neck of femur over the next 3 years. This is supported by evidence from other areas of the country and NICE. Based on the reach of the combined falls clinic and fracture liaison service at 984 people per annum. Phasing adjusted to reflect planned timelines for roll out of schemes.
Care homes	Dementia	22% reduction in admissions to care homes based on the "Department of Health (2009) "Living well with dementia: A National Dementia Strategy". Benefits model based on 780 new diagnoses of dementia per year within the memory assessment service. Time lag noted and hence benefits risk adjusted for 15-16.
Delayed transfers of care	Dementia	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Assumptions falling from *Counting the cost report* (2009) and DEMHOS study data that indicate that 25-35% of patients with dementia admitted with 4 specific medical problems; and evidence suggests that if this duration were to be reduced by seven days per patient, the total national savings would be almost £117m per year. This target represents a 50% reduction in excess bed days from the 2012 baseline for patients with dementia in first 10 diagnosis codes on admission.
Delayed transfers of care	Stroke	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case. Expected benefits to be achieved through targeting of services towards active management of length of stay at the HASU and ASU in line with PbR tariffs and trim points. Initial local evidence suggests an average reduction in excess bed days of 1 – 2 days per stroke patient utilising ESD with planned 35% increase in capacity people supported to go home straight from HASU and additional reduction in excess bed days in ASU. Evidence based on successful projects in Berkshire and Camden (REDS) and supported by the London Stroke network.

Other key assumptions from the financial model with respect to long-term conditions services:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- No direct benefits from Dementia support services, Stroke review, Falls co-ordinator or Palliative

Care services at this stage to eliminate overlap.

- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact

Non-financial benefits are included in the embedded benefits map:

Benefits map LTC.docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 Benefits Monthly Detail - Financial Benefits

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
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		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.
- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Improved long-term conditions management for in-scope services.
- Increase in preferred place of death.
- Interdependencies between service elements and other schemes (self-care) need to operate appropriately to deliver full benefits.
- Professional development and support from specialists in long-term conditions is important.

Scheme ref no.
2b
Scheme name
Older People Integrated Care (OPIC)
Scheme description
OPIC is the combined view of a number of different existing projects/services: Multi Disciplinary Team Case Conference (MDT), Care Navigation Service (CNS), Barnet, Community Point of Access (CPA), Risk Stratification Tool (RST), Barnet Integrated Locality Team. All focus on the delivery of assessment, care planning and co-ordination.
What is the strategic objective of this scheme?
<u>The over-arching objectives of the services above are to:</u> • Ensure that the right people receive proactive case management in a cost effective manner. • Allow care providers to focus case management on individuals that will benefit most. • Avoid duplication e.g. multiple assessments, by providing co-ordinated care. • Provide a Community Point of Access for referrals to community health services enabling clear and responsive communications between HCPs across all sectors. • Prevent unnecessary A&E attendances and unplanned hospital admissions. • Optimise individual patient's health status through case managed healthcare. • Optimise individual patient's community support through case management as well as access to social care. • Prevent or delay elderly admissions to long-term care and packages of care. • Empower patients to self-care and manage their condition. • Improve the patient's experience.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>01</u> <u>Multi Disciplinary Team Case Conference (MDT)</u> The MDT conference brings together health and social care professionals into a weekly case conference to assess and agree a care plan for the individual needs of frail and elderly patients identified as at highest risk of hospital attendance or significant deterioration in health. This is targeted at the most complex cases where standard measures have been unsuccessful or a particular risk is identified. **<u>02</u>** <u>Care Navigation Service (CNS)</u> The Care Navigation is the interface between the MDT, the Integrated Locality Team (ILT) and the patient. They improve the health, wellbeing and independence of frail and elderly patients through the provision of case management, care co-ordination and signposting. Target cohort generally originates from the MDT or the ILT. Over time the team will become an integral part of the ILT. **<u>03</u>** <u>Barnet Integrated Locality Team</u> Currently being piloted as a trail- blazer team, this is an MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. The teams will come together into a single unit to develop a joint assessment and care planning approach that links directly with users and carers. They will support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long-term conditions. This is based on the successful models based in Greenwich and other areas. **<u>04</u>** <u>Risk Stratification Tool (RST)</u> A software based risk stratification tool is being used to identify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

05 Barnet Community Point of Access (CPA)

The Barnet Community Point of Access acts as a central point to receive and manage referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care. Urgent calls are identified quickly and services deployed to prevent admissions and to support longer term care.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All projects noted are within the work plan for the Joint commissioning unit and hence have nominated service commissioners and project plans.

Service area	Commissioning lead	Provider	Progress
MDT	Muyi Adekoya	**Primary Care, Royal Free NHS Trust, Central London Community Health, London Borough of Barnet, North London Hospice, BCCG, Barnet, Enfield & Haringey Mental Health Trust, London Ambulance Service**	Operational since July 2013
CNS	Muyi Adekoya	**Central London Community Health**	Operational since May 2013
ILT	Muyi Adekoya	**Phase 1 - Primary Care, Community Health, Barnet, Enfield & Haringey Mental Health Trust & London Borough of Barnet. Phase 2 – planned Royal Free NHS Trust, North London Hospice,**	Trail blazer team live – August 2014
Risk stratification	Muyi Adekoya	**United Health**	Accelerated deployment July/Aug 2014
Community Point of Access	Muyi Adekoya	**Central London Community Health**	Operational since April 2014

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

A systematic review of integrated care (IC) report findings (over the last 10 years) as outlined in the HWB Fact Pack showed that of the 16 services that had assessed support for MDTs, 81% found that interventions had a positive impact on their IC Programme. In addition, all reviews concluded that

specialised follow ups by a multidisciplinary team reduces hospitalisations. The average impact of an MDT was a 15-30% reduction in hospitalisation (impact measured across systematic reviews).

57% (8 out of 13) of those who assessed care coordination said that it was an important component of integrated care. An average taken from two reviews showed that care coordination reduced hospitalisations by 37%.

64% (7 out 11) of those who assessed care plans found a positive impact. An average from 2 reviews suggested that hospitalisations were reduced by 23%.

This evidence is also backed up by feedback and benchmarked activity from areas such as Tower Hamlets, Torbay and Liverpool which have seen significant reductions in acute activity.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- MDT is £112.592
- Care navigation is £497,366
- ILT is £262,020
- Risk stratification tool is £121,983
- Community Point of Access is £298,065

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Savings estimate based on reduced non-elective admissions, reduced admissions to care homes and delayed transfers of care over the BCF period. This is based on:

Non-elective admissions	Benefits model based on evidence supporting reduction of hospital activity in the most at risk cohort identified from risk stratification. This is estimated at 30% reduction of costs across the system targeted to proportion of the target cohort (1992 people) subject to case management, personalised care plans and/or multi-disciplinary teams. This is in line with the scientific evidence and case examples contained in Barnet BCF Fact Pack which highlighted systematic reviews *(Holland et al, Heart 2005; Shojani et al, JAMA 2006; Graffy et al, Primary Health care Research & Dev, 2009)* of such services resulted in reductions of 15-37%. There is also broad support in recent UK based Integrate Care Programmes (Tower Hamlets, Torbay) with an emerging evidence base for quantified benefits. Local evaluation of pilot scheme in September 2015 has identified similar outputs to systematic reviews in relation to non-elective admissions (24% reduction). As this is an emerging service model expected to grow through 15-16, benefits will be subject to monitoring and further evaluation as the scheme progresses Assumptions for delivery of 486 (155 & 331) over BCF period.
Care homes	Although there is a limited amount of national evidence to suggest that Integrated care services will delay or reduce the need for permanent care home admissions (e.g. Cost of Dementia Care report by Health Foundation states that 18% fewer people could need residential care after two years with care management to coordinate health and social care); further work is required in Barnet to quantify such benefit particularly in the context of the high number of beds in the system (approx. 2800). This is particularly relevant in the context of implementation of Care Act responsibilities and cross-over with services such as Carers and enablement. A local evidence base has been derived from the evaluation of our pilot OPIC scheme (small scale demonstration of no additional costs to social care from projects and potential to

	reduce demand) and analysis and modelling of current enablement services (efficiency gains identified through demand management for more intensive services such as Homecare, residential and nursing care, acute care – estimates suggest 15-20% reduction). This is further supported by a successful ongoing programme of work within LBB to ensure that care home placements are offered appropriately within the support offer (5% reduction in placements in 13-14). On this basis, a target of 12 fewer permanent admissions to care homes has been set for 14-16 and 15-16. This will be monitored and re-validated in year.
Effectiveness of rehab/reablement	Target to increase people who leave enablement/rehab with no home care or increase to current package by 23 (11 & 12) through BCF period based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service has been secured for the ILT team to ensure clear pathways in and out and to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009.

Other key assumptions from the financial model with respect to OPIC:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- No direct benefits from Community Point of Access and Risk Stratification Tool included.
- Optimism bias applied to service lines to accommodate for potential overlaps, time lag in benefits realisation or to account for interventions where there would not have resulted in the desired impact.
- Approach will subject to continued evaluation through 15-16 and will flex to accommodate planned changes to service structure in line with the development of ILT and to revise benefits accordingly.

Benefits Map – OPIC:

Benefits Map 3 - OPIC (Annex 3).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL	
As is position	**Baseline position** *(current baslined budget - to the nearest £1,000)*														£0	
Benefits Forecast	**Forecast financial saving (£000s)**	Revenue budget saving														
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														
Actual Benefits Realised	**Financial savings realised (£000s)**	Revenue budget saving													£0	
		Other budget saving														
		Non cash efficiency														
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
	Non financial benefit	*Describe what the improvement is and give metric*														

Benefits Tracker Template:

1 **Benefits Monthly Detail - Financial Benefits**

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Fully integrated OPIC service with seamless transition between elements.
- Interdependencies with other services in terms of benefits.
- Primary care engagement in care co-ordination and MDT role.

Scheme ref no.
2c
Scheme name
Care Homes – Locally Commissioned Service (LCS)
Scheme description
To improve the quality and level of care provided in care homes throughout the borough.
What is the strategic objective of this scheme?
The objectives of the scheme include: • To improve the **quality of care** in homes. • To improve the relationship between the care home and the GP. • To commission a more holistic medical offer to care homes through a distinct service from GPs to include a fortnightly ward round, six monthly holistic reviews and post-admission reviews and medication reviews (over and above the service commissioned under current GP GMS and PMS contracts). • To increase the level of **proactive and preventative care** given in care homes, anticipating when issues may arise and preventing crisis. Particularly in relation to **preventing avoidable emergency admissions**. • To support people's preference of place of death through advanced care planning. • To provide education and training to care home staff and managers to empower them to improve quality of care. • To establish networks between care home to facilitate shared learning and best practice.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are 2 components to this scheme as outlined below: 1. **Care Homes Locally Commissioned Service** - Many GP practices provide care to people within care homes; however, it is acknowledged that this group have higher needs than the general population. Therefore, a locally agreed service has been commissioned by Barnet CCG, in addition to the essential and specialised services within the GMS/PMS contract. The service includes all care homes, including homes for elderly people and people with learning disabilities or multiple disabilities. The expected input from GPs is: a. Increased proactive GP input into care homes. b. Introduction of weekly GP ward rounds (with care home nurses as appropriate) in particular focussing on new admissions to the home and patients who have been recently discharged from hospital, ensuring that a medical review is carried out and a care plan is in place. c. Introduction of a 6 monthly holistic review of all patients under the care of the GP. d. Support the home with planning and delivery of end of life care, meeting the gold standards for such care, and e. Closer working with the home to promote high standards of clinical care within the home. 2. **Quality in Care Homes Team** – Commissioned via LBB, this dedicated resource supports the 105 care homes in Barnet in terms of benchmarking of core standards and providing support to improve quality. Key focus is on improving leadership in care homes by empowering management to take ownership of quality issues and to adopt alternative ways of problem solving and preventative strategies to improve standards. An integrated training programme ensures that all managers have appropriate core skills and knowledge.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service area	Commissioning lead	Provider	Progress
Care Homes LCS	Emma Hay (BCCG)	**Barnet GPs**	Operational since September 2014
Quality in Care Homes Team	Karen Jackson (LBB)	**London Borough of Barnet**	Operational since early 2013

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

The care market in Barnet is dominated by residential care; there are **104 nursing and residential homes for elderly care and 45 care homes** that cover mental health, learning disability and multiple disabilities. In total, these homes provide approximately **2800 - 3,051 beds** for a range of older people and those with mental health issues or learning disabilities.

Many GP practices (44 in Barnet) provide care to people within care homes, however, it is acknowledged that this group have higher needs than the general population and therefore, a service is required in addition to the essential and specialised services within the GMS/PMS contract. The Care Quality Commission published a review of health care in care homes and identified that support provided by GPs was an area for improvement (CQC 2012).

The Care Home Pilot - 2013

The recent 'care home pilot' in 2013, worked with 5 care homes, with the main objective of focusing on improving outcomes for Care/ Nursing Home residents within Barnet. The pilot focused on the implementation of changes to the way in which health and social care practitioners work within care homes. A key recommendation was for a consistent approach to daily management of medical input to care homes (in particular where support is provided by more than one GP practice) and the introduction of a weekly minimum half day round per care home.

The data

Data analysis of admissions into hospital from care homes conducted for 2012/13 revealed that, emergency admissions increased by 5% compared to the previous year (2011/12), costing an additional 27% on the back of more expensive mix of HRGs and unfavourable adjustments to the national tariff which totalled £6,618,774 (A&E and emergency admissions). Of the 2,328 people in care homes (2012/13), there were 1,394 A&E admissions with an average of 2 attendances at A&E for those with at least 1 attendance at A&E per year. In addition, the total cost of secondary care usage (A&E, outpatient, follow up, procedures) in 2012/13 amounted to £7,104,408.31 for patients with an NHS number who were living in care homes[1].

Due to changes in data access, a similar analysis has not been available in 2013/14, although data revealed that over a 10 month period (April 2013-January 2014) there were 554 inpatient admissions of the 3,051 residents in care homes costing a total of £1,830,414.

[1]Report produced by Barnet PCT, Informatics team

Care Home Staff

The Quality in Care Homes team mandate is broadly based on the eight themes within the ***My Home Life's*** vision of best practice underpinned by an evidence base developed by more than 60 academic researchers from Universities across the UK. The themes are grouped into three different areas:

- Those best practices which seek to personalise and individualise in homes – tailoring care to each individual.
- Those which are concerned with what needs to be done to help resident, relatives and staff navigate their way through the journey of care.
- Those concerned with the issues of leadership and management required to transform care into best practice.

Initial scoping in 2012 identified workforce as the first priority in Barnet to address particular needs in terms of lack of appropriately skilled staff to fill vacant posts within care homes and high turnover rates. Evidence suggested that critical factors contributing to this were a dis-empowered workforce, low wages and lack of career path.

A report from John Rowntree Foundation found that the approach did promote quality of life in care homes through:

- Positive relationships in care homes that enable staff to listen to older people, gain insights into individual needs and facilitate greater voice, choice and control.
- Care home managers playing a pivotal role in promoting relationships between older people, staff and relatives.
- Care home providers and statutory agencies considering how their attitudes, practices and policies can create pressure and unnecessary paperwork which ultimately reduce the capacity of care homes to respond to the needs of older people, and
- A reduction in the use of negative stereotypes of care homes that can impact on the confidence of staff and managers.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- Care Homes LCS is £915,000
- IQICH team is £231,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below)
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily from these schemes in terms of reduced accident and emergency attendances and admissions avoidance; and it is assumed that will accrue from December 2014 onwards.

Activity assumptions are based on a 2% reduction in acute costs (A&E, admissions and outpatients) in the target cohort of people for care homes. This is extrapolated to a target of 39 fewer non-elective admissions over the BCF period which represents a very prudent target taking into account significant optimism bias to account for overlap with other services, particularly OPIC and Rapid Care; and those homes/GP practices that do not participate. The scheme will be available for all GP practices and hence has an estimated target cohort of 2328 people.

Evidence to support assumptions is available from projects such as work undertaken in Cornwall and Scilly Isles (Improving quality of dementia care, HSJ Oct 2012) that found that training care home staff:

- Reduced falls and injuries.
- Reduced hospital admissions by 50%.

And the Integrating Care and Supporting Care Homes project (BGS Oct 2012) that showed significant reduction in non-elective admission spend.

Key assumptions from the financial model with respect to care homes:

- Estimated cost of an emergency admission is £2,004 based on local calculations
- Other benefits have been identified outside the BCF plan framework, primarily A&E attendances and outpatients appointments
- Quality in Care Homes Team is primarily a quality driven initiative with some non-quantifiable benefits within the BCF framework.

Benefits Map – Care Home Locally Commissioned Service

Benefits Map 5 - LCS (Annex 5).docx

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 **Benefits Monthly Detail - Financial Benefits**

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- GP engagement and delivery of scheme.
- Buy in from care homes and change in practice in terms of managing a higher proportion of care in the home environment.
- Delivery of key performance indicators.
- Reduced turnover of staff in care homes.

Scheme ref no.

3 (a & b)

Scheme name

Rapid Care and Seven Day Working

Scheme description

The Rapid Care service works to deliver an immediate response to a health crisis. The duties they perform include:

- Arranging appropriate services
- Assessing for delivering nursing care as required e.g. provision of IV antibiotics,
- Access to social work and enablement services as required.

What is the strategic objective of this scheme?

The objectives of this scheme are to put in place the following services:

- Extended hours service that provides full rapid assessment of health and social care need.
- Ambulatory Assessment Diagnostic and Treatment Service.
- Telehealth pilot in care homes.
- 7 day availability of social work assessment and enablement.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The inter-linkage between two services that provide an urgent but co-ordinated approach to an unplanned episode of ill-health or crisis.

1. **Rapid Care -** The primary aims of the Rapid Care expansion are to reduce unnecessary hospital admissions, better manage acute complications, and support end of life care so that people can remain in their own homes as long as possible. This will be achieved by providing urgent care for older people/people with long-term conditions and improving crisis response/support services. In addition, the expanded service will also work to improve frail and elderly access to quality acute health care community intervention.

   Key service deliverables:
   a. Triaged response via Community Point of Access.
   b. 2 hour response time.
   c. 7 day service.
   d. Use of skill mix including emergency nurse practitioners.
   e. Consultant cover.

   Target groups are all over 65s at risk of admission. Operational delivery is targeted towards those conditions that we have identified as high volume e.g. pneumonia, urinary tract infection and heart failure.

2. **7 Day Social Work & Enablement** – Supporting the Rapid Care service is 7 day access to social work assessment in the acute hospital setting and enablement services. This ensures that patients who attend A&E but could be adequately treated at home with other services can be assessed quickly and supported to return home with an appropriate package of care (health and/or social care). The team facilitates discharge home with transport, access to equipment and ongoing services. Enablement and home care packages can be established over 7 days.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

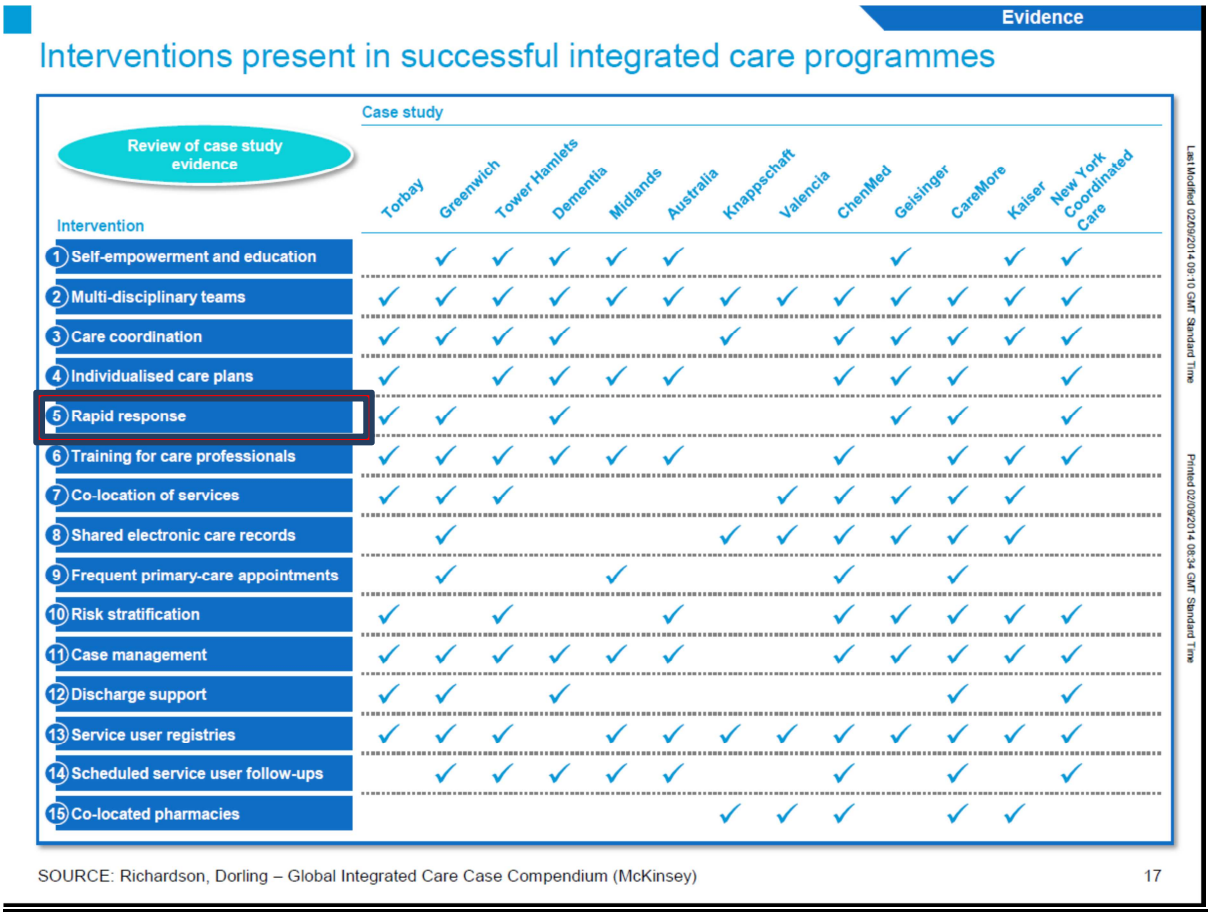
Service area	Commissioning lead	Provider	Progress
Rapid Care	Muyi Adekoya	**Central London Community Health**	Significant planned expansion occurred between October 2013 and April 2014.
7 Day Social work & Enablement	Liam Furlong/ Ette Chiwaka	**London Borough of Barnet/ Housing 21**	Ongoing

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

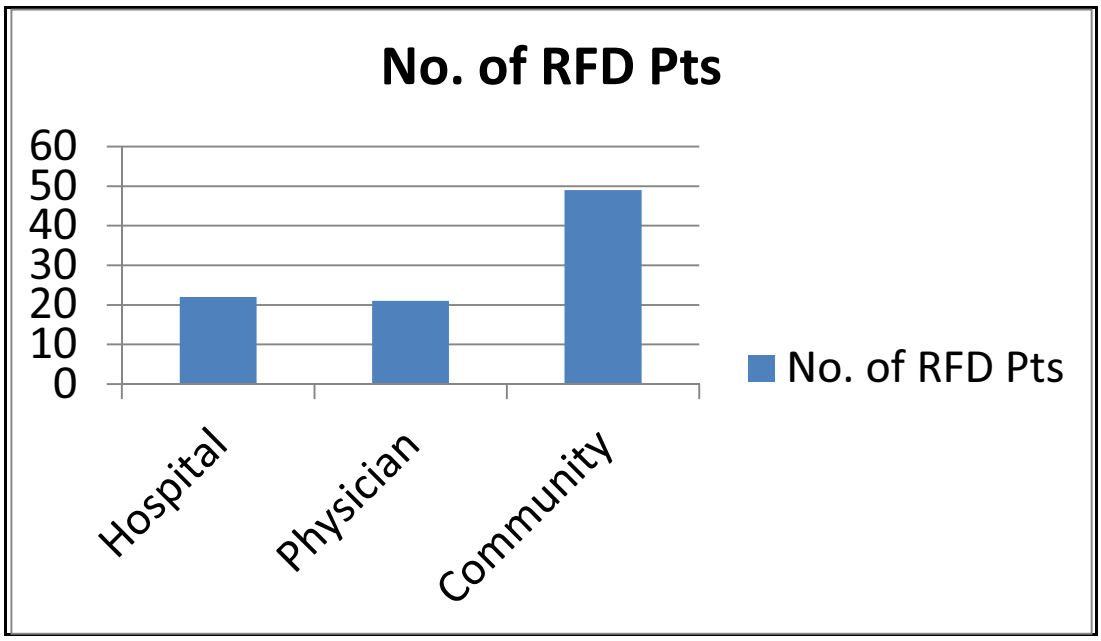
Rapid response is identified as key intervention present in successful integrated care programmes:



Evidence from Kings Fund – *Avoiding Hospital Admissions – What does the research evidence say?* Showed that for selected patients avoiding admissions by providing appropriate care at home gave similar outcomes at lower cost.

The evidence from Purdy S (2010) also suggests that hospital admissions can be reduced through active management of ambulatory care-sensitive conditions (ASC). Five conditions account for half of all ASC admissions, of which three disproportionately affect older people (urinary tract infection/pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD))

BCCG also commissioned an Appropriate Place of Care audit in July 2014 at both local acute hospitals and across community beds. This identified that of the 431 Barnet patients that were in the beds at the time of the audit 30% were either not considered as meeting the appropriate criteria for admission or did not meet the criteria for continued stay. As seen by the snapshot below, of those that were 'ready for discharge' a significant reason for delayed discharge was a wait for social care packages or care home beds (defined as community in the graph).Evidence also suggested that admissions were occurring over the weekend as a result of staff being unable to discharge pending social care assessments and placements. To address this, social work teams have been deployed in A&E departments at weekends and both home care and enablement services have been adjusted to accept new referrals.



Similarly, analysis of urgent care activity in 12/13 and 13/14 identified surge activity related to A&E attendances and non-elective admission on Sundays and Mondays indicating a bottle-neck in service delivery during this period identifying a need to implement consistent 7 days services including those to assess for and initiate social care packages. This led to the implementation of the 7 day social work service and variation of enablement contracts to support 7 day referrals.

Local evidence suggests that the model of care is working. The 7 day service has been in place for several months and is monitored as part of a BCCG QIPP scheme. Current estimates for savings in 14-15, as a result of Rapid Care and to a lesser extent OPIC, will be £771k-£1,2m.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in table below. Current indicative breakdown:

- Rapid Care is £1,314,215.
- 7 day social work & enablement is £300,000.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model has been completed

including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. The aggregated benefits are therefore detailed in the tables below. They list the schemes of work set up for each tier for the next two years and show:

- The total and proportionate cost of delivery relative to the total value of the proposed BCF pooled budget (described in Sections 4b and 5b below).
- Their contribution to the core BCF benefits and outcomes.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
2c	231,000	3.49	29	4.57				58,116
3a	636,171	9.59	413	65.04		10		865,962
3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*87,120 (Not BCF pool)*	n/a	119	11.66				238,476
2a	2,722,921	11.63	110	10.77	3		276	323,580
2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Benefits will manifest primarily in terms of admissions avoidance and effectiveness of rehab/reablement.

The model assumes an avoided admission with respect to 40% of the current referral capacity into Rapid Care using an optimism bias to account for those who were treated but were not acute enough for admission, inappropriate service users and the overlap with other services including falls. This is quantified as 864 (413 & 451) fewer admissions. In line with the evidence base above services are targeted to specified conditions and are available 7 days per week. Local impact for the service (and to a lesser extent OPIC) suggests that estimates for savings in 14-15 will be £771k-£1,2m.

It will also contribute to the reablement target as Rapid Care and 7 day capacity link very robustly with PACE and TREAT teams operating in the acute hospitals and intermediate care. Prudent target to increase people who leave enablement/rehab with no home care or increase to current package by 20 (10 per year) based on local analysis and modelling of current enablement provision and local service improvement initiatives. As above, efficiency gains of 15-20% expected through demand management for more intensive services such as Homecare, residential and nursing care, acute care. Access to enablement service is integrated within Rapid Care and is accessible from A&E to support ease of referral. Substantial evidence base as outlined in Developing Intermediate Care, Kings Fund 2009 and Halfway Home, DH 2009. Further work will continue to establish more robust targets through 2015-16.

Key assumptions from the financial model with respect to Rapid Care:

- Estimated cost of an emergency admission is £2,004 based on local calculations.
- Current commissioned capacity supports 180-200 referrals per month. Baseline modelling has been undertaken at 120 per month to prevent overlap.

Benefits Map – Rapid Care:

Benefits Map 4 - Rapid Care (Annex 4)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will validate and track the realisation of desired benefits through programme and project management methodologies and benefits management tools and techniques. This will enable the right people to take the appropriate action to deliver benefits and remove blockages to delivery.

- We will define financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. Project teams will prioritise work that will deliver the benefits and accurately model costs versus benefits.

- To record and measure how much benefit each project achieves we will use Benefit Cards, an important control document containing all the information for agreed benefits.

- The HSCI Steering Group, Tier and Project Sponsor will sign off Benefit Cards. They will include a description of the benefit and the case for it and details of the key measures impacted, used to calculate the benefit. They will show the calculated benefit and a profile of how we expect to and do realise it over time, to prove the level of benefit.

- Benefit Cards will also include details of barriers that could prevent the delivery of benefits and dependencies that may impact on such delivery.

- For hospital and residential care admissions, we will use data on the change in admissions to calculate the benefits realised. This will include the change in number of admissions for each defined period given to BCCG and LBB from providers, multiplied by the agreed average/unit costs metric for a placement or treatment or care package cost). We will then compare these figures against the targets/metrics in this plan. Where relevant we will use upper and lower ranges to forecast different scenarios. This will enable us to define the expected scenario for which we are most confident of delivery and to take action if fewer benefits are realised or consider potential stretch targets if performance exceeds expectations.

- A copy of the template Benefits Profile and Tracker used in the Benefits Card is below.

Benefits Profile Template:

Benefit profile			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	TOTAL
As is position	Baseline position *(current baslined budget - to the nearest £1,000)*														£0
Benefits Forecast	Forecast financial saving (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													
Actual Benefits Realised	Financial savings realised (£000s)	Revenue budget saving													£0
		Other budget saving													
		Non cash efficiency													
		TOTAL	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Non financial benefit	*Describe what the improvement is and give metric*													

Benefits Tracker Template:

1 **Benefits Monthly Detail - Financial Benefits**

This tracker will aid with the monthly monitoring of the projects financial benefits.

BENEFIT	REF	TYPE	ANNUALISED BENEFIT	IN-YEAR	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Name of the benefit	*Benefit reference number*	*Planned*								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
		Planned								
		Actual / Forecast								
TOTAL		*Planned*								
		Actual / Forecast	£ -		£ -	£ -	£ -	£ -	£ -	£ -

- Benefit Cards will also include a Benefits Realisation Plan, detailing the activities for each scheme to deliver and track the benefits achieved.

- We will agree a project work plan with relevant stakeholders. This will include milestones for achieving specific outcomes/benefits, timescales for reviewing progress to determine if work is on schedule and regular project impact assessments. The work plan will also include details of any handover and further work to embed activities post delivery. This will allow the service to continue realising benefits/outcomes once the project has been closed.

(Note: the detailed information about the benefits tracking process which we use to measure outcomes of our integrated care model has been repeated in each detailed scheme description in the 'feedback loop' section where it applies, for completeness)

What are the key success factors for implementation of this scheme?

- Stakeholders buy in to support referrals particularly primary care.
- User acceptability of model of care.
- Interdependencies with other services such as PACE and TREAT.

Scheme ref no.
4 (a & b)
Scheme name
Enablers – service and administrative
Scheme description
A suite of services or projects intrinsically linked to BCF pool as key enablers.
What is the strategic objective of this scheme?
The over-arching objectives of the scheme are to: • Secure ongoing delivery of key service lines associated with BCF tiers 1 and 2 that are not currently subject to service re-design or linked to benefits realisation processes. • Secure on-going delivery of critical underpinning projects for the integrated care model. • Deliver critical enablers to support delivery of projects within and alongside the BCF 5 tier care model. • Allow monitoring and management of the total BCF pool in conjunction with benefits/metrics e.g. unplanned hospital admissions, reduced care home admissions. • Provide framework to increase the size and scope of BCF pool over time.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The table below outlines the key elements of the enablers.

Scheme	Service line	Provider type	15-16 (£)	15-16 (£)
Scheme 4a. Enablers (services)	Carers services	Charity/Voluntary Sector	300,000	300,000
	Later life planners	Charity/Voluntary Sector	150,000	150,000
	Ageing Well	Local Authority	150,000	150,000
	Shared Care Records	Local Authority	262,021	262,021
	Community Equipment	Private Sector		1,169,761
	Other Community Services	NHS Community Provider		6,965,100
	Carers Breaks & additional enablement funds	BCCG		1,641,926
Scheme 4b. Enablers (administrative)	Protecting social care	Local Authority	3,080,000	3,080,000
	BCF Plan delivery	Local Authority	200,000	200,000
	Care Act Implementation	Local Authority		846,000
	DFG & Adult social care capital grant	Local Authority		1,872,000

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enablers are largely managed as business as usual services rather than on a project management basis. They feed into the core business of both BCCG and LBB in the context of managing the day to day delivery of the integrated care model, measuring benefits and ensuring supporting infrastructure is in place.

In line with the programme management approach, as the commissioning intentions/status of services change they will move into the 'active' commissioning cycle and will be project managed as required.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Why have we selected this scheme?

- Elements included link to over-arching strategic aims for BCF and hence align to planned or possible future service re-design e.g. community services / enablement.
- Elements noted to align to key priority cohorts to be targeted within integration programme (carers) or underpinning infrastructure (Shared Care Record).
- A number of services are those that are currently funded from existing budgets aligned to the BCF that require ongoing funding e.g. Section 256.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment: Outlined in tables below

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Although extensive financial modelling to support implementation of the 5 tier model has been completed, the projects listed in this section have not been included as they are not currently designated to contribute to the BCF metrics.

Over time the constituent elements of this scheme will be subject to change either through dis-investment and/or movement of funds into or out of the pooled budget; or through the natural progression of commissioning intentions and service re-design. As an example, Community Equipment is currently a designated budget within this scheme as a 'business as usual service line'; if it becomes a 'live project' the process will include analysis and outlining key benefits expected from any service improvements.

April 2014 to March 2015:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
1a	*35,000(Not BCF pool)*	n/a	23	3.62				46,092
2a	267,357	4.03	15	2.36			268	101,080
2b	1,057,451	15.94	155	24.41	12	11		472,761
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3b	300,000	4.52						
4a	862,021	12.99						
4b	3,280,000	49.44						
	6,634,000 (BCF Pool)	**100**	**635**	**100**	**12**	**21**	**268**	**1,544,011**

April 2015 to March 2016:

Sch Ref	Cost (£)	% of BCF Pool	No Reduced NEL Adm.	% Change NEL Adm.	No Reduced Care H Adm.	Reablement Effectiveness (Red. POC Post Int.)	DTOC (Reduced XS Bed Days)	Total Saving (£)
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2b	1,292,026	5.53	331	32.42	12	12		829,296
2c	1,146,000	4.89	10	0.98				20,040
3a	1,316,464	5.62	451	44.17		10		942,114
3b	300,000	1.28						
4a	10,636,589	45.43						
4b	5,998,000	25.62						
	23,412,000 (BCF Pool)	**100**	**1,021**	**100**	**15**	**22**	**276**	**2,353,506**

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Enablers support the other schemes. This scheme consists of a range of operational services that underpin the delivery of the integrated care model either as key infrastructure or as community support. Enabler projects or services include planning for later life, shared digital care records and other community services. Although the enablers in this scheme do not directly deliver the target improvements in the 6 core BCF metrics, each is measured against its own suite of performance indicators, such as numbers of carers assessments per year.

Where such indirect benefits are measurable across the whole integrated care model we will validate and track their realisation through benefits management tools and techniques if appropriate. We will define the best approach for each benefit, balancing the likelihood of establishing measurable links between them and project/service outputs against their complex nature and the information required for Benefit Cards as detailed above or alternative methods.

Where relevant we will define any indirect financial and non-financial benefits clearly so stakeholders understand the need and advantages of achieving them. We will agree a project work plan with them.

This will include milestones for achieving benefits, timescales for reviewing progress to determine if work is on schedule and regular impact assessments. Project/service teams will prioritise work accordingly. The work plan will also include details of any handover and further work to embed activities and continue to realise benefits long-term.

We will also embed the funding for enabler services in our Pooled Budget arrangements to ensure regular monitoring horizon scanning for future opportunities for benefits within these service lines. All this will enable the right people to take the appropriate action to facilitate realising these benefits and remove blockages to delivery.

What are the key success factors for implementation of this scheme?

- Ongoing delivery of enabling services.
- Interdependencies with other services identified in terms of benefits.
- BCCG and LBB understanding/engagement in enablers.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Barnet
Name of Provider organisation	Royal Free NHS Foundation Trust
Name of Provider CEO	David Sloman, however report is signed off by Kim Fleming (Director of Planning)
Signature (electronic or typed)	Kim Fleming

For HWB to populate:

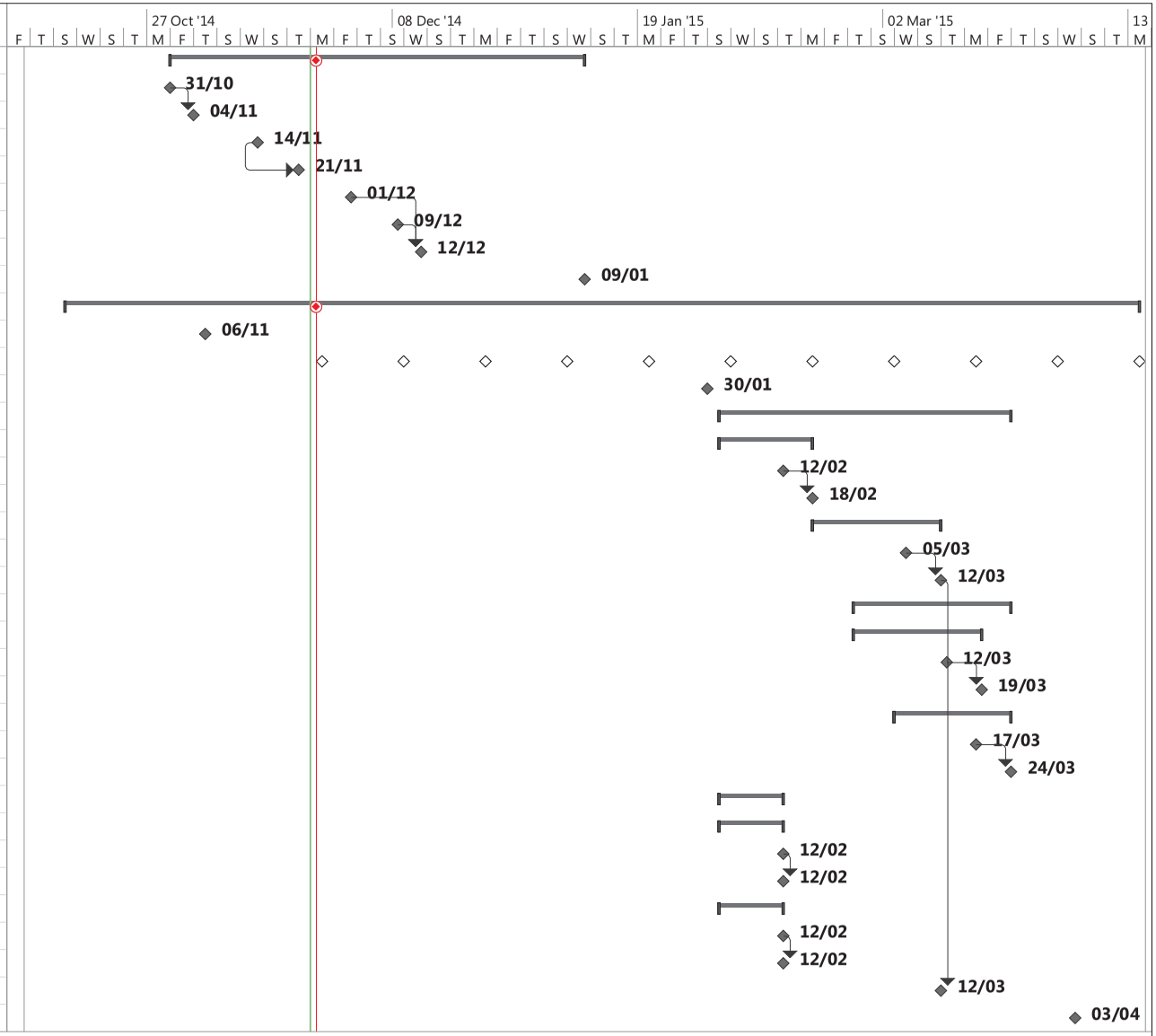
Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	29135
	2014/15 Plan	29502
	2015/16 Plan	30002
	14/15 Change compared to 13/14 outturn	+367(+1.2%)
	15/16 Change compared to planned 14/15 outturn	+500 (+1.6%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	134
	How many non-elective admissions is the BCF planned to prevent in 15-16?	891

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We are aware of BCCG plans and have been engaged in Better Care Fund discussions. We are committed to working with BCCG both now and in the future on this plan, however we are not in a position to sign off these activity reductions as we need to understand how the individual schemes of work explicitly link to the reductions planned.
2.	**If you answered 'no' to Q2 above, please explain why you do not agree with the projected impact?**	As above
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As above

[i] *Commissioning for Stroke Prevention in Primary Care -The Role of Atrial Fibrillation June 2009*
http://www.improvement.nhs.uk/heart/Portals/0/documents2009/AF_Commissioning_Guide_v2.pdf

ID	Task Name	Duration	Start	Finish
1	**BCF Plan (NHS E)**	**51 days**	**Fri 31/10/14**	**Fri 09/01/15**
2	**NCAR Outcome Received**	**0 days**	**Fri 31/10/14**	**Fri 31/10/14**
3	Final Submission Kick Off Mtg	0 days	Tue 04/11/14	Tue 04/11/14
5	Action Plan Submitted	0 days	Fri 14/11/14	Fri 14/11/14
6	**Action Plan Approved (NHS E)**	**0 days**	**Fri 21/11/14**	**Fri 21/11/14**
8	Checkpoint Meeting 1	0 days	Mon 01/12/14	Mon 01/12/14
10	Checkpoint Meeting 2	0 days	Tue 09/12/14	Tue 09/12/14
11	**Final BCF Plan Submitted**	**0 days**	**Fri 12/12/14**	**Fri 12/12/14**
13	**BCF Plan Approved**	**0 days**	**Fri 09/01/15**	**Fri 09/01/15**
15	**Pooled Budget**	**132 days**	**Mon 13/10/14**	**Wed 15/04/15**
21	HWB Finance Group Review	0 days	Thu 06/11/14	Thu 06/11/14
26	***KIT, Review Meetings (tbc)***	***100 days***	***Wed 26/11/14***	***Wed 15/04/15***
39	**Draft Schedule Agreed**	**0 days**	**Fri 30/01/15**	**Fri 30/01/15**
41	**Approvals**	**36 days**	**Mon 02/02/15**	**Tue 24/03/15**
42	HWB £ Group (PROPOSED)	12 days	Mon 02/02/15	Wed 18/02/15
45	Papers Submitted	0 days	Thu 12/02/15	Thu 12/02/15
46	Meeting	0 days	Wed 18/02/15	Wed 18/02/15
47	**HW Board**	**16 days**	**Wed 18/02/15**	**Thu 12/03/15**
51	Papers Submitted	0 days	Thu 05/03/15	Thu 05/03/15
52	Meeting	0 days	Thu 12/03/15	Thu 12/03/15
54	***Council (TBC)***	***19 days***	***Wed 25/02/15***	***Tue 24/03/15***
55	***A&S Committee***	***16 days***	***Wed 25/02/15***	***Thu 19/03/15***
58	*Papers Submitted*	*0 days*	*Thu 12/03/15*	*Thu 12/03/15*
59	*Meeting*	*0 days*	*Thu 19/03/15*	*Thu 19/03/15*
60	***P&R Committee***	***14 days***	***Wed 04/03/15***	***Tue 24/03/15***
63	*Papers Submitted*	*0 days*	*Tue 17/03/15*	*Tue 17/03/15*
64	*Meeting*	*0 days*	*Tue 24/03/15*	*Tue 24/03/15*
66	**CCG**	**9 days**	**Mon 02/02/15**	**Thu 12/02/15**
67	***Finance, Perf, Quality (tbc)***	***9 days***	***Mon 02/02/15***	***Thu 12/02/15***
70	*Papers Submitted*	*0 days*	*Thu 12/02/15*	*Thu 12/02/15*
71	*Meeting*	*0 days*	*Thu 12/02/15*	*Thu 12/02/15*
72	***Full Board (tbc)***	***9 days***	***Mon 02/02/15***	***Thu 12/02/15***
75	*Papers Submitted*	*0 days*	*Thu 12/02/15*	*Thu 12/02/15*
76	*Meeting*	*0 days*	*Thu 12/02/15*	*Thu 12/02/15*
78	**Pooled Budget Agreed**	**0 days**	**Thu 12/03/15**	**Thu 12/03/15**
80	**Pooled Budget In Place**	**0 days**	**Fri 03/04/15**	**Fri 03/04/15**



Project: FE FBC Business Case P
Date: Mon 24/11/14

Task	Inactive Task	Manual Summary Rollup	External Milestone	Manual Progress
Split	Inactive Milestone	Manual Summary	Deadline	
Milestone	Inactive Summary	Start-only	Critical	
Summary	Manual Task	Finish-only	Critical Split	
Project Summary	Duration-only	External Tasks	Progress	

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AGENDA ITEM 7

	Health and Well-Being Committee **29th January 2015**
Title	**Primary Care Co-Commissioning**
Report of	Maria O'Dwyer Director of Integrated Commissioning Margaret Chirgwin – Primary Care Strategy Programme Lead Barnet CCG
Wards	All
Date added to Forward Plan	December 2014
Status	Public
Enclosures	Appendix 1: NHS Letter from NHSE to Local Authority CEOs and HWBB Chairs -Update on Primary Care Co-Commissioning 18th Dec Appendix 2: London Councils to London Borough Leaders Health and Social Care Portfolio Holders and HWBB Chairs
Officer Contact Details	Maria O'Dwyer maria.odwyer@barnetccg.nhs.uk Margaret Chirgwin Margaret.chirgwin@barnetccg.nhs.uk

Summary

In late September an NSH England (NHSE) document released provided further information on Co-Commissioning, additional guidance was issued on 14th of November. Clinical Commissioning Groups (CCGs) are requested to put forward proposals by end of January 2015 for Joint Commissioning and earlier if Delegated Commissioning was the preferred option. Following internal and public discussion Barnet CCG Governing body in the December 2014 Committee meeting agreed to support in principle the proposal to join with other North Central London (NCL) CCGs and put in a **Joint Commissioning** proposal. The Guidance requires the CCG to review and confirm membership support including support for the necessary changes to the **CCG constitution** and a commitment to proceed towards joint commissioning arrangements and the setting up of a joint committee. From Jan –Feb 2015 the CCG will be committed to engage across NCL to engage with practices, HWBBs Healthwatch and Patients.

The proposed plan is that a Joint Committee would come into existence in shadow form in April 2015 and run in shadow until 1st October 2015 initially as Level 1 "greater involvement"

arrangements. From October it will start to operate formally as a Joint Committee under level 2 joint arrangements. This provides more time for constitutional changes to be put in place by March 2015. The terms of reference and membership of this Committee is currently under discussion.

This paper seeks the support and engagement of Barnet HWBB on it's in principle decision to develop a proposal to take Joint Co-Commissioning forward at the end of Jan 2015. The Board is requested to discuss how the HWBB will participate in a Joint Committee across NCL .The Board is also requested to consider the role of Public Health in this discussion, and feedback any views/considerations to the NCL lead for Primary Care (Chief Officer for Islington).

Recommendation

1. **The Health and Wellbeing Board is requested to note and support Barnet CCG's decision to develop a proposal to jointly co-commission with the other 4 NCL CCGs**
2. **Consider and discuss how the Health and Wellbeing Board will participate in Joint Co-Commissioning Committee across NCL**
3. **Consider the role of Public Health in Joint Co- Commissioning and feed any views /considerations into to NCL ongoing discussions**

1. WHY THIS REPORT IS NEEDED

1.1 Health and Social Care Act 2012 introduced substantial changes to the way the NHS in England is organised, in particular it created CCGs. It defined the responsibilities which did not include responsibility for the primary care contracts (GP, Pharmacists, Opticians and Dentists) which were previously managed by the PCT. However, on 1st October 2014 changes were made to the Act to allow CCGs to take on joint responsibility with NHS England (NHSE) for these contracts thus moving us back towards most of the responsibilities that the PCT held.

1.2 Initially Co-Commissioning is about the contracts NHSE holds with General Practice but in later years is likely to include the contracts with Opticians, Pharmacists and Dentists. So Barnet CCG, with our NCL CCG partners, are considering taking on joint responsibility with NHSE for:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

1.3 It will not include individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).

1.4 **The Options**

Model Zero: Do not get involved at all. However we do not think that this is really an option.

Or one of three options:

1.5 In June 2014 the 5 North Central London (NCL) CCGs put in a proposal to Jointly Commission with NHSE.

1.6 Following a discussion at the Committee and amongst the other NCL CCGs we believe that the best option for the CCG is to join again with the other NCL CCGs and put in a **Joint Commissioning** proposal.

Summary of Co-commissioning functions under each option

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

1.7 **Key Issues for Practices as Providers**

1.7.1 In many ways very little should change from a practice or patient point of view – the same NHSE staff as at present will do the daily management of contract.

1.7.2 However, there should be an improvement of the management of enhanced schemes with more local clinical involvement in their development and implementation. The CCG will be integral to decision making about things such as establishing new GP practices and the approval of Practice building developments, thus ensuring a sustainable General Practice provision for our population. These decisions will be taken across all five NCL CCGs in partnership with NHS England.

1.8 **Key Issues for the CCG and Practices as Members of the CCG**

1.8.1 Whatever option Barnet CCG takes on there are unlikely to be any new resources allocated to the CCG to do the work of managing the contracts and supporting practices with issues related to their primary care contracts – sharing the support work across the 5 CCGs will be more efficient and therefore we believe this is a better option than if we did any form of Co-Commissioning alone.

1.8.2 As CCG Governing Body is made up of mainly GPs the change in commissioning arrangements may give rise to further questions in relation to conflict of interest, however Barnet CCG are cognisant of this conflict and have processes in place to monitor such issues currently. Managing conflict of interest issues across the 5 CCGs will lend itself to reduce actual and perceived conflicts. There is further NHSE Guidance on how to manage this in the background papers.

1.9 **Constitutional Changes**

1.9.1 Changes to the CCG's constitution will be required and in order for the CCG to proceed with Co-Commissioning we will need agreement from GPs – the first change will be to add a few paragraphs to take on joint responsibility for the agreed areas (the first box above) and create the necessary Joint Commissioning Committee with NHSE and the other four CCGs. The second required change is to add the Terms of Reference for this committee as an annex to the constitution. Annex C and D (see background papers) give suggested wording. The CCGs as above will work on these to agree the final wording taking all CCGs views into account.

2. REASONS FOR RECOMMENDATIONS

2.1 Option 2 is being recommended because this is the one that the 5 NCL CCGs are all willing to sign up to at this time. It was felt that there was not enough information in November/December 2014 on Option 3 which is ultimately where the NCL CCGs would like to be but only when there is clear understanding of the risks involved and how these may be managed effectively.

2.2 The NCL CCGs are seeking to only have a Joint Co-Commissioning Committee in Shadow from April 1st 2015 to give enough time to develop full

membership and other stakeholder support for co-commissioning and to move to full joint commissioning and then to full delegated co-commissioning at a pace that ensures risks are minimised and benefits to the population maximised. There is an expectation that HWBB will participate in Joint Co-Commissioning (please see documents from NHS England and London Councils for further information).

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 **Model 0 – not in the NHSE proposal but CCG could decide to focus on our statutory responsibility to improve the quality of primary care and leave NHSE to be responsible for the GMS/PMS/APMS contracts.** Still work to coordinate with other primary care commissioners (PH England, Borough PH, NHSE) but no responsibility beyond improving quality.

3.1.1 This option was not believed to be a possibility and as the present situation has not been working well in particular with lack of information sharing and coordination of effort.

3.2 Co-commissioning as a single CCG or with a different combination of CCGs was considered but dismissed because so much work was undertaken last year to develop a joint proposal and it is unlikely to deliver efficiencies in the system.

3.3 **Model 1 – Greater Involvement – to be locally agreed with the Area Team**

3.3.1 This option was believed to be likely to entail increased level of work for the CCG without the gains of formal involvement in decision making.

3.4 **Model 3 - Delegated Arrangements – proposal due by 9th January**

3.4.1 This option was felt to be one the CCG would want but the lack of sufficient detail and the need for a fully developed proposal by 9th January made this option not feasible at this time in light of understanding impact and risk within the time frame.

4. POST DECISION IMPLEMENTATION

4.1 There is significant work currently underway at the moment to agree across the NCL CCGs the structure and functions of the Joint Co-commissioning Committee and the changes that will be needed to all 5 CCG Constitutions. As soon as the proposed Constitutional changes are available, The CCG will engage with each Member Practice and request that they confirm that they are happy for these changes to be made. We will need a 75% supporting vote to do this but are recommending that this is the only viable option available to the CCG. To date current engagement is supportive.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 This supports the CCG's Primary Care Strategy and the CCGs statutory requirement to ensure the ongoing development of the quality of primary care services provided to the population of Barnet.

5.1.2 This supports all 4 the Health and Well Being Strategy themes because General Practice and primary care more broadly has a role to play in each theme with a particular theme on theme 1 and 4:

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.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 This has financial implications for within the NHS (between the CCGs and NHSE) but should have no negative impact on service provision. It is hoped that there will be synergies that mean that more resources will become available for service provision to the Barnet population.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Social Care Act 2012 established health and well-being boards as forums where key leaders from the health and care system work together to improve the health and well-being of local communities. The Health and Well-being Board plays a key role in the local commissioning of health care, social care and public health through developing and overseeing a Joint Strategic Needs Assessment (JSNA) and Health and Well-being Strategy

5.3.2 The terms of reference of the Health and Wellbeing Board , as set out in part 15 of the Constitution, Annex A ; include the tasks of jointly assessing the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies. A further role includes considering all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration. A further duty is to promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

5.3.3 The Recommendations therefore, as set out in this report appear to be in accordance with applicable law and guidance, and what is set out in this report appear to be appropriate recommendations for the HWBB to consider.

5.4 **Risk Management**

5.4.1 The risks of Co-Commissioning are complex in particular around perceptions of and actual conflicts of interest. Managing conflicts of interest: statutory guidance for CCGs was released 18th December 2014 and is attached. Co-commissioning across the 5 NCL CCGs will help to reduce these potential conflict issues. The Guidance will also inform the proposed makeup and functions of the Joint Co-Commissioning Committee.

5.4.2 There is an additional risk in the failure to engage appropriately with member practices to change the constitution

5.5 **Equalities and Diversity**

5.5.1 There is no impact on Equality and Diversity issues.

5.6 **Consultation and Engagement**

5.6.1 There will be a process of engagement with member practices to seek the appropriate support to amend and make the necessary changes to the CCG constitution.

6. BACKGROUND PAPERS

6.1 Proposed next steps towards primary care co-commissioning: an overview Dr Amanda Doyle, Ian Dodge, Ivan Ellul and Julia Simon September 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf

6.2 Next steps towards primary care co-commissioning: Annex C: Model wording for amendments to Clinical Commissioning Groups' constitutions 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-c-mod-wrd-amends.pdf

6.3 Next steps towards primary care co-commissioning: Annex D: Model terms of reference for joint commissioning arrangements including scheme of delegation 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-d-mod-tor-jnt-comms.pdf

6.4 Managing conflicts of interest: statutory guidance for CCGs: NHSE Commissioning Strategy Directorate. First published: March 2013. Update released 18th December 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

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Gateway reference: 02776

Commissioning Strategy Directorate
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail: england.co-commissioning@nhs.net

18 December 2014

To Local Authority CEOs and Health and Wellbeing Board Chairs
cc. CCG Clinical Leads

RE: Update on primary care co-commissioning

A. Background and context

NHS England recently invited clinical commissioning groups (CCGs) to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

On 10 November 2014, we published Next steps towards primary care co-commissioning. This document sets out three possible models for primary care co-commissioning (greater involvement, joint commissioning and delegated commissioning) and the next steps towards implementation. The approach has been developed by the joint CCG and NHS England primary care co-commissioning programme oversight group, which includes two local authority representatives: Ged Curran (Chief Executive, Merton Council) and Merran McRae (Chief Executive, Calderdale Council). The group is co-chaired by Dr Amanda Doyle, Co-chair of NHS Clinical Commissioners and Chief Clinical Officer of NHS Blackpool CCG, and Ian Dodge, National Director: Commissioning Strategy, NHS England.

We want to encourage Health and Wellbeing Boards to have a conversation with their local commissioners of primary care, both CCGs and NHS England - and we have made the same recommendation to NHS commissioners. The

effectiveness of co-commissioning arrangements will be reliant upon the development of strong local relationships and effective approaches to collaborative working.

In this context, CCGs have an obligation to consult with each relevant Health and Wellbeing Board in preparing or revising their commissioning plan, as set out in annex A.

B. Invitation to participate in joint and delegated commissioning committees

In both joint and delegated commissioning arrangements, CCGs must issue a standing invitation to the local Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

Where there is more than one local Health and Wellbeing Board for a CCG's area, the CCG should agree with them which should be invited to attend the committee.

Health and Wellbeing Boards are under no obligation to nominate a representative, but we believe there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

If you have any queries or would like to find out more about the primary care co-commissioning programme, please email: england.co-commissioning@nhs.net

With best wishes,

Ian Dodge
National Director: Commissioning Strategy
NHS England

Dr Amanda Doyle
Chief Clinical Officer
NHS Blackpool CCG

Annex A: CCG statutory requirements in relation to CCG commissioning plans and Health and Wellbeing Boards

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012):

- CCGs must give each relevant Health and Wellbeing Board a draft of the plan and consult each such Board on whether the draft takes proper account of each joint health and wellbeing strategy published by it, which relates to the period that the plan relates to (section 14Z13(4)).

- Where a Health and Wellbeing Board is consulted, it must give the CCG its opinion on whether the plan takes proper account of each relevant joint health and wellbeing strategy.

- CCGs must include a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the commissioning plan in the final plan as published (section 14Z13(8)).

- Where a significant revision is made to an existing commissioning plan, CCGs must consult with the Health and Wellbeing Board as per section 14Z13, before finalising the revised plan (section 14Z12). They must also give a copy of the document to each relevant Health and Wellbeing Board.

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From: Cllr Teresa O'Neill

To: London Borough Leaders, Health and Social Care Portfolio Holders and Health & Wellbeing Board Chairs

12th December 2014

Dear colleagues,

Primary Care Co-Commissioning

Discussions at recent London Councils Leaders' Committee and Executive meetings have confirmed that we all recognise the need for local government to find ways of gaining real influence and leadership in health and care transformation. As part of this, NHS England's move to co-commissioning of primary care with Clinical Commissioning Groups (CCGs) is a key opportunity. However, the timescales to influence the arrangements being developed for 2015/16 are tight. So I wanted to flag briefly the latest information and opportunities.

NHS England invited CCGs to express interest in co-commissioning primary care in the summer. Most London CCGs did so, some individually but generally in groups. It appears that in most cases there was very little, if any, discussion about this with local authority partners or Health & Wellbeing Boards.

Mayor Jules Pipe, as Chair of London Councils, wrote to Simon Stevens in September, highlighting local government's interests in primary care and boroughs' strong desire to be partners in new local co-commissioning arrangements. No response has yet been received, but we understand that the letter fed into the shaping up the next stage of the process.

NHS England published guidance to CCGs for the next stage of primary care co-commissioning on 11th November. CCGs have until 9th January 2015 to submit proposals if they want primary care commissioning to be wholly devolved to them or until 30th January if they want to develop joint commissioning arrangements with NHS England. These will then be subjected to a regional moderation and national sign-off by NHS England, so that new arrangements can be implemented from 1st April 2015.

I understand that CCGs' engagement with boroughs or Health & Wellbeing Boards on their developing plans remains very varied, and in too many cases non-existent. For any boroughs struggling to get leverage in these discussions, I wanted to highlight some of the key points from the guidance or other discussions that may be of use, both in this short window when CCGs are determining their arrangements and as these start to operate in practice:

- Specific committees will have to be established to undertake primary care commissioning. The guidance is explicit that a local authority representative from the local Health & Wellbeing Board and a local Healthwatch representative will have a right to join these committees as non-voting attendees.

- Addressing conflicts of interests is a significant issue for CCGs. NHS England will issue specific guidance on this before Christmas. However, the existing guidance is clear that the committees must have a lay and executive majority and a lay chair.

There is, therefore, the potential to explore with CCGs whether boroughs could provide some of this lay membership and/or how membership might overlap with that of the Health & Wellbeing Board.

- One of the main drivers for many London CCGs pursuing sub-regional arrangements for co-commissioning primary care is to share a limited commissioning support resource. Boroughs who feel strongly that primary care commissioning would be better led at local level might want to explore with their CCG the potential for securing sufficient resource by better integrating commissioning functions with local authorities.

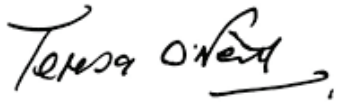
- CCGs are required to include their Health & Wellbeing Board in the preparation of commissioning plans, publish the opinion of the Board with these plans once agreed and Boards can refer plans to NHS England if they do not think they have had appropriate regard to the Joint Health & Wellbeing Strategy. There is no reason or suggestion that these requirements would not apply to any primary care co-commissioning plans.

- Health & Wellbeing Boards have the power to request any information necessary for the performance of their functions from any bodies represented on the Board.

London Councils officers are liaising with borough officers to get a picture of how engagement in primary care co-commissioning is playing out, not least to identify any issues that might need to be raised with NHS England at a London level. They will also explore with NHS England how the clear expectation in the guidance that CCGs will engage local authorities, Health & Wellbeing Boards and local communities in primary care decision making, is taken into consideration in the regional assurance process they undertake.

One other related issue to flag is the Strategic Commissioning Framework for Primary Care Commissioning. This is a proposed specification for primary care in London – ie defining what good should look like - to which all areas should be working, including through co-commissioning. NHS England and CCGs are supposed to be engaging widely on this between now and March. If this not happening in a meaningful way in your area, this should be raised with the CCG directly or London Councils officers who can facilitate the right links.

Best wishes,



Cllr Teresa O'Neill
Leader, London Borough of Bexley
London Councils Portfolio Holder for Health

London Councils policy contacts:

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Sarah Sturrock, Strategic Lead Health & Adult Services
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AGENDA ITEM 8

	Health and Well-Being Board **29 January 2015**
Title	**The Annual Report of the Director of Public Heath: From the Beatles to Beyoncé**
Report of	Dr Andrew Howe, Director of Public Health
Wards	All
Date added to Forward Plan	June 2014
Status	Public
Enclosures	Appendix A - The Annual Report of the Director of Public Health: From the Beatles to Beyoncé
Officer Contact Details	Carole Furlong, Consultant in Public Health, Carole.furlong@harrow.gov.uk 020 8420 9508

Summary

This report looks back over 50 years at a selection of topics which were public health issues fifty years ago and remain issues today. The report gives a timeline for each of the topics and some suggestions about what we need to do in the future to address them.

Recommendations

1. **The Board is requested to note the report.**

1. WHY THIS REPORT IS NEEDED

1.1 Each year, the Director of Public Health must publish an independent report on health in the borough. The annual report is the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be publicly accessible.

1.2 The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action.

1.3 Director of Public Health annual reports should:

- Contribute to improving the health and well-being of local populations
- Reduce health inequalities
- Promote action for better health, through measuring progress towards health targets
- Assist with the planning and monitoring of local programmes and services that impact on health over time

1.4 This year, to coincide with the Director of Public Health's 50th birthday, the report reflects on a number of topics which were and remain important public health issues over the past fifty years.

1.5 The topics covered in the report are

- Cardiovascular Disease
- Tuberculosis
- Sexually Transmitted Infections
- Tobacco control
- Vaccine Preventable Infections
- Healthy life expectancy

1.6 For each topic, the report includes changes that have happened over the past 50 years; an assessment of the current situation and any inequalities in health; and finally, consideration of the evidence based interventions needed in the coming years to continue to address these issues.

2. REASONS FOR RECOMMENDATIONS

2.1 The Board are asked to note this independent report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None

4. POST DECISION IMPLEMENTATION

4.1 The report does not have specific recommendations but highlights some of the broad actions that are needed to continue to address the issues across the heath and local government sectors. These actions will be addressed in the associated public health work streams and others are encouraged to take these into consideration in their commissioning plans.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

- The issues covered in this report will be considered in the development of the next Health and Wellbeing Strategy which will be developed between April and September 2015. It will be presented to the HWB in Autumn 2015..

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT,**

Property, Sustainability)

- Not Applicable

5.3 **Legal and Constitutional References**

- The responsibility for public health transferred to local authorities in April 2013 under the reforms set out in the Health and Social Care Act 2012. Health and Wellbeing Boards are given statutory effect by s194 of this Act.

- The Council's Constitution (Responsibility for Functions, Annexe A) sets out the Terms of Reference of the Health and Wellbeing Board. The Board has the following responsibility:
- *"To receive the Annual Report of the Director of Public Health and commission and oversee further work that will improve public health outcomes"*

5.4 **Risk Management**

- None

5.5 **Equalities and Diversity**

- The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies **to have due regard** to the need to:
    1. eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
    2. advance equality of opportunity between people from different groups
    3. foster good relations between people from different groups

  The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services

- The report considers the health inequalities on the different topics for example: Many of the issues highlighted in the report affect vulnerable people e.g. children affected by vaccine preventable diseases; prevalence of cardiovascular disease and Tuberculosis is higher in certain BAME groups; Cardiovascular disease risk increases as we age but is affected by the choices we make early in our lives.

5.6 **Consultation and Engagement**

- The report will be presented to the Clinical Commissioning Group and to any partnership board or community groups that would like to receive a presentation.

6. BACKGROUND PAPERS

6.1 None

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BARNET
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THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2014

FROM THE BEATLES TO BEYONCÉ

1964 - 2014

Five Decades of Change in Public Health

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CONTENTS

FOREWORD

This year, I celebrated my 50th birthday. Attaining your half century makes you think about your life and the things that have happened during it. My public health report this year reflects on the public health changes that I've seen over my lifetime.

The topics that I've chosen are varied but they have something in common – they've shown huge changes and yet they still present us with challenges for the future. Most of the topics are also examples of health inequalities.

We begin with a look at cardiovascular disease – the most significant cause of death when I was a child and still a leading cause of death today.

Tuberculosis is a disease that we all thought was something of the past. The memories of the sanatoria of my parents' and grandparents' generations faded with the arrival of antibiotic treatments. But TB hasn't gone away and we now have the problem of drug resistance to face.

Sexual health is perhaps an area that has seen the biggest changes – from the sexual liberation of the swinging sixties to the spectre of AIDS and the link between the wart virus and cervical cancer in the 1980s.

Smoking was ubiquitous in the 1960s and, although far fewer people smoke now, it remains the only legal product which if used according to the manufacturer's instructions, will kill half of its users.

Vaccines have become a mainstay of our prevention initiatives. They are one of the big success stories of modern medicine and more immunisation programmes are being introduced.

The final chapter looks at the combined impact of our health experience on life expectancy. We're living longer, but are we living those additional years in good health?

I hope you'll enjoy reading this report and my trip down memory lane.

Here's to the next 50 years!

Andrew Howe

Director of Public Health

Heart Disease

ALTHOUGH WE SHOULD CELEBRATE OUR SUCCESSES IT WOULD BE PREMATURE AND DANGEROUS TO REST ON OUR LAURELS. WE MUST CONTINUE TO TARGET INEQUALITIES WHERE THEY EXIST AND BUILD ON OUR WORK BY TACKLING THE ROOT CAUSES OF CORONARY HEART DISEASE THROUGHOUT THE POPULATION.
PROFESSOR PETER WEISSBERG, MEDICAL DIRECTOR, BRITISH HEART FOUNDATION

Introduction

Heart disease is not a new phenomenon for human kind; in fact Pharaoh Merenptah, who ruled around 1200 B.C., had reportedly suffered from atherosclerosis. Drs Adel Allam and Gregory Thomas verified his condition in 2008. They examined Merenptah and fifteen other preserved representatives of the ancient Egyptian upper class[1] ranging from 2,000 to 3,500 years old of these fifteen; nine had evidence of blockages from atherosclerosis.

Despite, the evidence from the mummies we cannot conclusively state when mankind first became aware of coronary heart disease (CHD). The ancient Egyptians made many contributions to medicine including producing the world's first physicians who for millennia enjoyed the reputation of being the most skilled in the world, producing the world's first medical knowledge and literature, influencing Hippocrates and contributing to the Hippocratic tradition and the development of medicine in ancient Greece[2]. The Ebers papyrus, one of the most important surviving, translated medical papyri, contains sections on the movement of the heart, the pulse and diagnostic percussion[2].

Observations about heart disease were made during the 16 and 1700s. Friedrich Hoffmann, chief professor of cardiology at the University of Halle, noted that coronary heart disease started with the "reduced passage of the blood within the coronary arteries." Angina, first described in 1768, was believed by many to have something

THE PUBLIC HEALTH IMPORTANCE

Heart disease or coronary heart disease (CHD) is the collective term that describes what happens when the heart's blood supply is blocked or interrupted by a build-up of fatty substances known as atheroma in the coronary arteries in a process known as atherosclerosis. Heart attack and angina (chest pain) are two manifestations of heart disease.

CHD is one of the main types of cardiovascular disease (CVD), the collective term for all diseases affecting the heart and blood vessels. CVD problems result in chronic conditions that develop or persist over a long period of time as well as acute events. Globally, CVD is the leading cause of death. The World Health Organization estimates that, by 2030 CHD will be the biggest cause of death worldwide.

CVD is also associated with a large burden of preventable illnesses. Public health initiatives focus on decreasing CVD by encouraging people to follow a healthy, balanced diet, avoid smoking, control their blood pressure, lower their blood cholesterol if necessary, exercise regularly and, if they are diabetic, maintain good control of blood glucose.

to do with blood circulating in the coronary arteries, though others thought it to be a harmless condition. Cardiologist William Osler worked extensively on angina, and was one of the first to indicate that it was a syndrome rather than a disease in itself[3].

The need to understand what caused or contributed to the development of heart disease led to a flurry of research papers during the latter half of the 20th century. Many of these came from the Framingham Heart study which was the first major research project to help identify risk factors for heart disease[4,5,6]. The research project introduced a new vocabulary around heart disease contributing the term "atheriosclerosis" (known as "atherosclerosis" today) to the International Classification of Diseases[†]. In the 1950s, it was believed that clogging of arteries (atherosclerosis) and narrowing of arteries (arteriosclerosis) was a normal part of aging and occurred universally as people became older. Further information on the risk factors associated with heart disease came when University of California researcher John Gofman and associates identified two cholesterol types: "bad" low-density lipoprotein (LDL) and "good" high-density lipoprotein (HDL). Gofman and colleagues discovered that men who developed atherosclerosis had elevated levels of LDL and low levels of HDL[3]. The American scientist Ancel Keys documented that the incidence and mortality rates of coronary heart disease varied as much as tenfold across countries, with the lowest rates in Crete. The work from this study provided some hints about the culprit behind this vast disparity. Keys found that saturated fat consumption was strongly associated with regional rates of heart disease, but that total fat intake was not. He suggested that it was the type of fat, as well as the Mediterranean diet in general, that predicted the difference in heart disease risk[7].

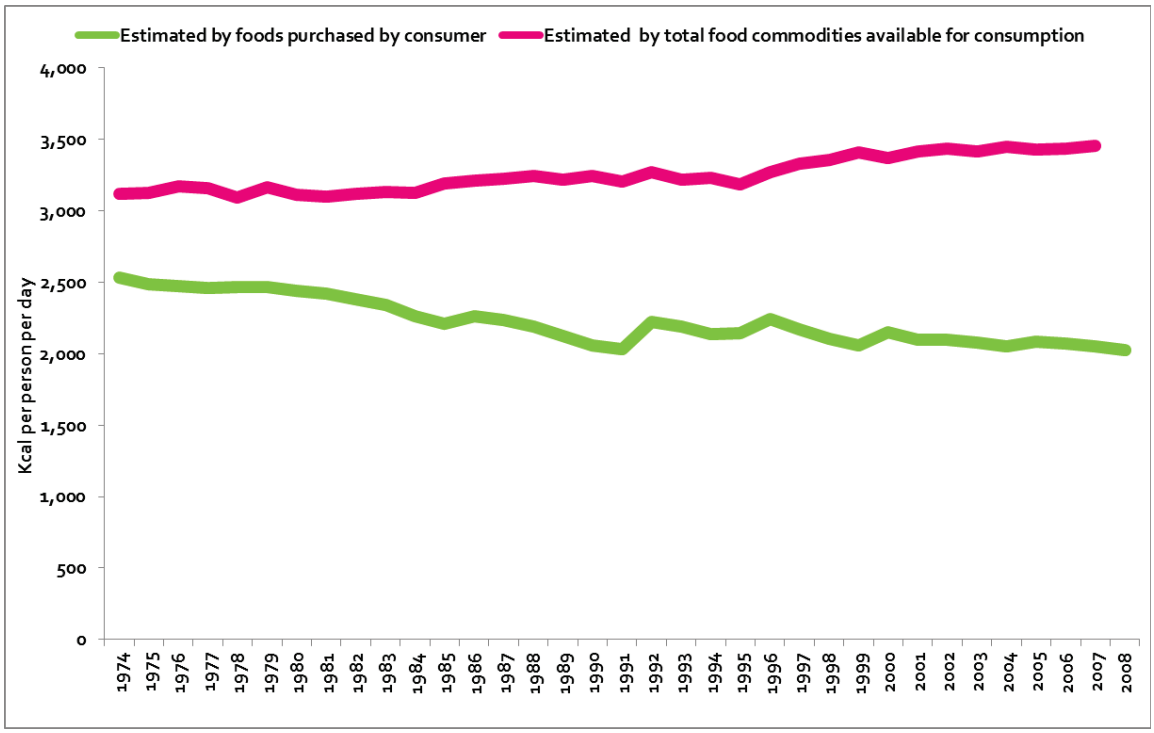
1964 - 2014

By 1965, the British Heart Foundation published a report listing the eight risk factors for heart disease which were compiled by the World Health Organization. The risk factors were high blood fat, high blood pressure, smoking; physical inactivity, genetics, diabetes, nervous stress and increased body weight, each of these risk factors would be explored to great success over the coming decades. There were countless other studies building on the work of Keys and colleagues and focusing on the specific types of fat. A conclusion was drawn that different types of dietary fat had varying effects on blood cholesterol levels and that different types of cholesterol had varying effects on heart disease. Unsaturated fats, especially polyunsaturated fats such as those found in walnuts, decrease the LDL cholesterol and raise the HDL cholesterol. While trans fats - liquid vegetable oils transformed into shelf-stable solids – 10-20% of which were found in margarines until the 1980s and small amounts of which naturally occur in diary products, beef, lamb and mutton – were associated with greater risk of heart disease and a double metabolic whammy of increasing LDL and decreasing HDL. Simultaneously, researchers globally showed that saturated fat – the kind found in butter

[†] A health care classification, providing a system of diagnostic codes for classifying disease including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

and lard – increases both LDL and HDL cholesterol, making it similar to carbohydrates overall but not as beneficial to health as polyunsaturated fats from nuts and vegetables.

FIGURE 1 TOTAL ENERGY INTAKE, COMPARISION OF TWO MEASURES, UNITED KINGDOM



Source: British Heart Foundation (2011) Trends in coronary heart disease, 1961 – 2011

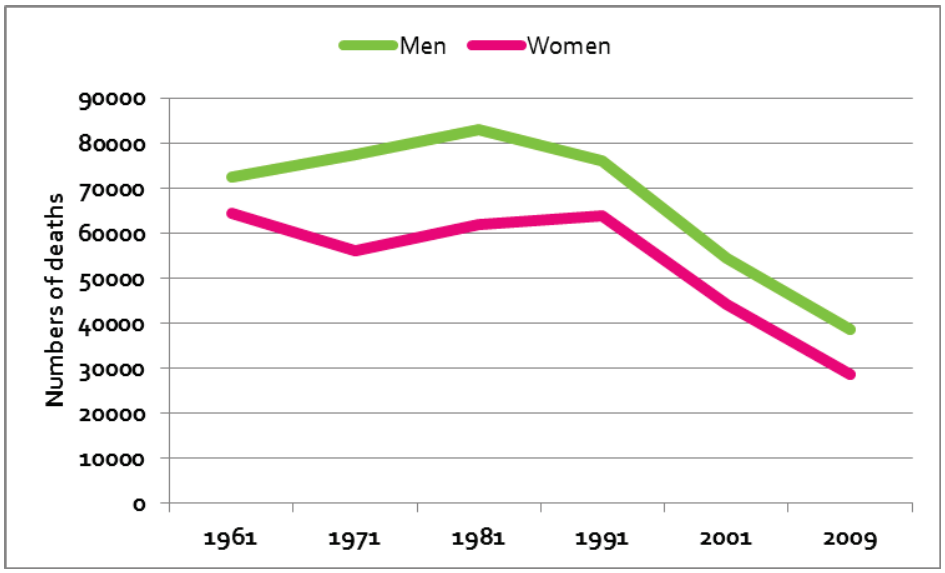
Overall, the quality of British diets has improved in some aspects since the 1970s; for example, saturated fat and sugar intake has considerably decreased. However, trends in total energy intake vary according to the method of measurement. When using household expenditure data, consumption of calories appears to have steadily decreased since 1961. Nevertheless, this does not take into account expenditure on food for consumption outside of the home. When energy intake is measured using food availability data (a measure of the food commodities available for human consumption in the UK, derived from import and export data), total energy intake increased between 1974 and 2007 (figure 1). The decrease in saturated fat levels in the British diet is reflected in trends in the types of foods we eat. In 1964, the majority of milk consumed came from whole milk; however this has changed over the past 50 years, so that by the early 1990s, the majority of our milk intake came from skimmed milk. A similar trend is seen in the types of oils and fats we eat. Butter, margarine and lard were the predominant types of fats eaten in the early sixties, but these have now been replaced by low fat spreads and vegetable oils, which are much lower in saturated fat.

During the 1980s and 90s amid nuanced research results, conventional wisdom and national guidelines shifted the spotlight to reducing total fat: the complicated message – that some fats are good and others are bad-

became over simplified. And so began our fixation with eliminating or reducing fat from our diets. The general public lived the mantra and the food industry jumped on board, removing fat from food and replacing it with sugar and carbohydrates and storing up further problems in the decades to come.

The proportion of deaths attributed to cardiovascular disease has fallen among both men and women from approximately half of all deaths in Great Britain in 1964; 48% among men and 54% among women, to about a third of all deaths among men (30%) and women (28%) in 2011.

FIGURE 2 ALL AGE CORONARY HEART DISEASE DEATHS, ENGLAND 1961 - 2009



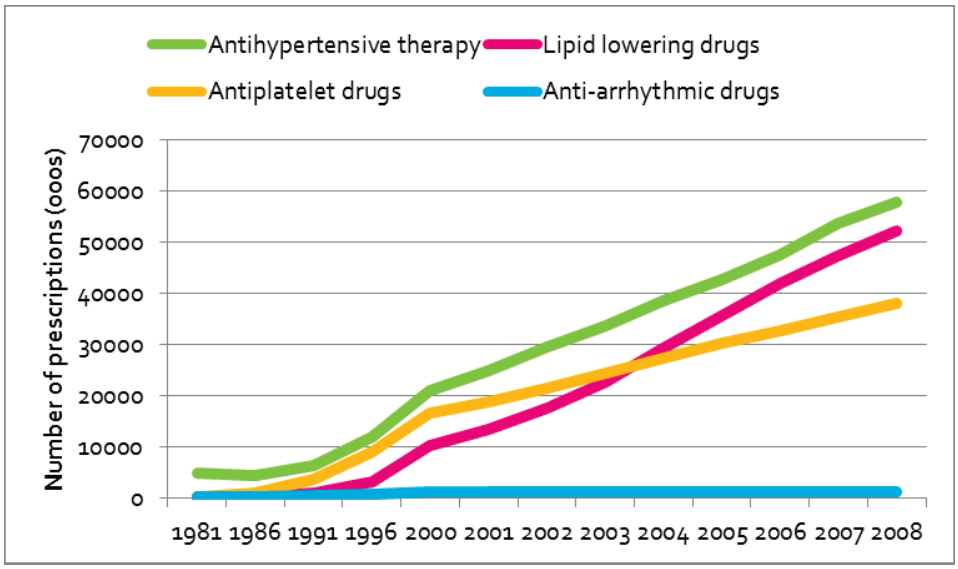
Source: British Heart Foundation (2011) Trends in coronary heart disease, 1961 – 2011

The numbers of men and women dying from heart disease have also fallen since 1961, with the most accelerated decline made since 1991 (figure 2). The decline was probably the result of a combination of factors including the impact of rationing during World War II - the frugal wartime regime had left the population healthier despite the food shortages – and medical innovation, a broad range of drugs became available for the treatment and prevention of cardiovascular diseases. A good thing considering that in the early 1960s the concept of preventing disease rather than treating it had yet to take hold. The four classes of drugs shown in figure four are evidence based therapy recommended by the National Institute for Health and Care Excellence (NICE) for the treatment of cardiovascular disease; anti-arrhythmics have been shown to reduce mortality following a heart attack and antiplatelet drugs are used as a secondary line of defense against the progression of heart disease.

More people have benefitted from life-saving lipid lowering drugs, the number of prescriptions made each year exploded from 295,000 to over 50 million between 1981 and 2008; operations to treat arteriosclerotic

heart disease have also increased from 700 in 1962 to 920 five years later. And by the mid 1970s, the surgery classification had changed to include all heart and intrathoracic vessels surgeries – resulting in a sharp increase from nearly 17,000 in 1974 to over 22,000 in 1976.

FIGURE 3 PRESCRIPTIONS USED IN THE PREVENTION AND TREATMENT OF CVD, ENGLAND 1981 – 2008



Source: Office for National Statistics (2009). Prescription cost analysis 2008. The Information Centre: Leeds

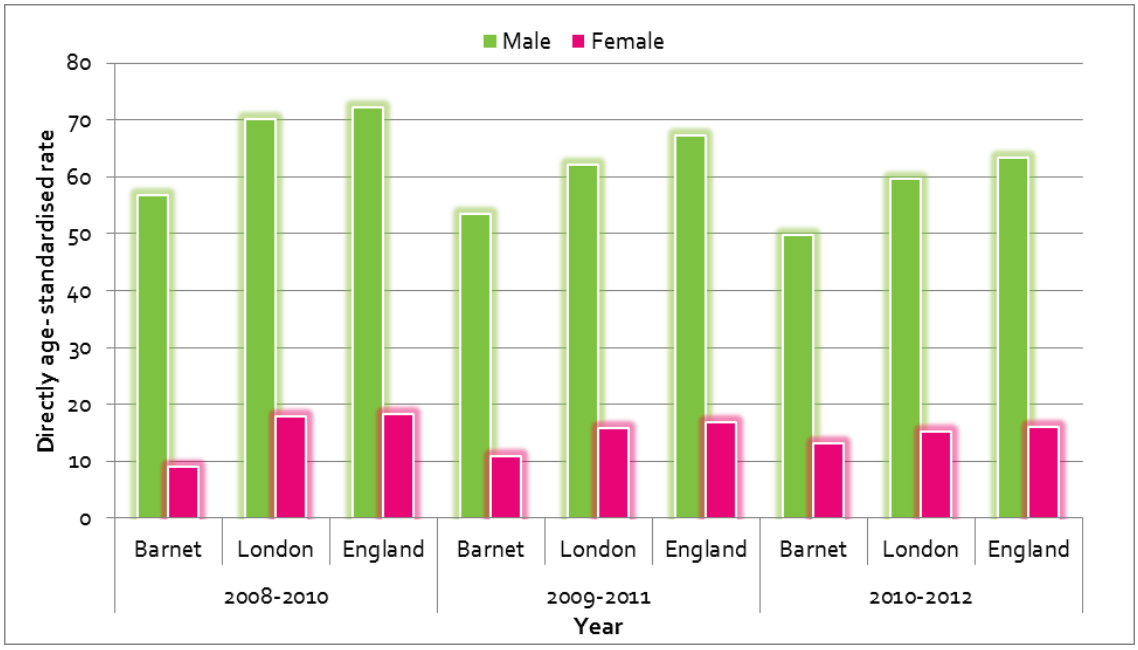
Analysis of mortality rates around the time of the 1971 census revealed that some ethnic minorities in the UK, particularly people of South Asian origin, bore a heavier burden of heart and circulatory disease than the rest of the population[8]. Indian-born men living in the UK were shown to have a 15% higher rate of death from heart disease compared to the population of England and Wales as a whole, and by the time the 1981 census data was analysed the difference has increased to 50%[9]. The increased risk of heart disease within these communities was recognized in the government's National Service Framework for heart disease published in 2000.

Between 2002 and 2012, the largest fall in age-standardised death rates for men and women (44% and 43% respectively) in England and Wales occurred in those dying from cardiovascular diseases.

Of the 499,331registered deaths in England and Wales in 2012, 28% were a result of cardiovascular diseases such as heart disease and strokes, currently it is the second most common cause of death after cancer (29% of all registered deaths). Approximately 23% of all deaths registered in England and Wales in 2012 were classified as deaths from potentially avoidable causes. Heart disease was the leading cause of avoidable death in men which represented 22% of all avoidable male deaths while lung cancer in women, accounted for 15% of all female avoidable deaths[10].

Heart disease is relatively uncommon below the ages of 35 years; over 75 years of age there may be more of a problem in diagnostic accuracy since there are likely to be multiple contributors to death. Consequently, most of the analysis is concentrated on ages 35 – 74. These years are often thought of as the most economically and socially productive years of adult life and so in public health terms we often look at years of life lost (YLL). The number of YLL is calculated by summing the number of deaths at each age between 1-74 years, multiplied by the number of years of life remaining up to the age of 75 years, this number provides a summary measure of premature mortality and is used in public health to compare the relative importance of different causes of premature deaths within a given population, to set priorities for prevention, and to compare the premature mortality experience between populations.

FIGURE 4 RATES OF YEARS OF LIFE LOST TO CORONARY HEART DISEASE, 2008 – 2012



Source: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development www.nchod.nhs.uk

The three year average rates of YLL for heart disease among men and women in Barnet have been consistently lower than both London and England since 2008 (figure 4). The higher rates in men compared to women can be explained by the fact that women tend to live longer than men therefore even though heart disease death rates in older men are higher than in older women there are many more older women who suffer from heart disease.

Among female residents in Harrow, the three year average rate for years of life lost to heart disease has been consistently lower than the rate observed nationally and regionally (figure 5). However, during the period 2010-2012, the rate of years of life lost to heart disease for men living in Harrow was for the first

time since 2008, higher than the rates observed in London and England, suggesting a greater proportion of premature death among men in Harrow compared with London and England.

What do we need to do now

The findings from the ancient Egyptian mummies mentioned at the beginning of this chapter should not be taken to mean that modern risk factors have no bearing on heart disease. The preserved representatives

FIGURE 5 RATES OF YEARS OF LIFE LOST TO CORONARY HEART DISEASE, 2008-2012

Source: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development www.nchod.nhs.uk

studied would have had diets high in salt which was used for food preservation and would have enjoyed the pampered lifestyle of the wealthy, so even these ancient people would have had risk factors similar to those of modern man.

Tackling Risk Factors

Much of the research around the risk factors associated with heart disease has informed a range of policies, strategies and health messages. Recent initiatives, like the Department of Health's 'Change4life campaign' which began in 2009 have helped to improve people's health through better diet and lifestyle advice. In addition, the British Heart Foundation and other voluntary sector campaigns have highlighted the benefits of taking regular exercise, eating a healthy diet, encouraging children to be heart healthy and being aware of dangers such as smoking, drinking, high blood pressure, and stress for long term heart health. More recently

the Department of Health's 'Healthy Lives, Healthy People' strategy for England included a tobacco control plan and a call to action to reduce obesity and sugar consumption in England.

In terms of diet and heart disease, researchers have highlighted the importance of focusing on healthy dietary patterns, rather than glorifying or demonizing specific nutrients. A healthy diet includes lots of fresh fruits and vegetables, whole grains, nuts, legumes, poultry and fish. An unhealthy diet contains plenty of processed meat, mounds of chips, lots of white bread and potatoes and processed breakfast cereals, large sugary drinks and packaged cakes for dessert. When it comes to fats in our diets – the latest advice is:

Foods rich in mono-and polyunsaturated fats (like olive oil, soybean oil, peanut oil, and canola oil) will lower your heart disease risk. Foods high in saturated fats (such as lard and animal fats like well-marbled meat) will not lower heart disease risk and research indicates they increase your risk of heart disease.

Don't replace foods rich in saturated fats with processed foods of refined carbohydrates (such as white bread and pastry).

Choose minimally processed foods with healthy fats – including nuts such as walnuts and peanuts, and fish such as salmon.

Given the diversity of the populations of Barnet and Harrow, the burden of cardiovascular disease within certain ethnic groups is an important consideration in terms of future progress. In addition to the higher rates of heart disease among South Asian Indians, men of South Asian origin are more likely to develop heart disease at a younger age and have higher rates of heart attacks, black African and Caribbean individuals have a higher risk of stroke and the highest death rates from stroke[11, 12]. The reasons for increased cardiovascular risk in these ethnic groups remain poorly understood, although traditional cardiovascular risk factors are still recognised to play an important role, as well as cultural and lifestyle factors.

Locally, both Barnet and Harrow have a range of lifestyle projects and initiatives in place that support residents in reducing their risk of heart disease including, local chage4life programmes, exercise on referral, stop smoking services and outdoor gyms.

Early Diagnosis and Risk Stratification

The Secretary of State for Health has prioritised reducing premature mortality and has a focus on improving prevention and early diagnosis; the NHS Health Check programme is a key deliverable in supporting this ambition. NHS Health Check is a national risk assessment and management programme for those aged 40 to

74 living in England, who do not have an existing vascular disease, and who are not currently being treated for certain risk factors. It is aimed at preventing heart disease, stroke, diabetes and kidney disease and raising awareness of dementia for those aged 65-74 and includes an alcohol risk assessment. The NHS Health Check should be offered every five years.

Both boroughs offer NHS Health Checks and follow-up intervention to the eligible population. These follow-up interventions have clear links to staying healthy initiatives and community development programmes and include lifestyle management advice and brief alcohol advice or referral.

Treatment

Effective treatment of heart disease saves lives; coronary heart disease can be successfully managed with a combination of lifestyle changes, medicine and in some cases, surgery. With the right treatment, the symptoms of heart disease can be reduced and the functioning of the heart improved.

The local CCG is responsible for the treatment of heart disease, although heart disease cannot be cured, treatment can help manage the symptoms and reduce the risk of further problems. A national review of heart disease services set out standards that define good heart disease care:

- ✓ Tackling factors that increase the risk of heart disease, such as smoking, poor diet and limited physical activity
- ✓ Preventing heart disease in high-risk patients and, where patients have heart disease, avoiding complications and tackling the progression of the disease
- ✓ Rapid treatment for heart attack, including the choice of angioplasty in a specialist cardiac centre
- ✓ Rapid diagnosis of heart disease and access to diagnostic tests
- ✓ Rapid access and choice of treatment centre for specialised cardiac care

Wider Determinants

Heart disease varies considerably across the social spectrum[11]. Research suggests that between 2000 and 2007, while approximately half the substantial fall in deaths from heart disease in England was attributable to improved treatment uptake across all social groups (ranging from 50% in the most affluent quintile to 53% in the most deprived), consistent with the equitable nature of the NHS. Changes in risk factors, such as lifestyle, accounted for approximately a third fewer deaths in 2007 than occurred in 2000, but were responsible for a smaller proportion of deaths prevented in the most affluent quintile compared with the most deprived (approximately 29% versus 44%, respectively). However, the benefits of improvements in blood pressure, cholesterol, smoking and physical activity were partly negated by rises in body mass index (BMI) and diabetes, particularly in more deprived quintiles[13].

The burden of CHD in the UK is immense and while much attention is attracted to the very visible and costly 200, 000+ hospital admissions annually the eightfold larger (approximately 1.6 million) mass of patients

living with chronic disease in the community remains largely hidden. These community patients will have a reduced life expectancy, impaired quality of life with all the services and costs associated with this including, disability benefits for those not working and higher rates of lost productivity for those who are working[14].

Prevention is key to further reducing the number of deaths from heart disease in the UK and while the majority of individuals know what they can do to prevent heart disease, they need to be supported at the macro level by minimising influences towards unhealthy behaviours and ensuring that healthy choices are the default option. Other countries have implemented effective, evidence-based interventions to tackle lifestyle risk factors such as substantial dietary reductions in salt, saturated fats, trans-fats and sugars concealed in processed food, fast-food takeaways and sweetened drinks; the most powerful measures involve legislation, regulation, taxation or subsidies, all of which tend to be equitable. Such measures would effectively tackle persistent inequalities in deaths due to heart disease[15-18].

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Tuberculosis

FEW DISEASES POSSESS SUCH SAD INTEREST FOR HUMANITY AS CONSUMPTION [TB], BOTH ON ACCOUNT OF ITS WIDESPREAD PREVALENCE AND IT DESTRUCTIVE EFFECTS, PARTICULARLY AMONG THE YOUNG.
DR J O AFFLECK, UNIVERSITY OF EDINBURGH, SCOTLAND (1885)

Introduction

Much like heart disease tuberculosis (TB) has plagued humans since ancient times and has had a variety of names through the ages including phthisis pulmonaris, the white plague and consumption. Tuberculosis is caused by the tubercle bacillus Mycobacterium tuberculosis, these bacteria are slow growing and can survive in the body for many years in a dormant or inactive state whereby people are infected but show no signs of TB disease. When the bacilli are awake and dividing people are said to have 'active TB'. During the 18th century it was known as the white plague due to the extreme pallor in those infected while in the 19th and early 20th centuries it was more commonly known as consumption because of severe weight loss as the disease appeared to "consume" those infected[1].

TB reached near epidemic proportions during the 18th and 19th centuries, largely due to the rapidly urbanising and industrialising societies of Europe, with high mortality rates even among the prominent; the poet John Keats and all three of the Brontë sisters (Charlotte, Emily and Anne) are all thought to have died of TB[2]. Robert Koch isolated the *Mycobacterium tuberculosis* bacteria in 1882 paving the way for greater understanding of the organism which spreads via the droplets coughed and sneezed out of the throat and lungs of people with the active disease. In 1913, it became a legal requirement to notify of cases of the disease and, by the mid-1930s over 50,000 cases of TB were diagnosed each year (figure 6).

THE PUBLIC HEALTH IMPORTANCE

Tuberculosis is a disease of immense public health importance. It is the leading cause of death among curable infectious diseases and was declared a global emergency in 1993.

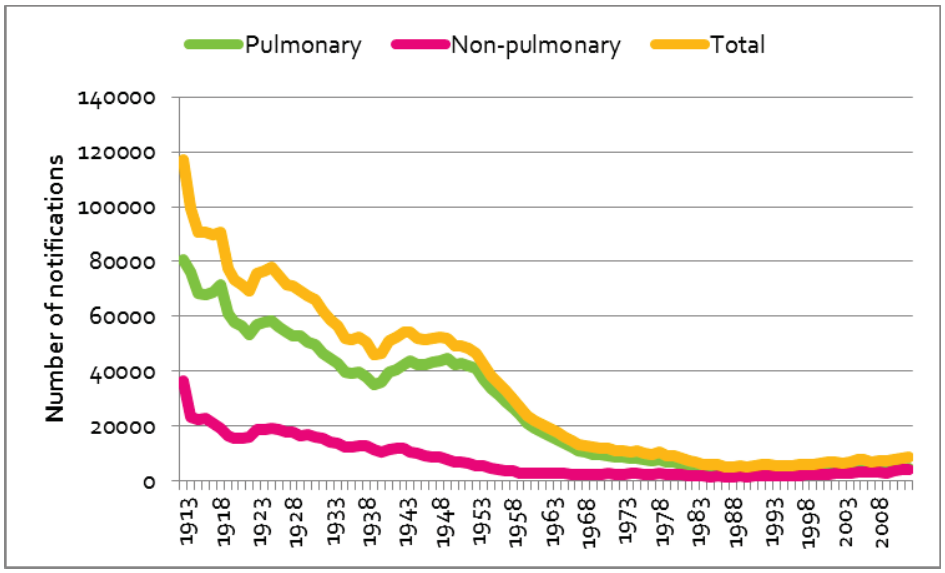
TB can affect any part of the body but is most common in the lungs and lymph glands. The disease develops slowly in the body, and it usually takes several months for symptoms to appear.

Around 9000 cases of TB are currently reported each year in the United Kingdom with most cases occurring in major cities, particularly in London.

The rate in Barnet is lower than the London average, while the rate in Harrow is significantly higher than the London average.

By 1921, a temporary reprieve was issued in the form of the BCG vaccine developed by Albert Calmette and Camille Guérin, leading to large numbers of children being vaccinated following World War I. Prior to the advent of penicillin, TB was so deeply feared that patients were sent to remote sanatoria where they were nursed for years while the defensive properties of their bodies dealt with the disease. Some recovered, and although they still carried the disease, they were healthy enough to work and survive. Many others were less fortunate, either dying from the disease or suffering from poor health for the rest of their lives. Since the 1940s, antibiotics have reduced the span of treatment from years to months and in 1952, a great advance was made when the antibiotic, Isoniazid, was found to work effectively against TB, fundamentally changing the prognosis of those infected, enabling those with TB to be effectively treated and cured of the disease.

FIGURE 6 TUBERCULOSIS NOTIFICATIONS BY SITE OF DISEASE, ENGLAND AND WALES 1913-2012



Source: Statutory Notifications of Infectious Disease (NOIDs) 1913-1982; 2010-2012 Enhanced Tuberculosis Surveillance (ETS), Centre for Infectious Disease Surveillance and Control, Public Health England

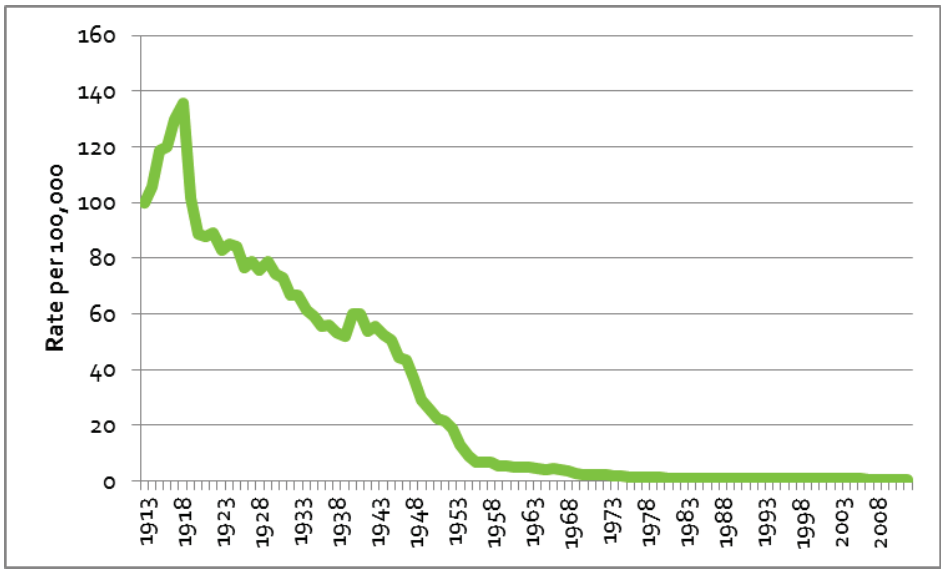
1964 - 2014

The Madras experiment in the early 1950s had provided the evidence that people with TB could be safely treated at home and so there was no need for sanatoria. TB sanatoria started closing or changing their remit in the 1960s as people were no longer sent away for treatment. The success of the new drugs meant that the mortality rate steadily declined (figure 7).

Other drugs were brought to market through the 1960s, by this time England was already seeing the health benefits of economic improvement, better sanitation, more widespread education, and particularly the

establishment of public health practice including specific measures for tuberculosis control. By the end of the 60's, TB was thought of as a disease of the past, poverty, and the developing world.

FIGURE 7 TUBERCULOSIS MORTALITY RATE, ENGLAND AND WALES, 1913 - 2012



Source: Centre for Infectious Disease Surveillance and Control, Public Health England

However, by the mid-1980s TB was making a resurgence. This in part was attributed to complacency due to the faith people had stored in the now standard TB drugs. There was also increased migration of people from nations where the disease was prevalent and by the late 1980s, the spread of HIV provided a new group of people at a high risk of catching TB.

Standard anti-TB drugs (isoniazid, rifampin, pyrazinamide and ethambutol) were used for decades but resistance to the medicines increased; the primary cause of resistance, inappropriate treatment. TB is not a quick fix disease. The nature of the bacteria means that some are killed by the medicines while others go dormant. People with TB need to take their medication for 6 to 12 months to make sure all of the disease is eradicated. However, people with TB often feel much better with a few weeks of starting treatment and may not appreciate the need to continue taking the tablets.

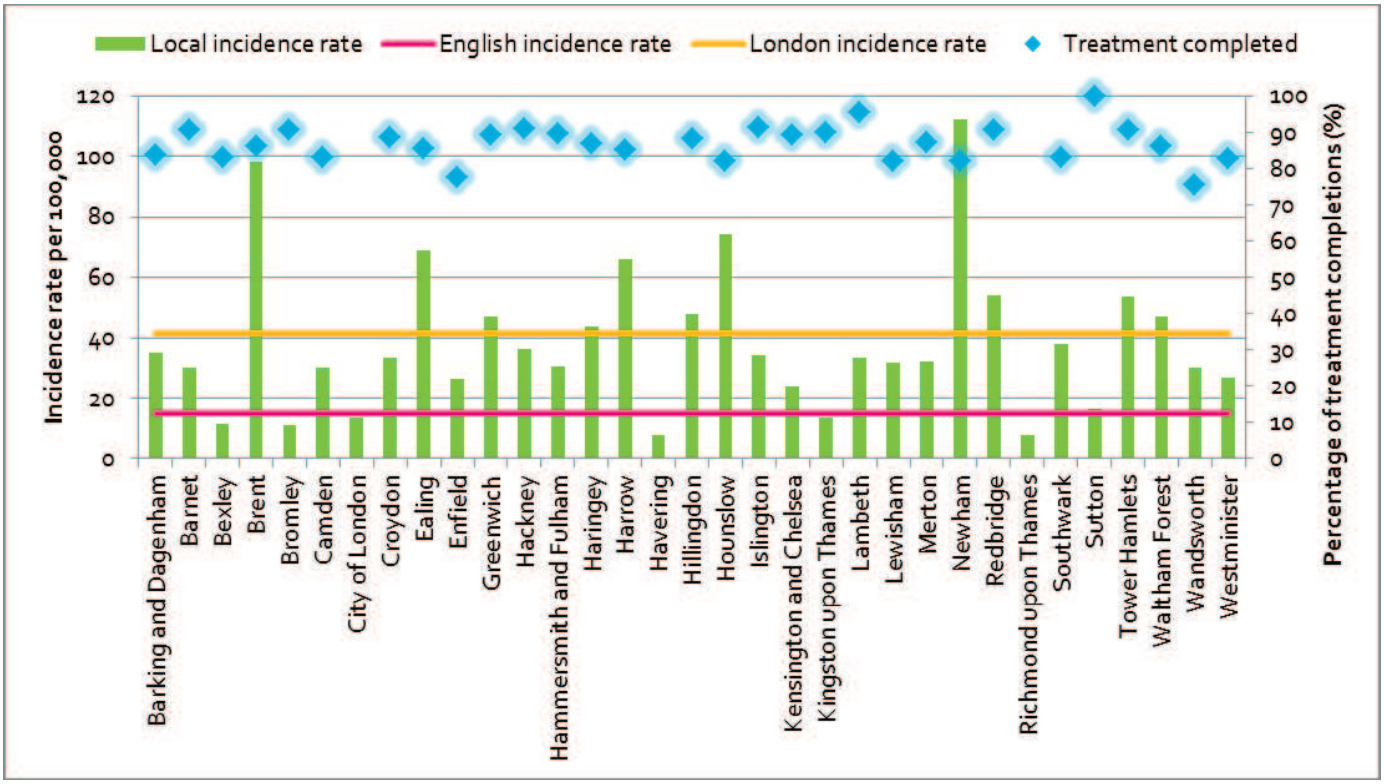
Disease strains that are resistant to a single anti-TB drug have now been documented in every country surveyed[3]. Multiple drug-resistant TB (MDR-TB) is a form of TB caused by bacteria that do not respond to isoniazid and rifampicin -- the two most powerful, first-line anti-TB drugs. MDR-TB is treatable and curable with the use of second-line drugs. However second-line treatment options are limited and the recommended medicines are not always available. The extensive antibiotic treatment required for MDR-TB (up to two years of treatment) is more costly and can produce severe adverse drug reactions in patients.

In some cases, more severe drug resistance can develop. Extensively drug-resistant TB (XDR-TB) is a form of MDR-TB that responds to even fewer available medicines, including the most effective second-line therapies. XDR-TB is resistant to the drugs classed as fluoroquinolones and at least one of three injectable second-line anti-TB medications (capreomycin, kanamycin or amikacin).

Whilst the goal had been to eliminate TB in the way that smallpox was eradicated in 1980s, success has been thwarted due to the challenges described above.

In 2010, there were 8,483 reported cases of tuberculosis (TB) in England – an incidence of 13.6 cases per 100,000 people, with 73% of cases among people born outside the UK. Almost two fifths (39%) were reported in London, a significantly higher proportion than any other UK region, consequently the region has been a focus of TB control.

FIGURE 8 INCIDENCE RATE OF TB, 2010-2012 AND PERCENTAGE OF PEOPLE COMPLETING TREATMENT*, 2012



Source: Public Health Outcomes Framework www.phoutcomes.info

** The percentage of people completing treatment for TB within 12 months prior to 31st December.*

NB Data on the percentage of people completing treatment in the City of London, Havering and Richmond Upon Thames could not be calculated as the number of cases is too small.

The latest available data released by Public Health England (PHE) suggests that new TB notifications in London residents may have stabilised: in 2013 there were 3,020 new notifications compared with 3,426 in 2012. The overall TB rate for London was 36.3 per 100,000 people in 2013 down slightly from 41 per 100,000 people in 2012. The resurgence of TB in parts of the UK is associated with changing patterns in its determinants and distribution. In the last half century, the disease has moved from one occurring throughout the total population to one occurring predominantly in specific population subgroups[4]. TB rates remain stubbornly high in northwest and northeast London (figure 8) the rates of TB have remained twice the London average for over a decade[5].

The TB rate in Barnet (30 per 100,000) remains slightly below the London average (41 per 100,000). Although patients were more often men a larger than usual proportion were made up of women aged 20-29 years. The majority of patients were born abroad: 16% were recent migrants (entered within the previous two years), while almost three in ten had been in the UK for more than ten years before diagnosis. Most patients were of Indian origin with the majority being born in India, the next most common group were those classified as "mixed/other", reflecting individuals from a range of backgrounds. A third of patients in Barnet with pulmonary disease had a delay of more than three months before diagnosis and the levels of drug resistance in the borough were above the London average. Fewer patients had social risk factors, such as homelessness, imprisonment and drug and alcohol misuse, than elsewhere in London[6].

The TB rate in Harrow has increased since 2004, and is one of the highest in London at 76 per 100,000, between 2011 (153) and 2012 (185) the numbers of cases increased by 21%. While the most common age group of diagnoses was 20-39 years, children aged less than ten were also diagnosed with TB. Almost all of the TB cases in Harrow were among those born abroad, 11% of whom had entered the UK within the previous two years however, the time since entry was not reported in 31% of cases. The majority of patients were of Indian ethnicity, mostly born in India, although some were from East Africa. Levels of drug resistance were similar to the London average, with very few patients having social risk factors. Treatment completion among patients with pulmonary TB was below the London average, in addition to this 8% of patients were lost to follow up, 10% died, among these patients TB caused or contributed to half of these deaths[6].

What do we need to do now

TB was, and remains, a stigmatised disease — a disease of the poor. The disease and conditions of poverty are inter-related: one cannot be successfully addressed without the addressing the other. The high burden of TB is set against a background of national guidance, policy and recent reorganisation within the healthcare system. Implementation of some of these measures has contributed to stabilising the rate of TB but has failed to reverse the upward trend.

Improving Housing Conditions

Local authorities can work to reduce TB transmission by addressing some of the contributory social factors that fall within their remit: e.g. overcrowding, poor housing, homelessness, and access to healthcare. Making improvements across these areas will help to reduce inequalities and TB transmission and improve general health outcomes[9].

Higher rates of disease are found in inner city areas, in communities with particular connections to higher-prevalence world regions, and in communities with high rates of homelessness and/or alcohol or substance misuse. This is because these factors and poverty are linked to conditions of overcrowding, poor ventilation, and poor nutrition, all of which provides fertile ground for the spread of TB. Both Harrow and Barnet have been identified as areas with the highest levels of fuel poverty in London, providing an exacerbation of all of the housing risk factors associated with TB. Since TB requires an airborne route for disease transmission, ensuring adequate ventilation and limiting close contact with people with active disease helps to eliminate the spread of TB to others[7].

People with diagnosed TB need to be considered as a high priority group in terms of housing support needs. This group is at a high risk of not completing their treatment due to an erratic lifestyle. Housing teams should be invited to case reviews where necessary.

Identifying and Treating TB Effectively

Effective local implementation of detection and treatment strategies can reduce the burden of disease from both a human and economic standpoint, minimising the risk of on-going transmission. Improving and supporting the basic elements of TB control are crucial. Prompt identification of active cases of disease, supporting patients to successfully complete treatment, and preventing new cases of disease occurring are critical components of any actions to reduce the spread of this disease[8]. Active TB is relatively inexpensive and straightforward to treat and cure when identified early[5].

The Clinical Commissioning Group (CCG), as commissioners of treatment services, need to ensure that the services are adequate for the local burden of disease. Rapid access clinics; enhanced case management; effective and comprehensive contact tracing; and supported housing for those with erratic lifestyles who are in treatment are all important elements of an effective TB service.

Reducing barriers to diagnosis and treatment and supporting people to complete their medication regimen will help to ensure that this disease is conquered in the coming half century.

Latent TB

Having a high treatment completion rate for people with TB is good but that is not sufficient to break the cycle. Steps must be taken to identify people with latent TB to ensure that they receive the antibiotics necessary to prevent their latent disease converting to active disease. Application of national guidance has been inconsistent in some parts of London and there is no systematic approach to detecting and treating latent

TB[5]. PHE are currently running a test programme in Harrow to identify latent disease. The results of this pilot will not be known for some months.

Raising Awareness of TB

Raising awareness in the community is vital. There are a few key messages to get across that will go a long way to reducing the social stigma associated with this disease: While the main message is that TB is preventable, treatable and curable. We also need to ensure that people know about the symptoms of TB – especially if they are visiting or being visited by someone from a high prevalence country; that they should seek treatment as early as possible to prevent onward transmission to their family and friends; that treatment takes a long time – 6 months or more – to be completely effective.

The conditions prevalent in many less developed countries and the rise in the number of people living with compromised immune systems has given rise to a situation where this disease, after thousands of years, remains a global public health problem. Additionally, the rapid increase in international travel has enabled people to travel widely, helping to spread the disease. Public health and medical science have come a long way in understanding and treating this disease in the past five decades but in order to eliminate the disease from our history we need to ensure it is controlled in both developed and developing nations.

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Sexually Transmitted Infections

THERE WERE THOSE WHO SAID THE ADVERTS INCREASED FEAR MORE THAN UNDERSTANDING. I THINK THEY DID BOTH. THEY STOPPED A LOT OF PEOPLE FROM HAVING SEX AT ALL FOR QUITE SOME TIME, BUT ONE UPSIDE WAS THAT THEY GOT EVERYBODY TALKING ABOUT SEX AND SAFER SEX
LORD FOWLER, HEALTH AND SOCIAL SECURITY SECRETARY, 1987

Introduction

For an activity that ensures the continuation of the human race, sex can be risky business. The intimate nature of contact provides the ideal opportunity for the spread of a number and range of organisms. Prior to the advent of modern medicine, the population's lack of awareness and understanding of sexually transmitted infections (STIs) contributed to its widespread transmission while few or no treatments were available to treat the conditions.

During the medieval period, syphilis and gonorrhoea were two of the most prevalent venereal diseases (VD) in Europe. The appearance of syphilis in Europe at the end of the 1400s heralded decades of death as the disease ravaged the continent. The first well recorded European outbreak of syphilis occurred in 1494 among French troops besieging Naples. From there it swept across Europe, killing more than five million people[1]. Huge primary ulcers, violent bone pains, headaches and impaired vision all came in rapid succession and often proved fatal in a short time as there was no effective treatment. By the 18th and 19th centuries, mercury, arsenic and sulphur were commonly used as VD treatments: all of which had distressing side effects and were of limited effectiveness.

THE PUBLIC HEALTH IMPORTANCE

STIs are a major public health concern. This is because they place a significant burden on healthcare resources both directly, through individuals seeking treatment and care, and indirectly, resulting from management of the complications of untreated infections which can lead to infertility, cervical cancer and ectopic pregnancy. STIs also increase the likelihood of HIV transmission.

The distribution of STIs in the population is highly uneven, as they disproportionately affect men who have sex with men, young people aged under 25 years and some ethnic minorities.

The epidemiology of STIs in the UK has shown remarkable changes over the 20th and early 21st centuries, reflecting changes in sexual behaviour, new diagnostic techniques, changes in sexual health service delivery and the implementation of control programmes, in a context of social, economic and demographic shifts within society.

Founded in 1746, London Lock hospital was the first voluntary hospital for venereal diseases. These hospitals survived well into the twentieth century and played a role in the development of the departments of the Genito-Urinary Medicine (GUM) that exist today[2].

Venereal disease went hand in hand with considerable social stigma. Such was the shame, many sufferers hid their symptoms, while others carrying asymptomatic disease went unawares. So by the 1800s VD was endemic, carried by up to 10% of men. The spread of VD was linked to extramarital sex and prostitution. The first Contagious Disease Act in 1864 allowed the compulsory medical examination of any woman believed by police to be a prostitute. Its enforcement, in several towns where troops were stationed, was a direct response to the high levels of VD among troops during the Crimean War[3].

In 1870, it was reported that a third of the outpatients attending St. Bartholomew's Hospital in London did so because of venereal disease[2]. The Victorians, for whom all things related to sex were considered not fit for decent conversation, ensured that the conspiracy of silence was perpetuated. It was against this backdrop, that a few dedicated people strove in obscurity, and little if any encouragement, to understand these infections. Philippe Ricord demonstrated that syphilis and gonorrhoea were different diseases and described the various stages of syphilis. Albert Neisser isolated the organism responsible for gonorrhoea (*Neisseria gonorrhoeae)*, while Fritz Schaudin and Eric Hoffman isolated the causative agent of syphilis, *Treponema pallidum* in 1905[2]. The first proven cure for syphilis, Salvarsan, was developed in 1910 by Paul Ehrlich. It remained the standard treatment until the arrival of penicillin during the Second World War (1939-1945) despite its serious side effects.

The early years of the twentieth century saw an awaking of the social conscience. A Royal Commission in 1913 sought to address the problem of venereal diseases. After three years, innumerable witnesses, and many hours of deliberation, they reached some definite conclusions. The Venereal Diseases Act of 1917 defined exactly which conditions came within the meaning of the Act; directed borough councils to provide free and confidential treatment and imposed legal penalties on any who failed to maintain confidentiality[2]; said that only authorised persons were to treat such conditions and made it a criminal offence for others to do so; and it forbade the commercial advertising of any drug or preparation claiming to treat the named diseases. The act didn't make everything better. As is the case now; some local authorities performed better than others; some were very progressive and engaged skilled staff and provided excellent facilities, some appointed staff but then gave little or no support, while others took the view that anything was

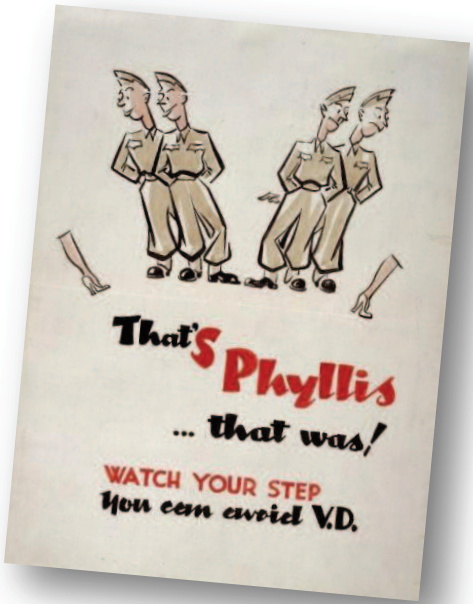
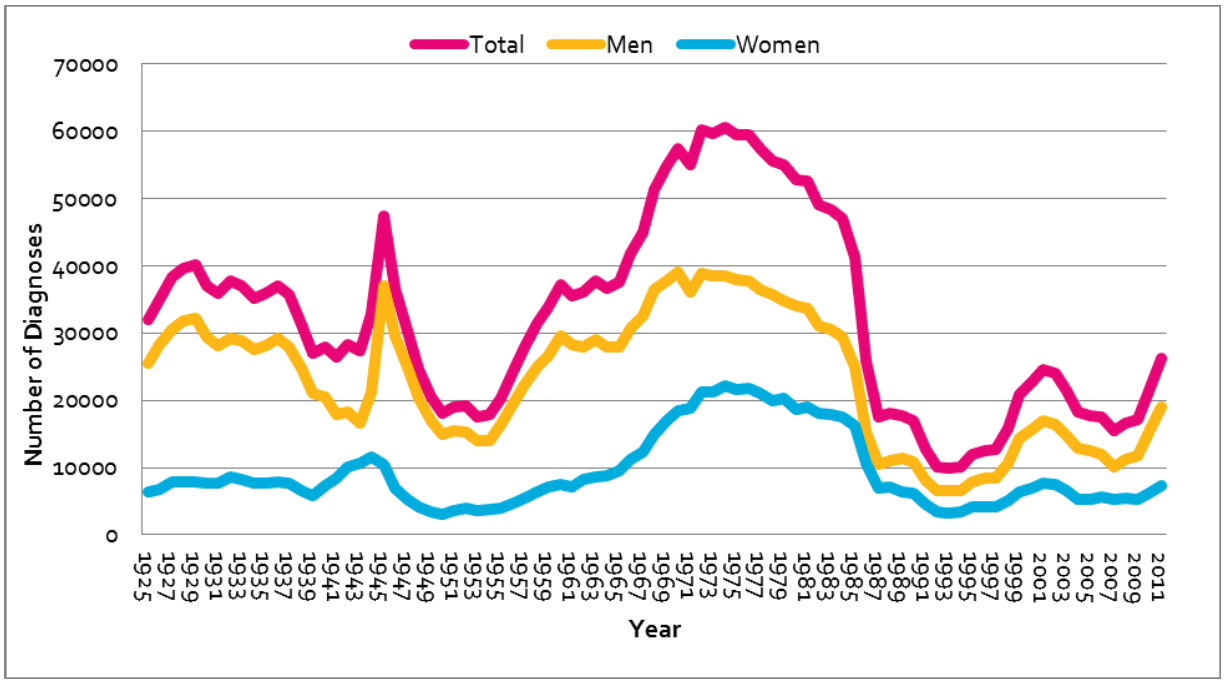


FIGURE 9 ANTI-VENEREAL DISEASE CAMPAIGN FOR ALLIED TROOPS IN ITALY 1943-1944

good enough for this sort of patient who ought to be grateful for the attic, basement or outhouse that was, not infrequently, offered.

Alongside laws, moral pressure remained key to fighting venereal disease. Few soldiers on active service in the 1900s were unaware of the possible physical and social consequences of sexual encounters, dangers that were often backed up with sickeningly graphic imagery. Not that it stopped them though. During the First World War (1914-1918) there were nearly half a million hospital admissions for venereal disease among British troops alone[3]. Every day thousands of men were unavailable for active service. This manpower wastage was not forgotten. During the Second World War preventative efforts intensified through films, lectures, posters, leaflets and greater availability of condoms (figure 9). Infection rates remained stubbornly high, but treatment times were drastically reduced with the arrival of penicillin[4]. Venereal disease cases even gained priority access to the drug if it meant a faster return to the front line. Diagnosis of syphilis and gonorrhoea in England, Scotland and Wales peaked in 1946, coinciding with the return of the armed forces after World War II[1]. There was a sharp decline immediately thereafter, associated with the widespread availability of penicillin as well as the return to social stability (figure 10).

FIGURE 10 DIAGNOSES OF GONORRHOEA IN ENGLAND & WALES, 1925-2012



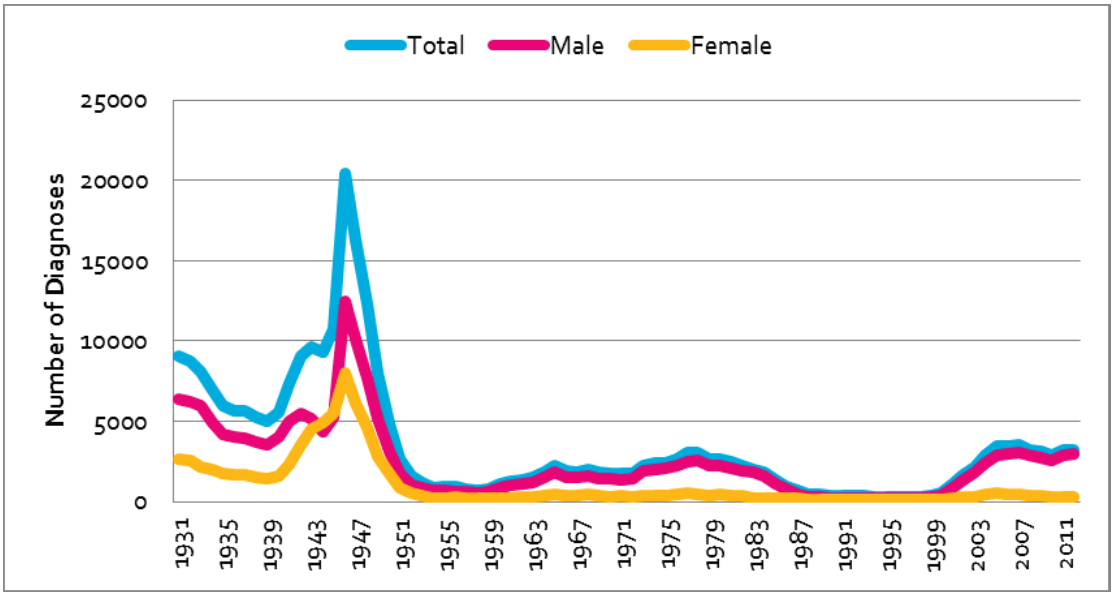
Source: Centre for Infectious Disease Surveillance and Control, Public Health England

1964 – 2014

The launch of the contraceptive pill played a major role in women's liberation and contributed to the sexual freedom of the so-called Swinging Sixties. Initially, the pill was only only available to married women, but the law was relaxed in 1967. Between 1962 and 1969, the number of women taking the pill rises dramatically, from approximately 50,000 to 1 million. In addition, the use of penicillin and other antibiotics provided an effective cure of bacterial STIs leading the public to perceive these infections as less of a threat paving the way for more relaxed attitudes to sexual risk during the 1960s and 1970s.

Accordingly, there was a steady increase in diagnoses of STIs. Syphilis diagnoses in men increased, whereas the number of cases in women remained constant, suggesting that sex between men became the major route of acquisition of syphilis during this period (figure 11). However, diagnoses of gonorrhoea, and the viral STIs genital herpes and genital warts increased in both men and women, indicating that these infections were more commonly acquired through heterosexual sex. For some of these STIs, the increases may reflect greater public awareness and/or improved diagnostic sensitivity, in addition to increased incidence of infection[4].

FIGURE 11 SYPHILIS (PRIMARY, SECONDARY AND EARLY LATENT) IN ENGLAND, WALES & SCOTLAND, 1931-2012



Source: Centre for Infectious Disease Surveillance and Control, Public Health England

When AIDS was first reported in America in 1981 it provoked reactions which echoed those that had accompanied syphilis for so long. That many of the earliest cases were among men who have sex with men created a climate of prejudice and moral panic. The emergence of HIV and AIDS in the early 1980s is now believed to have had a significant impact on the incidence of other acute STIs. Diagnoses of syphilis and gonorrhoea declined sharply in the early to mid-1980s, coinciding with extensive media coverage of AIDS,

national public health campaigns, and associated adoption of safer sex practices. Similarly, the number of diagnoses of genital herpes and genital warts, both of which had increased steadily since 1972, stabilised (and in the case of herpes, decreased briefly) during the mid-1980s. These changes are likely to be associated with general population-level behavioural modification in response to the HIV/AIDS epidemic and in particular to the stark, unambiguous warnings of the world's first major government-sponsored national AIDS awareness campaign, and arguably the most successful (figure 12).

FIGURE 12 NATIONAL BILLBORD ANTI-AIDS CAMPAIGN POSTER IN LONDON (CIRCA 1987)

By the mid to late 1990s there was resurgence in diagnoses of many STIs, and the annual number of reported cases increased considerably from 1995: Complacency had once again set in, people infected with HIV were living longer and scientists were working hard on finding a cure.

In the last decade reported cases of many STIs have continued to increase. Almost half a million STIs are now diagnosed in the UK each year although much of this rise is associated with improved diagnosis, unsafe sexual behaviour is likely to be contributing in certain population groups since men who have sex with men, young people aged less than 25 years, and some ethnic minorities are disproportionately affected.

The patterns of maintenance and spread of STIs within populations differ for each type of STI, as they are influenced by multiple factors including individual susceptibility to infection, the likelihood of transmission, the capacity of the bacteria or viruses to cause disease and the duration of infection. Gonorrhoea has a high probability of transmission at each sex act but a low duration of infectiousness, and can only persist in population groups with more dense sexual networks and high rates of partner change, or where there is particularly poor access to treatment. At the other end of the spectrum, genital herpes simplex virus has a low probability of transmission at each sex act; however, because it is incurable and its infectiousness life-long, it can be maintained in populations with lower rates of partner change by multiple sex acts with the same partner[5].

Since 1987, the number of new HIV diagnoses steadily increased to a peak of 7,844 in 2005. Current estimates suggest that there may be around 30,000 individuals in the UK who are unaware that they have HIV[3]. Presentation of HIV infections at a late stage of infection for treatment and care can considerably reduce the effectiveness of treatment and an individual's life expectancy. Although recent years have seen a small decrease in new infections each year, HIV rates in gay and bisexual men continue to remain at

worryingly high levels. In 2010, there were 3,080 new infections diagnosed in MSM – the highest ever annual total in this group.

London has the highest rates of acute STIs in England, 66% higher than England as a whole[6]. In 2012, nearly 110,000 (109, 672) people were diagnosed with acute STIs. This represents a rate of 1, 336.7 diagnoses per 100,000 adults compared with rate of 803.7 per 100,000 as the England average. There was a 5% rise in acute STI diagnoses in London GUM clinics in 2012 compared to 2011 and a 16% rise compared to 2003.

In Harrow, the acute STI rate was 1, 529 per 100,000 in 2012 which was significantly higher than the England rate but lower than the London rate. The acute STI rate in Barnet in 2012 was 801.9 per 100,000 which is significantly lower than Harrow, London and slightly lower than England.

In 2013, rates of syphilis in London (19.8 per 100,000) were 70% higher than England (5.9 per 100,000), gonorrhoea rates were 66% higher (155.4 compared with 52.9 per 100,000), rates of genital warts were 19% higher (163.9 compared with 133.4 per 100,000) and there was a 35% difference in genital herpes (89.9 compared with 58.8 per 100,000).

Chlamydia is the most commonly diagnosed bacterial STI in the UK and is extremely widespread. Prevalence is highest in young adults aged less than 25 years and ranges from between 2% and 3% in the general population to between 9% and 10% in those attending healthcare settings for chlamydia screening. The risk of Chlamydia infection is linked to having unprotected sex and a higher number of sexual partnerships. Most infections are asymptomatic, and as a result may go untreated. Untreated infections can have serious health implications, including pelvic inflammatory disease (PID), infertility and ectopic pregnancy.

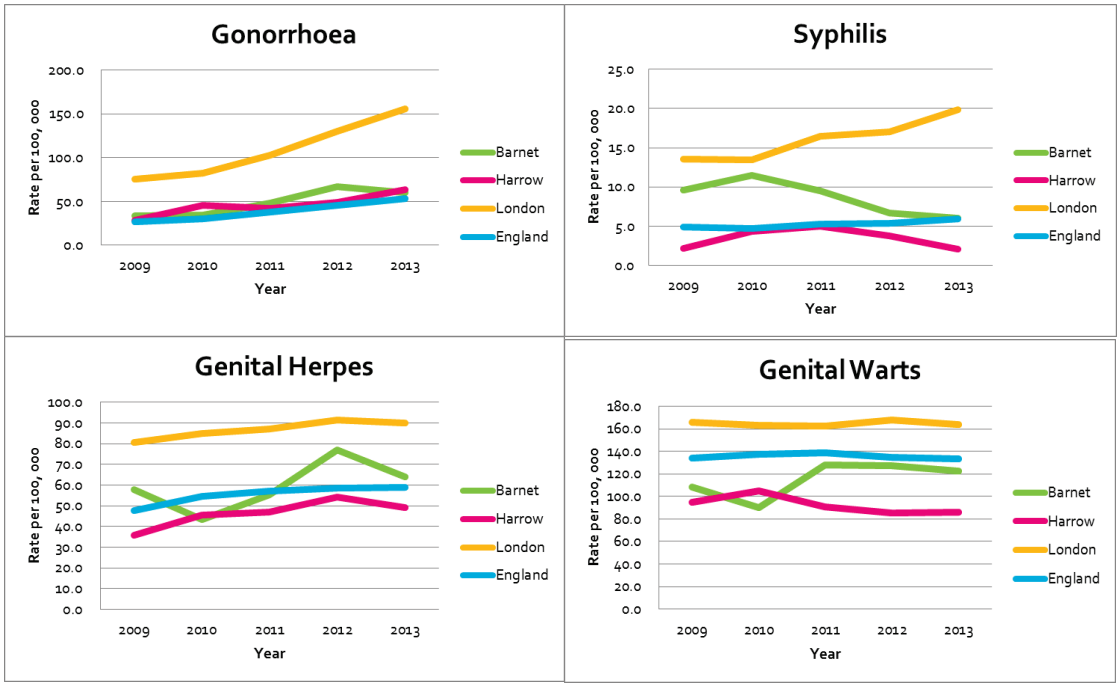
In 2013, the rate of chlamydia diagnosis among 15-24 year olds in both Barnet (1098 per 100,000) and Harrow (1087 per 100,000) was significantly lower than the rate in England (2016 per 100,000). The proportion of people screened within this age group was also significantly lower in both boroughs (16.0% in Barnet and 14.7% in Harrow) when compared to the England average (24.9%). PHE recommends that local areas should be working towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 among young people (aged 15 to 24 years).

In 2013, the rates of syphilis, gonorrhoea, genital warts and herpes in Barnet were similar to the England average, while in Harrow the rates of syphilis and the viral infections (warts and herpes) were significantly better than England but the rate of gonorrhoea was significantly worse. Over the previous five years rates of these infections have remained consistently lower than the regional average (figure 13).

In 2013, HIV testing uptake among men who have sex with men (97.4%), women (86.0%) and heterosexual men (92.2%) in Barnet was significantly higher than the in England (94.8%, 75.8% and 84.9% respectively). In Harrow, uptake among men who have sex with men (96.2%) were similar to the England while the rates among men (90.8%) and women (86.0%) significantly higher. The proportion of people presenting with HIV at a late stage of infection for the period 2010-2012 can be seen in figure 14, there are issues with late

presentation in both boroughs; Harrow is in the top five and Barnet is in the top 10 of London boroughs with the highest proportion of adults who present late for HIV diagnosis and care.

FIGURE 13 SELECTED RATES OF SEXUALLY TRANSMITTED INFECTIONS DIAGNOSED IN BARNET HARROW, LONDON AND ENGLAND, 2009-2013



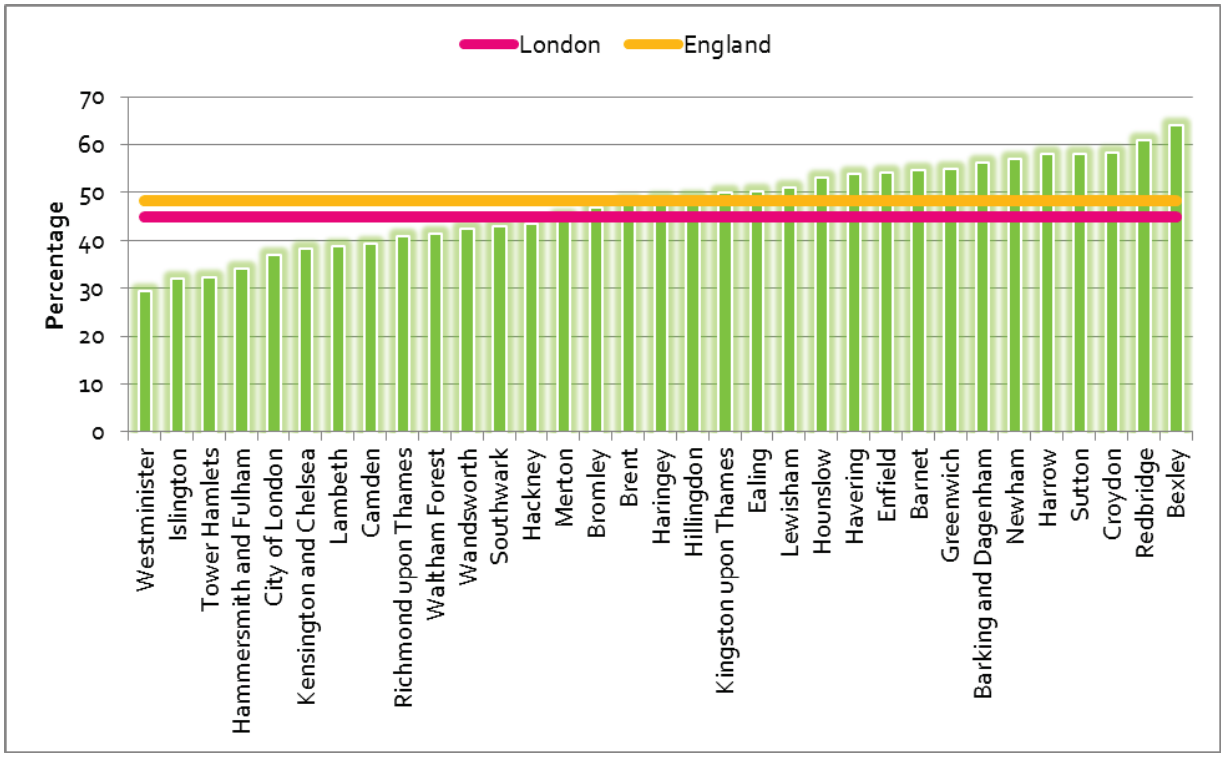
Source: Centre for Infectious Disease Surveillance and Control and Sexual and Reproductive Health profiles (http://fingertips.phe.org.uk/profile/sexualhealth), Public Health England

In areas with a high prevalence of diagnosed HIV infection (>2 per 1,000 population aged 15-59 years) UK national guidelines recommend expanding HIV testing among people admitted to hospital and new registrants to general practice[7]. In 2012, 64 of 326 (20%) local authorities (LAs) in England had a diagnosed prevalence above this threshold. And in London all but one of the 33 LAs had prevalence above this threshold. In 2013, the prevalence of diagnosed HIV infection among 15-59 years olds in Barnet was 3.00 per 1,000, while in Harrow it was 2.21 per 1,000.

A synthesis from eight testing pilot projects undertaken in hospital services and general practices across England demonstrated that the offer and recommendation of a routine HIV test was both feasible and acceptable to patients and staff[8]. In June 2012, an audit was undertaken among 40 sexual health commissioners for areas with higher diagnosed HIV prevalence. Findings indicated that 31% (11/35) had commissioned HIV testing for some new patient registrations in general practice, but only 14% (5/35) had commissioned routine HIV testing as part of general medical admissions to hospitals[9].

A lot of attention is paid to sexually transmitted infections among young people; however there is increasing evidence that reminds us that sexual risk taking behavior is not just the preserve of the young. A cross sectional study showed that more than 80% of 50-90 year olds are sexually active with cases of sexually transmitted infections more than doubling in this age group in the past 10 years[10]. A 2008 study provided evidence of significant increases in attendance at GUM clinics among those aged 45 years and over[11]. In a 2012 report from the HPA on HIV in the United Kingdom showed that 20% of adults accessing HIV care are older than 50, up from 11% in 2001. This is in part because of prolonged survival; however, new diagnoses in over 50s, doubled between 2000 and 2009 to account for 13% of the total.

FIGURE 14 PERCENTAGE OF ADULTS (AGED 15 OR ABOVE) NEWLY DIAGNOSED WITH HIV AND A CD4 CELL COUNT LESS THAN 350 MM^3, 2010-2012



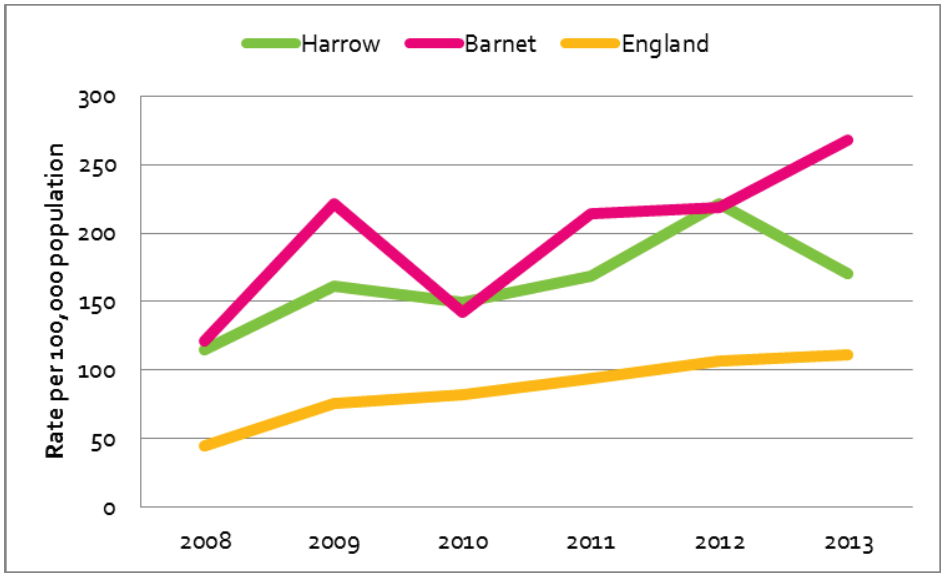
Source: Sexual and Reproductive Health Profiles, Public Health England *http://fingertips.phe.org.uk/profile/sexualhealth*

Since 2008, the rate of all STIs among over 45 – 64 year olds in Barnet and Harrow has consistently exceeded the England average. There was a 33% increase in the diagnosed rate among residents of Harrow and a 55% increase and clear upward trajectory among Barnet residents (figure 15).

One of the reasons for this increase in sexually transmitted infections in this age group may be the increased popularity of erectile dysfunction drugs that have made sex possible for millions of aging men. It could also possibly be the determination of baby boomers who ushered in the sexual revolution, to stay sexually active as they age. Or the low rate of condom use among older couples, who no longer worry about pregnancy and

may not think that they are at risk for sexually transmitted infections. The contribution of any or all of these factors to the rising STI rate in this age group is not clear largely because very few researchers have studied the issue in this population.

FIGURE 15 RATE OF ALL SEXUALLY TRANSMITTED INFECTIONS AMONG 45-64 YEAR OLDS, BARNET, HARROW AND ENGLAND



Source: Centre for Infectious Disease Surveillance and Control, Public Health England

There are a number of different factors which influence relationships and the practice of safer sex. These include, personal attitudes and beliefs, social norms, peer pressure, religious beliefs, culture, confidence and self-esteem, the misuse of drugs and alcohol and coercion and abuse. The third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) was carried out in Britain between September 2010 and August 2012 (the first survey was undertaken in 1990-1991 and the second survey in 1999-2001. Over the 1990s the survey saw an increase in the average number of opposite-sex partners people reported, and more people reporting same-sex experience. Over the last decade the gender gap narrowed. The survey found further increases in the average number of opposite-sex partners increased for women only. Twenty nine percent of women and 31% of men aged 16-24 years at interview had reported having sexual intercourse with someone of the opposite sex before the age of 16 compare to 4% women and 15% of men aged 65-74 years at interview, highlight how dramatically the age at first intercourse has changed over the last 50 years[12].

Significant progress has already been made in improving sexual health at the national level – access to GUM services has improved by promoting rapid access to accessible services, high rates of coverage for antenatal screening for HIV, syphilis and hepatitis B have led to extremely low rates of mother-to-child transmission of HIV and congenital syphilis[13], access to services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice,

developments in diagnostic tests for STIs and HIV have increased screening outside of GUM clinics[14] – but there is more that could be done as demonstrated by the following statistics:

- Almost half of adults newly diagnosed with HIV were diagnosed after the point of which they should have started treatment[15]
- Rates of infectious syphilis are at their highest since the 1950s[16]
- Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics [17]
- In England during 2011, one person was diagnosed with HIV every 90 minutes[15]
- In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region for condom use among sexually active young people; previously, England was in the top ten[18]

What do we need to do now

The control of STIs is rooted in decreasing the average number of secondary cases that an infected person will generate in a population. This can be achieved by reducing the duration of infectiousness of an affected individual, through early testing, reducing the number of susceptible individuals, through vaccination, and reducing the transmission of infections, through the rate of sexual partner change[19]. Effective local interventions can have a significant influence on the transmission of infections and therefore the control of STIs and there is evidence to suggest that the spending on sexual health interventions and services is cost effective[5].

Sex and Relationships Education in Schools

More can and should be done to prioritise prevention, this can be achieved by building knowledge and resilience among young people, building an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex and recognising that sexual ill health can affect all parts of society, often when it is least expected. Good sex and relationships education in schools is important if we are to improve the health of the next generation. The programmes to reduce teenage pregnancies have had a big impact and we shouldn't lose this impetus.

Prevention campaigns

Raising awareness in the general population of good sexual health is important. Promoting safer sex is an important intervention that is cost effective. We need to work with colleagues in Public Health England to ensure that these messages get across to our local population.

Access to good quality services

We need to ensure that information about local services is available in a range of formats, and is widely available from a range of outlets. As the responsibility for commissioning sexual health services has now come to public health in local authorities, we need to ensure that we commission these services based on a robust

assessment of local need. Services should be available at times and in settings which are convenient for people and should offer rapid access. We also need to ensure that there are robust care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services and services for the victims of sexual exploitation, violence and assault.

Early diagnosis of HIV

Identifying HIV infection early is both clinically and cost effective. Modern drug treatments give people with HIV a near normal life expectancy if started early. Treatment of patients with late diagnosed HIV is more expensive and associated with multiple difficult to treat infections often requiring specialised hospital treatment. GPs should be encouraged to offer HIV testing as a routine part of new patient registration and of course all new patients attending sexual health services should also be offered an HIV test. We also need to raise awareness in the community of the importance of HIV testing and reduce the stigma associated with it.

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Tobacco Control

TOBACCO IS THE ONLY LAWFUL PRODUCT WHICH KILLS IT CONSUMERS WHEN USED EXACTLY AS THE MANUFACTURERS INTEND. DESPITE OUR SUCCESS IN REDUCING SMOKING RATES, 80,000 PEOPLE IN ENGLAND ARE STILL DYING EVERY YEAR FROM SMOKING RELATED DISEASES, MORE THAN THE NEXT SIX CAUSES OF PREMATURE DEATH PUT TOGETHER **ACTION ON SMOKING AND HEALTH (ASH)**

Introduction

Tobacco has been used for more than 2,000 years but its history really begins with the arrival of Christopher Columbus in the Americas in 1492 when he was offered a dried leaf with a certain fragrance by the natives. The Spanish and Portuguese took the lead in the mass cultivation of tobacco for profit, which began in earnest in the 1530s and 40s and was made possible and economically viable through the forced labour of enslaved indigenous peoples and trafficked Africans. Sir Francis Drake brought it to England and introduced Sir Walter Raleigh to pipe smoking and he in turn introduced it to Queen Elizabeth I. At that time, tobacco was thought to have medicinal properties, curing everything from toothache to worms and halitosis to cancer.

Perhaps the earliest public health advocate was King James I of England. In 1605, his "counterblaste to Tobacco", said that smoking is a "*custome lothesome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black and stinking fume thereof, nearest resembling the horrible stygian smoke of the pit that is bottomless*". He was the first to impose a heavy tax on tobacco. It is interesting to note that the Royal College of Physicians at that time dismissed the King's comments.

THE PUBLIC HEALTH IMPORTANCE

Smokers under the age of 40 have a five times greater risk of a heart attack than non-smokers
Smoking causes

- around 80% of deaths from lung cancer,
- around 80% of deaths from bronchitis and emphysema, and
- about 17% of deaths from heart disease.

More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, pancreas, stomach, liver and cervix.

On average, cigarette smokers die 10 years younger than non-smokers.

The earliest know advert for tobacco was in 1789 but tobacco advertising started in earnest in the late 19th century with the development of colour lithography and the inclusion of collectable tobacco cards. Adverts

promoted health benefits and used celebrities and doctors to endorse their products. Marketing and advertising developed and by the end of the First World War advertising had become targeted at the new and untapped market – female smokers.

Tobacco took hold and by the early 1930s, the UK had the highest rates of male lung cancer in the world. In 1948, 82% of men and 41% of women were smokers. Although there were suggestions from some doctors that lung cancer was related to smoking in the late 19th and early 20th century, it was in 1951 that the first large-scale epidemiological study of the relationship between smoking and lung cancer was published by Richard Doll and Bradford Hill in the British Medical Journal. They interviewed 5,000 patients in British hospitals and found that of the 1,357 men with lung cancer, 99.5% were smokers.

1964-2014

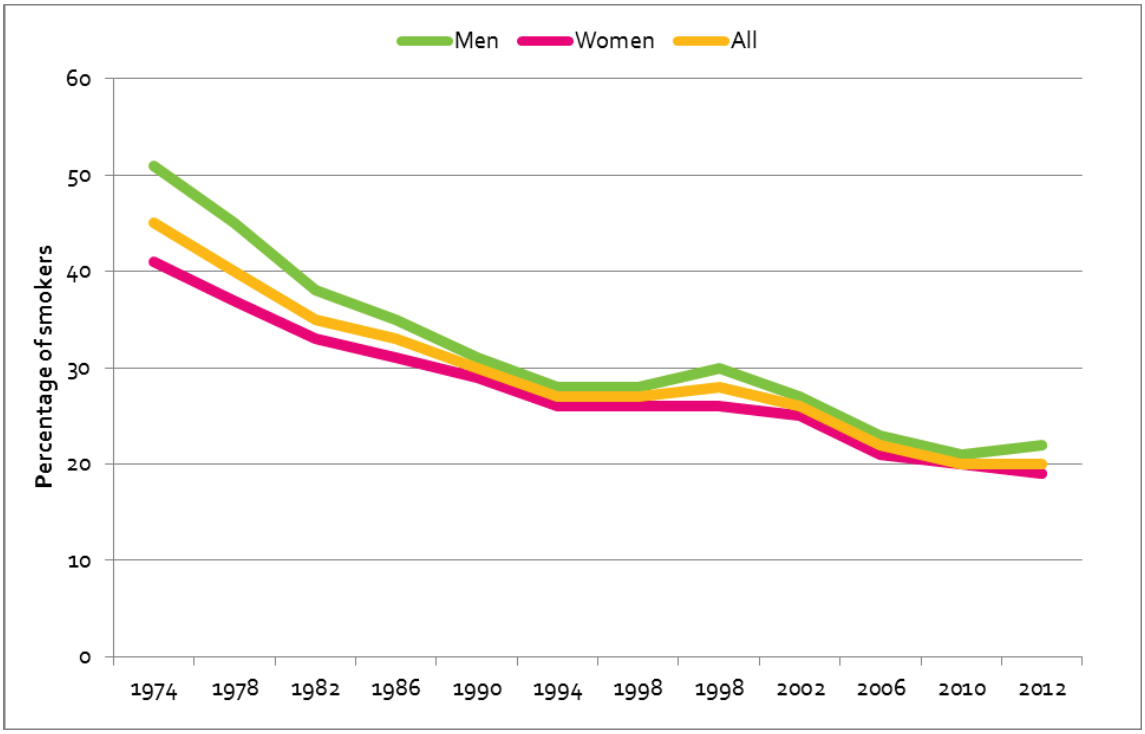
By the mid 1960s, the rates of smoking in men had dropped from their peak in 1948, but smoking rates in women continued to increase and peaked in the mid 1960's with 45% of the female population smoking. Cigarettes were pervasive throughout society, so much so that a popular brand of children's sweet in the 1960s included candy and chocolate cigarettes and "sweet tobacco", a coconut treat that looked like rolling tobacco. Tobacco companies sponsored television programmes in the USA and advertised their products during children's television programmes[1].

The first calls to restrict advertising came in 1962 from the Royal College of Physicians, who highlighted the health problems and recommended stricter laws on the sale and advertising of tobacco products.

In 1964, Doll and Hill published a report on the impact of giving up smoking. They followed a large cohort of doctors and found that the rates of lung cancer were far lower in those that had stopped smoking compared to those who continued. The 1st August 1965 saw the first advertising ban on cigarettes (although not cigars or loose tobacco) on UK television. Advertising was still allowed in other media.

In 1971, the first health warnings were added to all cigarette packaging as a result of an agreement between the government and the tobacco industry[2]. These messages were basic and did not detract from the brand advertising significantly. Advertising through mediums other than television was still allowed, so there were film adverts in cinemas as well as those in print media and advertising hoardings.

FIGURE 16 SMOKING RATES 1974-2012



Source: Office for National Statistics

Also in 1971, a new survey was launched by the Office of Population Census and Surveys (now the Office for National Statistics). The General Household Survey asked people about their lives, their lifestyles and the way they lived. The survey reported in 1974 giving a robust picture of smoking in the population. It found that 51% of men and 41% of women smoked; that smoking varied by age, geographical area and socioeconomic status.

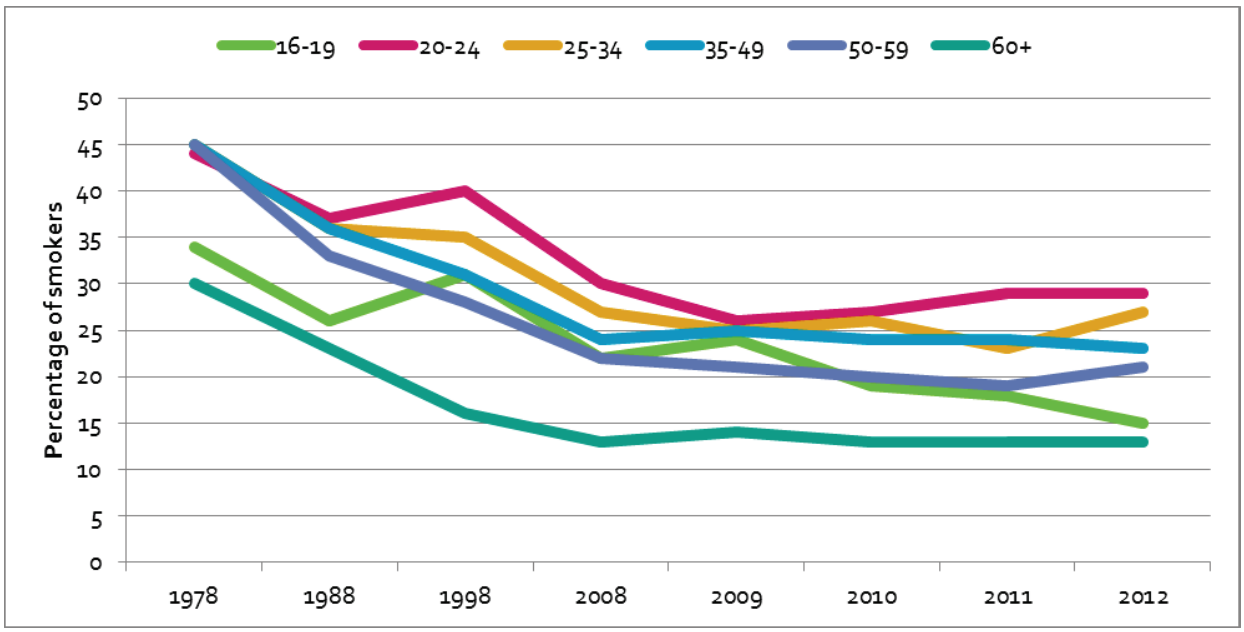
The campaigns to encourage people to stop smoking, which had been left to local activists, were brought together in the first national No Smoking Day on Ash Wednesday in 1983, when it was called "Quit for the day". The campaign has been held annually and the materials and focus changes each year to help spur smokers into action.

In 1986, stricter guidelines on tobacco advertising were introduced which prohibited showing a person smoking in the advert. This resulted in more creative and abstract marketing campaigns that reinforced cigarette manufacturers brand identity. Sponsorship of sporting events was prominent and many small shops had signage and awnings sponsored by the tobacco industry.

Smoking rates were on the decline, particularly in men. In 1982, 38% of men smoked and by 1986 it was down to 35%. The decline in smoking among women was not as large as in men, with 33% smoking in 1982

and 31% by 1986 (figure 19). Rates of smoking varied with age and over time. People aged 60+ have the lowest rates and this is probably for two reasons – that the past smokers have either already died or have stopped due to smoking related diseases (figure 17).

FIGURE 17 SMOKING RATES BY AGE GROUP 1978-2012

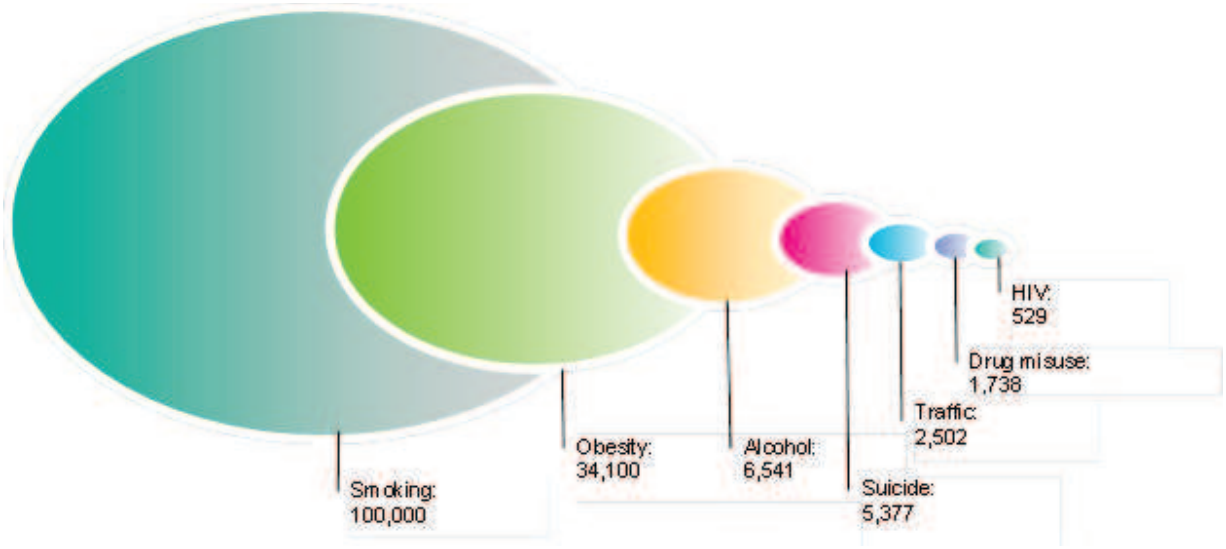


Source: Office for National Statistics

Smoking is the leading cause of preventable death and disease in the UK. About half of all life-long smokers will die prematurely, losing on average about 10 years of life. Smoking kills more people each year than the obesity, alcohol, suicide, road traffic accidents, the use of illegal drugs and HIV infection combined (figure 18).

The 1990s began with the implementation of the Television without Frontiers directive[4] which banned television advertising of tobacco products across the European Union. This meant that there was finally a ban on TV advertising of cigars and loose tobacco in the UK - some 25 years after the ban on TV advertising of cigarettes.

FIGURE 18 DEATHS IN ENGLAND FROM EXTERNAL CAUSES



Source: ASH Factsheet on smoking statistics – illness and death

In 1997, the new Labour government pledged to ban all tobacco advertising. In December 1998 Smoking Kills – a White Paper on tobacco was released, which included targets for reducing the prevalence of cigarette smoking among adults in England to 24% by 2010.

The Tobacco Advertising and Promotion Act was introduced in 2002. Over the following years, a ban on tobacco advertising was phased in. General tobacco advertising was banned in February 2003 and promotional events, excluding sports, were banned in May of the same year. Sponsorship of sporting events in the UK was banned in July 2003 but non-UK based events, like F1 racing were still sponsored by the tobacco industry. To get around the ban, brand-sharing identities were used in UK events – i.e. using the colours and patterns associated with the tobacco brands.

In 2003, the European Union halted the branding of cigarettes as "light" or "mild", saying that this misleads consumers about the dangers of smoking. Stark health warnings such as "Smoking Kills" that cover at least 30 percent of the front of each packet and 40 percent of the back were introduced. In countries with more than one national language the messages have to cover an even greater area. The EU Television without Frontiers advertising ban was extended by the Tobacco Advertising Directive, which took effect in July 2005. This extended the ban on tobacco advertising to cover other forms of media such as the internet, print media, radio, and sports events like F1.

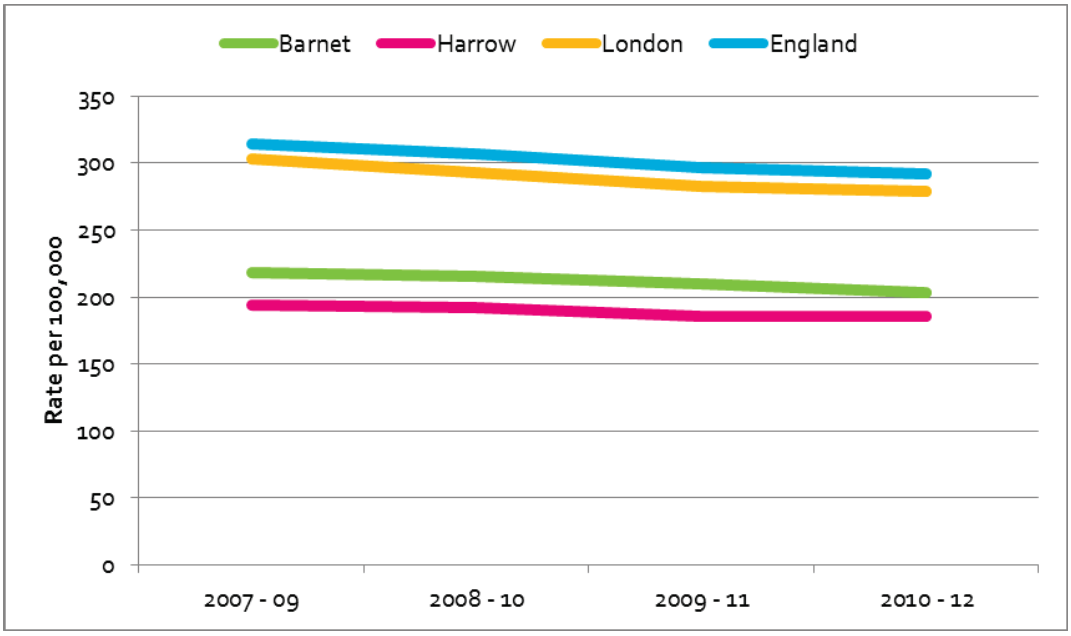
In 2004, the Department of Health (DH) approved a Public Service Agreement (PSA) which revised the target set in 1998 downwards with an aim to reduce the prevalence of cigarette smoking among adults in England to 21% or less by 2010.

In addition to the national No Smoking day campaigns, other campaigns have taken place to encourage people to quit with themes including the impact of smoking on arteries and on the addictive nature of smoking amongst others (figure 19).

FIGURE 19 GRAPHIC IMAGERY OF THE ADDICTIVE NATURE OF CIGARETTES, NHS CAMPAIGN

Perhaps the biggest impact on smoking in recent years has been as a result of the Smokefree law which came into effect in 2007 as part of the Health Act 2006. Smoking is no longer permitted in enclosed and "substantially enclosed" workplaces, as well as in work vehicles if they are used by more than one person at any time. The law also applies to all public places that are fully enclosed or "substantially enclosed" and all forms of public transport. In 2010, the white paper *Healthy Lives, Healthy People* set out the Government's long term policy for improving public health and in 2011 a new Tobacco Control Plan was published. The plan sets out national ambitions to reduce smoking prevalence in England.

FIGURE 20 RECENT TRENDS IN DEATHS DUE TO SMOKING, 2007/09 – 2010/12



Source: Tobacco Profiles, Public Health England

Prior to October 2011, cigarette vending machines were still allowed in licensed premises but were only allowed to display a picture of what was available (one image per brand) and no advertisements could be

included on the machine. Cigarette vending machines were banned in public areas of all English, Welsh and Northern Irish pubs, clubs and restaurants in October 2011 and in Scotland in April 2013, with a fine of £2500 for non-compliance.

Although smoking rates have come down, across England, smoking causes more deaths than the next eight external causes put together. Smoking related illnesses killed 204 people in Harrow and 384 people in Barnet in 2012[5].

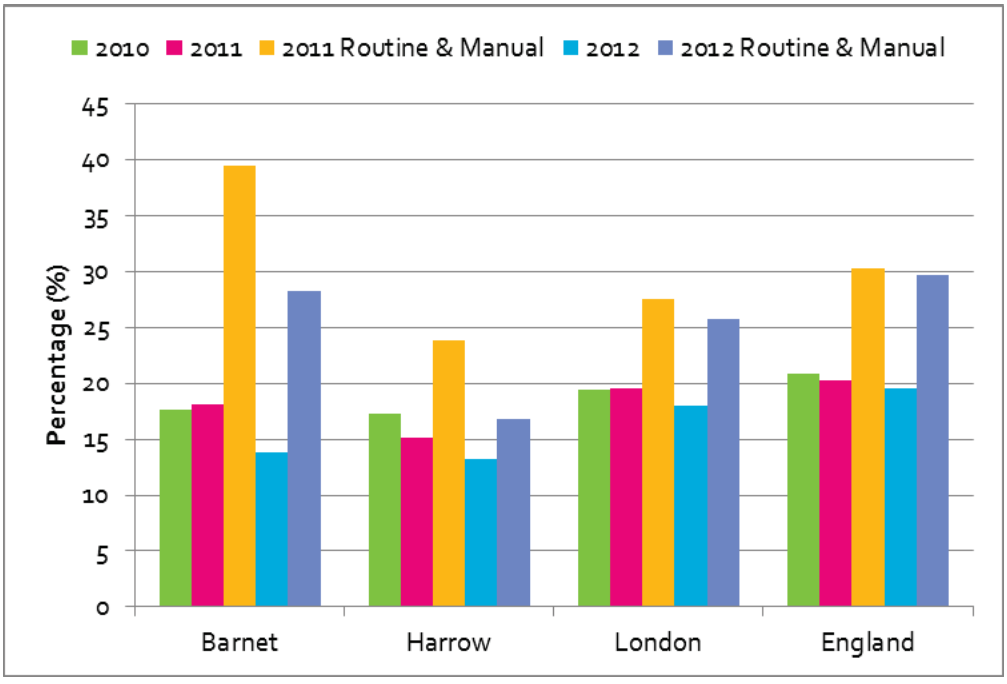
The rate of death from smoking reflects the past history of smoking. Both Barnet and Harrow have consistently had lower rates of smoking and thus the death rates from smoking are lower than those of London and England. Deaths due to smoking are continuing to decrease in all areas (figure 20).

TABLE 1THE COST OF SMOKING TO UK HOUSEHOLDS WITH DEPENDENTS

Percentage of household income spent on smoking (net)		
income	Both parents smoke 20 per day	One parent smokes 20 per day
£ 10,000.00	51%	26%
£ 15,000.00	34%	17%
£ 20,000.00	26%	13%
£ 21,000.00	24%	12%
£ 25,000.00	20%	10%
£ 30,000.00	17%	9%
£ 40,000.00	13%	6%
£ 50,000.00	10%	5%

Source: ASH

FIGURE 21 SMOKING PREVALENCE IN WHOLE POULATION AND IN ROUTINE AND MANUAL (RM) GROUPS



Source: Tobacco profiles, Public Health England

Smoking rates in both Harrow and Barnet have decreased considerably in the past two years according to the Integrated Household Survey. In 2010, almost 18% of people in Barnet smoked and this has reduced to just under14%. In Harrow, just over 17% of adults smoked in 2010 which has reduced to just over 13% in 2012. Smoking remains an issue of inequalities. Smoking prevalence in people in routine and manual occupations remains higher than the average smoking prevalence at any point in time but it is falling in the same way that the total rate is falling (figure 21).

As well as being more likely to smoke, those in routine and manual occupations also earn less. Smokers in lower income households spend a greater proportion of their household income on cigarettes and this has an impact on child poverty (Table 1).

What do we need to do now

The drop in smoking rates doesn't mean we can be complacent about smoking. Smoking related hospital admissions cost the equivalent of £32.43 for every person in Barnet and £26.36 for every person in Harrow. This of course doesn't include social care costs, the costs to businesses of employing smokers who take more time off due to ill health, the costs of smoking related fires or the cost of cleaning up smoking related waste.

There are four elements of tobacco control that we need to focus on:

- **Stopping Young People from starting to smoke:**

To maintain the profits from cigarettes, the tobacco industry must attract young smokers to replace the smokers who have died. We must provide young people with the knowledge and skills to make the choice to say no to tobacco. Our local Cut Films projects do just this. Schools, colleges and youth groups across the boroughs took part in the film making competition and some were successful in winning national awards (figure 22).

FIGURE 22 THE *ARTY FILMS* GROUP FROM BARNET, WINNERS OF THE NATIONAL CUT FILM AWARDS 2014

- **Helping people to quit:**

Stopping smoking is not easy. Our local services are provided through a specialist service and by Pharmacists, GPs, practice nurses, health care assistants, midwives and community psychiatric staff. The services provide an evidence based stop smoking service with excellent quit rates. Smokers quitting with pharmacological and behavioural support are four times more likely to quit than if they go it alone.

- **Ensuring compliance with legislation and considering local legislation**

Smokefree legislation has been in place for the past seven years. There has been a high level of compliance although there have been recent issues in both boroughs centered around shisha bars breaking smokefree laws. There are other things that could be considered in terms of local legislation, for instance, making certain outdoor public spaces that are controlled or owned by the council smokefree. More radical ideas might include requiring all shops selling tobacco to be registered. This would mean that any smuggled or illicit tobacco sales would be automatically outside the law.

- **Monitoring and addressing up and coming risks**

As already mentioned shisha, also known as bubble pipe or hookah, is an emerging trend in both boroughs. There are concerns about the lack of knowledge about the harmful effects, about the normalisation of smoking shisha in some groups and lack of awareness about the legislation around supplying tobacco in this form. A campaign is planned to address these issues.

One of the more recent introductions has been that of "e-cigarettes". There have been calls for a ban on advertising of these products on the grounds that they could normalise smoking behaviour for young people and encourage them to take up smoking tobacco. This is a topic that we will have to keen an eye on in future.

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Vaccine Preventable Infections

IT IS ESSENTIAL THAT WE GET AHEAD OF MEASLES AND THE ONLY WAY TO DO THIS IS TO PROTECT PEOPLE BEFORE MEASLES CATCHES THEM. THE SAFETY RECORD OF MMR IS NOT IN DOUBT AND THE BEST THING THAT PARENTS CAN DO, IF THEIR CHILDREN HAVE NOT HAD TWO DOSES OF MMR, IS TO MAKE AN APPOINTMENT WITH THE GP NOW.
PROFESSOR DAVID SALISBURY, DIRECTOR OF IMMUNISATION, DEPARTMENT OF HEALTH

Introduction

One of the key tenets of public health is to prevent disease; one way of achieving this is through vaccination. Second only to clean water, vaccination is the most successful public health intervention in terms of preventing morbidity and mortality.

Vaccination is the process of protecting individuals from infection by administering an inactivated or weakened form of a disease (or a related product) without the risk of getting the disease. Most vaccines usually confer long term, so called 'active immunity' but there are also special antibody vaccines available which provide immediate short-term protection (passive immunity) against some diseases[1].

The practice of trying to protect people from infectious disease through inoculation is very ancient and started with a technique known as variolation – the process of inoculating smallpox lesions into the skin or mucus membranes of others probably started in the East around 1000 AD[2]. By 1700, the practice of variolation had spread to India, Africa and the Ottoman Empire. Two different methods of variolation emerged. In contrast to Asians and Africans who inoculated through blowing dried smallpox scabs up the nose (in the same way that people took snuff), Europeans and Americans tended to inoculate through puncture in the skin. Variolation was introduced into America by Onesimus, an enslaved African. In a letter to the London's Royal Society in 1716, Mather proposed 'ye Method of Inoculation' as the best means of curing

THE PUBLIC HEALTH IMPORTANCE

Few medical interventions compete with vaccines for their cumulative impact on health and wellbeing of entire populations. Vaccination has greatly reduced the burden of infectious disease.

Paradoxically, a vociferous anti-vaccine lobby thrives today in spite of undeniable success of vaccination programmes against formerly fearsome diseases that are now rare in developed countries.

Understandably, vaccine safety gets more public attention than vaccination effectiveness, but independent experts and WHO have shown that vaccines are far safer than therapeutic medicines.

Vaccinations offer a range of disease control benefits including, eradication (smallpox), elimination (polio), and mitigation of disease severity (rotavirus disease), prevention of infection (human papillomavirus (HPV) and the control of mortality, morbidity and complications at the individual and societal levels.

Efficacious vaccines not only protect the vaccinated, but can also reduce disease among unvaccinated individuals in the community through "indirect effects" or "herd protection".

smallpox and noted that he had learned of this process from 'my Negro-Man Onesimus, who is a pretty intelligent fellow'. Mather revealed how Onesimus had[3]:

"...undergone an Operation, which had given him something of ye Small-Pox, and would forever preserve him from it, adding, that it was often used among [Africans] and whoever had ye Courage to use it, was forever free from ye Fear of the Contagion. He described ye Operation to me, and showed me in his arm ye Scar"

EXCERPT FROM A DESTROYING ANGEL: THE CONQUEST OF SMALLPOX IN COLONIAL BOSTON (1974)

The first person to introduce variolation to England was Lady Mary Wortley Montagu, wife of the British Ambassador to Constantinople, she became fascinated with the Turkish practice of inoculating healthy children with a weakened strain of the smallpox (engrafting) to confer immunity from the more virulent strains of the disease. Lady Mary brought the method to the attention of the London College of Physicians and to Charles Maitland, surgeon to the British Embassy, who successfully carried out experimental inoculations on six condemned prisoners in 1723. Unfortunately, the trend in inoculation and the enthusiasm was brief. Edward Jenner would eventually be given the credit for the smallpox vaccine despite Lady Mary's efforts to embed the technique[2].

Jenner was assigned his place in history by exploring the 18th century folklore that cowmen and dairy maids who had cowpox lesions on their hands did not seem to catch smallpox. In 1796, a dairy maid, Sarah Nelmes, consulted Jenner about a rash on her hand. He diagnosed cowpox rather than smallpox. Jenner realised that this was his opportunity to test the protective properties of cowpox and he chose James Phipps, the 8 year old son of his gardener on whom to perform his first vaccination. On 14th May 1796 he made a few scratches on one of James arms and rubbed into them some material from one of the pocks on Sarah's hand. Within days James became mildly ill with cowpox, the next step was to test whether cowpox would now protect James from smallpox. On 1st July Jenner variolated the boy; as predicted James did not develop smallpox

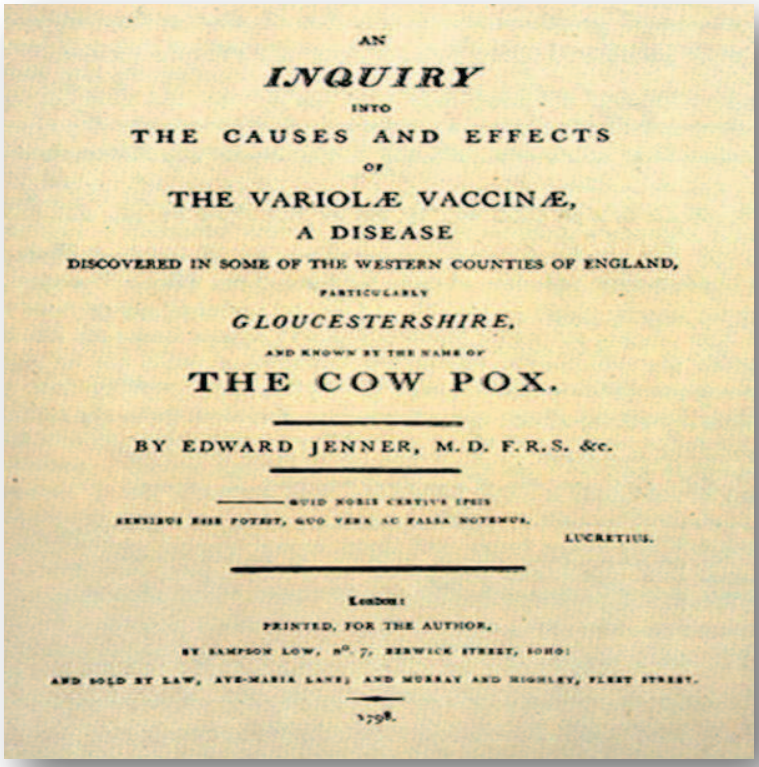

AN
INQUIRY
INTO
THE CAUSES AND EFFECTS
OF
THE VARIOLÆ VACCINÆ,
A DISEASE
DISCOVERED IN SOME OF THE WESTERN COUNTIES OF ENGLAND,
PARTICULARLY
GLOUCESTERSHIRE,
AND KNOWN BY THE NAME OF
THE COW POX.
BY EDWARD JENNER, M.D. F.R.S. &c.
LUCRETIUS.
London:
PRINTED, FOR THE AUTHOR,
BY SAMPSON LOW, N°. 7, BERWICK STREET, SOHO:
AND SOLD BY LAW, AVE-MARIA LANE; AND MURRAY AND HIGHLEY, FLEET STREET.
1798.

FIGURE 23 JENNER PUBLISHED HIS WORK *AN ENQUIRY INTO THE CAUSES AND EFFECTS OF VARIOLAE VACCINAE* IN 1798

either on this occasion or on the many subsequent ones when his immunity was tested again.

In the 50 years following Jenner's first inoculation the number of deaths from smallpox fell from about 23,000 to 5,000 a year. Vaccination against smallpox for infants within four months of birth was made compulsory in 1853. This led to opposition from those who demanded freedom of choice. The term 'conscientious objector' entered English law in 1898 to describe those who risked fines and imprisonment by refusing vaccination for their children[4].

The next major advance took place thanks to the work of Louis Pasteur. Pasteur worked on the attenuation[‡] of chicken cholera vaccine in the late 1870s he drew on concepts that had been developing for at least 40 years. At the end of the 19th century killed vaccines for anthrax (1880), rabies (1880), typhoid (1896) plague (1897) and cholera were produced.

More advances emerged in the 20th century; Calmette and Guerin developed the Bacille Calmette Guerin (BCG) vaccine from a strain of bovine mycobacteria. It was the first live vaccine for humans to be produced since the rabies vaccine. The chemical inactivation of diphtheria and other bacterial toxins led to the development of the first toxoids: diphtheria and tetanus. Wilson Smith and colleagues isolated the Influenza A virus in ferrets in 1933. In 1937, Anatol Smorodintsev and colleagues in the Soviet Union reported on the administration of the Wilson Smith strain to humans, this is considered to be the first live human influenza virus vaccine. Other vaccine developments included Yellow fever (1935), Pertussis (1926), Typhus (1938) Diphtheria (1923), and Tetanus (1927). After World War II, most of the other vaccinations familiar from the vaccination schedule were developed. The first licensed polio vaccine using the cell culture technique was the trivalent formalin inactivated polio vaccine of Jonas Salk licensed in 1955. About six years later live polio virus vaccines grown in monkey kidney cell cultures by Albert Sabin (1962) came into wide use.

1964 - 2014

By 1971, the world's first vaccination –for smallpox- was discontinued in the UK and by 1980 the disease was eradicated worldwide.

During the 1970s and 80s several bacterial vaccines consisting of purified capsular polysaccharides were developed e.g. Pneumococcal (1992), meningococcal (1992), and Haemophilus influenza type b (Hib) (1992). A plasma derived Hepatitis B vaccine was developed in 1981. This was replaced by a recombinant vaccine grown in yeast cells in 1986 replacing the need to use a blood derived product. The vaccines that were developed during this period were measles (1960), rubella (1962), mumps (1967), hepatitis A (1992), Men C conjugate (1999), PCV, Rotavirus and HPV (2006)[2].

[‡] Attenuation takes an infectious agent and alters it so that it becomes harmless or less virulent, but are still viable

TABLE 2 THE UK IMMUNISATION SCHEDULE 2013-2014

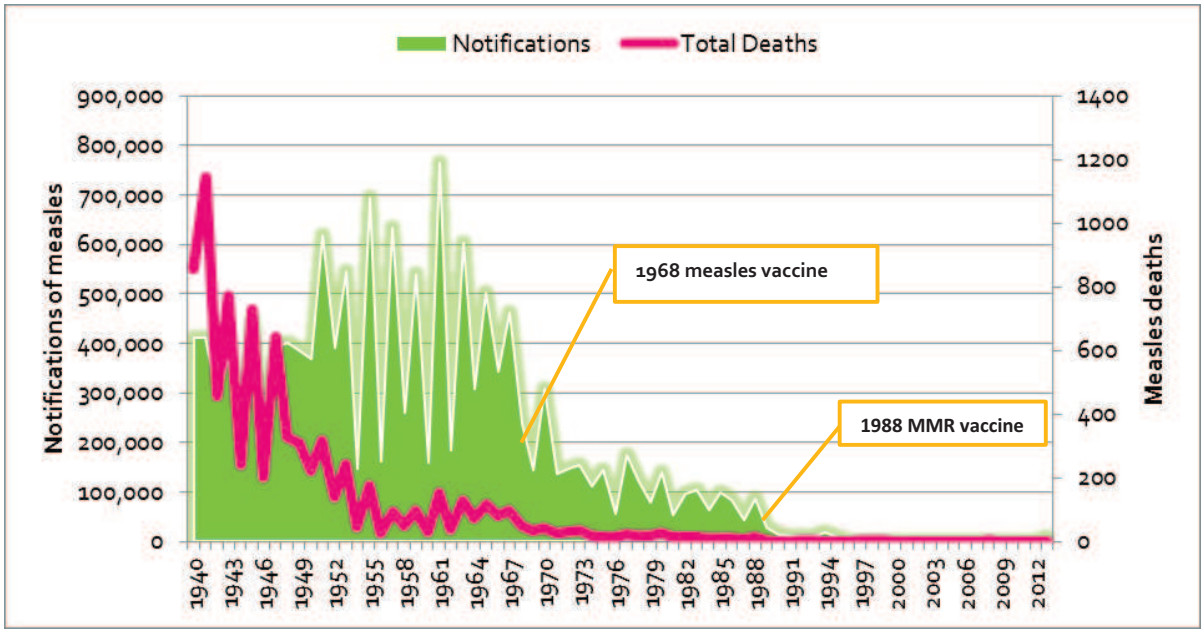
Routine Vaccination Schedule	
When to immunise	**Diseases Protected Against**
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Pneumococcal disease Rotavirus
Three months old	Diphtheria, tetanus, pertussis, polio and Hib Meningococcal group C disease (MenC) Rotavirus
Four months old	Diphtheria, tetanus, pertussis, polio and Hib Pneumococcal disease
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC Pneumococcal disease Measles, mumps and rubella (German measles)
Two and three years old	Influenza (from September)
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)
Around 14 years old	Tetanus, diphtheria and polio MenC
65 years old	Pneumococcal disease
65 years of age and older	Influenza
70 years old	Shingles
Immunisations for those at Risk	
When to immunise	**Diseases Protected Against**
At birth, 1 month old, 2 months old and 12 months old	Hepatitis B
At birth	Tuberculosis
Six months up to two years	Influenza
Two years up to under 65 years	Pneumococcal disease
Over two up to less than 18 years	Influenza
18 up to under 65 years	Influenza
From 28 weeks of pregnancy	Pertussis

Source: Public Health England,
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/227651/8515_DoH_Complete_Imm_schedule_A4_2013_09.pdf)

Today, vaccinations are a mainstay of the NHS. Table 2 lists the various vaccines currently available through the national immunisation program. This comprises routine childhood and adult vaccinations, as well as vaccines recommended for certain subsets of the general population deemed to have an increased susceptibility to infection. In addition to the routine vaccinations, there are also specific vaccines made available for people working in certain occupational settings and travel vaccinations to protect against infections abroad.

Children are more at risk from infections and environmental hazards and suffer more from health inequalities than the rest of the population. The role of vaccines in reducing disease is an important part of work to improve the health of children.

FIGURE 24 NOTIFICATIONS AND DEATHS FROM MEASLES IN ENGLAND & WALES, 1940-2013*



Source: Registrar General's annual returns, Office for National Statistics, Centre for Infectious Disease Surveillance and Control, Public Health England.

*** Provisional data***

The HPV vaccine prevents infection by the two human papillomaviruses types (types 16 and 18) that cause over 70% of cervical cancers. The vaccine does not protect against all of the other cancer-causing types, so it's vital that women still go for routine cervical screening tests when they are older. The HPV vaccine is contentious, largely because it is offered only to girls and they are below the age of consent at the time of the offer. The vaccine is only offered to girls to protect them from cervical cancer; obviously boys do not get this type of cancer. By protecting girls against the two most common causes of cervical cancer eventually there will be fewer viruses circulating and so the risk for boys will decrease as there will be fewer opportunities of them coming into contact with these virus types, and passing them on. While most girls don't start having sex until they are 16 or older, it is recommended that they have the vaccination at 12 to 13 years to get the most benefit from the vaccine. If the vaccine is given after a young woman becomes sexually active, it is possible that she may already have been infected by a HPV type that the vaccine can protect against.

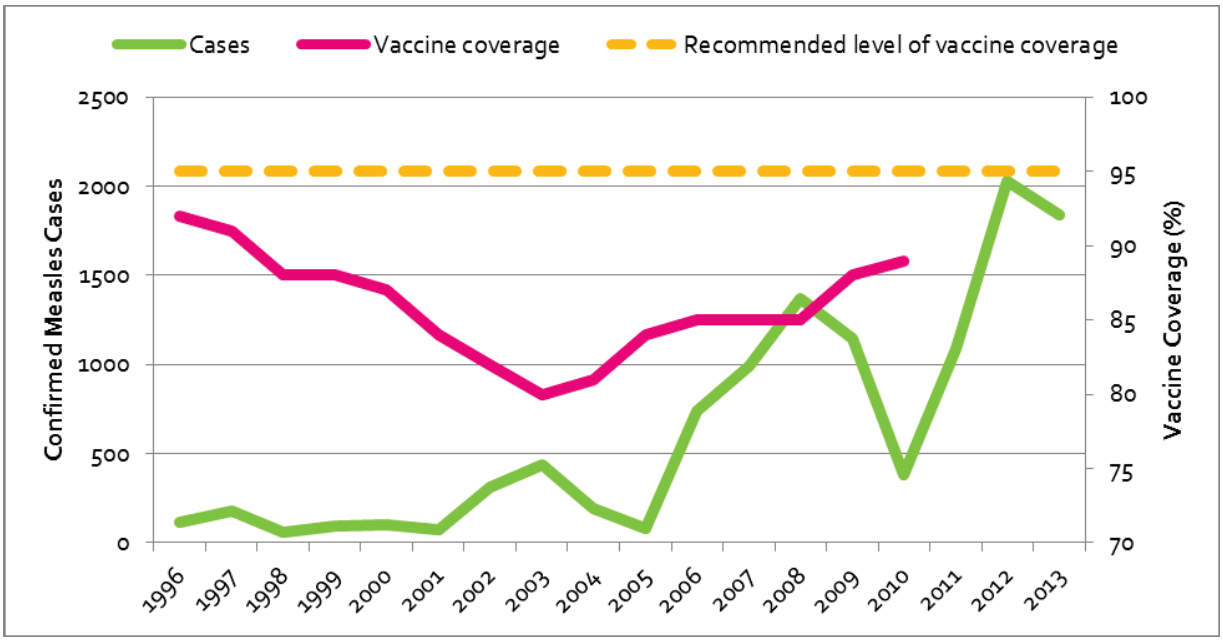
Some vaccinations in the schedule are given singularly and other preparations come as a combined formulation such as MMR. Sometimes one dose is sufficient to give long-lasting immunity, whereas in other cases booster doses are needed at intervals to maintain immunity. The mode of delivery of vaccination can be done via subcutaneous or intra-muscular injections, orally or intra-nasally.

Vaccinated individuals are not only protected from the disease but they are less likely to be a source of infection to others, particularly those who cannot or do not receive vaccinations. This level of protection conferred upon non immunised people is termed 'herd immunity'. However, for herd immunity to work properly there must be certain level of vaccine coverage within a population[5]. When the vaccine coverage is low the diseases of the past return.

The case for vaccination

Measles is an extremely contagious disease caught through direct contact with an infected person, or through the air from coughs or sneezes. Measles is usually a childhood infection. It is most common in the one to four year old age group in children who have not been immunized. However, you can catch measles at any age if you haven't been vaccinated or haven't had the disease in the past. It is estimated that around one in every 5,000 people with measles will die as a result of a serious complication. However, it is now uncommon in the UK because of the effectiveness of the MMR vaccination.

FIGURE 25 LABORATORY CONFIRMED CASES OF MEASLES AND VACCINE COVERAGE IN ENGLAND AND WALES, 1996 - 2013



Source: Centre for Infectious Disease Surveillance and Control, Public Health England

The available measles vaccine is highly effective, with the first dose given at 12-15 months and a second dose at four to five years. The measles vaccine is a live vaccine. It contains a strain of the measles virus that has been attenuated in order to stimulate an immune response to natural measles virus but will only produce very mild symptoms of measles if any at all.

Prior to the introduction of measles vaccine in 1968 there were between 150,000 and 600,000 cases notified each year in England and Wales (Figure 24). Prior to 2006, the last death from acute measles was in 1992. In 2006, there was one measles death in a 13 year old boy who had an underlying lung condition and was taking immunosuppressive drugs.

Another death in 2008 was also due to acute measles in an unvaccinated child with congenital immunodeficiency. In 2013, one death was reported in a 25 year old man following acute pneumonia as a complication of measles. All other measles deaths since 1992 shown in figure 15 are in older individuals and were caused by the late effects of measles. These infections were acquired during the 1980s or earlier, when epidemics of measles occurred.

The MMR vaccine has received a lot of public attention in recent years, much of it adverse. The controversy started when Andrew Wakefield published a study in The Lancet in 1998, reporting on an association between MMR vaccine and the development of inflammatory bowel disease and autism[6]. Uptake of the vaccine amongst two-year-olds in the UK declined from around 92% in early 1995 to around 84% in the first quarter of 2002 (figure 25). The World Health Organization recommends vaccination coverage of around 95% to prevent outbreaks of disease. The research was retracted after the study was found to be flawed and that there was no evidence to support the claims expressed[7]. However, the negative publicity generated and fuelled by adverse media reports led to some parents becoming concerned about the potential side effects of MMR. Many became reluctant to have their children vaccinated. Uptake of the vaccine amongst two-year-olds in the UK declined from around 92% in early 1995 to around 80% in the 2003/04, although the numbers are now gradually improving, particularly following vaccination catch-up campaigns.

Because of the poor uptake of MMR, there was an increase in the incidence of measles, mumps and rubella cases in the UK, with hotspots of disease occurring in some parts of London and in Wales. The numbers of confirmed measles cases in England hit the highest levels since 1996 in 2012 with 1912 confirmed cases reported. A successful national catch up campaign was introduced in April 2013 to ensure that at least 95% of all 10-16 year olds had received at least one dose of a measles containing vaccine[8].

What do we need to do now

While vaccinations are an important public health intervention, they are the responsibility of NHS England as commissioners of the immunistation programme. Outlined below are three components that form an effective strategy for increasing vaccine uptake[10]:

Implementation of immunisation programmes

Immunisation programmes should be multifaceted and coordinated across different settings this should increase timely immunisations among groups with low or partial uptake. This programme should form part of local child and older adult health strategies. Along with an identified healthcare professional within every GP practice who is responsible and provides leadership for the local immunisation programme, there should be a guarantee that access to immunisations services are improved, where necessary, this may take the form of extending clinic times so there are more appointments available, sending tailored invitations, reminders and recall invitations and introducing home visits for those failing to attend after recall invitations in order to discuss any concerns about the immunisation process.

Contributions from educational settings

The school nursing team should check the immunisation records of all children up to the age of 5 when the child joins a nursery, nursery school, playgroup, Sure Start children's centre or when they start primary school. The checks should be carried out in conjunction with parents and other healthcare professionals. Immunisation coordinators should work with educational staff and parents to encourage schools to become venues for vaccination.

Targeting groups at risk of not being fully immunised

In order to increase uptake in this group there should be an understanding of what is preventing these individuals from being fully immunised. Once this has been established these barriers can and should be dismantled. Barriers to immunistation may relate to transport, language, communication difficulties and physical or learning disabilities. This may be alleviated by providing longer appointment times, walk-in vaccination clinics, translation services, mobile, home or outreach services. Immunisations coordinators should also consider using retail outlets, places of worship and other community venues to disseminate accurate, up-to-date information on immunisations or hold immunisation sessions

At present, the greatest threat to vaccination is resistance, given the backdrop of declining prevalence of many infectious disease and heightened fears over vaccine safety. Reassuring the public that vaccines are safe, necessitates the effective detection of vaccine-related side-effects and rigorous investigation of any safety concerns.

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Healthy Life Expectancy

"IF WE ARE NOT CAREFUL WE WILL JUST END UP IN A SITUATION WHERE INSTEAD OF PEOPLE RETIRING THERE WILL JUST BE MORE ON INCAPACITY BENEFIT."
PROF. LES MAYHEW, CASS BUSINESS SCHOOL

Introduction

For a long time, public health professionals have solely focused on helping people to live longer, with little thought to the quality of those additional years of life. Probably, unsurprising given that in order to investigate, improve and protect health we have largely focused on what kills people. But improving the public's health requires more than simply delaying death or increasing life expectancy at birth, it necessitates an awareness and understanding of disease and levels of functioning.

At its simplest, life expectancy (LE) is an estimate of how long the average person might be expected to live[1]. LE is most often quoted for an entire lifetime; LE at birth is the number of years that a newborn baby would live if they experienced the death rates of the local population at the time of their birth, throughout their life. It is a theoretical measure rather than a true prediction of life expectancy, since death rates may increase or decrease during a person's lifetime, and people may move to areas with different mortality risks.

LE can also be calculated for other ages. For example, LE at age 65 indicates the number of further years that a 65-year-old might be expected to live. As a person who reaches 65 has already survived many years, their LE when added to their current age (65) will generally be greater than the corresponding estimate of a baby's LE at birth. For example, a 65-year-old man might have a LE of 15 years, meaning that he might be expected to live until the age 80; whereas a boy's LE at birth might only be 73 years.

THE PUBLIC HEALTH IMPORTANCE

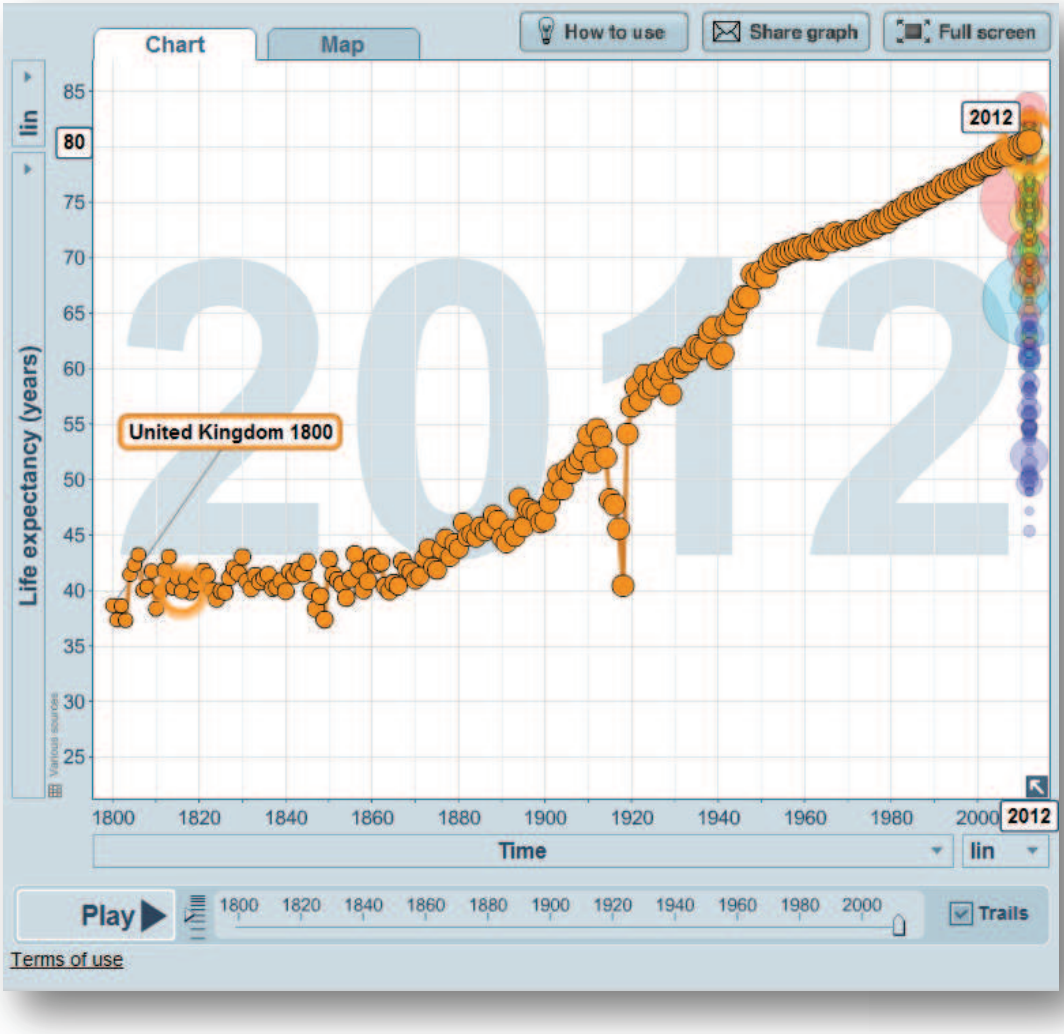
The importance of healthy life expectancy as a summary measure of population health is reflected in its inclusion in the two high-level outcomes in Public Health England's Public health Outcomes Framework.

It is necessary to track healthy life expectancy and life expectancy by area deprivation as life expectancy increases, to see whether these years of additional life are equally distributed across the population and how many are spent in states of good health or in poor health and disability.

This is also relevant to the recent changes to the state pension age in the UK where people are expected to extend their working lives to take account of improvements in life expectancy.

Back in the 1800s, LE in the United Kingdom was 39 years, by 1964 it had increased to 72 years and in 2012 the average life expectancy was 80 years (figure 26) 79.2 years for men and 83.3 years for women. With the exception of the World War I and the flu pandemic of 1918 life expectancy has steadily increased in the UK. Improvement in water and sanitation supplies inspired by the 1848 Public Health Act, nutrition and the control of infectious diseases have supported the increase in life expectancy between the late 1800s and 2012.

FIGURE 26 LIFE EXPECTANCY IN THE UNITED KINGDOM 1800 – 2012



Source: Gapminder.org (Caveat: data before 1900 is highly uncertain)

By 2032, life expectancy is expected to rise to 83.3 years (an increase of 4.1 years) for men and to 86.8 years (an increase of 3.8 years) for women[2]. That being said there were 13,350 centenarians (aged 100+)

in the UK in 2012 and principal projections suggest that around 1 in 3 babies born in 2013 will live to celebrate their 100th birthdays providing a projected rise from 14,000 in 2013 to 111,000 in 2037[3]. But living longer doesn't necessarily mean living in good health as Abraham Lincoln so aptly stated "in the end it's not the years in your life that counts. It's the life in your years".

1964-2014

In the early 1970s Daniel Sullivan developed a method to account for both illness and death in a single index capturing the expected years of survival free of disability[4]. Healthy life expectancy (HLE) is a summary measure of population health that has evolved from Sullivan's method[5]; it is an estimate of the years of life that will be spent in good health, and by extension the quality of life.

Like LE, HLE is most often expressed for an entire lifetime but it can also be expressed from age 65. HLE at birth is the number of years that a newborn baby would live in 'healthy' health if they experienced the death rates and levels of general health of the local population at the time of their birth, throughout their life[1].This measure is used to look at health trends over time and compare the health of different populations and population sub-groups. It is a measure that is useful in resource allocation, planning of health and other services, and evaluation of health outcomes.

A recent study of trends in HLE at birth across 187 countries and over 20 years, estimated that global HLE has increased by about four years from 1990 to 2010[6]. The increase in HLE in the UK among men was 3.7 years and among women 2.7 years (table 3). The gains in HLE over this period are mainly thought to have occurred through reductions of child and adult mortality rather than reduction in the prevalence of disability. A large component of this disability comes from mental and behavioural disorders, such as major depression, anxiety, and alcohol and drug use disorders. Other major contributions to the prevalence of disability come from musculoskeletal disorders including low back pain, neck pain and osteoarthritis

TABLE 3 LIFE EXPECTANCY AND HEALTHY LIFE EXPECTNCY AT BIRTH IN 19190 AND 2010

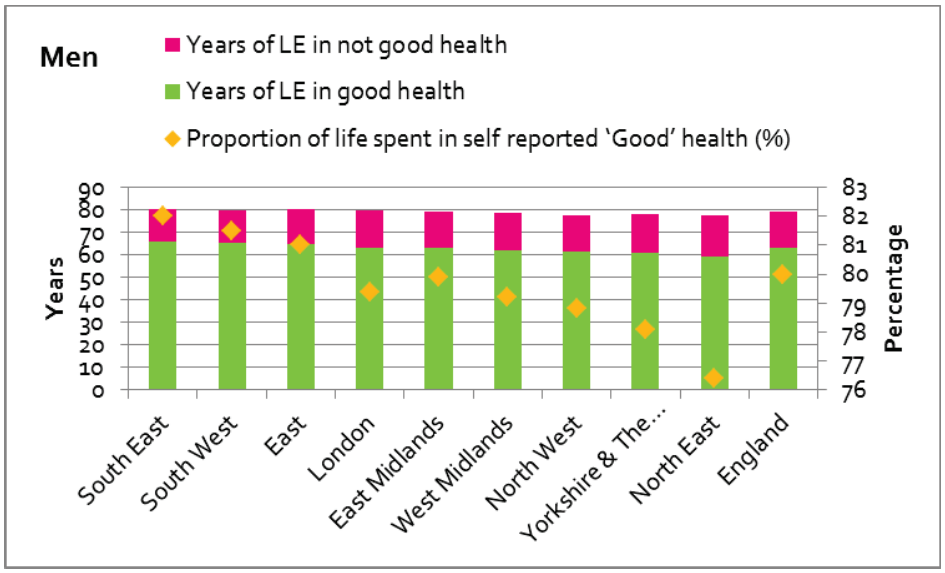
	1990		2010	
	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy
Men	72.9	63.4	77.8	67.1
Women	78.3	67.4	81.9	70.1

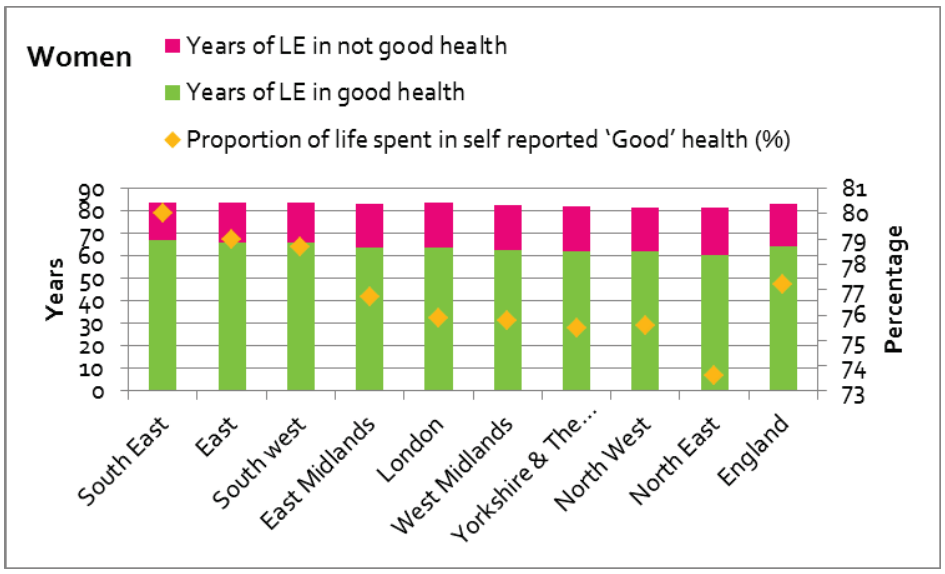
Source: Salomon JA et al. 2012

Between 2010 and 2012, HLE at birth in England was 63.4 years for men and 64.1 years for women. A clear North-South divide was observed with regions in the South East, South West and East of England all have significantly higher HLE than the England average (figure 27). The West Midlands, North West, North East and Yorkshire and The Humber all had significantly lower HLE than the England average. HLE for men in

London and some other regions was significantly below the state pension age of 65 for men. When women were assessed against the same state pension age of 65, which is where it will be by 2018, the same is true.

FIGURE 27 LIFE EXPECTANCY (LE) AND HEALTHY LIFE EXPECTANCY (HLE) FOR MEN AND WOMEN AT BIRTH* BY REGION 2010-2012**





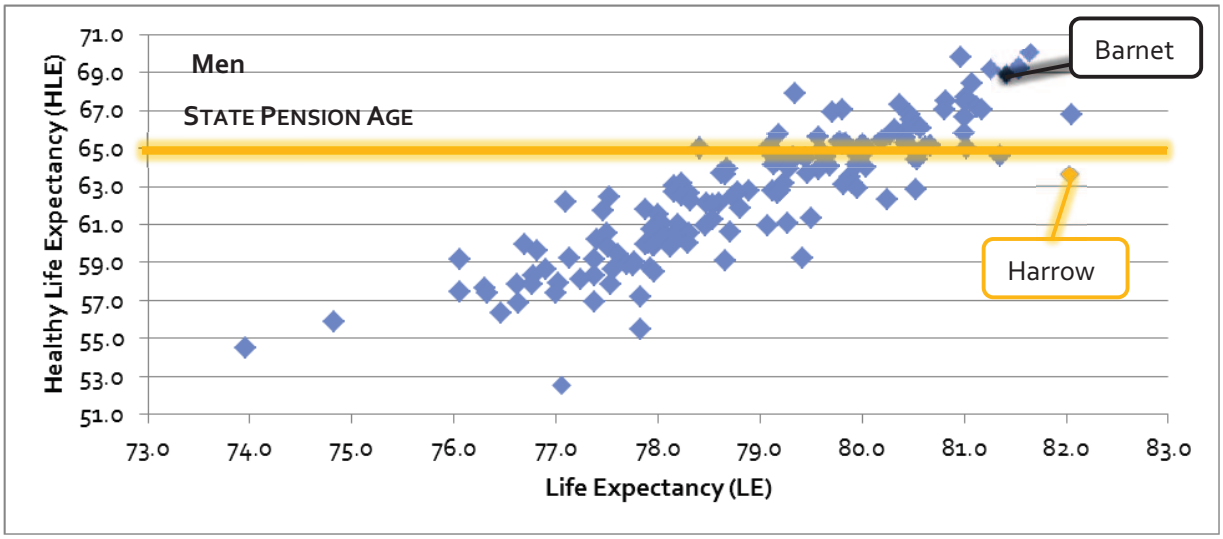
Source: Office for National Statistics (ONS)

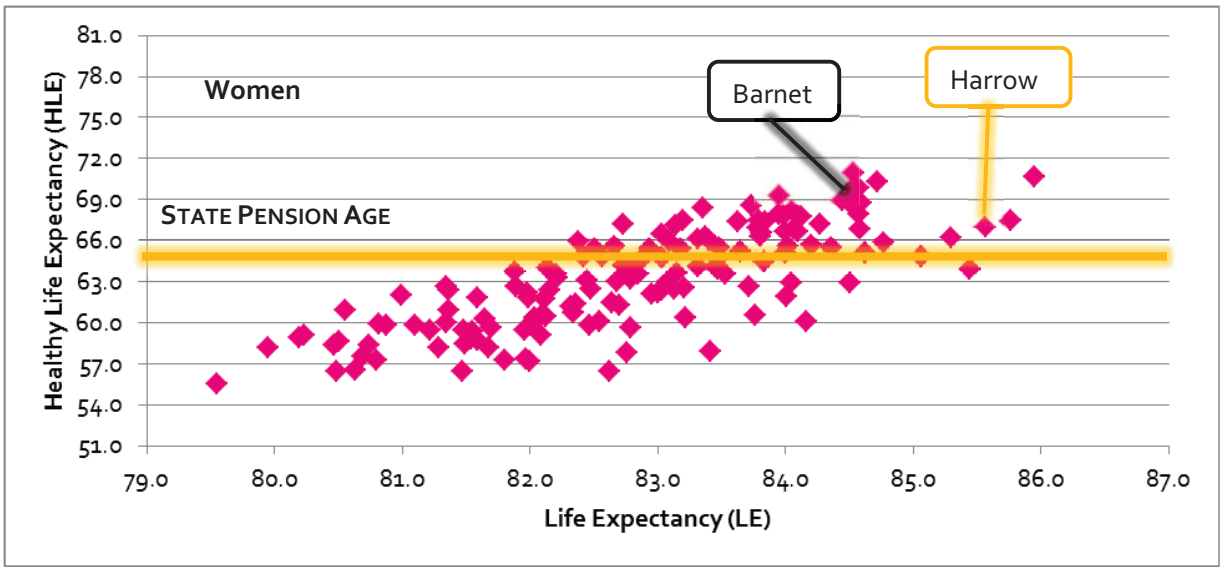
*** Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.***

**** Regions are presented by gender sorted by HLE***

Using the state pension age to give context to HLE, Barnet residents of both genders have a HLE above the state pension age (68.9 years for men and 69.9 years for women) suggesting that the average resident would be in relatively good health at and after pensionable age. On the other hand, male residents in Harrow have a HLE which is lower than the current state pension age (63.6 for men compared with 67.1 for women) (figure 28).

FIGURE 28 LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY AT BIRTH FOR MEN AND WOMEN 2010-2012





Source: Office for National Statistics (ONS)

** The State Pension Age will be 65 for women by 2018*

Healthy life expectancy was lowest in Tower Hamlets (55.7 years for men, 54.1 years for women) and highest in Richmond upon Thames (70.3 years for men, 72.1 years for women), leading to an inequality gap in healthy life expectancy between London boroughs of 14.6 years for men and 18.0 years for women; this is much greater than the gap in life expectancy itself.

The calculation of LE, HLE and the difference between the two – which can be interpreted as the average number of years of healthy life lost to poor health – provides a direct and simple method to assess the relation between changes in mortality and morbidity.

In the most deprived 10% of Lower Super Output Areas (LSOA) in England (known as decile one), healthy life expectancy was 18.4 years lower for men and 19.0 years lower for women than the least deprived 10% of LSOAs (decile ten). This inequality is almost twice as wide as the difference seen in life expectancy at 9.2 years for men; for women it is almost three times wider than the difference in life expectancy at 6.8 years. When assessing life expectancy with the same measure it is 9.4 years for men and 6.9 years for women, suggesting greater inequality exists in the prevalence of self-assessed 'Good' general health than mortality.

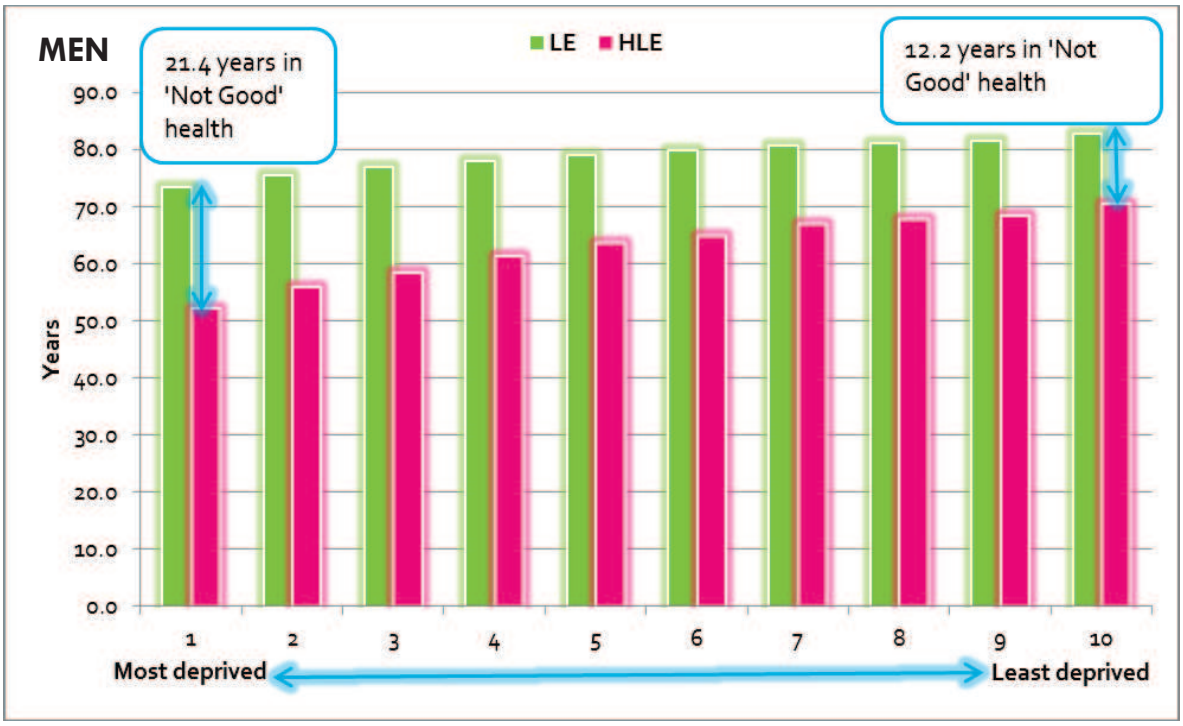
Men in decile ten (least deprived) can expect to spend 12.2 years in 'Not Good' general health, despite having longer lives. Those in the most deprived areas can expect to spend 21.4 years of their already short life in 'Not Good' health. For women these figures are 14.2 years in 'Not Good' health in the least deprived decile and 26.4 years in the most deprived decile (figure 29). Therefore a major public health objective is to increase HLE so that it comes closer to LE, thus reducing the gap or period of ill-health.

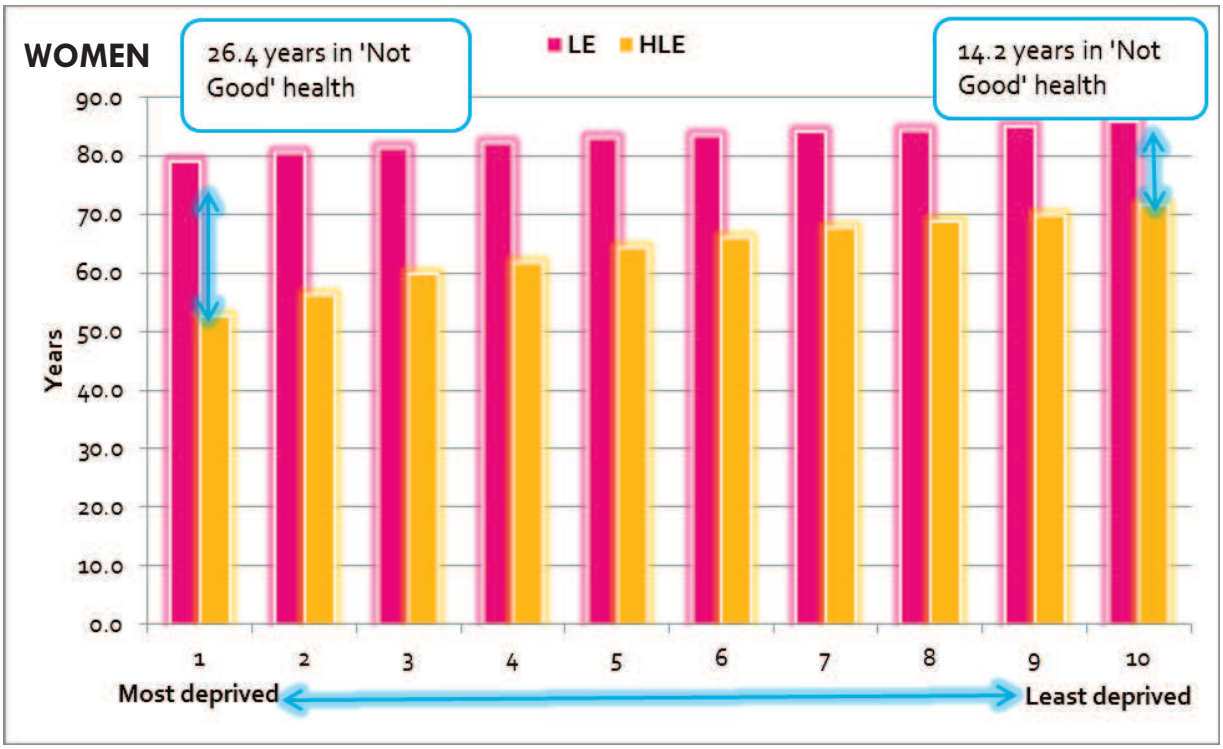
An area has a higher deprivation score than another if the proportion of people living there, who are classed as deprived is higher. Using the indices of multiple deprivation, three LSOAs in Harrow fall within the top 20% most deprived in England; they are in the wards of Hatch End, Stanmore Park and Roxbourne. No LSOAs fall into the top 10% of the most deprived nationally. Twenty-three Harrow LSOAs are in the least deprived 20% in the country, eight (in the wards of Pinner, Hatch End, pinner South and Headstone North) of which are in the least deprived 10%. Like Harrow, Barnet do not have any LSOAs that fall within the top 10% most deprived and seven –East Finchley, Colindale, Edgware, West Hendon, Golders Green, Burnt Oak and Underhill - which fall within the top 20% most deprived LSOAs in the country.

The difference in healthy life expectancy between adjacent deciles is not equal. Not only do those in the most deprived areas suffer worse health outcomes: across both genders they also have the biggest difference between themselves and their neighbouring more advantaged decile, implying that they would need to make bigger improvements to achieve the healthy life expectancy of the decile above them. The biggest differences are seen between decile one and two for men at 3.8 years and decile one and two and two and three for women, both at 3.6 years (figure 30). Conversely, the smallest difference between adjacent deciles was observed between seven and eight and eight and nine for men and seven and eight for women all at 0.8 years. Interestingly, the gap widens again for both genders between nine and ten, where men see the

difference increase to 2.0 years and women see a 1.7 year increase. For women the difference between deciles nine and ten is the same as between deciles five and six [7].

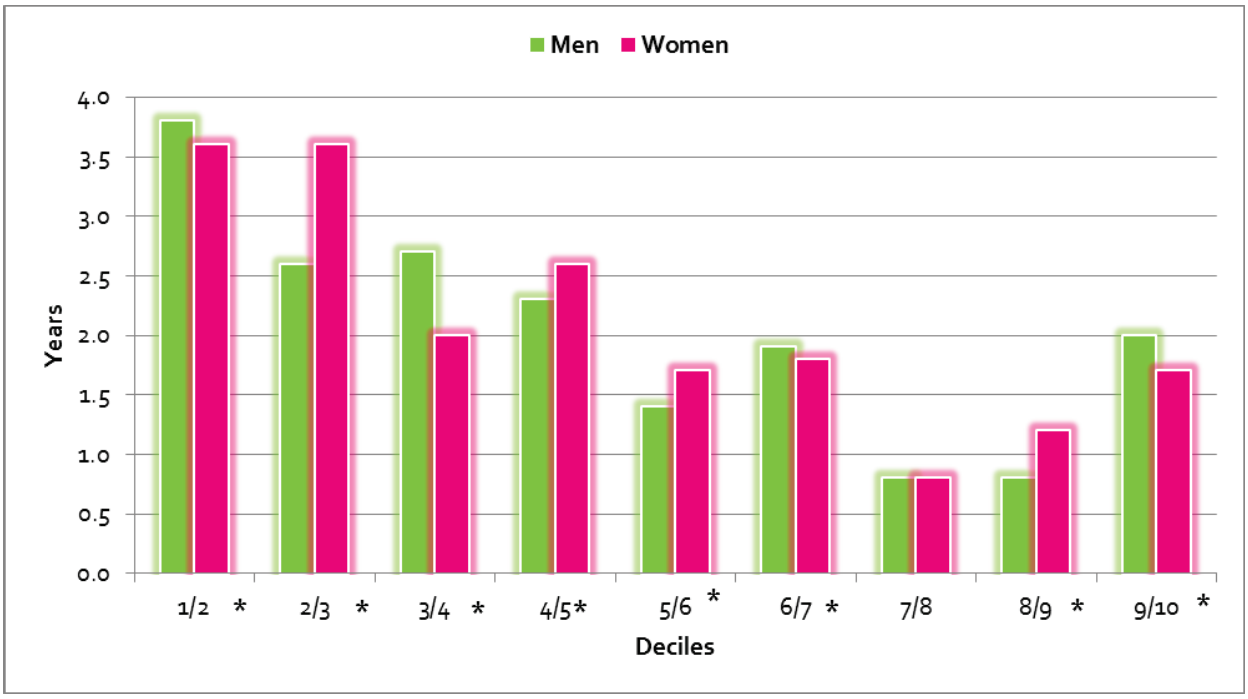
FIGURE 29 LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY BY DECILES OF DEPRIVATION FOR MEN AND WOMEN, ENGLAND 2009-2011





Source: Annual Population Survey (APS) – Office for National Statistics

FIGURE 30 DIFFERENCE IN HEALTHY LIFE EXPECTANCY BETWEEN ADJACENT DECILES FOR MEN AND WOMEN, 2009-11



Source: Annual Population Survey (APS) – Office for National Statistics

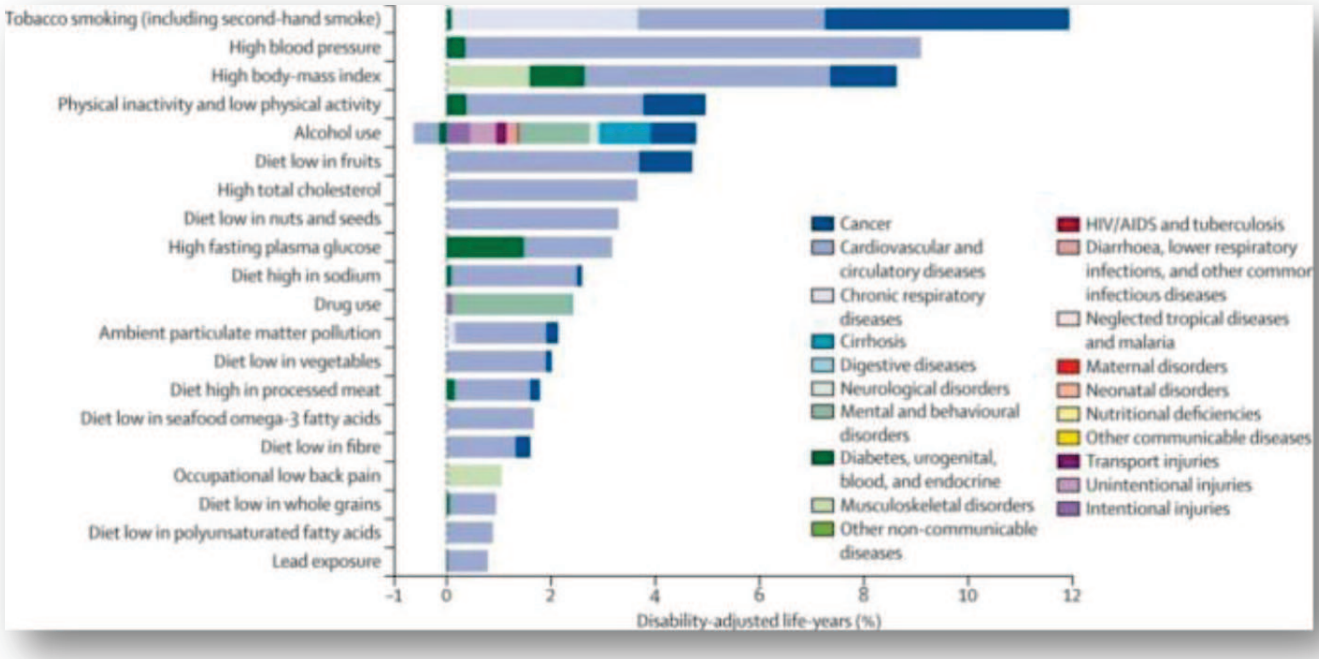
*** Denotes significant difference between the two deciles for men and women respectively**

With the exception of the difference between deciles eight and nine for men and seven and eight for women, the difference between all other adjacent deciles was found to be statistically significant, indicating that the differences between the most and least deprived deciles, are not occurring by chance

This difference between deciles may indicate an 'access to resources' effect, where the least deprived decile of the private household population hold 44% of the total aggregate wealth[7], this may account for the greater increase in healthy life expectancy observed between decile nine and ten; on the other hand falling below a "resource threshold" may present a disproportionate risk to health, as observed in the greater declines in healthy life expectancy occurring between decile two and decile one. It is worth noting, however, that it is not the area itself which is deprived but the circumstances and lifestyles of those residing in the area that affects an area's deprivation score relative to another area. This means that not all residents of a deprived area are deprived, and conversely, not all deprived people live in deprived areas.

These differences in access to resources between the most and least deprived deciles are also evident in the level of physical activity, level of wellbeing, prevalence of mental ill health and reporting of health problems[8].

FIGURE 31 BURDEN OF DISEASE ATTRIBUTABLE* TO 20 LEADING RISK FACTORS FOR BOTH GENDERS IN 2010**



Source: Murray CJL et al. 2013

*** Expressed as a percentage of UK disability-adjusted life-years***

**** The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes***

Using data from the Global Burden of Disease, Injuries and Risk Factors Study 2010 (GBD 2010) to establish some of the leading preventable risks that explain the patterns of health loss in the UK between 1990 and 2010, tobacco smoking (including second hand smoke) was found to be the leading factor for disease[9], despite falling rates of smoking among both men and women. High blood pressure and high body mass index, or being overweight, each caused about 9% of the burden of disease in 2010 (figure 31).

Work carried out by the King's Fund found that current lifestyles present a serious threat to population health, particularly amongst more disadvantaged groups, while there have been some improvements in lifestyle risks across the population; the greatest improvements are in higher socio-economic and educational groups where there have been significant reductions in the

"…We have learned not to try too hard to be middle-class. It never works out well and always makes you feel worse for having tried and failed yet again. Better not to try. It makes more sense to get food that you know will be palatable and cheap and that keeps well. Junk food is a pleasure that we are allowed to have; why would we give that up? We have very few of them."

Linda Tirado

proportion with three of four unhealthy behaviours (smoking, excessive alcohol use, poor diet and low levels of physical activity). This has not been replicated among unskilled groups – individuals with no qualifications were more than five times as likely as those with higher education to engage in all four unhealthy behaviours in 2008, compared with only three times as likely in 2003[10]. Importantly, more than 60% of the population has a negative or fatalistic attitude towards their own health, this is particularly prevalent in more disadvantaged groups; if current attitudes continue rates of avoidable ill-health and health inequalities are likely to increase[1].

So why are these four unhealthy behaviours so pervasive in disadvantage groups when public health messages advising the adoption of healthier lifestyles are ubiquitous? A number of explanations have been put forward including the affordability of healthy and unhealthy foods[11] and the relative ease of access to alcohol[12, 13], but to some extent these are downstream problems for disadvantaged individuals. People living in deprived circumstances must manage sporadic income, juggle expenses and make difficult tradeoffs and even when decisions have no financial bearing these recurrent preoccupations can be ever present and distracting. Our brains have limited cognitive capacity and these preoccupations leave fewer cognitive resources available to guide choice and action[14]. People living in deprived circumstances make decisions which at face value are objectively damaging but at the time and given the circumstances make sense, the powerful excerpt below goes some way to explaining the decisions made while living in poverty.

"I smoke. It's expensive. It's also the best option. You see I am always, always exhausted. It's a stimulant. When I am too tired to walk one more step, I can smoke and go for another hour. When I am enraged and beaten down and incapable of accomplishing one more thing, I can smoke and feel a little better, just for a minute. It is the only relaxation I am allowed. It is not a good decision, but it is the only one that I have access to. It is the only thing I have found that keeps me from collapsing and exploding."

Linda Tirado

"..We know that the very act of being poor guarantees that we will never not be poor. It doesn't give us much reason to improve ourselves... Poverty is bleak and cuts off your long-term brain... I make a lot of poor financial decisions. None of them matter in the long term. I will never not be poor, so what does it matter if I don't pay a thing and a half this week instead of just one thing? It's not like the sacrifice will result in improved circumstances the thing holding me back... [is] that now that I have proven that I am a Poor Person that is all that I am or ever will be. It is not worth it to me to live a bleak life devoid of small pleasures so that one day I can make a single large purchase. I will never have large pleasures to hold on to. There's a certain pull to live what bits of life you can while there's

money in your pocket, because no matter how responsible you are you will be broke in three days anyway. When you never have enough money it ceases to have meaning…You grab a bit of connection wherever you can to survive. You have no idea how strong the pull to feel worthwhile is. It's more basic than food… Whatever happens in a month is probably going to be just about as indifferent as whatever happened today or last week. None of it matters. We don't plan long-term because if we do we'll just get our hearts broken. It's best not to hope. You just take what you can get as you spot it."

LINDA TIRADO "THIS IS WHY POOR PEOPLE'S BAD DECISIONS MAKE PERFECT SENSE" HUFF POST NOVEMBER 22ND 2013

What do we need to do now

In a nation where free universal health care and public health programmes have been the norm for more than five decades, one would not expect to observe the inequalities in healthy life expectancy described above. Increasing healthy life expectancy is important at both the individual and population level. At the individual level living longer in better health is preferable to a longevity marred by disease and disability; it allows people to enjoy their later years and reduces social isolation and loneliness. At the population level, increasing healthy life expectancy means that fewer people are claiming incapacity benefits, more are able to continue to work for longer which could encourage economic growth[15] and fewer people need to rely on already stretched health and social care services. It is unlikely that increasing spending on services will solve the healthy life expectancy issue. Resources are scare and both the NHS and local authorities are under immense pressure from constrained budgets and increasing demand. We need a new approach.

Wider Determinants

The circumstances in which we live our lives have an impact on our health; they impact on the opportunities we have to make healthy choices. Greater attention should also be paid to the determinants that collectively influence health and wellbeing – physiological risk, psychosocial risks, risk conditions as well as behavioural risks, in other words the root causes of ill health underscored in the Marmot Review[16]. The constant strain of poverty, low paid work, un- and underemployment, poor or insecure housing and debt leads to a lack of control, poor environments, emotional distress, social isolation and physiological impacts on blood pressure, stress hormones and cholesterol all of which impact not only lifestyles choices but our vulnerability to mental and physical illness.

The new approach needs to find effective ways to support people in lower socioeconomic groups; the ability to live a meaningful life should exist in a reasonable amount for all. This could be achieved by supporting community finance initiatives, controlling payday lenders, providing debt counselling and benefits advice, integrating support across the public sector to improve employment prospects, developing a locally integrated system that joins up schools, vocational training, apprenticeships, employers and employment support to ensure

young people are given the best chance to develop skills needed to get a good job and support out of work adults into employment, increase the quality of high quality housing, implement and regulate the living wage at local authority level and work with local businesses to promote the living wage through recognition schemes[17].

Prevention priorities

Public health prevention priorities should be holistic in nature and with a comprehensive understanding of the population served and their social and health needs. Efforts to improve and protect health, prevent disease and injury, and deliver high-quality healthcare to the population must be tailored to address the risks and causes associated with the greatest burden, in addition to improving the quality of life of disadvantaged groups if overall health performance is to improve[9], as such, diet, alcohol physical inactivity and smoking have been and will remain part of the public health agenda.

Since the prevalence of many chronic disease conditions rises steadily with age, a longer life span will inevitably lead to more years spent with disability. Principal among the causes of chronic disability are musculoskeletal disorders, mental health disorders, substance misuse and falls, all of which garner comparatively less policy attention. To address these, concerted public health and high quality medical care strategies should be systematically implemented[9].

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AGENDA ITEM 9

	Health and Well-Being Board **29 January 2015**
Title	**Early Years Sub-Group – update on progress**
Report of	Val White, Commissioning Director (Children & Young People)
Wards	All
Date added to Forward Plan	12 November 2014
Status	Public
Enclosures	Appendix A: Health and Wellbeing sub-group terms of reference
Officer Contact Details	Sam Raffell, Commissioning and Policy Advisor,sam.raffell@barnet.gov.uk, 020 8359 3603

Summary

The over-arching aim of publicly-funded community based services for children under 5 is to protect and promote the health and wellbeing and development of children. The early years of childhood development present the best early intervention opportunity across the public sector to improve outcomes for children in Barnet.

The paper gives a short overview of the proposed approach to improve integration and joint working across early years through an early years sub-group to improve services across the public sector in Barnet. The terms of reference attached at Appendix A outlines the role of the group, key objectives and a high level work plan.

The group will be made up of early years commissioners and providers from across Barnet and will be accountable to the health and well-being board. The group is designed to deliver changes recommended through the early years review (presented to the Health and Well-being Board on 12 June 2014) and deliver the priority areas across the council and CCG.

The group will provide direction to shape early years provision, be involved in co-design of future service models, help secure organisational buy-in to early years integration and lead on the key work streams (Information sharing, locations and assets, pathways and service development and integration) outlined in the terms of reference.

Recommendations
1. **That the Health and Well-Being Board approves the terms of reference, including objectives and high level work plan for the health and wellbeing early years sub-group.**
2. **That the Health and Well-Being Board makes any comments, amendments or recommendations on the health and wellbeing early years sub-group proposed approach.**

1. WHY THIS REPORT IS NEEDED

1.1 The report provides an update on the Early Years sub-group, outlining the groups terms of reference, including objectives and high level work plan for 2015 for approval by the health and wellbeing board.

2. REASONS FOR RECOMMENDATIONS

2.1 The recommendations being made above are to ensure the health and wellbeing early years sub-group terms of reference, objectives and work plan match the health and wellbeing board's priorities.

2.2 The council, the clinical commissioning group (CCG) and other key partners have made the early years of children's lives a priority area. Barnet council has undertaken an Early Years Review aimed at improving Early Years provision across Barnet. This review was informed by an independent review of health visiting, school nursing and family nurse partnership.

2.3 The transfer of responsibility of various public health services to the London Borough of Barnet together with other health reforms provides a unique opportunity to consider the relationship between a number of core services and how they may be delivered and specified so as to get the best possible outcomes and value for money.

2.4 The group will be made up of early years commissioners and providers from across Barnet. The group is accountable to the health and wellbeing board and is designed to deliver the recommended changes as part of the early years review and deliver the priority areas across the council and CCG.

2.5 The group will provide direction to help shape early years provision in line with the health and wellbeing plan priorities, Barnet's Children and Young People Plan and recommendations made through the early years review. It will also be involved in co-design of future services, lead on developing workstreams that address cross-cutting issues and help secure organisational buy-in for further integration of services. This directly relates to the decision at Health and Well-being board on 18 September 2014, where the board agreed to oversee the aspects of the Children and Young People's Plan that relate to health and well-being and to take partnership decisions for these areas.

2.6 The objective of the group is to give strategic direction and support to how early years services will function in 2015-16 onwards, in particular the approach for closer working and opportunities for integration between health visitors, midwives, children's centres and other health services. The group will also;

2.6.1 Focus on improving the identification and support of vulnerable families in Barnet and to improve their children's health and wellbeing.

2.6.2 Oversee the implementation of the agreed recommendations of the early years review and the Health visitor, school nursing and family nurse partnership review.

2.6.3 Lead on the key four work streams to improve early years provision in Barnet;

i. Information sharing – data, consent and IT
ii. Location and assets
iii. Pathways, signposting and service development
iv. Integration

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 If the recommendation is approved the health and wellbeing early years sub group will continue as planned, taking into account comments or amendments made by the board.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The key outcomes for the early years health and wellbeing sub-group are aligned with both the Public Health Outcomes Framework ('Children in Poverty' and 'School readiness') and a key principle of the Barnet Health and Wellbeing Strategy ('Preparation for a healthy life – enabling the delivery of effective pre-natal advice and maternity care and early-years development')

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The approval of the approach will have no direct resource implications as resource will be utilised from the council and partners existing resource allocation.

5.3 Legal and Constitutional References

Health and Well-Being Boards have a number of statutory duties designated

through the Health and Social Care Act (2012) that inform the nature of decisions that should be taken to the Health and Well-Being Board meetings

5.3.1 The Health and Well-Being Board's terms of reference by virtue of the Council's Constitution Responsibility for Functions Annex A, includes a responsibility:

(1) To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.

(2) To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.

(3) To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

(4) To consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.

(5) To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.

(7) To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

5.4 Risk Management

5.4.1 There is a risk that without a shared approach across both commissioners and providers of early years health and wellbeing services the recommendations identified through the early years review to improve the service for families in Barnet will not be achieved. The early years sub-group has the ability to mitigate this risk by creating a clear plan to improve service integration across Barnet.

5.5 Equalities and Diversity

5.5.1 The Council and all other organisations exercising public functions are required under the Equality Act 2010, to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; advance equality of opportunity between

those with a protected characteristic and those without; promote good relations between those with a protected characteristic and those without. The relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. It also covers marriage and civil partnership with regard to eliminating discrimination.

5.5.2 A part of the early years review full business case an equalities impact assessment was completed. The early years health and wellbeing group will continue to pay due regard to the Equality Act 2010 as part of its on-going work programme.

5.6 **Consultation and Engagement**

5.6.1 The early years health and wellbeing group will be informed by previous papers such as the early years review full business case and the health visitor and school nursing review, which have been based on a significant amount of consultation and engagement.

5.6.2 The group will engage with key stakeholders across early years services as part of the on-going work.

6. BACKGROUND PAPERS

6.1 Children's, Education, Libraries and Safeguarding Committee, 28 October 2014, item 9 Early Years Review Full Business Case.

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Early Years Review – Health and well-being working group

1. Background

The over-arching aim of publicly-funded community based services for children under 5 is to protect and promote the health and wellbeing and development of children. The early years of childhood development present the best early intervention opportunity across the public sector to improve outcomes for children in Barnet.

The Council, the Clinical Commissioning Group and other key partners have made the early years of children's lives a priority area. Barnet council has undertaken an Early Years Review aimed at improving Early Years provision across Barnet. Moreover, the transfer of responsibility of various public health services to the London Borough of Barnet together with other health reforms provides a unique opportunity to consider the relationship between a number of core services and how they may be delivered and specified so as to get the best possible outcomes and value for money within the envelope of public funding that will in the future be available. The services which this relates to are the following:

- Health Visiting
- Family support and outreach work (children's centres)
- Family Nurse Partnership
- Community Midwifery
- Speech and Language Therapy
- Maternal mental health services

This document outlines the terms of reference and broad work plan for the group and has been informed by previous meetings where members committed to using the group to improve early years health and wellbeing provision.

2. Role of the group

The group will be made up of early years commissioners and providers from across Barnet. The group is accountable to the health and wellbeing board and is designed to deliver the recommended changes as part of the early years review and deliver the priority areas across the council and CCG.

Practically, the group will;

A. Provide direction and help shape early years provision in line with the health and wellbeing plan priorities, Barnet's Children and Young People Plan and recommendations made through the early years review.

B. Be involved in the co-design of future service models and pathways for early years services.

C. Help secure organisational buy-in for early years integration. Develop our thinking on the outcomes and performance measures that together would contribute towards and achieve integrated service provision.

D. Lead on developing the work streams detailed in section 5. Members of the group will be their organisations' representatives and will be accountable for ensuring the objectives of each organisation are given due consideration.

3. Objectives

The overarching objective of the group is to give strategic direction and support to how early years services will function in 2015-16 onwards, in particular the approach for closer working and opportunities for integration between health visitors, midwives, children's centres and other health services. This will include;

A. Support improved relationships between various health and local authorities early years services across Barnet, focusing on improving the identification and support of vulnerable families in Barnet and to improve their children's health and wellbeing.

B. Oversee the implementation of the agreed recommendations of the early years review and the Health visitor, school nursing and family nurse partnership review.

C. Help develop a clear pathway and protocols to ensure that when risk factors during pregnancy are identified that GPs, midwives and health visitors can effectively trigger the appropriate, targeted support.

D. Ensure that the Speech and Language Therapy service (SALT) provision develops stronger partnership working with the health visiting service as part of the integration of early years settings such as children's centres.

E. Lead on the key four work streams to improve early years provision in Barnet;

- Information sharing – data, consent and IT
- Location and assets
- Pathways, signposting and service development
- Integration

4. Core Members

The members of the group will include a range of commissioners and providers of early years services across Barnet. The core membership will be as follows;

- Judy Mace - Head of Joint Children's Commissioning (CCG/LBB) - Chair
- Scott Johnston – Head of Midwifery (Barnet and Chase Farm Hospitals)
- Ian Mckay – Head, Children's Young People and Women's Services (East London Foundation NHS Trust)
- Janet Lewis - (Central London Community healthcare NHS Trust)
- Maternity Lead (North Central London CCGs)
- Mai Buckley – Director of Maternity (Royal Free London NHS Foundation Trust)
- Sam Raffell – Commissioning and Policy Advisor (LBB)
- Janet Diamond – Head of Service - Early Years (LBB)
- Nicky Brown – Commissioning Manager (NHS England)
- Laura Fabunmi - Public Health Consultant (Children Lead) (LBB)

Membership of the group may change moving forward.

5. Work streams

The following work streams have been proposed as key work streams to develop a more integrated, improved and collaborative early years' service in Barnet, meeting the objectives set out in the health and wellbeing strategy.

1. **Information sharing – data, consent and IT** - There is a need for information sharing to be improved across early years services to ensure all services can effectively support families, especially those who are most vulnerable.

2. **Location and assets** - The sub-group should act as a key link between local authority and health services to ensure that on-going reviews of assets is considered across health and the local authority, ensuring the best use of public sector assets.

3. **Pathways, signposting and service development** - A key objective of the health and wellbeing group is to develop clear pathways to ensure that when risk factors are identified during pregnancy by GPs, midwives and health visitors the right support is offered.

4. **Integration** - There is a clear recognition that closer integration of services between health and local authority led early year's services would help to improve outcomes. There is a specific focus on health visiting, the

commissioning of which will transfer to public health in October 2015. There are also opportunities for integration with the RFH acquisition of BCH hospital.

5. Timings

The group will meet on a bi-monthly basis over the next 12 months. After 12 months the group will complete a report for the health and well-being group outlining how the group has performed against its objectives and the next steps for the group.

6. Quorum

There would be at least five members of the working group present one of whom should be an LBB senior officer to chair the meeting

7. Governance

The work of this group will ultimately be accountable to the Health and Wellbeing Board, with the group providing progress reports to the board on request.

8. Review date

These terms of reference will be reviewed on an annual basis should the life span of this group continue beyond a year

9. Date ratified

Terms of Reference will be ratified at the first meeting of the early years health and wellbeing group.

AGENDA ITEM 10

	Health and Well-Being Board **29 January 2015**
Title	**The Dementia Manifesto for London**
Report of	Commissioning Director - Adults and Health
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1: Dementia Manifesto for London Appendix 2: CCG DDR letter December
Officer Contact Details	Dawn Wakeling Commissioning Director - Adults and Health dawn.wakeling@barnet.gov.uk 02083594290

Summary

The Health and Well-Being Board considered the Dementia Manifesto for London at the meeting on the 13th. November 2014 and requested more information on signing up to the Dementia Manifesto for London. The Dementia Manifesto for London was produced by the Alzheimer's Society as a way of raising the awareness of local politicians as part of the run up to the local elections in 2014. There is no mechanism for health and social care organisations to sign up to this.

The "Opportunities for Change" campaign in 2014 also launched a number of aspirational local and national actions. These have formed the basis for consultation and agreement to develop a local Barnet Dementia Manifesto which reflects local ambition and if agreed, will be mainstreamed into the on-going health and social care integration work to ensure joined up delivery.

A verbal summary of the outcomes from the Older Adults' Partnership Board will be presented at the Health and Well-Being Board in January.

Recommendations

1. **That the Health and Well-Being Board agree to the development of a local Barnet Dementia Manifesto, which builds on the progress to date on dementia care in Barnet.**
2. **That, subject to agreeing recommendation 1, the Health and Well-Being Board embeds the actions from the final Barnet Dementia Manifesto, when complete, into the Health and Well-Being Strategy refresh.**
3. **That, subject to agreeing recommendation 1, the Health and Wellbeing Board recommend to NHS Barnet CCG's Governing Body that actions from the final Barnet Dementia Manifesto are embedded into the NHS Barnet CCG Delivery Plan.**
4. **That, subject to agreeing recommendation 1, the Health and Well-Being Board recommend to the Council's Adults and Safeguarding Committee that actions from the final Barnet Dementia Manifesto are embedded into the Adults and Safeguarding Commissioning Plan.**

1. WHY THIS REPORT IS NEEDED

1.1.1 At the Adults and Safeguarding Committee meeting on the 2nd July 2014, the Health and Well-Being Board were asked to consider implementing the Alzheimer's Society's Dementia Manifesto for London in order to help deliver the proposed savings.

1.1.2 The Health and Well-Being Board considered a report on implementing the Dementia Manifesto for London at its meeting on the 13th November 2014 and requested further information on the implications of signing up to the Dementia Manifesto for London. The report presented in November highlighted new services and good practice in Barnet which have been developed to improve treatment, care and support and quality of life for people with dementia and their carers. The Health and Well-Being Board agreed to continue supporting the delivery of the three key outcomes (see p.207 of the report to the Health and Well-Being Board November 2014 and paragraph 1.4.2 of this report).

1.2 ***Background to the dementia manifesto for London***

The Dementia Manifesto for London was launched on March 10th 2014 as part of the campaign by the Alzheimer's Society to raise awareness about dementia across London in the run up to the local elections. The Alzheimer's Society is a very successful campaigning organisation whose role is to campaign for "a fairer deal" for people with dementia and their families. The intention of the Dementia Manifesto for London was to ensure as many councillors and candidates as possible signed up to support the manifesto and take action locally, strengthening relationships between councillors and the Alzheimer's Society, and creating new relationships with candidates with a view to securing local political commitments.

1.2.1 The issue of dementia formed part of local manifestos in Barnet with an expressed commitment to strengthening services for people with dementia as a priority for the future.

1.2.2 The Dementia Manifesto for London was launched across London and targeted a number of boroughs as part of the election campaign:

- Newham
- Barking and Dagenham
- Bexley
- Croydon
- Greenwich
- Merton
- Harrow
- Hillingdon
- Enfield

1.2.3 In some boroughs such as Enfield, this resulted in an event to coincide with the launch of the Dementia Manifesto for London.

1.2.4 Not one London borough has signed up to the Dementia Manifesto for London and the advice from the Alzheimer's Society is that this was not the intention of this document. They have further confirmed that there is actually no mechanism to enable any organisation to sign up to the Manifesto.

1.3 ***The Dementia Manifesto for London***

The Dementia Manifesto for London is attached at Appendix 1.

1.3.1 The Dementia Manifesto for London is a document that focuses almost exclusively on the role of local authorities reflecting the aspirations of the Alzheimer's Society to raise awareness amongst local councillors as part of London's local elections. However the overarching aim of the document cites the vision for better outcomes for people with dementia and their families across the health and social care system as identified by the three key ideas in the Manifesto:

1) Timely diagnosis and appropriate-post diagnosis support.
2) Receive best quality care and support.
3) Feel part of a dementia-friendly community and have choice and control over their own lives.

1.3.2 In summary the Dementia Manifesto for London requests that politicians sign up to ensuring that local authorities prioritise:

1) Raising awareness of dementia through all council services and local authority partnerships
2) Providing information and advice, including access to a dementia advisor and ensuring that everyone has a named contact
3) Increasing training for staff working with people with dementia
4) Ensuring that everyone who has been diagnosed with dementia has a package of care
5) Making sure health see dementia as a priority
6) Working in an integrated way with health services to develop care pathways, using Better care Fund money
7) Working with hospitals and provide home from hospital support.
8) Offering specific leisure and entertainment services for people with dementia
9) Setting up local Dementia Action Alliances and promoting dementia friends
10) Working with London-wide organisations such as TfL to ensure good reliable transport
11) Ensuring health and social care services for people with dementia are designed with people with dementia and their carers.

1.3.3 Through the Health and Social Care Business Case, attention has been given to developing a whole system approach to supporting people with dementia and their families within available resources identified in the main through the Better Care Fund. The key exception to this is the additional funding which has been requested from the public health budget to develop a dementia friendly community based early intervention response for people with dementia and their carers as part of Tier 2 of the 5 tier model. In addition, the Council is also making a number of investments to better support carers as part of the 5 year Commissioning Plan for the Adults and Communities Delivery Unit. One initiative specifically focuses on carers of people with dementia

1.3.4 It is difficult to accurately estimate the costs of fully implementing the Dementia Manifesto for London because of the lack of activity data which identifies people with dementia across health and social care services. However, it is clear that implementing a response which means that 4,000 people have a named contact including access to a dementia advisor, and the assessment and provision of a support package to all 2,311 people who have been diagnosed with dementia (57.78% of people with dementia) would call for resources above and beyond that currently allocated health and social care envelope. The Alzheimer's Society estimate the cost of providing a community care package as being £24,128 – if every person with a diagnosis of dementia received a care package of this size then the cost to the health and social care system would be £55,759,808 per annum.

1.3.5 The key issue for Barnet is to identify those local priorities Barnet wish to achieve within the available cost envelope.

1.4 ***Dementia 2014: Opportunity for Change***

In 2014, the Alzheimer's Society also launched the "Dementia 2014: Opportunity for Change" report and campaign.

1.4.1 Dementia 2014: Opportunity for change provided a comprehensive summary of the key areas affecting people with dementia over the previous year in England, Wales and Northern Ireland. It considered the significant political and public attention that dementia has received in that period and what impact this is having for people living with the condition. Building on the success of the G7 summit on dementia, it gives an update on aspects of dementia research including trials, cause, prevention, care and treatment. It explores how well people are living in their communities and details the changes that need to be made to improve their quality of life. The report also draws together evidence from our annual survey, which involved more than 1,000 people with dementia and their carers, alongside new analysis from Alzheimer's Society, King's College London and the London School of Economics and calls for 14 actions to improve the quality of life for people with dementia.

These are as follows:

Action 1: All statutory health and/or social care bodies in England, Wales and Northern Ireland to set targets for stepped yearly improvements in diagnosis rates up to 75% by 2017

Action 2: Twelve weeks from referral to diagnosis

Action 3: Establish a minimum standard of integrated post-diagnosis support for people with dementia and carers

Action 4: Governments to build on progress and commit to appropriately resourced national strategies in England, Wales and Northern Ireland

Action 5: An open debate with citizens on the funding of quality health and social care that meets the needs of people affected by dementia

Action 6: A fully integrated health and social care system that puts the needs of people first

Action 7: People with dementia and their carers must be involved in the commissioning, design and development of services

Action 8: High-quality mandatory training for all staff providing formal care for people with dementia

Action 9: All communities to become more dementia friendly

Action 10: Everyone should have improved awareness of dementia

Action 11: All businesses to take steps towards becoming dementia friendly

Action 12: Dementia research should receive a level of investment that matches the economic and human cost of the condition

Action 13: All people with dementia and carers should have access to the best evidence-based care and research

Action 14: People affected by dementia and their carers should be given greater opportunity to participate in dementia research

1.4.2 Not all of these actions are within the responsibility of local Health and Well-Being Boards. However the "Opportunity for Change" document brings together aspirations across the health and social care economy which resonate locally, rather than focusing primarily on the role of the local authority in developing an integrated approach. There are also some common themes running through both initiatives. In addition the recent announcement for payment to GPs on diagnosis of dementia offers some opportunities to strengthen the local offer.

1.4.3 It is recommended that the Health and Well-Being Board adopts the principles of the Dementia Manifesto for London and seeks to further it with the specific actions presented below. The DH and NHS England have written to Health and Well-Being Boards requesting that the Boards give attention to supporting GPs and CCGs to improve diagnosis rates as alongside enabling GPs to be fully cognisant of the full range of services available to patients and their families post-diagnosis (attached at Appendix 2). The action plan addresses these outcomes.

1.4.4 This approach has also been discussed with and approved by the national Alzheimer's Society as an exemplar of best practice. These will be consulted upon a starting point for developing a "Barnet Dementia Manifesto" with the Older Adults Partnership Board, GPs leads, the Alzheimer's Society and local providers:

- Barnet CCG will develop targets for stepped yearly improvements in diagnosis rates up to 75% by 2017
- Barnet CCG will set a target of twelve weeks from referral to diagnosis
- All GPs will offer information at the point of diagnosis
- A clear offer for integrated post-diagnosis support for people with dementia and carers will be developed by Barnet Council and the CCG
- Barnet Council and Barnet CCG will commit to designing a fully integrated health and social care system that puts the needs of people first
- Barnet Council and Barnet CCG commit to involving people with dementia and their carers in the commissioning, design and development of services
- High-quality mandatory training for all staff providing formal care for people with dementia
- All hospitals to become more dementia friendly
- All communities to become more dementia friendly
- Everyone should have improved awareness of dementia through the promotion of dementia friends
- All businesses to take steps towards becoming dementia friendly
- All contracts to consider including developing a dementia friendly approach as part of a Social Value requirement.

Performance measures will be developed to measure success.

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Social Care Business case and other Council led initiatives already demonstrate the local commitment to meeting the needs of people with dementia and their families through early intervention and access to a range of support. However these initiatives are in a number of different places and also do not reflect the changing national priorities for GPs.

2.2 It is therefore recommended that the existing good work and aspirations are brought together in one place to enable all stakeholders and residents to be aware of the local offer. In recognition of the importance of meeting the needs of Barnet residents and their families who are affected by dementia, it is recommended that this is best done through a “Barnet Manifesto” based on national best practice targets together with local aspirations, and implemented through the Health and Well Being Strategy, the CCG Business Plan and the Adults and Safeguarding Business Plan.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The previous report considered whether the actions from the Dementia Manifesto for London were being implemented and the value of signing up to the Dementia Manifesto for London was debated.

3.2 It is not recommended that the Health and Well-Being Board sign up to the Dementia Manifesto for London. It is not possible for local authorities or CCGs to sign up to the London Dementia Manifesto. The Dementia Manifesto for London was created to raise awareness amongst political parties and candidates as part of the local election campaign in 2014. The creation of a Barnet Dementia Manifesto is recommended as a better alternative as it will enable the development of a locally relevant set of actions owned by key stakeholders and developed in conjunction with local residents.

4. POST DECISION IMPLEMENTATION

4.1 The implementation of the Barnet Dementia Manifesto will form part of the wider Health and Social Care Integration (HSCI) business case, the CCG Business Plan and the Adults and Safeguarding Business Plan.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

Implementing the relevant aspects of the Dementia Manifesto for London and the Barnet Dementia Manifesto as part of the Health and Social Care Integration business case furthers the borough's strategic objective of promoting an independent and informed over 55 population in the borough and promoting a strong partnership with the local NHS so that families and individuals can maintain and improve their physical and mental health.

By implementing the recommendations of the Barnet Dementia Manifesto, partnership arrangements would be strengthened with respect to support for people with dementia and residents in the borough will have better accessibility to information about dementia, and how those with dementia can lead independent lives.

In addition, it will also support the Health and Well-being Strategy through encouraging better community support for people with dementia and their carers, and enable people to take responsibility for their own and their family's health and wellbeing

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

The Dementia advisor and the memory assessment service are funded through CCG and Council budgets.

The targets and aspirations of the draft Manifesto will be costed individually before implementation and funding will be found within the available budgets.

5.3 **Legal and Constitutional References**

The Care Act (2014) puts people and their carers in control of their care and support. The current approach to dementia meets our statutory obligations. The Act requires local authorities to have provision in place to ensure that people:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support (including information about the types of care and support are available – e.g. specialised dementia care)
- have a range of high-quality care providers to choose from

The Council's Constitution (Responsibility for Functions, Annexe A) sets out the Terms of Reference of the Health and Well-Being Board. The Barnet Health and Wellbeing Board has the following responsibilities:

"To promote partnership, and as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health"

5.4 **Risk Management**

Risks in implementing the Barnet Dementia Manifesto, in particular financial risks, will be managed through the business plans.

5.5 **Equalities and Diversity**

As a public body the Council has a duty under s149 of the Equality Act 2010 to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

Implementing the Barnet Dementia Manifesto will have positive effects on those with dementia who are living in the borough and their carers.

It is estimated that around 1,400 men and 2,600 women in the borough have dementia – this is because dementia becomes more prevalent with older age and more women currently live for longer. Life expectancy is increasing for men and services will need to reflect this.

Dementia friendly communities will increase the understanding of dementia and reduce any discrimination and stigma associated with the illness.

5.6 **Consultation and Engagement**

Consultation with a number of carers for people with dementia, as well as people with dementia was undertaken in mid-2014. People expressed the

desire for better and more accessible information, advice and better support from the community as a whole. There was support and enthusiasm for creating dementia friendly communities with a particular focus on businesses becoming more dementia aware.

Further consultation on the specifics of a Barnet Dementia Manifesto will be undertaken at the Older Adults Partnership Board held on the 22nd January 2015.

6. BACKGROUND PAPERS

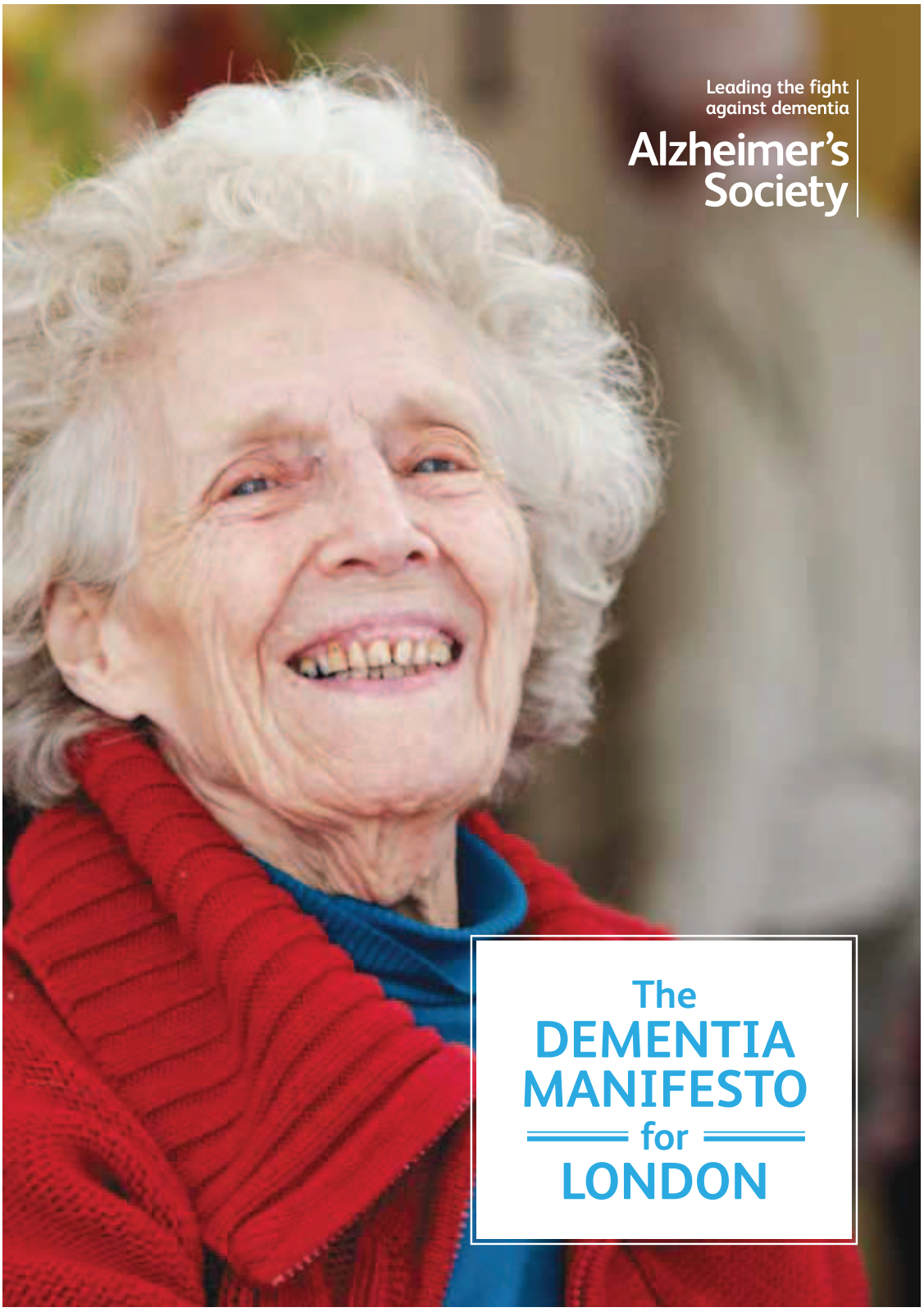
Implementing the Dementia Manifesto, Health and Well-Being Board 13th November 2014:
http://barnet.moderngov.co.uk/documents/s19141/Implementing%20the%20Dementia%20Manifesto.pdf

Minutes from Adults and Safeguarding Committee, 2nd July 2014:
http://barnet.moderngov.co.uk/documents/g7929/Printed%20minutes%2002nd-Jul-2014%2019.00%20Adults%20and%20Safeguarding%20Committee.pdf?T=1

Business Case for the delivery of Barnet Health and Social Care – Integration of Services, 2nd October 2014
http://barnet.moderngov.co.uk/documents/s18033/Business%20Case%20for%20Barnet%20Health%20and%20Social%20Care%20-%20Integration%20of%20Services.pdf

Dementia Manifesto for London
http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2100

Opportunity for Change
http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2317


Leading the fight
against dementia
Alzheimer's
Society
The
DEMENTIA
MANIFESTO
for
LONDON

Less than half of people with dementia feel part of their community.

2


3

Dementia is the biggest health and social care challenge facing London today. It's the most feared health condition for people over the age of 55[1] – but affects all ages.

There are 70,000 people across London living with dementia, and even more friends and family affected by the condition. Many of these people are not living well. They are isolated and can't access the vital care and support they need and deserve.

This manifesto explains how local authorities can make our communities more dementia-friendly and transform the lives of people with dementia.

Alzheimer's Society is calling on local councils and communities across the city to support the vision of a dementia-friendly London. There are three key ideas running through *The Dementia Manifesto for London*. We want every person with dementia in the city to:

1. **Get a timely diagnosis and appropriate post-diagnosis support.**
2. **Receive the best quality care and support.**
3. **Feel part of a dementia-friendly community and have choice and control over their own lives.**

[1] 'Public Awareness of Dementia', Alzheimer's Society 2008.

We know that improving the lives of people with dementia in London requires a tailored response because the city has some unique challenges, including:

- A postcode lottery of dementia care and support. Neighbouring boroughs can have wildly differing services, diagnosis levels and memory clinic waiting times.
- Most of the 25,000 people from black and minority ethnic communities who have dementia in the UK are living in London. This number is likely to rise faster than other groups of people in the future and there tends to be lower awareness of dementia in these communities. People are also far less likely to have a diagnosis or access the support they need.[2]
- Older people in London are more isolated than those from other areas of the UK, despite the city having the densest population in the country.[3]
- People with dementia occupy a quarter of all London's hospital beds[4]. More support is needed for them to maintain their independence in the community.

With action from London boroughs now, everyone with dementia in the future can have better quality of life.

Kate Moore
Operations Director, Greater London Alzheimer's Society

[2] 'Dementia does not discriminate', Report produced by the All-Party Parliamentary Group on dementia, July 2013.
[3] 'Social isolation among older Londoners', Institute of Public Policy Research, October 2011.
[4] 'Cost of Care', Alzheimer's Society, 2009.

Timely diagnosis and better post-diagnosis support

Only 48% of people with dementia in England currently have a diagnosis. Across London boroughs, this figure varies from 33% to 63%. People are getting the diagnosis they need too late. Assessment and diagnosis of dementia soon after someone has experienced symptoms is essential. It means they, and their carers, can access the care and support they need. Working closely with Clinical Commissioning Groups, local authorities can help to provide a more integrated package of care and support.

- Late diagnosis can be due to people delaying seeking help. Getting a diagnosis can also take a long time, even once concerns have been raised with health professionals.
- Many people with dementia, and their carers, say they feel abandoned after a diagnosis, with no ongoing support to help them cope. They can often feel anxious and unsure about the future.

Our vision

Clinical Commissioning Groups have committed to increasing the number of people diagnosed with dementia to at least 66 % by 2015. To help achieve this aim, care homes and general hospitals, as well as primary care and memory services, need to establish a diagnosis pathway for people with suspected dementia.

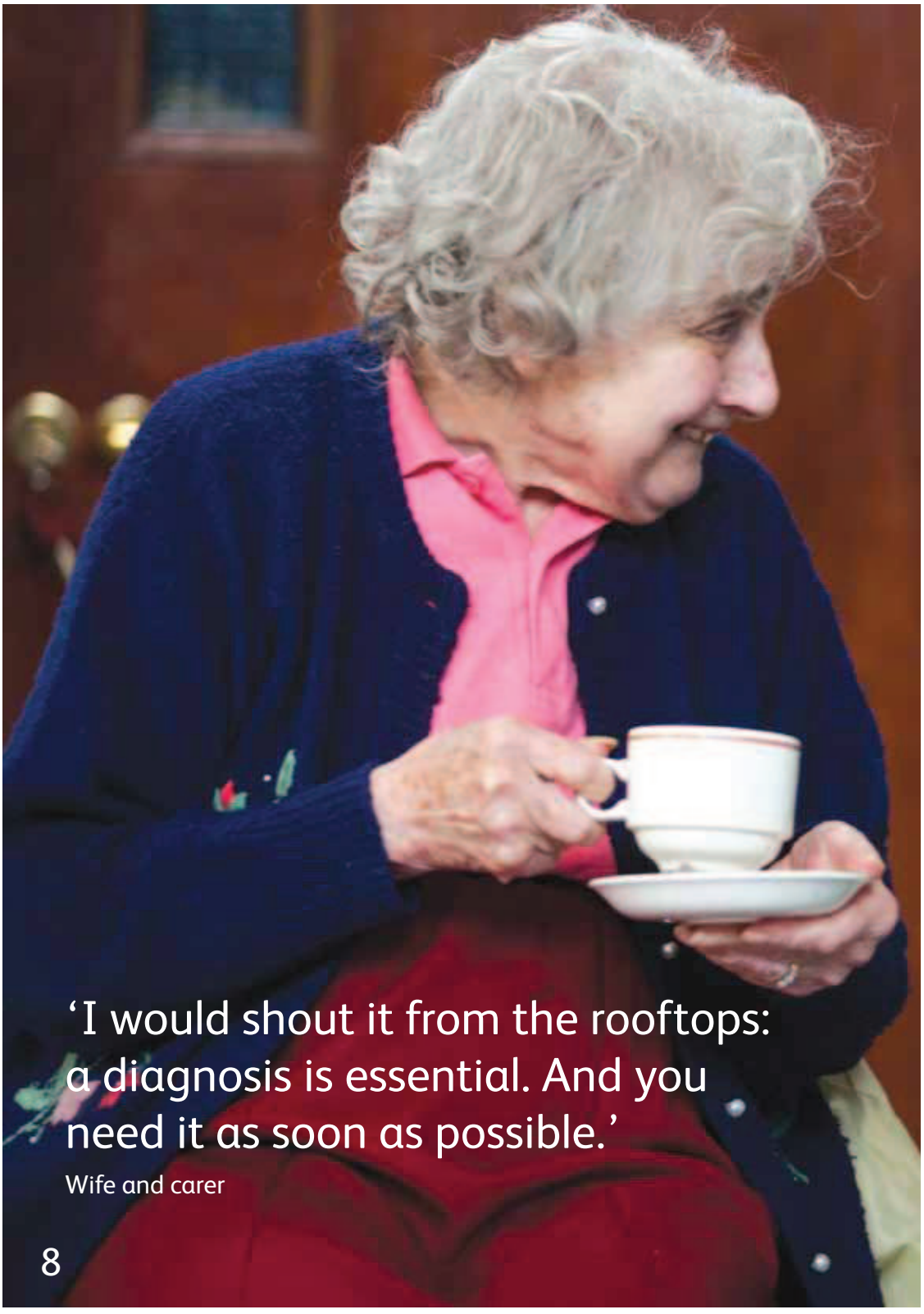
Appropriate, comprehensive and person-centered post-diagnosis support will meet the needs of local people, especially those living in the community. Priority must be given to commissioning support services that focus on ensuring people with dementia and their carers can access personally tailored information plus practical and emotional support. Access to peer support services and activities, such as support groups and dementia cafes, should also be provided.

How local authorities can help:

- Make dementia a health priority and prioritise integrating dementia support with health and social care services.
- Work with professionals and service providers to develop good referral pathways for people with suspected dementia.
- Ensure there is a package of support for people with dementia as soon as they are diagnosed.
- Commit to ensuring that people with a diagnosis and their carers have access to a dementia adviser, a named contact for people with dementia, or equivalent, as well as our post-diagnosis pack, The Dementia Guide.
- Ask GP surgeries, libraries, schools and community centres to display dementia advice material, such as our leaflet Worried About Your Memory, to encourage people to seek help if they suspect someone may have memory problems.
- Work with black and minority ethnic communities to raise awareness of dementia, to increase diagnosis rates and access to services.

‘I always feel better in myself after the Dementia Adviser has left. Because after discussing things with her, her explaining, her help and understanding makes me feel better in myself that day.’

Person living with dementia


‘I would shout it from the rooftops: a diagnosis is essential. And you need it as soon as possible.’
Wife and carer
8


9

Providing quality care for people affected by dementia

People with dementia deserve the best quality of care possible. Yet they tell us that it's difficult to get the support they need to remain independent. Their carers are often left to struggle alone. Lack of support at home means people with dementia are often admitted to hospital in an emergency. They stay there longer than necessary or go into a care home much earlier. Local authorities can help people with dementia to live well by providing quality and integrated health and care services.

- Nearly 70 % of people with dementia feel lonely and trapped in their own homes, with limited or no social networks, and are unable to live well.
- Less than half (42 %) of people with dementia think their community has the services they need to help them live well with dementia.

Our vision

We believe everyone with dementia should have access to a range of high quality services that address their individual needs. In having some choice over what support they get, people with dementia can achieve their own goals.

Care must be provided by staff who have had relevant training in dementia and are sufficiently rewarded and supported. This reflects the high level of skills required to support people with dementia to maximise their quality of life.

It's important that carers have access to support, such as short breaks. Such services help them maintain their own health and wellbeing, which is so vital when they are caring for someone with dementia.

How local authorities can help:

- Ensure information is accessible to all residents affected by dementia so they can make informed decisions about care.
- Increase specific training for staff working with people with dementia and ensure they have access to appropriate support.
- Work with local hospitals to deliver home from hospital services for people with dementia and reduce the chances of them being unnecessarily readmitted.
- Ensure people with dementia, and their carers, are involved in both designing and commissioning dementia health and social care services.
- Develop more integrated and high quality health and social care for people with dementia, using money from the £3.8 billion Better Care Fund.

‘Alzheimer’s Society Dementia Cafés and Singing for the Brain sessions have been such a big help to us. Meeting other carers where everyone was in the same boat meant that you could talk freely and people understood.’

David Thomas McGrail, husband and carer

Building a dementia-friendly London

Around three quarters of people think that communities and society as a whole are not geared up to deal with dementia. [5] For many of those living with dementia, having a good quality of life is a distant dream. Support with everyday things like shopping or participating in their community is not available. Local authorities can help to build dementia-friendly communities which will ensure people with dementia live well. Together we can create the world's first dementia-friendly capital city.

- Two thirds of people with dementia live in their own homes in the community.
- A third of people with dementia live on their own.
- Less than half of people with dementia feel part of their community.

Our vision

In dementia-friendly communities people living with the condition have high aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them.

These communities are aware of dementia. They are also supportive of people living with the condition and their carers. The result is a community that is more inclusive, improves the ability of people with dementia to remain independent, and gives them more choice and control over their own lives.

[5] 'Building dementia-friendly communities: A priority for everyone', Alzheimer's Society, August 2013.

How local authorities can help:

- Increase awareness and understanding of dementia by making our Dementia Friends sessions available to staff and the wider community. Dementia Friends might help someone find the right bus or spread the word about dementia on social media.
- Appoint a dementia lead to ensure the needs of people with dementia are taken into account throughout their borough.
- Commit to becoming dementia-friendly by helping to establish a local dementia action alliance in their borough. The alliance brings together organisations, from bus companies to care providers, to improve the lives of people with dementia in the local area.
- Play an active part in the pan-London Dementia Action Alliance – an initiative that asks members to come up with three actions they will take to make life better for people with dementia.
- Offer specific and appropriate activities, including existing leisure and entertainment choices to meet the needs of people with dementia.
- Work with Transport for London, and others, to ensure transport is consistent, reliable, responsive and respectful to the needs of people with dementia.

‘My wife Yvonne gives me a list of what I need to get or do that day. I take it to the newsagent or the bank and they tick things off for me when they’re done.’

Derek, a person living with dementia in Havering

Meeting London's dementia challenge isn't just for national government and the NHS – it is local action that will make the biggest change.


In London boroughs, the number of people living with dementia who have a diagnosis varies from 33 % to 63 %.

To find out more about Alzheimer's disease or any other form of dementia, visit alzheimers.org.uk or call the Alzheimer's Society National Dementia Helpline on 0300 222 1122.

For questions about this manifesto and the recommendations inside, please email **ChangeLondon@alzheimers.org.uk** or call **020 7423 1033**.

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Leading the fight against dementia

Alzheimer's Society

DM14

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2 December 2014

NHS England Publications Gateway Reference 02633

To: cllr.h.hart@barnet.gov.uk

Dear Councillor Hart,

As you will be aware in February 2014, the Secretary of State for Health published a package of measures designed to improve the lives of people with dementia by ensuring better access to a timely diagnosis and then access to the advice, care and support that they need. This letter is to ask for the engagement of all Health & Wellbeing Boards in the drive to improve services for people with dementia.

This supports the specific ambition that nationally, two thirds of the estimated number of people with dementia will have a diagnosis and access to post diagnosis support by March 2015. Recent data from the Health and Social Care Information Centre (HSCIC) for 2013-14 shows that only 55% of the estimated number of people with dementia (nationally) had a formal diagnosis.

There is a tremendous amount of work being undertaken by Clinical Commissioning Groups (CCGs) and Local Authorities and within the Third Sector across the country to improve the care of people with dementia. Whilst diagnosis of dementia is a matter for the NHS, access to post diagnostic support (not just for the person with dementia but also for their families and carers), is a matter for all members of local Health & Wellbeing Boards. Indeed many areas have recognised this in their Better Care Fund service plans.

To support your work at local level we are highlighting the current dementia

diagnosis rates for the CCGs within your area which is 57.8% as recorded by NHS Barnet.

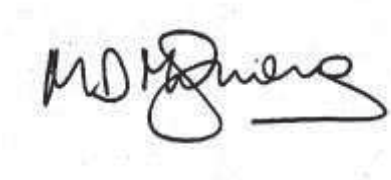
This information has already been sent to CCGs, who are now receiving monthly updates on progress. Information on dementia diagnosis will also be available on the MyNHS website.

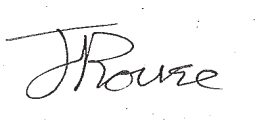
We would encourage you to support CCGs and GP practices in your area – for example by engaging with them so that they can be confident they know all the services available to support people following a diagnosis. This is an important part of the complex diagnosis journey in ensuring people are being supported by health, care services and the community to live as well as possible with the condition.

A time-limited Intensive Support Team has been established within NHS England to provide support to CCGs primarily but with some limited resource to link with Health & Wellbeing Boards. At this stage we are asking Health & Wellbeing Boards to tell us about the dementia work they are undertaking. We are particularly interested in hearing about any challenges or barriers in your area and any good practice on improving care that you would be willing to share with others. I would therefore be grateful if you respond to Deborah Cohen at Deborah.Cohen@cpft.nhs.uk by 12th January 2015.

I would like to thank you in anticipation of your support.

Yours sincerely





Dr Martin McShane
Director (Domain 2) Improving the quality of life for people with Long Term Conditions

Jon Rouse
Director General of Social Care, Local Government and Care Partnerships

AGENDA ITEM 11

	Health and Well-Being Board **Thursday 29th January 2015**
Title	**Healthwatch Barnet update and Hospital Discharge Report**
Report of	Selina Rodrigues, Head of Healthwatch Barnet
Wards	All
Date added to Forward Plan	June 2014
Status	Public
Enclosures	Appendix 1:Healthwatch Barnet (Advocacy in Barnet and Jewish Care) Hospital Discharge Report Appendix 2: Royal Free responses to Healthwatch Barnet Hospital Discharge Report Appendix 3: Central Local Community Healthcare Response - Hospital Discharge Consultation for Older Adults
Officer Contact Details	**Selina.rodrigues@healthwatchbarnet.co.uk** **020 8364 8400**

Summary

This report provides the Health and Wellbeing Board with:

- A summary of Healthwatch Barnet performance in Year 2, April-November and
- The Healthwatch Barnet, Advocacy in Barnet, Jewish Care Report on Hospital Discharge (Appendix 1)

Recommendations

1. **That the Health & Well-Being Board notes the Report and provides comments on their content.**

1. WHY THIS REPORT IS NEEDED

This report provides the Health and Wellbeing Board with a summary of Healthwatch Barnet activity for Year 2, Quarters 1 and 2 and shows how it is meeting its contractual targets. It also includes a report on hospital discharge by local providers.

2. REASONS FOR RECOMMENDATIONS

2.1 Healthwatch Barnet welcomes any comments from the Board.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

N/A

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

Through its representation on statutory bodies and its ongoing relationship with health and social care fora and residents, Healthwatch Barnet will contribute to the development and delivery of the Health and Well-Being Strategy and other relevant strategies and initiatives.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet. The Healthwatch contract value is £197,361 per annum. The contract commenced on 1 April 2013 and expires on 31 March 2016; the contract sum received is £592,083. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

5.3 **Legal and Constitutional References**

Section 182 to 184 of the Health and Social Care Act, 2012, in amending the Health and Social Care Act 2008 and The Local Government and Public Involvement in Health Act 2007, and regulations subsequently issued under these sections, govern the establishment of Healthwatch, its functions and the responsibility of local authorities to commission a local Healthwatch. The Terms of Reference of the Health and Wellbeing Board are set out in the Council's Constitution (Responsibility for Functions, Annex A), The Health and Wellbeing Board is required:

(1) 'To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.'

(5) To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients

5.4 **Risk Management**
N/A

5.5 **Equalities and Diversity**
One of the core objectives of Healthwatch Barnet is to ensure the views and experiences are heard and represented of those group with protected characteristics under the Equality Act, and with under-represented communities and individuals. Healthwatch Barnet runs targeted activities with people from protected groups (as defined in the Equality Act 2010) and its work is further enriched by our engagement programme with children and young people and older adults.

5.6 **Consultation and Engagement**
Consultation and engagement with local residents about their experiences of health and social care, is one of the key objectives for Healthwatch Barnet and as such, is central to its work programmes. This Report provides a summary of the main engagement activity for this financial year and confirms that Healthwatch Barnet is meeting its contractual targets for engaging with a wide range of diverse communities.

6. BACKGROUND PAPERS

The Health and Wellbeing Board received papers from Healthwatch Barnet as follows:

- At its meeting of 25 April 2013, the Health and Well-Being Board noted a paper from Healthwatch Barnet on its establishment and initial activity.
- At its meeting on 26 June 2013, the Health and Well-Being Board noted a paper from Healthwatch Barnet on its activities and priority future actions.
- At its meeting of January 2014, the Health and Well-being Board noted a paper from Healthwatch Barnet on its activities.
- At its meeting of March 2014, the Health and Well-being Board noted a paper from Healthwatch Barnet and Barnet Mencap about the report, Talk To Me.
- At its meeting of June 2014, the Health and Well-being Board noted Healthwatch Barnet's Annual Report for Year 1 and reports from its charity partners as follows: Community Barnet Children and Young People Team Report; Home-Start Barnet Engagement with Families and Young Parents Report; Barnet Centre for Independent Living summary of feedback from mental health service users.

7. DETAILS

7.1 **Consultation on Year 2 activities**
After a successful first year, in which Healthwatch Barnet was recognised in the Healthwatch England national awards, the staff team undertook consultation with local communities on the Year 2 priorities. As at the end of Quarter 2 Year 2, Healthwatch Barnet is on track to meet its contractual targets. A verbal update for the end of Quarter 3 will be provided at the meeting. Further details are provided below.

7.2 Through a series of community engagement events, Healthwatch Barnet consulted with local residents on its key priorities and activities for Year 2, as follows:

- Consultation on year 2 priorities with community organisations and Partnership Boards took place in May and June 2013.
- Consultation on Year 2 priorities took place through an open meeting for local residents in June, with 63 people attending. 13 evaluation forms were completed, of which 3 said the event was excellent, 7 said it was good and 2 said it was average. 11 said they found out new information. There were 15 recorded follow-up actions, where participants said they would take further action as a result of the meeting, such as making contact with health and social care services, or volunteering.

7.3 **Year 2 performance on contractual targets at end of Quarter 2 (April-September 2014)**

Reach: (promotion of health and social care issues and raising awareness of Healthwatch Barnet to local residents.)
Target: 12,000.
Achieved at end Q2: 17,756.

Engage (residents are provided with the opportunity to actively express their views on an individual basis.)
Target: 1200.
Achieved at end Q2: 506.

Volunteer Roles
Target: 105.
Achieved at end Q2: 110

7.4 **Details of Healthwatch Barnet activity**
The following section provides highlights of activity in the period April-November 2014.

7.4.1 Hospital Discharge
Two of Healthwatch Barnet charity partners, Jewish Care and Advocacy undertook research on hospital discharge in Barnet during summer 2014. We were aware of poor experiences, some of which had been reported to the Older Adult Partnership Board, and in addition, Healthwatch England was running a Special Inquiry in this area, focusing on vulnerable people. On the whole, most people had good experiences at all the local hospitals. However,

a quarter of people had difficulties, including long waits for their medication and hospital transport and lack of communication and care. We have sent the reports to the local hospitals and asked them to say how they will improve these services. The report is attached at Appendix 1.

7.4.2 Enter and View meal-time review Barnet Hospital

Concerned about local people's feedback on hospital meal-times, the Enter and View team undertook visits to six wards at Barnet Hospital during spring 2014. The full Report was presented to Barnet Council Health and Overview Scrutiny Committee in December 2014 and is available on Healthwatch Barnet's website.

The team recognised that good patient care takes place, but highlighted that

- some patients unable to eat independently or who were immobile were not supported at meal-times
- although the experience for most of the patients was very positive, may patients were unaware that they could request snacks and drinks between meals
- patients unable to eat independently or who are immobile did not always get the opportunity to wash hands before a meal or get prompt help with eating when the food arrives.
- mealtimes were not always "protected" meaning that meals were sometimes interrupted by treatment, and there was little monitoring of when food was uneaten.

Royal Free London has responded positively to the Report, saying "the reports have been extremely helpful to us in our determination to improve the experience of patients at meal-times" and has committed to changes, including nutrition link nurses for each ward, and protected meal-times being managed by senior nurses. They will also ensure that patients understand they can ask for snacks and drinks between meals, have a wider choice of Kosher and Halal food and ensure hand-wipes are available.

7.4.3 Healthwatch Barnet Primary Care Group Dentistry

Healthwatch Barnet Primary Care Group volunteers are investigating how easy it is to access an NHS dentist, and the transparency of dental costs for service users. These two areas have been identified to us as concerns in the local area.

Co-incidentally, the consumer body Which? is also researching people's experiences of dental services in England, with a focus on charging. Once the survey is complete, if permission has been given, they will share the relevant results with local Healthwatch to understand the current situation in more detail. This is potentially an opportunity for Healthwatch England, local Healthwatch and Which? to nationally highlight good practice and raise any issues of concern or trends in negative patient experience.

7.4.4 Healthwatch Barnet Primary Care Group Choose Well Local Leaflet

The Primary Care Group and the Practice team at Watling Practice in Burnt Oak have produced a leaflet for patients, with contact details for all local services from pharmacies to A&E to direct them to the most appropriate

services. These are currently being issued by GPs through appointments. If successful it could be used in other practices.

7.4.5 Mental Health services

Healthwatch Barnet was commissioned by Barnet CCG to hold a focus group with local residents, as part of the CCG's review of services. Working with Barnet Voice for Mental Health, the Focus Group attracted twenty-four people, including young people, carers and those from different faith and ethnic communities. Our report and recommendations were submitted to and endorsed by the CCG Board, specifically in relation to investment in primary and community care services to reduce demand on acute and crisis services. Barnet CCG will liaise with local people, including those from the Mental Health Partnership Board, for their feedback and recommendations on how these services should be developed.

7.4.6 Youth Health Forum

The first meeting of the Forum was held in November. Ten young people attended, between the ages of fifteen to twenty-two. The forum is currently scoping a project on how teachers can be helped to give support/sign-post to young people with emotional concerns or developing mental health symptoms.

7.4.7 Volunteers/Podiatry and Phlebotomy Services Review

The Board will note that the expertise and commitment of Healthwatch Barnet volunteers are key to Healthwatch Barnet's delivery and its assurance that is focusing on issues that are priorities for the local population. Volunteers are also offered training and development and the opportunity to be involved in regional and sub-regional fora and activity. Two volunteers are currently active in the pan-London End of Care Alliance and the CQC consultation on EoLC, which enables them to develop their knowledge of national issues and programmes and also to inform Barnet staff and volunteers and engender positive change. One recent example is our volunteer that attends the Central London Community Healthcare patient engagement group. Patients fed back their poor experiences with the podiatry and phlebotomy services in Barnet, and from our volunteer raising this issue, CLCH has reviewed the pathways, with patient representatives to identify how improvements can be made.

7.4.8 Promotion of Healthwatch Barnet

One of Healthwatch Barnet's challenges for Year 2 was to increase the awareness of the national and local Healthwatch network. We have subsequently held sessions to reach local people that would not necessarily be involved in the charity or statutory services networks, including at Job Centre Plus, drop-in at local libraries and stalls at all the local hospitals, which in the last quarter has reached approximately 160 people.

Three events will take place to enable local people to help support and improve local services. We are pleased to deliver these in partnership with local statutory services, to enable us to pool expertise and resources and ensure we reach as wide a range of local residents as possible. The local events are:

- January 13th: Consultation on The Care Act (with Barnet Council).

- February 19th Health Engagement event for the lesbian, gay, bisexual and transgender community and those that work and volunteer with them (with the support of Barnet Council Domestic Violence department).
- February 25th: Delivering Patient Participation Groups (with Barnet Clinical Commissioning Group).

7.4.9 Engagement with Barnet communities

Another challenge for Year 2 was to ensure we engage with a range of Barnet's diverse communities. To this end, we are contracting with the consortium Multi-Lingual Well-Being Service, the partner organisations of which will promote Healthwatch and capture feedback from Turkish, Somali, Chinese, Iranian and Afghani community.

7.5 **Summary of activity and projects.**

The information below provides an update on

- activities undertaken to date to meet these priorities
- future activity

Priority	**Activity**	**Progress**
Older Adults	Enter and View to hospitals. Enter and View to care homes. Consultation with older adults on dementia care and hospital discharge and hospital transport, in liaison with charity partners Advocacy in Barnet, Age UK Barnet, and Jewish Care.	E+V to care homes is continuing. The planning group is exploring how a Kings Fund tool that summarises good dementia care, could be used to review the quality of care to residents in care homes. The E+V meal time review at Barnet Hospital also included visits to and reports on geriatric wards. The Hospital Discharge Report engaged with 136 local residents. It found that many patients and carers had experienced good quality services, but a significant minority (25%) had not. The report is currently with the providers, Royal Free Hospital and Central London Community Healthcare for comment. Healthwatch Barnet Engagement Group and staff are currently exploring, with commissioners and key charities, the general quality

		of dementia services in Barnet and whether more detailed community consultation should be undertaken on particular aspects of social care or community, primary or secondary health services. Healthwatch Barnet is represented on the new Barnet Council Transport Group which will explore the quality of services in the Borough.
Mental Health	Enter and View to mental health community and hospital settings.	An Enter and View visit has taken place at Thames Ward to review whether recommendations from our visit in summer 2013 have been implemented and sustained. A visit to Oaks ward took place in November, following a CQC visit, both of which were positive. Further visits to wards for patients with mental health conditions are planned for winter 2014/2015. Barnet CCG commissioned Healthwatch Barnet to deliver a focus group on the quality of mental health services. The CCG was pleased that the focus group included those that do not usually attend such fora, different ethnic groups and also young people under 24. Our report and recommendations were submitted to and endorsed by the CCG Board, specifically in relation to investment in primary and community care services to reduce demand on secondary and acute care.
	Charity partner BCIL will review BEH Mental Health Trust complaints process, to develop	This project is due to start in December 2014.

	a person-centred approach. Liaison with the CQC about any key issues as required.	Quarterly meetings take place with the CQC and Barnet Council Care Quality Team.
Learning Disability	Led by charity partner Barnet Mencap, consultation on the quality of services for people with autism or Asperger Syndrome.	This project is due to start in November 2014. BCCG has a working group to implement the recommendations of the HWB-Barnet Mencap report, Talk To Me (March 2014), to provide summary of appointment letters in Easy Read and double appointment times for people with learning disabilities.
Young parents and parents of young families.	Led by charity partner Home-Start Barnet, consultation on parents' experiences of and barriers to childhood immunisation.	This project started in September 2014 and the report will be submitted to the Health and Wellbeing Board in March 2015.

Carers	Led by charity partner Barnet Carers Centre, TBC.	
Children and Young People	Youth Health Forum	The first meeting of the Youth Health Forum took place in November 2014. There were ten participants from the ages of 15 to 22. The Forum is keen to carry out projects relating to mental health. In addition Public Health will consult with the group over the development of sexual health services for young people.
Engagement with key communities.	Healthwatch Barnet to undertake an equality analysis to review reach and engagement in year 1 and to identify any potential further engagement and activities with key communities.	Community Barnet's Parenting Consortium will undertake specific consultation with some of Barnet's key ethnic communities and will potentially undertake consultation on dementia sexual health services and alcohol usage. Multi-Lingual Wellbeing Service has been invited to become a charity partner to Healthwatch Barnet to help engage with and disseminate information to key ethnic communities in the Borough.
Effective patient engagement	Promote effective patient engagement with Barnet CCG and Royal Free Hospital over acquisition of Barnet and Chase Farm Hospital and redefined healthcare pathways. Promote effective patient engagement with Barnet CCG in its development of the Patient Reference Group,	On-going meetings are taking place with RFH Directors and senior staff at Barnet CCG to develop patient workshops on the re-design of pathways, in early 2015. Three volunteers contributed to the initial high-level clinical workshops in June 2014. Healthwatch Barnet Engagement Group gave guidance and feedback to Barnet CCG on developing its Patient Reference Group, including the format,

	including with key communities and under-represented groups. Promote effective patient communication and engagement with the Health and Social Care Integration Programme.	structure and topics for meetings and effective communications. BCCG positively welcomed these recommendations which will be implemented going forward. Two Healthwatch Barnet volunteers are part of the Shared Care Record Governance and Information Management project teams for the HSCI Programme.
Primary care services	Healthwatch Barnet Primary Care Group work plan, includes dental services, GP website reviews, and promotion and involvement of Patient Participation Groups.	The Primary Care Group is currently researching local dentistry services. Through Healthwatch England and Which?, this potentially will be part of a national project to explore the quality of services, particularly around charges for treatment. The Primary Care Group and Barnet CCG are currently planning an event to promote Patient Participation Groups, for patients, GPs and Practice Managers, due to be held in February 2015.
OTHER ACTIVITY		
Social Care	The Care Act Domiciliary Care Review	Event with Barnet Council on The Care Act to take place on January 13th 2015. Liaison with Barnet Council on its project to review standards of domiciliary care.

Community Consultation		Event with the Gypsy, Roma, Traveller community to raise awareness of diabetes and to gather their feedback on using diabetes/health services took place in June 2014. Community consultation with homeless people and the adult safeguarding group to gather their experiences of health and social care services took place in June and July 2014. From this, a report was sent to Healthwatch England for their Special Inquiry into Hospital Discharge.

Hospital Discharge Consultation

For Older Adults

October 2014

Introduction

This report outlines the findings and recommendations for hospital discharge in Barnet. Alerted to local and national concerns about hospital discharge, Healthwatch Barnet approached its charity partner Advocacy in Barnet to undertake research into patients' and their carers' experiences. Advocacy in Barnet's extensive contacts and experience with patients, particularly older and frail adults, and their knowledge of hospital and discharge processes was considered valuable in liaising with a range of patients, some of whom would have experienced distressing or difficult experiences. Healthwatch England is undertaking a Special Inquiry into hospital discharge and this report has been sent as a submission of evidence of people's experiences.

This report is in two sections with the report from Advocacy in Barnet in Section 1 and the report from Jewish Care in Section 2. **The recommendations are the combined feedback from both organisations.**

Advocacy in Barnet
Advocacy in Barnet is a registered Charity that offers a free, independent and confidential advocacy services to people who are aged 50 and over living in the London Borough of Barnet and surrounding boroughs. Advocates visit people in their own homes, in care homes, at day centres and on wards in hospitals.
The advocate's role is to inform people of their rights, represent their needs, secure their wishes, and empower them to speak up and where they cannot speak on their behalf. Advocacy in Barnet has been providing advocacy services to Barnet residents for over 17 years. Volunteers are at the heart of the organisation and form a large part of the delivery team. Advocacy in Barnet offers financial, hospital and care home advocacy services and end of life care services.

Jewish Care is the largest health and social care organisation serving the Jewish community in London and the South East. It runs over seventy centres, caring for more than 7,000 people and their families every week.

Healthwatch Barnet
Healthwatch Barnet is part of a new national network, led by Healthwatch England, established in April 2013. It listens to the experiences and views of patients and service-users of health and social care. It promotes and supports the involvement of people in the monitoring, commissioning and provision of local care services; it liaises with Barnet Council and health and social providers to make recommendations to improve services and to highlight good practice. It has a place on the Health and Wellbeing Board and the Clinical Commissioning Board and represents people's views and experiences.

Recommendations

Hospital discharge process as an issue has been acknowledged both by professionals and patients. From the research and feedback from patients it is clear that high number of patients are happy with the care and the discharge process, but that there are still a significant number of patients who are experiencing poor care whilst on Wards, poor discharge planning and disappointing after care.

The role of facilitator/co-ordinator to ensure a hospital discharge is timely and appropriate is a much need one for people who are vulnerable and have no other social network to support their wishes and preferences. Advocates also play a key role in supporting patients who are frail, unwell or have difficulty in comprehending their treatment and discharge processes.

Although, the report highlights some patients felt they were inappropriately discharged and some too early, it is fair to say that some patients are very keen to get home as soon as possible and often leave hospital declining an assessment. Evidence also suggests that, if a patient has an informal carer (either relative or friend) in place, it is often assumed the carer will provide care. Carers have rights to an assessment to ensure they are physically and mentally able to provide care and this is aspect of person centred care is often overlooked in hospital.

To aid patient recovery, to avoid delays and re-admission, we recommend that the following actions are undertaken.

1. For hospital providers to confirm their commitment to ensuring consistency in the care that is provided to patients and that every patient has a right to good nursing care experience. Providers should make it clear to patients and their carers on admission and discharge the standards of care that they should be able to expect.

2. That hospitals improve communication between professionals and patients and their carers. Patients to be asked whether they would like their family/carers to be involved in discussions and decisions relating to discharge and if so, for this to be a planned part of the system. Patients should have clear explanation of when professional hospital staff may need to contact carers or families without the patients' express permission (such as if the patient wishes to discharge him/herself against medical advice).

3. In some cases the keenness of some patients to get home is a contributory factor in a poor discharge, as is the hospital's over reliance on the informal carer to take too much responsibility; the hospital should be able to check with the informal carer that all is in place for an appropriate discharge. If enablement is not in place when the patient leaves hospital, it is very difficult to arrange once they are at home.

4. For Doctors and Consultants to maintain compassion and understanding whilst liaising with patients and their families.

5. To reduce waiting periods for discharges by improving medication and transport arrangements coordination.

6. To give enough notice to patients' family regarding patient's discharge date and time.

7. To encourage discharges before 6pm, and avoiding late evenings and night discharges.

8. To improve the planning of patients' after care plan by listening to patients' concerns and wishes.

9. To offer rapid and easy access to independent advocacy services on wards and on discharge.

10. Lastly, although, it was not one of the objectives of this consultation to identify how many patients had neither family nor friends, out of 124 patients Advocacy in Barnet spoke to, it was noted that at least 40% either had no family or friends or had family who lived far or had conflict within the family. It is critical for the discharge team to consider that elderly patients may not always have family or friends and plan discharge, including liaison with social care and voluntary organisations, accordingly. Communication about the Enablement Package could be improved.

REPORT FROM ADVOCACY IN BARNET

Project Aims and Objectives

The aim of the consultation was to gain feedback from patients on their experience of being discharged in the past 18 months from Barnet General, Chase Farm, Edgware Community, Finchley Memorial or Royal Free Hospitals.

The objectives were to utilise the questions (as outlined in the engagement agreement by Healthwatch Barnet and proposed by Healthwatch England) to undertake hospital discharge consultation and obtain feedback by holding:-

- 4 - 5 Focus groups to engage with no less than 40 older people who have used hospital services;
- Community survey/s in 2 hospitals and commercial centres to engage with no less than 40 individuals;
- 1:1 consultation to support engagement and participation to be undertaken with no less than 40 people in hospital, care homes, day centres and community settings;
- Invitees will represent a cross section of diversity including representatives of the Asian, Afro Caribbean communities and other BME groups, deaf people and carers in the Borough.

In order to achieve the objectives, Advocacy in Barnet employ the above-mentioned approaches to engage with patients and their relatives to seek their feedback. Twelve DBS checked volunteers were trained to engage in this consultation. Initially, three volunteers carried out a pilot run at a local Church community centre where five members participated in the consultation. This pilot activity helped with reviewing and revising the consultation document.

After the pilot work, a four weeks delivery plan was implemented where activities were carried out throughout the borough. The consultation was carried out as follows:

- Four volunteers carried out community surveys at Barnet General and Finchley Memorial Hospitals over a four week period.
- Ten volunteers engaged in seven focus groups organised at six community organisations.
- Volunteers also engaged with Barnet residents at two health centres, two community centres, three libraries and three care homes.
- Through Advocacy in Barnet's Hospital Advocacy Project, volunteers carried out 1:1 consultation with fifty patients (recently discharged from the Royal Free Hospital).

In total 124 members of the public have been reached and supported in completing Hospital Discharge Consultation.

Background

Hospital discharge issues and the need for its improvement have been in the news for some years now. "In 2013, there were concerns over 78,424 hospital bed days lost due to delayed discharges. Brimelow, A. Delayed Hospital Discharges Examined. BBC News. http://www.bbc.co.uk/news/health-25059887 . Accessed 15th August 2014.

Some months ago hospital discharge process was again in news, this time it was around patients being discharged late at nights and its impact on the patients' recovery. "Growing pressure on NHS hospitals has led to hundreds of thousands of patients being discharged in the middle of the night, despite efforts to cut back on the controversial practice, it has been revealed." Nadra Ahmed, chair of the National Care Association said: "They are going back without any relevant information about how their care might have changed, what the diagnosis might have been, their paperwork is not following

because people are off duty, and often [patients are] without the relevant medication they need for the following day or even through the night."

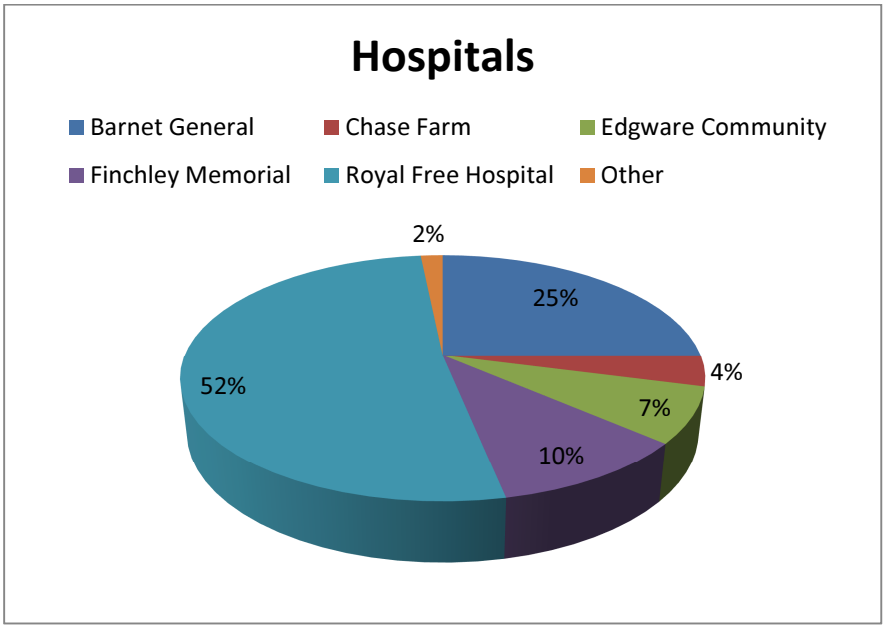
Healthwatch England (HWE), the national umbrella body for all local, is currently undertaking a special inquiry into people's experience of hospital discharge. HWE has unique powers to advise and can require organisations such as the Care Quality Commission and Monitor to respond in writing and on public record to justify their decisions. HWE uses the evidence, collected from local Healthwatch, to advise the Secretary of State for Health, NHS England and local authorities about the changes that are needed to improve people's experiences.

Healthwatch Barnet's Year 2 priorities include liaising with and supporting older adults. Individual Barnet residents had provided case studies about their poor experiences of hospital discharge and this, linked with the national issues, prompted HWB and AiB to undertake further research in this area. It is hoped that this research will be helpful to the providers and commissioners of local services, to help improve not only patients' experiences but also their longer-term care and their wellbeing.

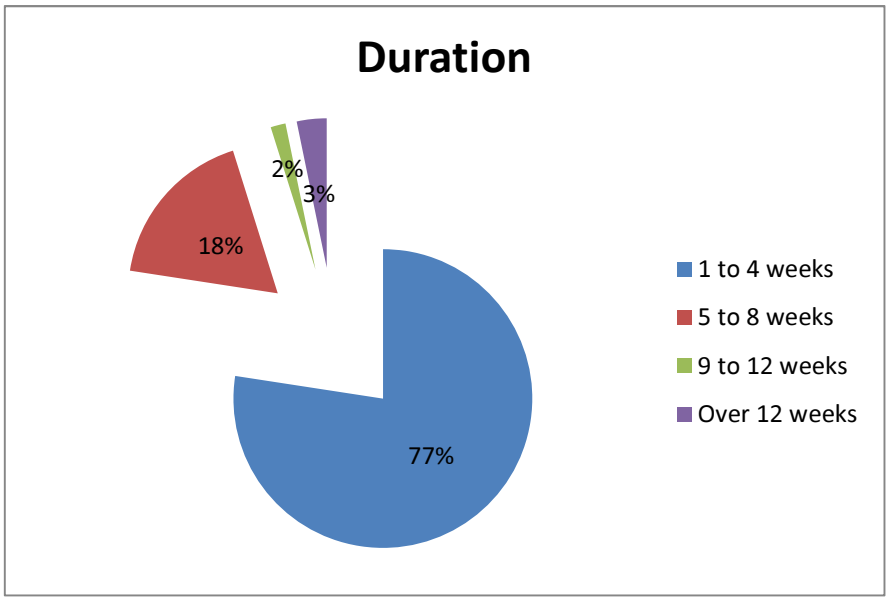
Key Findings

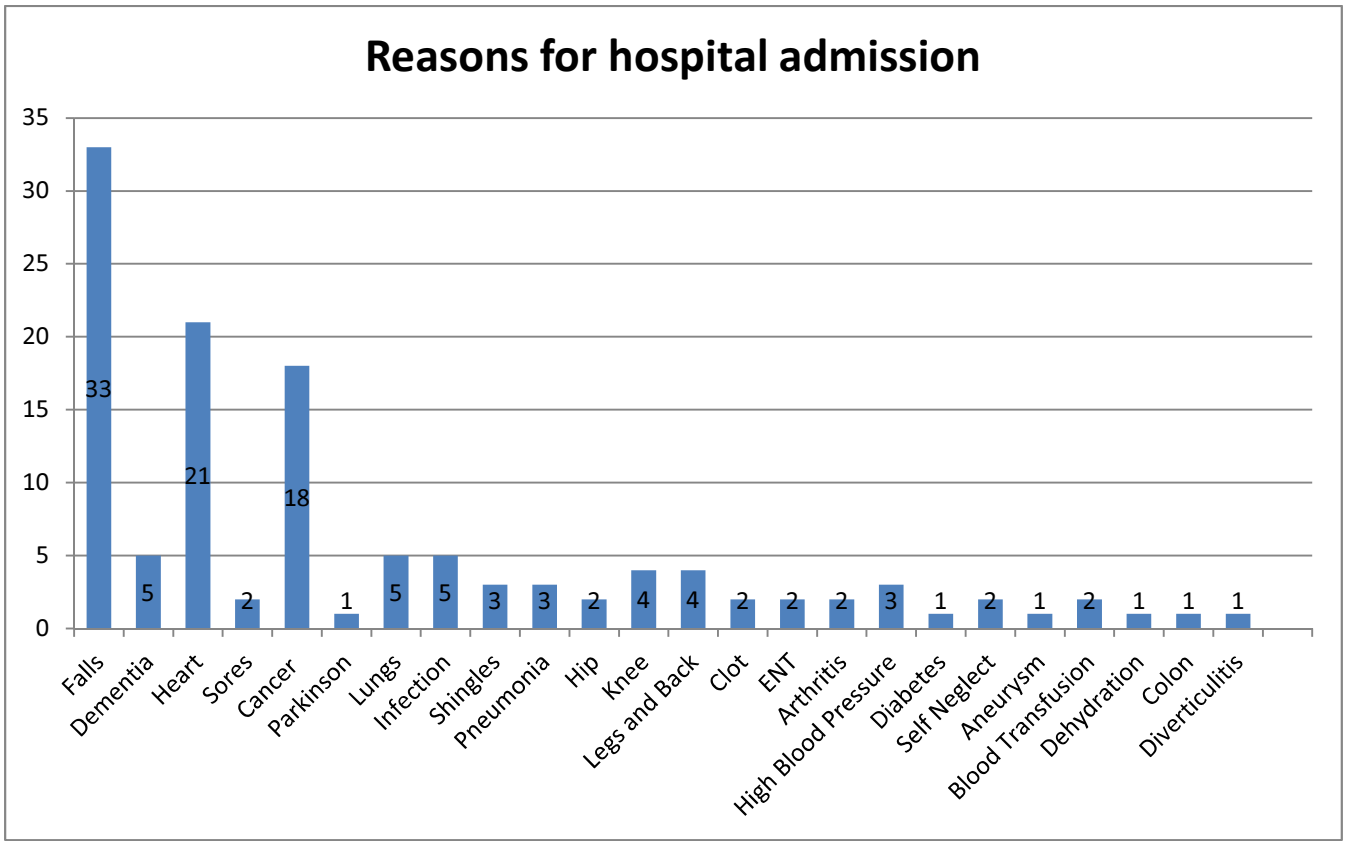
Profile of Hospital Admissions

The following diagrams show the profile of hospitals used, the duration of the stay and reason for hospital admission.



Hospitals	Numbers
Royal Free	64
Barnet General	31
Chase Farm	5
Edgware Community	9
Finchley Memorial	13
Other	2
Total	124


Duration
2%
3%
18%
77%
1 to 4 weeks
5 to 8 weeks
9 to 12 weeks
Over 12 weeks

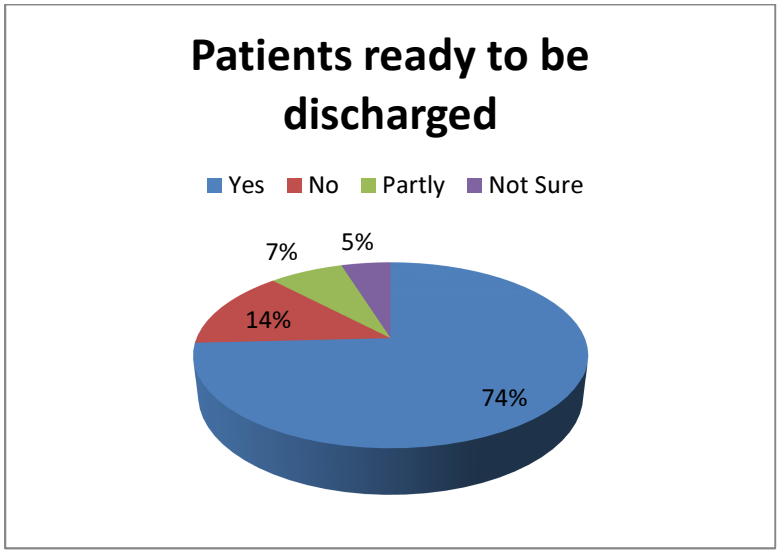

Reasons for hospital admission
35
30
25
20
15
10
5
0
33
5
21
2
18
1
5
5
3
3
2
4
4
2
2
2
3
1
2
1
2
1
1
1
Falls
Dementia
Heart
Sores
Cancer
Parkinson
Lungs
Infection
Shingles
Pneumonia
Hip
Knee
Legs and Back
Clot
ENT
Arthritis
High Blood Pressure
Diabetes
Self Neglect
Aneurysm
Blood Transfusion
Dehydration
Colon
Diverticulitis

Key Findings: Summary of Patients' Experience

The following section provides details of the patients' experiences of discharge. This is shown as

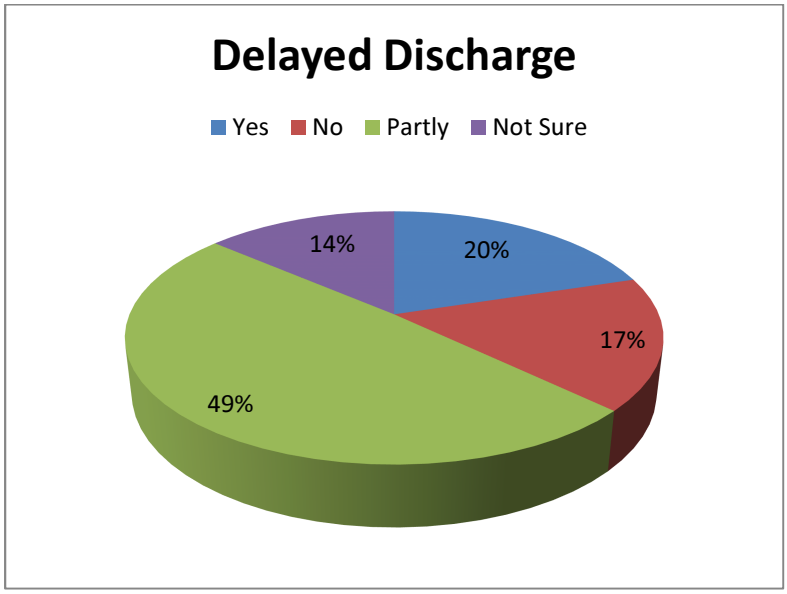
- A pie-chart showing patients' overall experience at all hospitals.
- A table to show the patients' experience at specific hospital settings.

Q1. Did you feel well enough / ready to leave the hospital at the time you were discharged?'



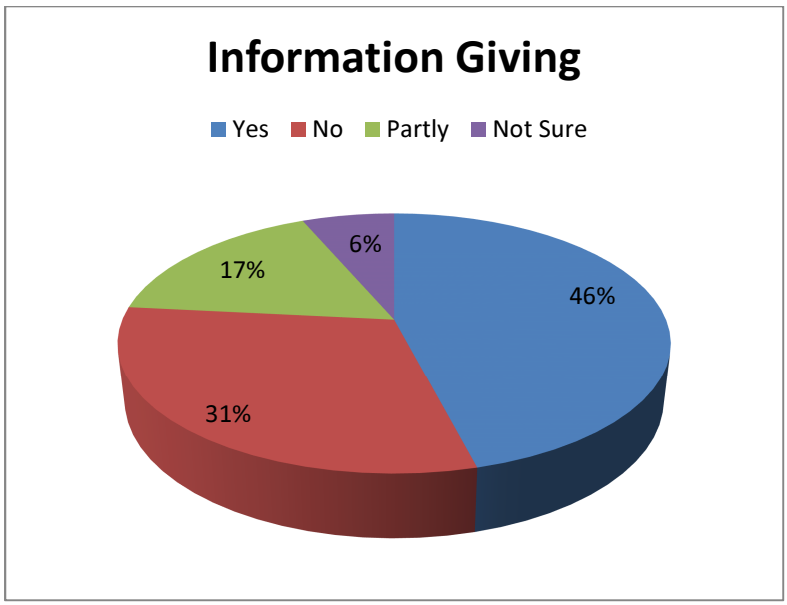
Hospital	Yes	No	Partly	Not Sure
Royal Free	72%	17%	6%	5%
Barnet General	80%	7%	13%	0%
Chase Farm	60%	40%	0%	0%
Edgware Community	67%	22%	11%	0%
Finchley Memorial	84%	8%	0%	8%

Q2. 'Did you feel your discharge had been delayed?'



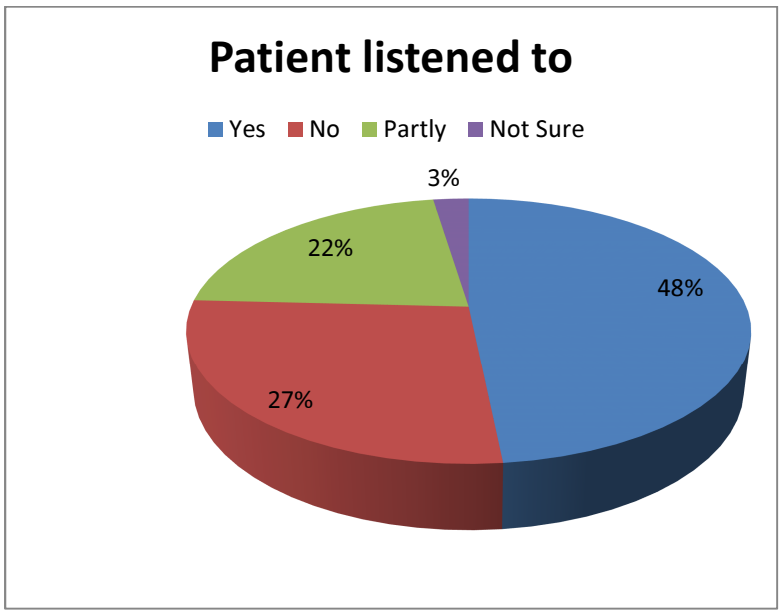
Hospital	Yes	No	Partly	Not Sure
Royal Free	27%	41%	22%	10%
Barnet General	16%	52%	13%	19%
Chase Farm	20%	60%	0%	20%
Edgware Community	11%	78%	0%	11%
Finchley Memorial	0%	78%	7%	15%

Q3. Did staff explain your choices when they were making plans for you to leave hospital?



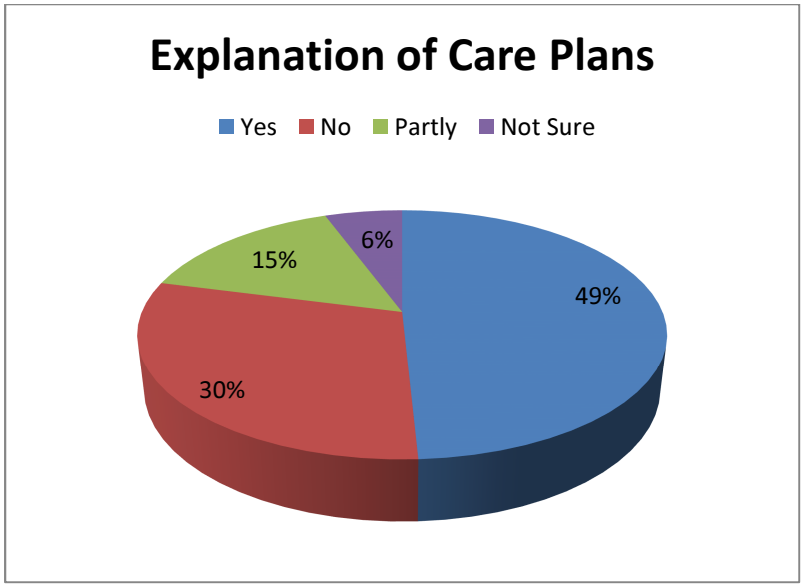
Hospital	Yes	No	Partly	Not Sure
Royal Free	33%	20%	42%	5%
Barnet General	52%	19%	16%	13%
Chase Farm	60%	40%	0%	0%
Edgware Community	56%	11%	33%	0%
Finchley Memorial	84%	8%	0%	8%

Q4. Were you given the chance to talk about anything that you were worried about before you left hospital?



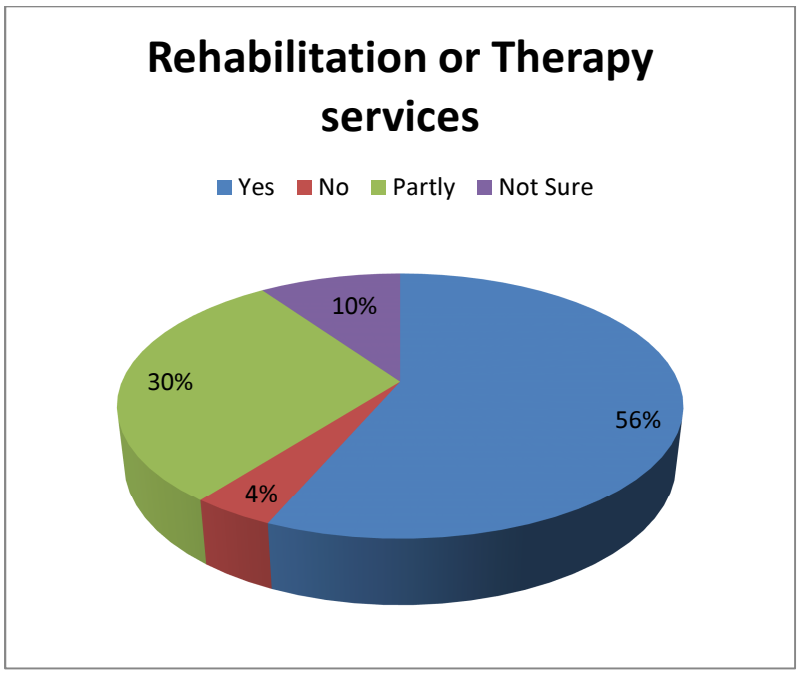
Hospital	Yes	No	Partly	Not Sure
Royal Free	39%	19%	38%	4%
Barnet General	47%	35%	18%	0%
Chase Farm	60%	40%	0%	0%
Edgware Community	56%	11%	33%	0%
Finchley Memorial	92%	8%	0%	0%

Q5. Did the staff explain and help you to understand the plans that were made for you when you left hospital?



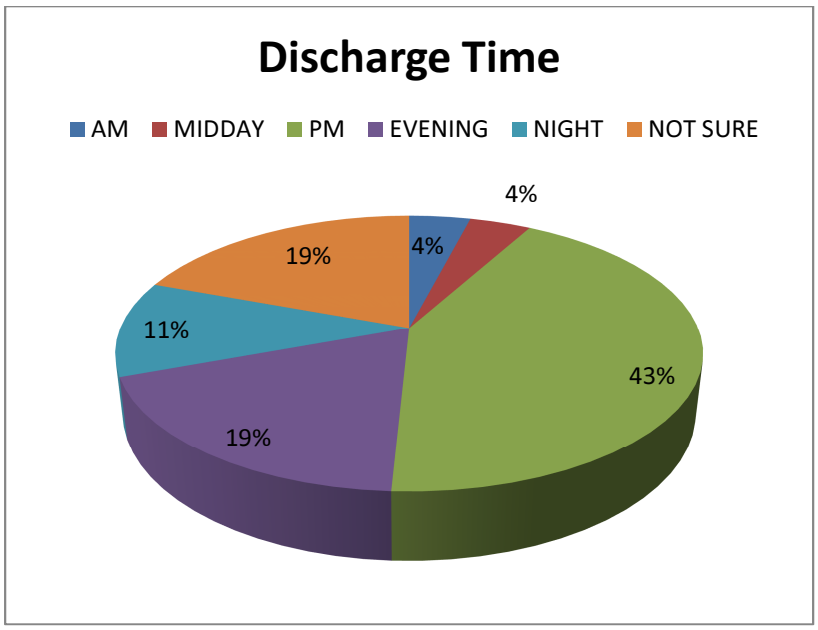
Hospital	Yes	No	Partly	Not Sure
Royal Free	41%	14%	44%	1%
Barnet General	45%	26%	16%	13%
Chase Farm	60%	20%	0%	20%
Edgware Community	55%	11%	34%	0%
Finchley Memorial	92%	8%	0%	0%

Q6. Were you offered any rehabilitation or therapy services?



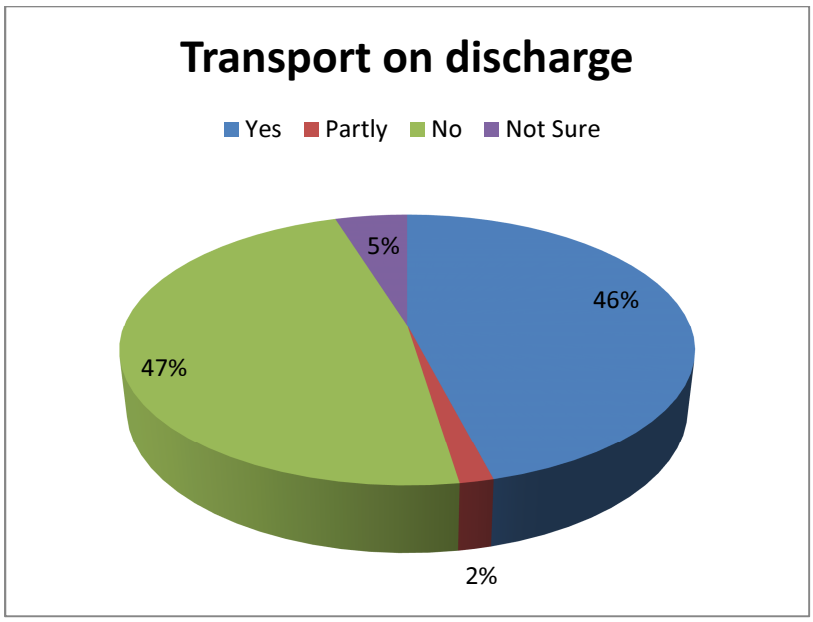
Hospital	Yes	No	Partly	Not Sure
Royal Free	40%	25%	5%	10%
Barnet General	52%	32%	0%	16%
Chase Farm	80%	20%	0%	0%
Edgware Community	56%	44%	0%	0%
Finchley Memorial	45%	47%	0%	8%

Q7. Do you remember what time were you discharged from hospital?



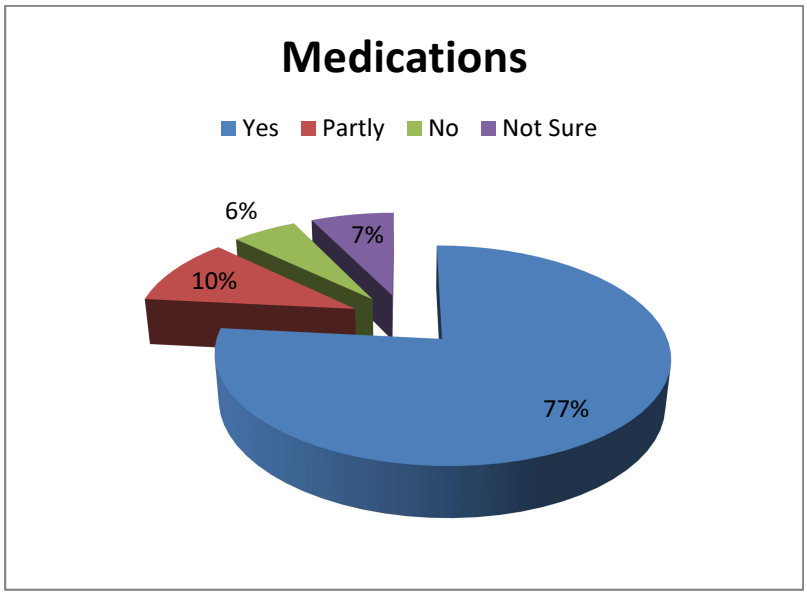
Hospital	AM	MIDDAY	PM	EVENING	NIGHT	NOT SURE
Royal Free	3%	2%	42%	27%	9%	17%
Barnet General	3%	13%	42%	23%	10%	9%
Chase Farm	0%	0%	60%	0%	0%	40%
Edgware Community	22%	0%	33%	0%	0%	45%
Finchley Memorial	0%	0%	47%	0%	0%	53%

Q8. Was transport arranged for you?



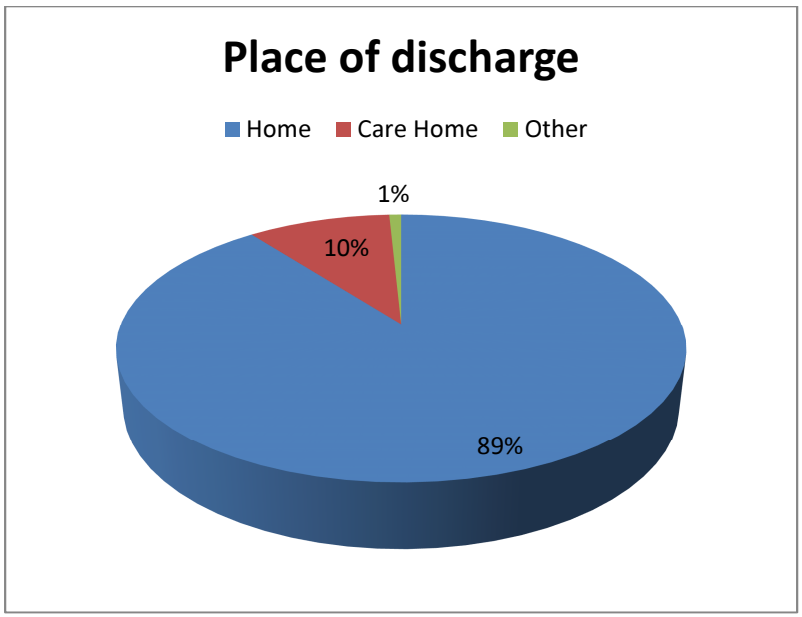
Hospital	Yes	No	Partly	Not Sure
Royal Free	52%	43%	0%	5%
Barnet General	39%	61%	0%	0%
Chase Farm	20%	80%	0%	0%
Edgware Community	45%	44%	11%	0%
Finchley Memorial	46%	54%	0%	8%

Q9. Were you given clear instructions regarding your medication?



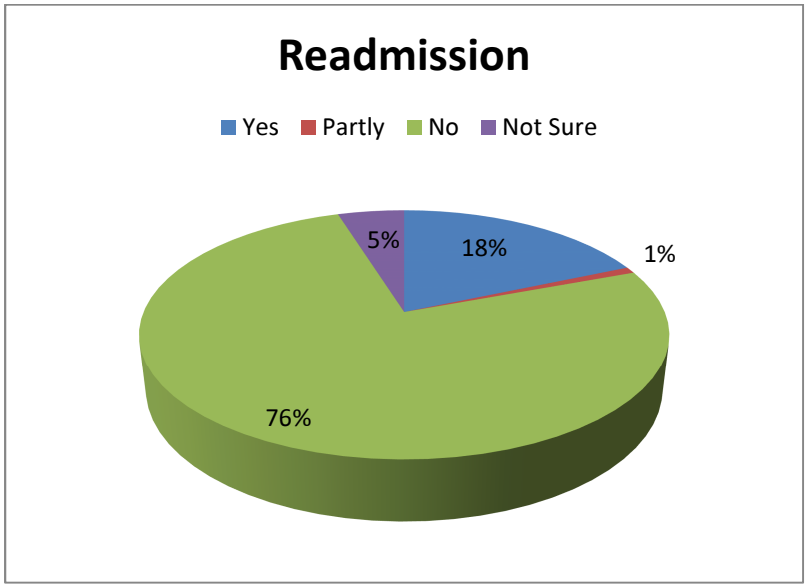
Hospital	Yes	No	Partly	Not Sure
Royal Free	74%	6%	9%	11%
Barnet General	80%	10%	7%	3%
Chase Farm	60%	0%	40%	0%
Edgware Community	89%	0%	11%	0%
Finchley Memorial	84%	0%	8%	8%

Q10. Where were you discharged to?



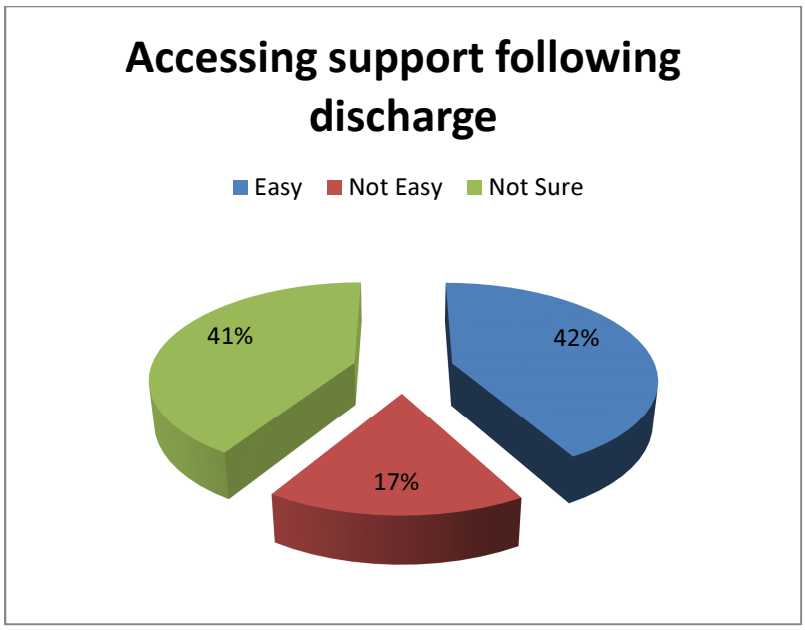
Hospital	Home	Care Home	Other
Royal Free	88%	11%	1%(hospice)
Barnet General	97%	3%	0%
Chase Farm	100%	0%	0%
Edgware Community	100%	0%	0%
Finchley Memorial	100%	0%	0%

Q11. Were you readmitted within 28 days for the same or a related problem?



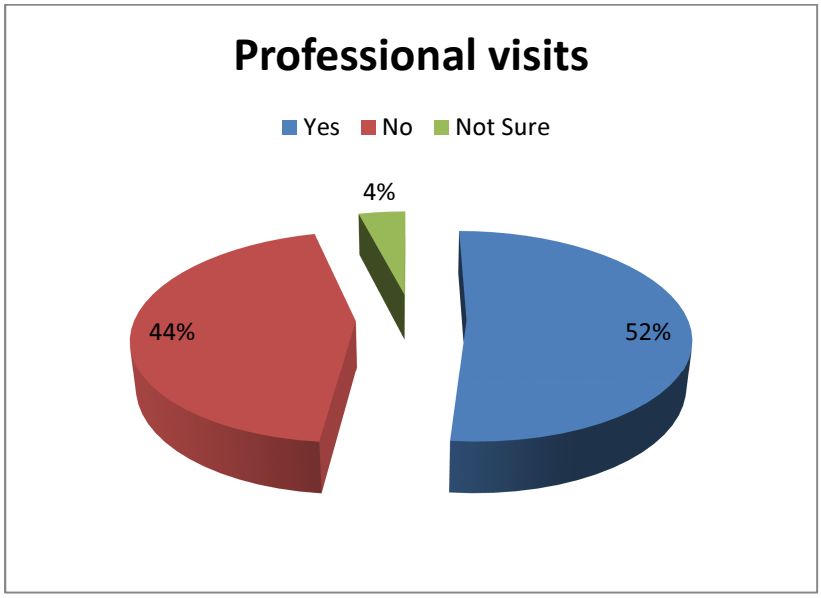
Hospital	Yes	No	Partly	Not Sure
Royal Free	19%	73%	0%	8%
Barnet General	26%	71%	3%	0%
Chase Farm	40%	60%	0%	0%
Edgware Community	11%	89%	0%	0%
Finchley Memorial	0%	92%	0%	8%

Q12. How easy was it to obtain support following discharge?



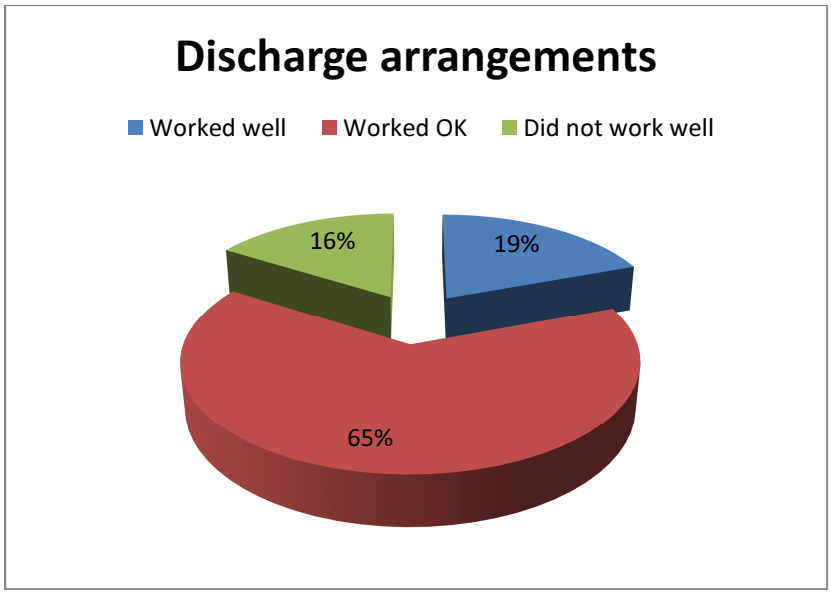
Hospital	Easy	Not Easy	Not Sure
Royal Free	37%	19%	44%
Barnet General	42%	13%	45%
Chase Farm	40%	40%	20%
Edgware Community	75%	11%	22%
Finchley Memorial	53%	8%	39%

Q13. Did anyone contact you to find out how you were getting on following your discharge including your GP?



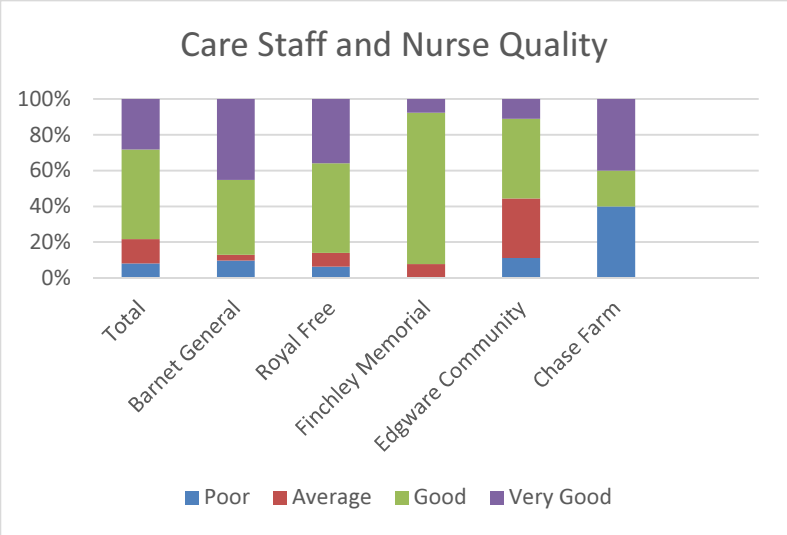
Hospital	Yes	No	Not Sure
Royal Free	59%	36%	5%
Barnet General	32%	68%	0%
Chase Farm	80%	20%	0%
Edgware Community	67%	22%	11%
Finchley Memorial	38%	54%	8%

Q14.How did the arrangements work out when you left hospital?



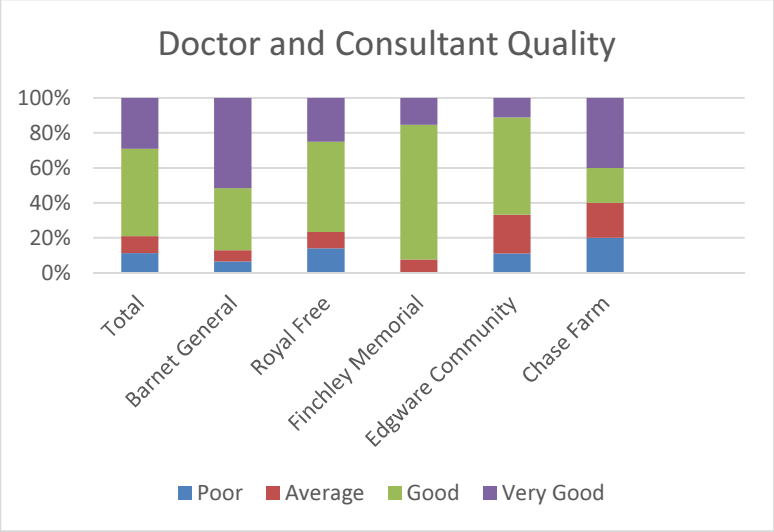
Hospital	Worked well	Worked OK	Did not work well
Royal Free	18%	59%	23%
Barnet General	55%	45%	7%
Chase Farm	0%	60%	40%
Edgware Community	0%	78%	22%
Finchley Memorial	0%	100%	0%

Q16. How were you treated by healthcare staff including nurses?



Hospital	Poor	Average	Good	Very Good
Royal Free	6%	8%	50%	36%
Barnet General	10%	3%	42%	45%
Chase Farm	40%	0%	20%	40%
Edgware Community	11%	33%	45%	11%
Finchley Memorial	0%	7%	85%	8%

Q17. How were you treated by the medical team including Consultants / Doctors?



Hospital	Poor	Average	Good	Very Good
Royal Free	14%	9%	52%	25%
Barnet General	6%	6%	36%	52%
Chase Farm	20%	20%	20%	40%
Edgware Community	11%	22%	56%	11%
Finchley Memorial	0%	8%	77%	15%

Key Findings: Qualitative Responses

These responses relate to Royal Free London sites and not those managed by CLCH. The qualitative information provided by patients showed that many had positive experiences, but there are still patients that have faced poor after care, uncooperative and insensitive staff, poor communication, long waiting times and staff not involving family/cares.

Poor after care

Discharge papers should be legible, back up at home, I live alone. Asked, but no response. In hospital nursing, poor. Prior to admission waited 8 days for a bed. Wrist smashed up, ended up with metal plate and nuts and bolts. Organised my own private physio therapy- as NHS not helpful, should have been discharged earlier. Chase Farm

Would have preferred a better after care. Very disappointed with no after care. PACE team said they would refer me to Barnet Social Work team but never did. Also, they discharged me a day later. Royal Free.

Where he had to go in to hospitals after discharge for further tests, Doctors did not inform him of any results. He also struggled as did not have an interpreter to help him question these hospital visits. Barnet Hospital

As I have had so many frequent stays in hospital I would have welcomed being discharged to a care home for a short period prior to returning home. This is because I live alone and am unwell and have little support around me. My health progresses very slowly – had I been placed in a short stay care home I believe this would have assisted me greatly. Royal Free.

Didn't come home with a closed medication box, medications were very messed up.' That made him very anxious and worried. Barnet General

Another patient mentioned that although he found care provided by nurses good, he was prescribed with incorrect medication that then caused problems with his kidney, and he had to be admitted for that. Royal Free.

Uncooperative and insensitive staff

Another issue raised that was quite dominant was about the uncooperative and insensitive approach from doctors and consultants.

Results of the scan were incorrectly analysed and my whole family were called as Doctor told them that I was dying. It was extremely upsetting and disturbing for me and my family. And no apologies were received from the Doctor. Royal Free.

Communication issues

Another common issue raised was around ineffective and inefficient communication not only between the ward team but also between patients / carers and ward team.

I would like to have one person appointed to me so that I could be informed about all aspects of my discharge.' Another relative said that she received calls from at least 5 different professionals that made things very complicated and her very restless. Barnet Hospital.

Communication between members of staff team terrible and he was concerned about the accuracy of the records. Relative of a deceased patient mentioned that his father was put into palliative care without consulting the family and that the family was given only 24 hours' notice about this. Despite of his and his family's requests Doctor stopped all the treatments and the patient was send to a care home where he died 3 days later. Family felt they were misguided by the ward team and Doctors, however, nurses were very good. Royal Free.

Found it very difficult to arrange a family member to be at his house at 10pm. Also, was given a very short notice before he was discharged. Hospital name was not mentioned.

Not involving family/carers

From the consultation, a common theme emerged of, not involving family, carers or next of kin in the discharge process. This led to confusion, delayed discharges and readmission.

Admitted in the hospital due to dehydration and carer's stress. This was due to her not being involved in the discharge process when her husband was discharged. Barnet Hospital.

Whilst I was being moved backwards and forwards between two hospitals, no one informed her family members of her movements. Barnet Hospital.

Discharge process was poor, none of her family members were involved in it and the aftercare was hopeless. Royal Free.

Long waiting times

The other common areas that are worrying are around, long waiting periods once the patients have been informed of their discharge, late evenings and nights' discharges and giving short notices to the family of discharges.

I waited four and half hours for medication only to be told none was necessary. Waiting time to be discharged, after being told you can go home, too long.' Barnet Hospital.

Another patient said, 'Short notice about discharge. Long delay of 7 hours, waiting for medication and instructions on how to administer. Barnet Hospital.

Was rushed to get out of the hospital. Barnet Hospital.

One carer was told by the discharge manager that she needed to discharge her mother as they desperately needed a bed. Royal Free.

Methodology

This section provides a summary of the data collection techniques and the reason for using them
The research was conducted using a mixed method methodology, based on both quantitative and qualitative research designs. Focus groups and interviews were carried out concurrently with surveys and the results were analysed together.
Using surveys and focus groups, strengthen the ability to draw conclusions as well as confidence in the conclusions themselves. The interviews, focus groups and surveys examined different dimensions of the same experiences.

Surveys
Self-completion survey questionnaires were employed to gather quantitative data about service users' experiences. 44 participants were recruited to complete our questionnaire and take part in our survey. The questionnaire included 6 open question and 19 closed questions. The questionnaire further collected the participants' demographic backgrounds. The questionnaire targeted service users aged 50 years and older, both male and female, and from most of the Borough's geographical areas. The questionnaire further represented the research population's diverse ethnicity, and occupational and socio-economic status.

Focus groups
A total of 30 participants, aged 50 years and older, were recruited to participate in 7 focus groups. We spoke to mixed sex groups with a composition that was representative of the Borough's diverse ethnic, religious and socio-economic backgrounds.

Interviews
A total of 50 participants, aged 50 and older, were recruited to participate in 1:1 semi-structured interviews.

Ethics
The ethical issues of transparency, confidentiality, informed consent and avoidance of harm, amongst others, were taken very seriously as they relate directly to the integrity of this piece of research and to Advocacy in Barnet in general. The research adhered to the professional codes of practice, legal requirements and compliance with the Data Protection Act 1998 (DPA).

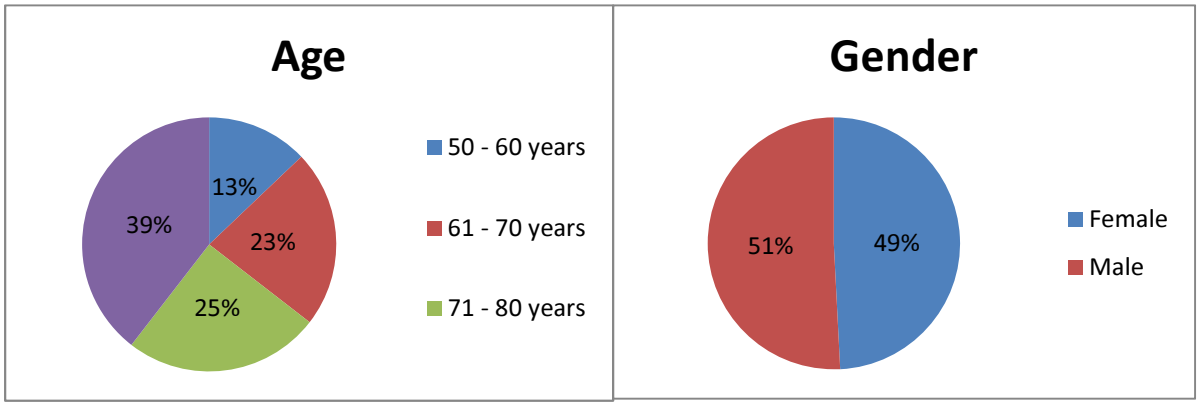
Challenges
Advocacy in Barnet has achieved the target of engaging 124 patients / carers in the Hospital Discharge Consultation process. However, it also faced a few challenges in supporting patients to give feedback:

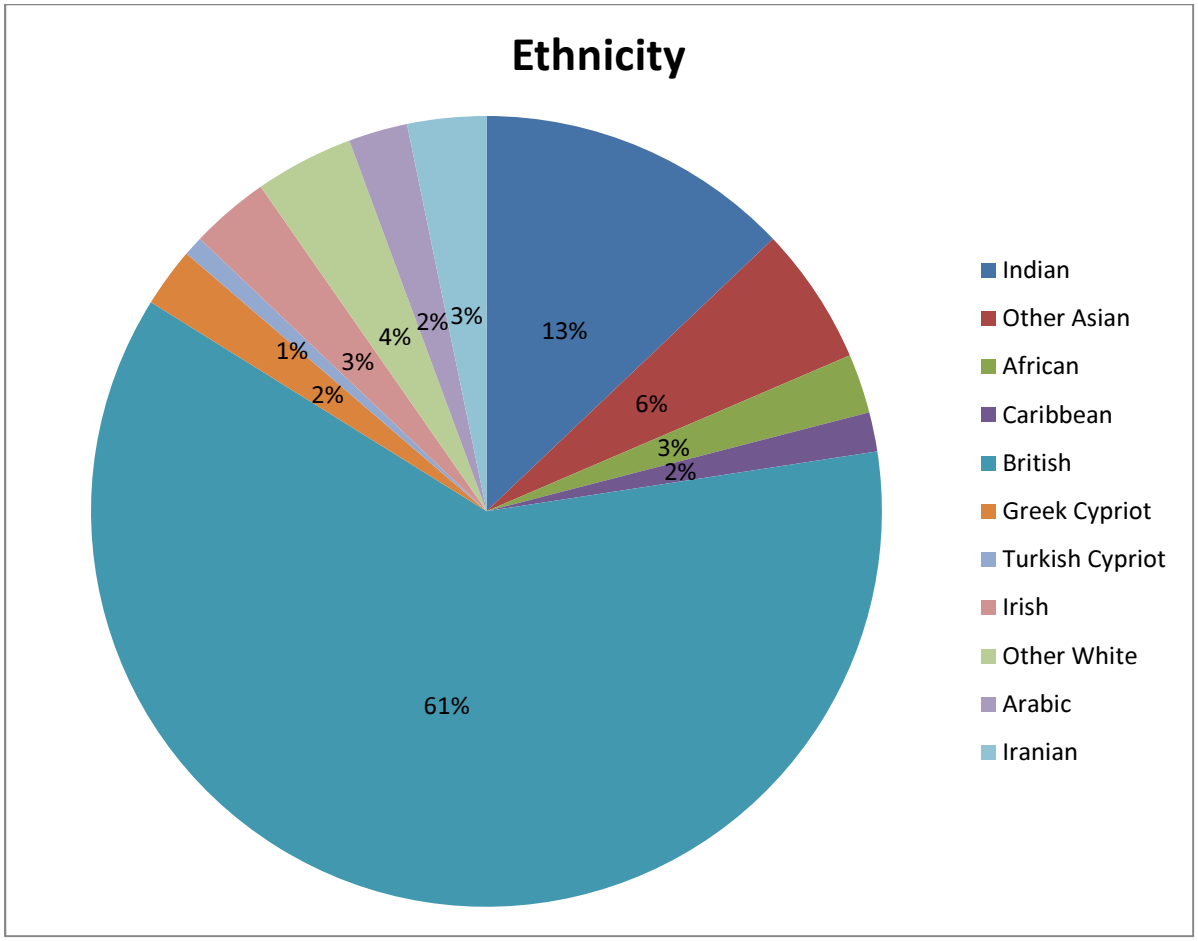
- A number of people were concerned of the consequences of giving feedback. Advocacy in Barnet reassured participants that they did not have to disclose their names, and if they did want to put their names on the survey form and wanted to keep their names anonymous then that was possible to.
- Some had language barriers due to English not being their first language.
- A number of people who did not meet the criteria of 'being discharged in the last 18 months' still wanted to give their feedback. Unfortunately, where the survey was specifically carried out for patients being discharged in the last 18 months, although we spoke to patients who wanted to share their discharge experiences before 18 months, such information does not form part of this report.
- Arranging sessions at various day centres at a short notice was difficult, as day centres have activities booked months in advance. This is always a challenge with consultation and we are pleased to have achieved engagement with 124 individuals in a short timescale.

Demographic Profile

In total 124 members of the public were encouraged and supported in completing Hospital Discharge Consultation.

In total 124 members of the public were encouraged and supported in completing Hospital Discharge Consultation. Out of 124 members of the public nearly 40% were over the age of 81 years, with a small percentage in the age band of 50 – 60 years. We were pleased to achieve nearly a 50:50 ratios in regards to participants' gender, despite male engagement in such consultations traditionally being hard to achieve. We liaised with patients of various abilities including people with hearing impairments and those from various ethnic backgrounds including Iranian, Asian, European and Afro Caribbean.




Ethnicity
13%
6%
3%
2%
61%
2%
1%
3%
4%
2%
3%
Indian
Other Asian
African
Caribbean
British
Greek Cypriot
Turkish Cypriot
Irish
Other White
Arabic
Iranian

Hospital Discharge Consultation Questionnaire

Advocacy in Barnet are carrying out a 'Hospital Discharge Consultation' in Barnet on behalf of Healthwatch Barnet. The aim of this consultation is, to gain feedback from patients' on their experience of being discharged in the past 18 months from either Barnet General, Edgware Community, Chase Farm, Finchley Memorial or Royal Free Hospitals. This consultation is scheduled for the month of July 2014 and the findings will be reported back to Healthwatch Barnet. Healthwatch Barnet will then put forward these findings to the Local Authority which will be further used to improve the discharge process. Any information you provide us with will be used specifically for the aforementioned purpose. We will inform you of the findings once the consultation has ended (if you wish to be informed). Thank you in advance for your help and time.

A) About you (please circle / tick your answer)

1. Age: 50 – 60 61 – 70 71 – 80 81 and over
2. Gender: Female Male
3. Post Code: N2 N3 N12 N20 NW2 NW4 NW7 NW9 NW11 EN4 EN5 Other:.....
4. Ethnicity: .....

B) Discharge details (please circle/tick your answer)

5. Please tick which hospital/s were you discharged from:

   Barnet General Edgware Community Finchley Memorial Royal Free Chase Farm

6. How long did you stay in hospital?

   1 – 4weeks 5 – 8weeks 9 – 12weeks over 12 weeks

7. What were you admitted for?.....

C) Please tell us what happened when you were being discharged from the hospital. (please circle / tick your answer)

8. How were you treated by healthcare staff including Nurses?

   Poor Average Good Very Good

9. How were you treated by the medical staff team including Consultants / Doctors?

Poor Average Good Very Good

10. Did you feel well enough / ready to leave the hospital at the time you were discharged?

Yes Partly No Not sure

10a. If not, what would you have liked to have happened? What additional care or time did you need? .....

10b. If yes, did you feel your discharge had been delayed? Yes Partly No Not sure

11. Did staff explain your choices when they were making plans for you to leave hospital?

Yes Partly No Not sure

12. Were you given the chance to talk about anything that you were worried about before you left hospital? Yes Partly No Not sure

13. Did staff explain and help you to understand the plans that were made for you when you left hospital? Yes Partly No Not sure

14. Were you offered any rehabilitation or therapy services? Yes Partly No Not sure

Please detail .....

15. Do you remember what time you were discharged from hospital?.....

16. Was transport arranged for you? Yes Partly No Not sure

17. Were you given clear instructions regarding your medication? Yes Partly No Not sure

D) Please tell us what happened after you were discharged from the hospital. (please circle / tick your answer)

18. Where were you discharged to? Home Care Home

19. Were you readmitted within 28 days for the same or a related problem?

Yes Partly No Not sure

20. How easy was it to obtain support following discharge? Easy Not Easy Not sure

21. If you were discharged to a care home, did you feel the care home was well equipped to deal with your illness and care needs? Yes Partly No Not sure

22. Did anyone contact you to find out how you were getting on following your discharge including your GP? Yes No Not sure

23. How did the arrangements work out when you left hospital?

Worked well Worked OK Did not work well

E) Please tell us, what do you think could be improved for people in your position when being discharged from a hospital.

24. What would you have wanted to happen when you were discharged, what support would you have liked?.....

.....

Any other comments:

.....

Thank you ☺

If you would like us to inform you of the findings of this consultation then, please leave your name and contact details:

Name:.....

Number:.....

Address:.....

You can email your completed form to Heena Cornwell on heena@advocacyinbarnet.org.uk

Or you can post it to us on the below address

Advocacy in Barnet

4-5 The Concourse, Grahame Park, Colindale, London NW9 5XB

REPORT FROM JEWISH CARE

Project Aims and Objectives
Healthwatch Barnet contracted Jewish Care to monitor positive and negative hospital discharges we experience via our resources who have direct contact with members of the public. We anticipated being able to identify particular groups of people affected, such as vulnerable adults who have dementia and no advocate. We also wanted to know what, if any, are the causes of a recurrent admission. We hoped it would highlight gaps in service delivery for Jewish Care and provide the information Healthwatch require to feedback to Healthwatch England.

Jewish Care asked for responses on all local hospitals. The data and comments below relate to hospital providers, not just CLCH settings.

Methodology
Over a 3 month period from July-September, we asked the Registered Managers of our 12 care homes, 2 day care and 2 dementia day care centres, domiciliary and social work teams to complete a questionnaire (attached) when they were involved in a hospital discharge.

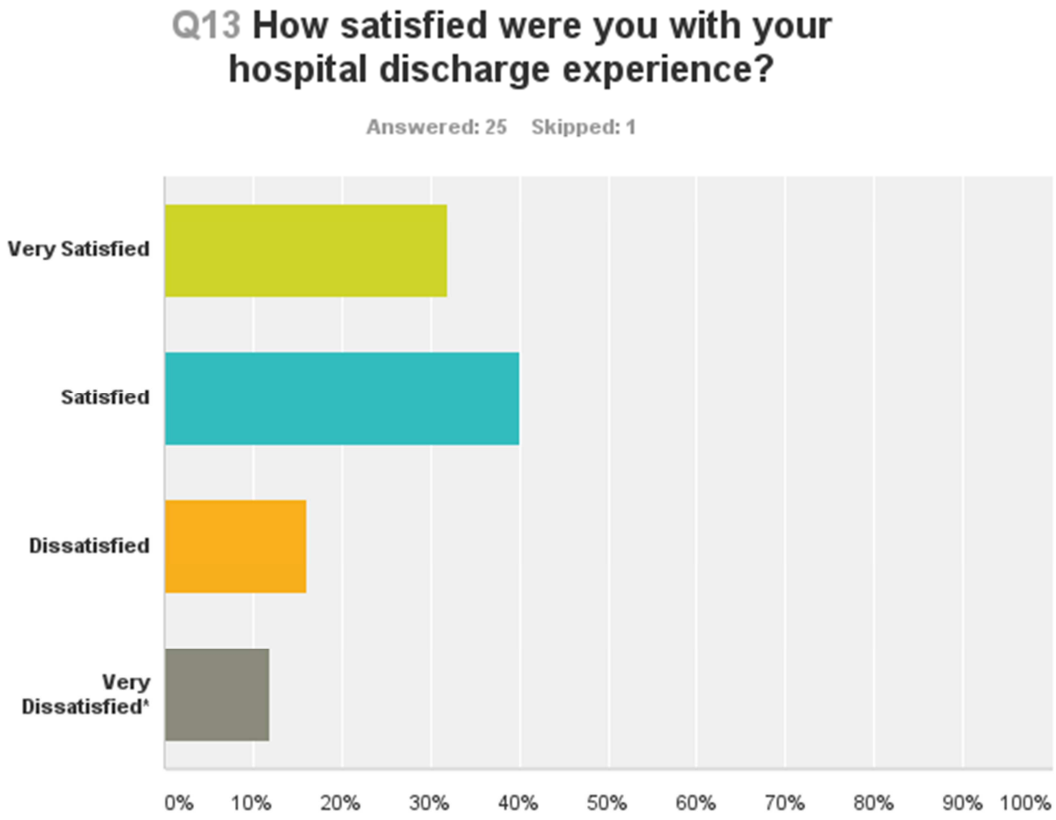
Wherever possible, we requested the person who experienced the discharge to also complete a questionnaire (attached).

The data is based on 26 patient responses and 24 health professional responses. During the 3 months, reminders were sent by email, telephone and face to face which did result in a small increase in responses. There was some confusion about the content of the questionnaire and the responses give suggestions of how it could be improved if doing a similar survey in future.

Hospital	**Total**	**Satisfied**	**Dissatisfied**
Finchley Memorial	3	2	1
Edgware Community	1	1	
Total	4	3	1

Key Findings

1. Satisfaction/Dissatisfaction.
The majority of patients were either very satisfied or satisfied with their hospital discharge experience. However, 28% were unhappy with their experience.



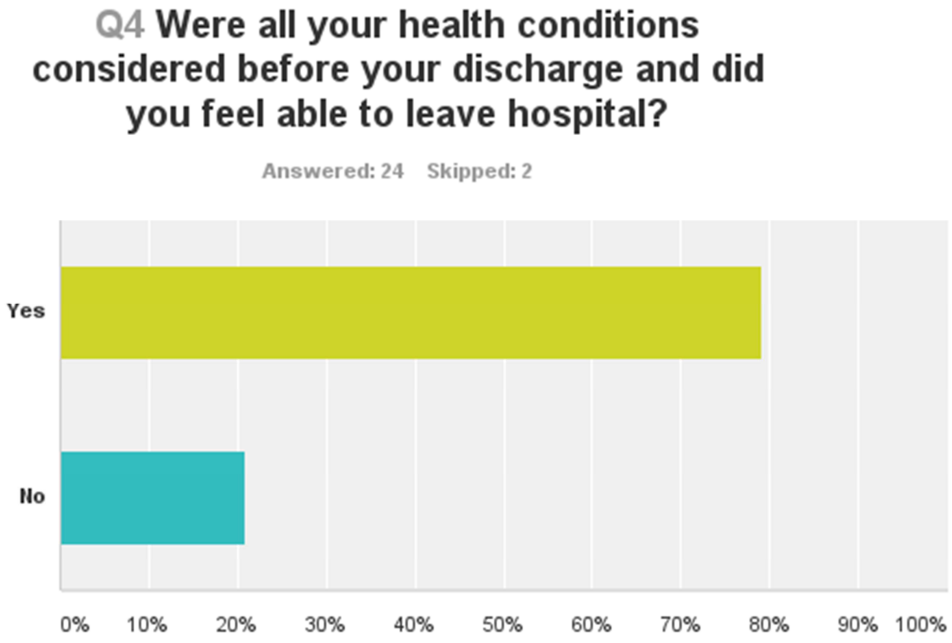
The fact that the large majority of patients were satisfied is encouraging. Positive feedback includes:

- *"I cannot emphasise how good the care was."*
- *"Everything went without problems"*
- *"Very happy with input. Sent ward a thank you letter"*
- *"Nurses very helpful."*

However, the proportion of patients that were dissatisfied was high. Typical complaints include:

- *"I felt the process was too slow."*
- *"I did not feel ready to go home." (See key message 2)*

2. Health conditions.
Whilst the majority of people felt able to leave hospital, 20% of respondents felt unable to leave hospital.



A significant number of discharged patients had negative comments about their discharge:

- *"I felt I was turfed out."*
- *"I felt that I should have stayed longer in hospital as I was not feeling well and was very weak."*
- *"I was still bleeding when I was discharged."*

Healthcare professionals also appear to suggest that some patients have not been discharged appropriately, with 10% claiming that they have experienced an inappropriate discharge in the last 6 months.

- *"Sometimes, residents are discharged from hospital without their hearing aid, dentures or walking stick and have to be chased up without success."*
- *"In one case, the ward discharged a resident without her medication or discharge summary notes. These were sent later in the evening after the care manager complained."*
- *"Discharge was mid-afternoon, but client had to wait a further 2 ½ hours to wait for his medication. He is now on a bed downstairs; cannot get upstairs to have a shower. When his wife commented on this she was told that he will just have to manage with a bed bath. However, after 9 weeks in hospital and several health issues, there is no enablement package and wife is doing everything."*

According to healthcare respondents, reasons why patients may have been discharged early often result in poor communication between nurses and discharge co-ordinators and also include:

- *"I insisted I was discharged."*
- *"My daughter insisted I did not stay long in hospital"*

3. Transport
Patients requiring transport consistently referenced the long wait times.

Of the 8 respondents requiring transport to get home, only one was within an hour. The remaining 7 patients had to wait between 1 and 3 hours, with one patient having to wait more than 3 hours.

- *"I was satisfied with the hospital experience, but very dissatisfied with the long wait for transport."*
- *"I had to wait too long for transport, I cannot walk like I used to."*

Social care staff have similar concerns about the delays in releasing patients:

- *"I feel the time between being told you are being discharged and actually being discharged is too long. This resident felt like she was waiting a long time for transport to come back to home."*
- *"Waited too long for the medication to be delivered from the pharmacy."*

Example scenario from the survey:

- *"A resident who had been in hospital with a fractured tibia was now medically fit for discharge. We had been to assess in the morning and it was agreed she would come back in the afternoon. At 7.00pm the resident had still not arrived after numerous calls to hospital and assurance she would be. At 8.00pm I rang the ward and protested that a 97 year old should not be discharged at this time of night. The resident turned up at 8.30pm. Complaint made to ward but I did not follow it up."*

4. Help after discharge
Feedback suggests that most patients felt it was easy to obtain help if they needed it after discharge.

Positive feedback includes:

- *"It was very easy and I was advised to be seen by an after care team."*
- *"They arranged a care package of daily care for six weeks."*

However, some respondents appeared unhappy with the level of aftercare:

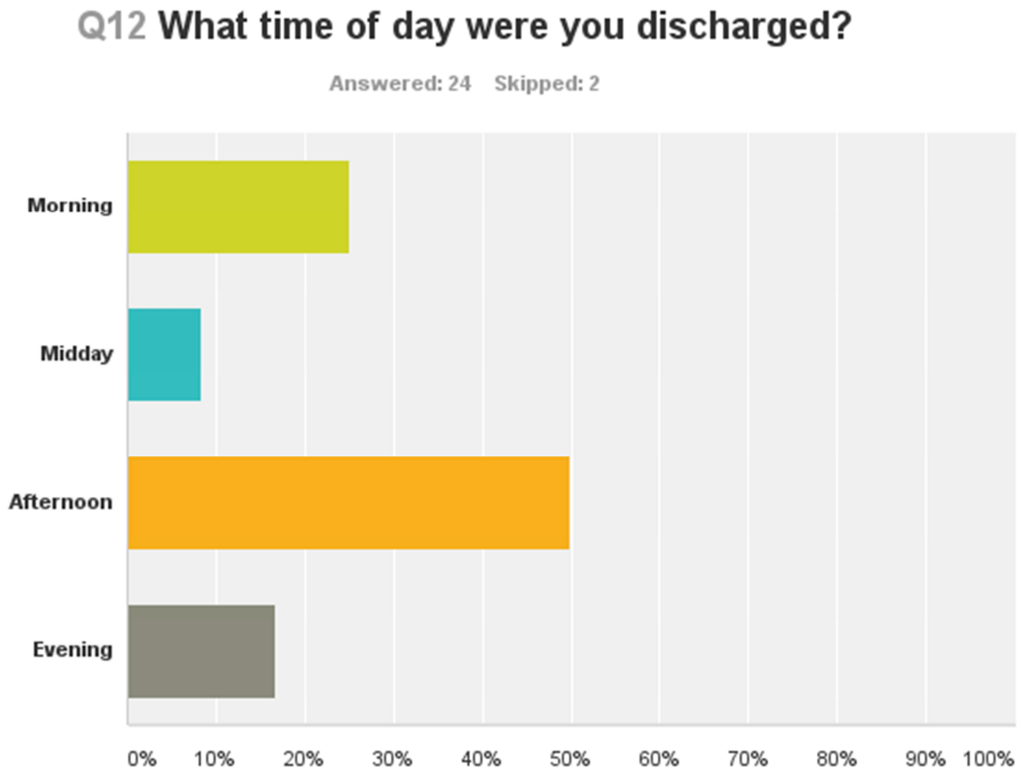
- *"It was not even discussed."*
- *"I was not offered an enablement package. This has now been put in place 3 weeks late."*

From responses from healthcare professionals who were asked if the person had mental health, disability, dementia or palliative needs, 9 patients had dementia, 2 were palliative and 2 had mental health. The responses were mostly from carers working in our care homes. They were acting as an advocate for the resident and we anticipate, without their involvement, the resident/patient would not have been able to voice their wishes and preferences about their discharge experience.

An example scenario from the survey about not understanding discharge process:
"Needs not met. No kosher meals, although requested. Scared of infection; filthy ward – no cleaners. Client chose to leave 2 days early – no package of care offered. There were no cleaners on ward so unable to bath; bathrooms and toilets were unhygienic and no district nurse referral".

5. Time of discharge
A significant number of patients were discharged in the evening

Although most patients were discharged during the day, 17% were discharged in the evening, which reduces the likelihood of a successful discharge. Patients released in the evening have difficulties arranging transport and it can be disorientating for the patient. For others returning home at night, there are concerns about lack of food in the home and ability to shop.



Thank you.

Advocacy in Barnet would like to thank all the volunteers, participants and organisations that gave their valuable time and worked with us to help us complete this research.

ROYAL FREE LONDON

Responses to Healthwatch Barnet Hospital Discharge Report

1. **For hospital providers to confirm their commitment to ensuring consistency in the care that is provided to patients and that every patient has a right to good nursing care experience. Providers should make it clear to patients and their carers on admission and discharge the standards of care that they should be able to expect.**

   RESPONSE: The Royal Free NHS Foundation Trust is committed to ensuring a consistency in high quality of nursing care across all sites and within all clinical areas. Our mission is to deliver world class expertise and local care. The values we have developed are around ensuring that we are welcoming, respectful, communicating and reassuring.
   The mission and values are communicated to patients, carers and staff so that their expectation will be around consistently high standards of care.

2. **That hospitals improve communication between professionals and patients and their carers. Patients to be asked whether they would like their family/carers to be involved in discussions and decisions relating to discharge and if so, for this to be a planned part of the system. Patients should have clear explanation of when professional hospital staff may need to contact carers or families without the patients' express permission (such as if the patient wishes to discharge him/herself against medical advice).**

   RESPONSE: To assist in communication at all levels for a patient's care, the flow coordinators (currently in post at Barnet hospital and the same model being rolled out at the Royal Free site) and the ward staff converse with patients and carers at admission. We use the Ticket Home programme (established six months ago at the Barnet and Chase sites) to explain what is happening. This will also be rolled out at the Royal Free site with the flow coordinators implementing.

   What is Ticket Home?

   - Ticket Home is a checklist-like tool that facilitates communication among many disciplines.
   - It is a laminated card that is placed at the patient bedside, with sections for multidisciplinary input (e.g. Physiotherapy, Occupational therapy instructions), information about whether the patient requires transportation home, whether their medication reconciliation has been done and follow up appointments scheduled,
   - Planned date of discharge is set on admission and communicated to the Patients and relatives, and must be updated regularly

The Aim of Ticket Home

- Helps both the patient and the family better understand what to expect during the hospital stay and anticipate what goals need to be met to enable the expected date of discharge to be met
- Aim to strive to meet the anticipatory goals ahead of time – by showing patients when and where they will discharged, and involving them in their care
- The anticipated date of discharge is also very helpful for the patient's family or other caregivers. They can plan their availability around that anticipated date.
- It may be more difficult to anticipate the date of discharge for many medical admissions, but the concept of Ticket Home should still be adopted, this will improve ward organization

Morning Discharges

- Discharges should be planned for the morning, enabling medically fit patients to settle into the home environment much earlier in the day
- GPs, District Nurses and Home Care staff are more likely to be available
- Staffing levels may be higher in the morning allowing for a more effective information exchange with patient/and or carers
- Delayed morning discharges will have a cascade effect of admissions from A and E or transfers from ITU. Bottlenecks may be created due to lack of bed availability.

Discharge to the Discharge Lounge

- The discharge lounge must be used if the patient is considered suitable for the lounge. This information will be displayed on the Ticket Home
- Patients/ Relatives and Carers must be informed that it is expected that discharges will occur before 11am, and if the patient is waiting for transport or relatives they will be asked to wait in the lounge.

What next

- The Ticket Home, individualised for each ward needs is laminated for each patient, the individual ticket should also be given to patient/ carer
- The Ticket home should be placed on the patient's locker or behind the bed head
- Each patient should have a completed form
- Day of actual discharge should be recorded against PDD set.

Whilst we can appreciate the request that carers or families are contacted without the patient's permission, we do have a duty of care to the patients to respect their privacy.

Unless a patient doesn't have capacity we cannot go against their wishes about contacting next of kin. For patients that do not have capacity, we act in their best interest in terms of discharge planning.

3. **In some cases the keenness of some patients to get home is a contributory factor in a poor discharge, as is the hospital's over reliance on the informal carer to take too much responsibility; the hospital should be able to check with the informal carer that all is in place for an appropriate discharge. If enablement is not in place when the patient leaves hospital, it is very difficult to arrange once they are at home.**

   RESPONSE: Patients should always be asked for their agreement to contact formal or informal carers. When they agree for this, this is done by the ward staff. Similar to discharge arrangements, patients without capacity will be acted on by the ward in the patients' best interest.

   To determine care needs for patients in preparation for their discharge, all patients are risk scored using a standardised national tool. In the case of an emergency admission, this is done as soon as possible after admission. For a planned admission (e.g. a planned surgical procedure) this is done at preadmission.

   The risk tool is to guide when the patient should be referred to social care for an assessment of their care needs (this is called a section 2 notice). Within 24hours of a receipt of a notice to assess, the social worker for the borough that the patient lives should assess and discuss post discharge care arrangements with the patient. Patients with capacity can opt out of a social care assessment.

4. **For Doctors and Consultants to maintain compassion and understanding whilst liaising with patients and their families.**

   RESPONSE: All clinicians are committed to maintain compassion and understanding whilst liaising and communicating with patients and their families and their carers. We want all patients to feel confident, safe and well carer for and reassured that they are in safe hands.

5. **To reduce waiting periods for discharges by improving medication and transport arrangements coordination.**

   RESPONSE: The introduction of flow coordinators has been a key enabler in our Home For Lunch programme. As the name suggests, this is all about a morning discharge to get patients back to their usual place of care by lunch.

   Home for Lunch is in place at Barnet and Chase sites and is for roll out to the Royal Free site in early 2015. The key objective was to increase the number of patients that are discharge safely before lunchtime, thereby reducing length of stay by improved discharge planning and process. The project has included significant service transformation e.g. pharmacy hours.

   Discharge processes have been improved by ensuring that all staff groups and external providers of health or social care understand the need for timely discharge of patients from hospital

As with all projects, the delivery was via a detailed transactional project plan which included milestones, timelines and given responsibility defined

Four Matrons across the Barnet and Chase site were identified as the key project leaders, along with a project manager from the Quality, Innovation and Productivity team. These key people were responsible for ensuring that targets were met and key actions delivered – where a key task or action was at risk in terms of delivery, mitigation reports are submitted and immediate action taken.

Initially the Home for Lunch project involves 5 wards across Barnet and Chase sites -Cambridge and Canterbury at Chase Farm & Cedar, Juniper and Quince at Barnet

This is now across all wards on the two sites.

The key benefits of Home for Lunch have included

- Increased patient satisfaction
- Community services available at an optimum time
- Social Services available at an optimum time
- Bed capacity is released – thereby Emergency department waits for beds reduced significantly

6. **To give enough notice to patients' family regarding patient's discharge date and time.**

   RESPONSE: Planned discharge dates (referred to as PDDs), are included as part of Ticket Home.

   The PDD needs flexibility to reflect changing patient needs. We are currently planning an audit for the first quarter of 2015 to look at how many PDD change (either move forward or back) and the reasons for this.

   Changes to PDD should be communicated to the patient by the ward and be available for families and carers via the Ticket Home.

7. **To encourage discharges before 6pm, and avoiding late evenings and night discharges.**

   RESPONSE: The key priority as detailed above is Home for Lunch. This is a key enabler to proactive improvements in hospital flow.

8. **To improve the planning of patients' after care plan by listening to patients' concerns and wishes.**

   RESPONSE: We actively work with our partner organisations in planning for a patient's discharge home. A good example of joint hospital, community and social care integration in joint discharge planning is the Post Acute Care Enablement service (PACE).

PACE has been in place at the Royal Free site for 5 years now and supported over 6500 patients across Barnet and Camden. The same model was implemented for the Barnet and Chase sites a year ago to support patients from Barnet and Enfield and plans are progressing for Hertfordshire patients too.

We want as many of our patients and their families and carers as possible to participate in their discharge planning. We will use the additional information and responses in the Healthwatch report to inform this process.

9. **To offer rapid and easy access to independent advocacy services on wards and on discharge.**

   RESPONSE: We work with both internal and external agencies so that we can provide access to advocacy services on the wards and on discharge .Our PALS service is an important point of access for patients on all 3 sites.

10. **Lastly, although, it was not one of the objectives of this consultation to identify how many patients had neither family nor friends, out of 124 patients that were spoken to, it was noted that at least 40% either had no family or friends or had family who lived far or had conflict within the family. It is critical for the discharge team to consider that elderly patients may not always have family or friends and plan discharge, including liaison with social care and voluntary organisations, accordingly. Communication about the Enablement Package could be improved.**

    RESPONSE: We fully appreciate that patients may not have any direct family or have reasons why their family does not wish to be involved in their care.

    All patients are offered the opportunity for an assessment by social care for care needs on discharge.

    Our therapists should always be involving patients in their onward care needs.

    For patients who do not meet the threshold for social care (or choose not to want their involvement), we do offer referral to third sector support services that we work directly with. This includes the option of referral to British Red Cross who can support with befriending and simple tasks such as shopping for patients on a short term basis.

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Hospital Discharge Consultation for Older Adults

October 2014

CLCH Response

Thank you for sending us the Hospital Discharge Consultation including our services at Finchley Memorial and Edgware hospitals. We appreciate the time that your team have dedicated to this, and it is very useful to have this feedback which helps us to learn about the experience of those using our services, and how we can improve on this.

Though a relatively small number of our patients were surveyed, there are some themes which we will focus on. This report is timely, as we are currently reviewing our discharge policies and procedures. We have responsibility for ensuring that discharge processes are as efficient and effective as possible in order to maintain patient safety, provide the best patient journey and experience in addition to maximising patient flow.

Through our discharge process, we aim to provide a consistent approach to the discharge of patients. The intended outcome is to enable a timely, safe and effective discharge process through the multi professional team working in partnership with the patient, their family members and other stakeholders whilst maintaining the maximum level of independence for the person. Through effective and robust discharge planning, we would aim to achieve the following outcomes;

- The person and where relevant, their family / carers are engaged from admission in planning of discharge
- The person and where relevant, their family / carers are enabled to make informed choices and decisions about a discharge destination
- A safe, timely and effective discharge process is planned between the patient and the multi-professional team to ensure that any services and support are in place at the point of discharge including medication, equipment and transport for discharge.
- The patient and where relevant, their family and carers are supported and educated to provide the persons ongoing care needs, and know who to contact if they have any concerns

From your report, it is clear that we do not always achieve this consistency in our discharge planning, and there is more that we need to do in ensuring that patients and family members are fully engaged in the process, are provided with information and choices, and are supported following their discharge. These points are aligned to the recommendations within your report.

To enable us to focus on continuing improvement, we aim to audit our discharge processes annually, and identify actions from this to strengthen our processes.

Tony Pritchard

Deputy Chief Nurse

Central London Community Healthcare NHS Trust

AGENDA ITEM 12

	Health and Well-Being Board **29th January 2015**
Title	**Minutes of the Financial Planning Sub-Group**
Report of	Strategic Director for Commissioning
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1- Minutes of the Financial Planning Group – 6th November 2014
Officer Contact Details	Jeffrey Lake jeff.lake@harrow.gov.uk 0208 3593974 Zoë Garbett zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report is a standing item which presents the minutes of the Financial Planning Sub-group and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan.

Recommendations

1. **That the Health and Well-Being Board notes the minutes of the Financial Planning Sub-Groups of 5th November 2014 and 14th January 2015.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health and Well-Being Board on the 26th May 2011 agreed to establish a Financial Planning sub-group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial

planning sub-group meets bi-monthly and is required to report back to the Health and Well-Being Board.

1.2 The Barnet Health and Well-Being Board on the 13th November 2014 agreed to receive the minutes of the Health and Social Care Integration Board as a standard item on the agenda to ensure that adequate attention is given at Board level to the work that providers are doing to support delivery of Barnet's integrated care proposals

1.3 Minutes of the meeting of the Financial Planning sub-group held on the 5th November 2014 are presented in appendix 1 and minutes of the meeting held on the 14th January 2015 are presented in appendix 2.

1.4 In 2014/15, the section 256 allocation for Barnet Council is £5,428,324 to deliver both the main social care services which also have a health benefit, and £1,206,000 for Better Care Fund preparations. The Health and Well-Being Board Financial Planning Sub-Group utilise its delegated powers to approve spend against these budgets during 2014/15, which will support delivery of the vision for integrated care that has been developed for Barnet.

1.5 These budgets will be used to support the delivery of existing initiatives and the development and delivery of new initiatives as well as ensuring appropriate protection for social care services.

1.6 The Board is asked to note that the agenda for the 5th November 2014 meeting focused on a number of areas of integrated commissioning including the five tier model and Better Care Fund plans as well as SEND reforms. A number of decisions were taken at the meeting that the Board should be aware of:

- The group discussed the closure of a branch surgery in East Finchley with issues arising around consultation and impact on patients (such as travel time). The group discussed mitigations to negative impacts such as increasing opening hours at the Muswell Hill surgery, the availability of home visits and transport options. The CCG agreed to meet with and support the practice as well as informing NHS England of discussions and liaising with Healthwatch.
- SEND reform joint operational structure and plan is being developed and would be bought to the group in January 2015.
- Barnet has allocated a Better Care Fund (BCF) advisor who will provide support in resubmitting plans in January 2015 to NHS England. The section 75 agreement for the BCF is delayed due to the current status of the BCF plans being rated as approved with conditions.
- With regards to the 5 Tier Integrated Model the Financial Planning Group will be periodically review the size of the pooled budget to agree any increases to the pool over and above the BCF minimum pooled budget in line with the Frail Elderly Business Case.
- The group agreed the Section 256 template could be submitted to NHS England to ensure draw down of the funds from NHS England to the London Borough of Barnet

1.7 The Board is asked to note that the agenda for the 14th January 2015 meeting focused on the Children and Families Act, CCG co-commissioning, CCG recovery plans and mental health commissioning. A number of decisions were taken at the meeting that the Board should be aware of:

- With regards to the implementation of the closure of East Finchley branch surgery; changes will be implemented from 31st March 2015, doctors will see patients in their homes, other surgeries are able to take on patients and increase opening hours.
- The impact of the Children and Families Act is being considered by the CCG and the full impact is not known yet. A section 75 agreement is being looked at. The group will receive a further update in March.
- CCG are looking at joint commissioning agreements with NHS England with regards to Primary Care Commissioning. Co-commissioning will be in shadow form from April – October 2015 and will be undertaken on a five borough North Central London footprint. The group highlighted there is a need to consider Public Health and engagement. Primary Care priorities will need to be linked with the Health and Well-Being Strategy and a separate report should go forward to the HWBB.
- With regards to the CCG recovery plan, the Local Authority needs to be fully engaged in the development of the CCG delivery plans.
- A consultation is being organised by the CCG around mental health commissioning. Plans will focus on treatment in the community and preventing acute admissions.
- Health and Social Care Integration Board is being reformed and will start to meet regularly.
- The arrangements for the pooled budget for the BCF are being worked on. A separate report will go forward to the HWBB on proposed principles for consideration in January 2015.

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Well-Being Board established the Health and Well-Being Financial Planning Sub-Group to support it to deliver on its Terms of Reference; namely that the Health and Well-Being Board is required:

To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

2.2 Through review of the minutes of the Health and Well-Being Financial Planning Sub-Group, the Health and Well-Being Board can assure itself that the work taking place to ensure that resources are used to best meet the health and social care needs of the population of Barnet is fair, transparent, stretching and timely.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided the Health and Well-Being Board is satisfied by the progress being made by the Financial Planning Sub-Group to take forward its programme of work, the sub-group will progress its work as scheduled in the areas of the Better Care Fund, mental health re-commissioning and implementation of the SEND reforms.

4.2 The Health and Well-Being Board is able to propose future agenda items of forthcoming sub-group meetings that it would like to see prioritised if it is not satisfied with the work that the Sub-Group is taking forward on its behalf.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Integrating care to achieve better outcomes for vulnerable population groups, including older people, those with mental health issues, and children and young people with special needs and disabilities, is a key ambition of Barnet's Health and Well-Being Strategy.

5.1.2 Integrating health and social care offers opportunities to deliver the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and the CCG's Quality, Innovation, Productivity and Prevention Plan (QIPP) and Financial Recovery Plan.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The Health and Wellbeing Financial Planning Sub-Group acts as the senior joint commissioning group for integrated health and social care in Barnet. it has the following functions that relate to the management of local resources:

a) *To oversee the development and implementation of plans for an improved and integrated health and social care system for children, adults with disabilities, frail elderly, those with long term conditions, and people experiencing mental health problems.*
b) *To govern the implementation and delivery of the Better Care Fund including the implementation of the 5 tier model for frail elderly, holding the Joint Commissioning Unit and partners to account for its delivery.*
c) *To approve the work programme of the Joint Commissioning Unit.*
d) *To agree any business cases arising from the Joint Commissioning Unit including in relation to the integrated care model*
e) *To recommend to the Health and Well-Being Board, Council Committees and the CCG Board how budgets should be spent to further integration*

between health and social care.

f) To ensure appropriate governance and management of additional budgets delegated to the Health and Well-Being Board.

5.2.2 Projects and enablement schemes linked to Section 256 funding are reviewed by the Financial Planning sub-group to ensure that the projects have a clear programme of work and that approved business cases are adequately resourced to deliver the agreed outcomes.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Well-Being Board has the following responsibility within its Terms of Reference:

To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet.

5.3.2 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 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended). This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

5.3.3 Under the Health and Social Care Act 2012, a new s2B is inserted into the National Health Service Act 2006 introducing a duty that each Local Authority must take such steps as it considers appropriate for improving the health of the people in its area. The 2012 Act also amends the Local Government and Public Involvement in Health Act 2007 and requires local authorities in conjunction with their partner CCG to prepare a strategy for meeting the needs of their local population. This strategy must consider the extent to which local needs can be more effectively met by partnering arrangements between CCGs and local authorities, and at 195 of the Health and Social Care Act there is a new duty-- Duty to encourage integrated working:

s195 (1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

s195 (2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose

of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

5.3.4 As yet, there is no express provision in statute or regulations which sets out new integrated health budgets arrangements, and so the s75 power remains.

5.3.5 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

5.4 Risk Management

5.4.1 There is a risk, without aligned financial strategies across health and social care, of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The Financial Planning sub-group has identified this as a key priority risk to mitigate, and the group works to align timescales and leadership of relevant work plans which affect both health and social care.

5.5 Equalities and Diversity

5.5.1 All public sector organisations and their partners are required under s149 of the Equality Act 2010 to have due regard to the need to:

a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

5.5.2 The protected characteristics are:

a) *age;*
b) *disability;*
c) *gender reassignment;*
d) *pregnancy and maternity;*
e) *race;*
f) *religion or belief;*
g) *sex;*
h) *sexual orientation.*

5.5.3 The MTFS has been subject to an equality impact assessment considered by Cabinet, as will the specific plans within the Priorities and Spending Review as these are developed. The QIPP plan has been subject to an equality impact assessment considered by NHS North Central London Board.

5.6 **Consultation and Engagement**

5.6.1 The Financial Planning sub-group will factor in engagement with users and stakeholders to shape its decision-making in support of the Priorities and Spending Review, and Barnet CCG's financial recovery plan.

5.6.2 The Financial Planning sub-group will also seek assurance from group members that there is adequate and timely consultation and engagement planned with providers as the integrated care model is implemented.

6. BACKGROUND PAPERS

6.1 None.

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DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 5th November 2014
North London Business Park
3.00pm – 5.00pm

Present:
(KK) Kate Kennally, Strategic Director for Communities, London Borough of Barnet (LBB)
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(HMG) Hugh McGarel-Groves (Chair), Chief Finance Officer, Barnet CCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(NF) Nicola Francis, Family Services Director, LBB

In attendance:
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB
(RH) Ruth Hodson, Head of Finance, LBB
(MK) Mathew Kendall, Assistant Director- Community and Wellbeing, LBB
(HM) Dr Howard Mulkis, GP Partner, East Finchley GP Practice

Apologies:
(PC) Peter Coles, Interim Chief Operating Officer, Barnet CCG
(JH) John Hooton, Deputy Chief Operating Officer, LBB
(AH) Andrew Harrington, Director of Transformation, Barnet Clinical Commissioning Group (CCG)

	ITEM	ACTION
1.	**Business Proposal for the closure of a branch surgery in East Finchley** Dr Mulkis explained that NHS England had asked the GP practice to gather views from the HWBB about closing one of its branches. The practice has 2 branches, and that the proposal is to close the smaller one at East Finchley. The main surgery in Muswell Hill has more facilities and staff whereas the East Finchley practice has much more limited service provision, leading to difficulties in maintaining the site. The building at East Finchley is also leased rather than owned. Dr Mulkis explained that the practice would be able to provide a better service for patients if all staff/ services were based at one sight. The group asked Dr Mulkis who would take responsibility for informing patients about their options if the closure goes ahead. The group pointed out that older people might not want to travel to the Muswell Hill branch. Dr Mulkis explained that NHS England had asked the practice to write to their patients to explain the plans. There had been 71 responses from patients. He explained that most patients had expressed sadness but understanding about the proposals. Dr Mulkis explained that if patients are housebound and want to remain at the practice, the practice will have to ensure that all patients can stay with the practice and can receive home visits. Dr Mulkis said he was not clear on capacity at other surgeries to take on local patients.	

	The group asked if staffing would remain the same if the proposals went ahead. Dr Mulkis explained that one partner is going to retire next year. The practice is looking to have extra part time help if the proposals go forward. MO'D noted that the practice is part of the north GP practice network in Barnet, and that the business proposals looked to be going in the right direction in terms of ensuring effectiveness in service delivery. **MOD agreed to set up a meeting with the practice to review the plans and identify how the CCG could support them. MO'D also agreed that the CCG should talk to NHSE about any fall out/ difficulties arising from the proposals.** KK asked how GPs would mitigate any adverse impacts of the proposals on practice patients/ what benefits there are for patients of the change. Dr Mulkis explained that they will continue to offer home visits for patients in the whole practice area. He suggested there might be more requests for home visits if the East Finchley surgery closed, but he said that the practice didn't think would be a huge additional burden to support frail elderly residents coming from East Finchley if the practice there closes. Dr Mulkis also explained that NHS England will insist that the practice at Muswell Hill is open 8am-630pm on weekdays if the changes go ahead. The practice is not open for these hours at present. This will be a benefit for patients, and if the proposals went ahead Dr Mulkis said the practice could consider alternative extended opening hour models, which would off-set any negative impacts resulting from longer travel times for some patients. DW suggested that to ensure that patients were better informed about travel support options such as Dial a ride, some of the elderly patients could be linked into the Altogether Better project in East Finchley. MO'D agreed to type up a formal response for NHS England, reflecting the feedback from Financial Planning Group members, and also to alert HealthWatch and Cllr Alison Cornelius (in her role as Chair of Health Overview and Scrutiny) of this discussion, so they know this decision has been considered from a health and wellbeing perspective. HMG suggested the practice might want to produce a script for staff to help explain to patients what the proposals are. He suggested that the practice could share a draft of the script with the communications teams of the CCG/ Council to help tidy up the messaging. MOD agreed to feed back on progress at the next meeting. CM to send a link to the published minutes to the practice.	**MOD** **MOD** **MOD** **CM**
2.	**Minutes of the last meeting** The group noted the draft minutes and noted final changes to these in advance of publication for Health and Well-Being Board.	
3.	**Action Log** The group reviewed the action log and noted the following:	

	Mental health commissioning: Not progressed yet- but MOD/DW aiming to present a paper at January HWBB. Charlotte Benjamin and MOD will develop an action plan, in partnership with DW. This will be bought to the financial planning group in January 2015. **Better Care Fund (BCF):** CCG to confirm if they can contribute to funding the capacity needed to take this work forward in 2014/15 **Adults and Safeguarding Committee Commissioning Plan:** HMG to circulate commissioning intentions letter to each major provider **Redefine the purpose of the Health and Social Care Integration Board:** DW confirmed that proposals were being developed and would be bought back the next Financial Planning Group meeting **HWBB Provider engagement:** the group heard that a letter from Cllr Hart had been sent to the Secretary of State for Health.	**DW/ MOD** **HMG** **HMG** **DW**
4.	**SEND reforms** MOD circulated the paper that went to the CCG Governing Body on 23rd October. MOD fed back that she had not met with Penny Richardson since the last meeting but that Linda Edwards who will be leading this work at the CCG has met with Penny and they are working to produce an action plan by the end of November MOD confirmed that the MOU and joint operational structure/ plan would be ready for the January 2015 meeting KK pointed out to the group that there was a detailed paper going to the November HWBB on how Barnet has met the Commitments of the Disabled Children's Charter. MOD agreed to feed in comments from the CCG to this paper.	**MOD**
7.	**Outcome of the BCF plan assurance process** DW explained that Barnet's plan had been approved subject to conditions. Barnet has been appointed a Better Care Fund advisor, who is very supportive of the current plan and will help the team to include more detail about how to achieve 3.5% savings. DW explained that the advisor wants to ensure wide HWBB Member engagement in the process of revising the current plan. DW and MOD to brief Cllr Hart and Debbie Frost about these intentions The revised plans have to be resubmitted in draft by mid-December (14th), in advance of completion by 9th January 2015. KK suggested that delays to / incomplete delivery of the BCF needed to be put on the financial risk registers for both organisations. She also asked DW and MOD to quantify the time being spent by officers on this process.	**DW/ MOD** **RH/ HMG** **DW/ MOD**

	HMG asked to see the LBB adult and children services risk registers. The group agreed to review risk registers at the next meeting.	**CM to add to agenda**
D W	**5 tier integrated model** DW explained to the group that the current status of Barnet's BCF means that organisations cannot enter into s75 agreements until approved. On this basis, she explained that the team have written a integrated care 'principles document that can be agreed in advance of the plan being approved by NHSE. DW stressed the importance of ensuring that finance colleagues work with Capita colleagues on the technical details of the document. DW explained that guidance on Section 75s and pooled budgets was issued in October, which has been helpful. The team have reviewed the existing overarching s75 and it is pretty much compliant with good practice, but both organisations need to seek legal opinion that the s75 is in fact still fit for purpose. DW explained the staged approach to pooled budgets, and proposed periodic reviews of the size of the pool at this meeting to agree when increases to the pool can be made, and ensure that both the core and influenced budgets in the BCF remain accurate. KK suggested the legal advice was necessary regarding how to treat the existing S75 schedules. KK stressed that this group is the managing body for the pooled budget, and that it needs to create a suitable monitoring regime over the spend, budget and outcomes of the BCF. DW explained the group may need to update the ToR for this group, and will also need to develop a formal process about how to measure benefits. Regarding lead organisational responsibility for the pooled budget, HMG said the CCG will need to check their governance rules about who can lead on budgets on their behalf, and will also need to work out how to manage their block contract spend too. DW called for detailed meetings with finance teams to test out these principles. DW also explained that there is still further work to do on what the BCF is actually funding, and there is a need to improve on placeholder positions in the business case where these exist. KK advised that the draft S75 schedule needs to be ready when Barnet gains full BCF approval (by end January 2015), and that the group needs to be confident that there is money in place to start BCF delivery in April 2015. KK said the finance teams need to look at the administrative burden of managing the BCF, which will require new finance and performance reports. KK suggested	**DW/ MOD** **DW** **HMG** **RH/ HMG** **RH/ HMG**

	this would require dedicated capacity to make this work. KK asked that part of pooled budget meetings with finance colleagues should seek to assure that all of the money is in place to deliver the BCF proposals. DW & MOD agreed to bring back a timetable of activity to the next meeting.	**DW/ MOD**
8.	**2014/14 Section 256 submission** MK introduced the draft completed S256 template. He explained the content of this template has been agreed at this group at previous meetings, and that only the template is different. He explained that the categories in the template are prescribed. He invited comments/ queries from the group and advised group members could email him with these. The group agreed they were happy for the template to be submitted to NHSE but agreed it needed to be signed by DW and HMG.	**All** **DW/ HMG**
10.	**AOB** The group agreed that the other items of business on the agenda had been sufficiently covered in other meetings.	
11.	**Date of the next meeting** **Thursday 14 January 2015 11.00 am to 1.00 pm – Chapman Room, NLBP**	

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DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 14th January 2015
North London Business Park
11.00pm – 1.00pm

Present:
(KK) Kate Kennally, Strategic Director for Commissioning, London Borough of Barnet (LBB)
(DW) Dawn Wakeling, Commissioning Director – Adults and Health, LBB
(HMG) Hugh McGarel-Groves (Chair), Chief Finance Officer, Barnet CCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(NF) Nicola Francis, Family Services Director, LBB

In attendance:
(RH) Ruth Hodson, Head of Finance, LBB
(MK) Mathew Kendall, Assistant Director- Community and Wellbeing, LBB
(JL) Jeffrey Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(PT) Paul Thorogood, Head of Finance, CSG

Apologies:
(RS) Regina Shakespeare, Interim Chief Operating Officer, Barnet CCG
(JH) John Hooton, Deputy Chief Operating Officer, LBB
(AN) Andy Nuckcheddee, Interim Head of Corporate Governance & Quality, Barnet Clinical Commissioning Group (CCG)
(ZG) Zoë Garbett, Policy & Commissioning Advisor, LBB

	ITEM	ACTION
1.	**Welcome / Apologies** DW introduced herself as Chair and welcomed those present.	
2.	**Minutes of the last meeting** MOD didn't feel the Minutes accurately reflected the agreed points of the last meeting surrounding closure of a branch surgery in East Finchley. MOD has followed it up and the key issues are as follows. • Changes will be implemented by 31 March. These will include the redesigning of the appointment system. • Doctors will see patients in their own homes. They will offer a wider range of services e.g. electronic prescription service. • They have consulted the CGG. Other surgeries have agreed to pick up patients • They have agreed to Increase surgery hours. MOD to incorporate points from email report receipt from Primary Care Team	

3.	**Children & Families (C&F) Act Progress Update** MOD confirmed Judy Mace has now started as Head of Joint Children's Commissioning, she has picked up the Children's and Families Act with the team and has started meeting with paediatricians. Judy has already met with Penny Richardson. KK asked whether there is a financial impact on the CCG and if so what is it? MOD confirmed things have progressed since the last meeting. It is not clear yet what the resource impact will be. Although we have had discussions with paediatricians regarding the requirements the impact on financial and people resources is not yet clear. A discussion followed regarding the agreed implementation plan for a task and finishing group. Where were resources coming from as a whole? MOD explained the CCG had a Children's Planning Group Judy has been speaking to Penny Richardson. She is putting processes into place regarding policy and MOU. **Section 75 (s.75)** MOD explained that there had not been sufficient time given to how it would be managed. MOD explained joint papers were back from the local authority and CCG to support actions. – **Target date April**. KK emphasised the need to ensure underpinning structures are in place. She considered s.75 to be the enablers to this decision and stressed the importance of establishing a decision making process. NF explained that it hadn't been a priority – it would pick up once we had the new service manager. MOD – Update due for the next meeting in March.	**MOD/JM**

4.	**Co-Commissioning** MOD explained that the paper shows where we are. She pointed out the importance of a considered approach to how the five CCGs would manage primary care contracts and how we could implement joint commissioning arrangements. MOD pointed out that a key issue would be managing conflict of interest. Terms of reference are being set up and a joint letter is going out to GPs today re planned changes i.e. co-commissioning and changes to the constitution. Co commissioning will be in shadow form from April – October 2015. It will reflect Level 1 engagement and full joint co-commissioning will come into being from October 2015. MOD confirmed that work had stated regarding engagement with patients, LMC and as of today with the HWBB. PT asked whether the changes affected other professionals or primarily GPs. MOD confirmed it was only GPs in the first instance it doesn't include other professionals i.e. dentists etc. as yet. A discussion around Engagement and Public Health followed. JL explained that they were beginning to recognise that capacity with the five CCGS needed to be coordinated. They were developing a conversation at borough level. He has spoken to Matt Powls re primary care . MOD added that David Riddle is working with Alison Blair Chief Officer Islington and this was a conversation that needed to take place. A conversation around the recent NHSE letter followed and the involvement of the HWBB. MOD explained the issue was around planning in advance which is limited and as this is an iterative process. MOD agreed she would have a follow up conversation with Alison Blair who is leading process for NCL. KK explained the HWBB report needed to address issues raised in the letter. It should include HWBB's decisions/roles it set out the HWBB's strategy to reflect the co-commissioning plans. DW said Zoe would help this process when she returned. MOD explained that the decision would be made by NHSE. KK suggested that Primary Care priorities needed to be linked with the HWBB. MOD asked JL if he had a view how we might take this forward inclusive of a view in regard to HWBB and Public Health involvement in co-commissioning. **JL and MOD to have a follow up discussion.**	**MOD** **MOD/JL**
5.	**CCG Recovery Plan** HMG explained that he was not in a position to share the contents of the plan. It had only been sent out to NHSE last week and BCCG would be meeting with them on Friday. Robert Larkman has been reviewing the CCG from a governance point of view and Jonathan Wise has completed a report and BCCG has decided to fully reflect his report in the recovery plan. It was anticipated that BCCG would breakeven in the next 5 years. DW asked what the breakeven figure was.	

	HMG explained that BCCG had an accumulative deficit and the recovery plan had to evidence the repayment of the deficit. BCCG has had an extra allocation which is the main reason it was on target to break even in 5 years. KK asked whether BCCG were in "special measures" HMG confirmed they were not. There were difficulties surrounding Barnet Chase Farm which was why Barnet was put under [special] conditions. KK explained that a recovery plan was different from a delivery plan. How do we work together to shape a delivery plan? It was a case of transactional savings verses transformational savings. We need to prepare business cases to identify planning work. We should start the next financial year with a single view. MOD explained BCCG had been in recovery for some time and were in the transformational stage but there was still work to do. KK asked for clarification as to how the group was being used to achieve alignment of the plans and what processes are going to be in place before the Board. MOD confirmed that Matthew Powls was leading on planning and suggested a meeting could be arranged with KK re delivery plan and how we are taking this forward. **KK and Matthew Powl to meet.**	**KK**
6.	**Mental Health Commissioning Action Plan/TDA** DW confirmed the group were supposed to come back with a plan but there is as yet no timetable for review. MOD explained MHT was committed to working with stakeholders. KK asked whether there would be an increase in mental health investment in Barnet. HMG explained that engagement groups were to be set up. NHSE have said BCGG must reduce their deficit so there may not be the capacity to invest in mental health. DW added that the general impression was that none of the CCGs would be in a position to increase mental health investment. MOD added that the key was to work towards managing more people in the community become it becomes acute. Aim to move it to community rather than Trust.	
7.	**Health & Social Care Integration Board Proposals** There hasn't been a Board meeting since May. The Board intends to formally reform and meet quarterly. DW and MOD to considered if this is regular enough as a lot of the work was being fed though steering groups.. MOD explained that cases regarding VBC were to be tested. Work is ongoing re VBC and pilot integrated team plus developing evaluation.	**DW/ MOD**
8.	**Feedback on closure of East Finchley GP Surgery** Refer to Item 2	

9.	**Organisational Risk Registers** A discussion followed regarding the risk share and the BCF in relation to the £23m figure. The discussion that followed centred around the level of risk and the broader pooled budget. HMG agreed for the purpose of ongoing pooled budget it is a figure we are working with now and we are following the guideline which dictate we must pool for the BCF and have a risk share, although nature of this can be agreed locally. KK understood that there could be a pooled budget with each party bearing its own risk – as per existing s75s.	
10.	**Timetable on BCF Implementation/Risk Sharing** A brief discussion followed about paper being presented to HWBB outlining the key conditions around risk share which require further discussion and timetable.	**ALL**
11.	**AOB**	

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AGENDA ITEM 13

	Health and Well-Being Board **29th January 2015**
Title	**Forward work programme**
Report of	Strategic Director for Communities
Wards	All
Date added to Forward Plan	January 2014
Status	Public
Enclosures	Appendix 1- Forward work programme of the Health and Well-Being Board Appendix 2- Forward work programme of Council Committees and Barnet CCG's Board
Officer Contact Details	Zoë Garbett Commissioning and Policy Advisor (Public Health and Wellbeing) zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report introduces forward work programme for the Health and Well-Being Board and outlines a series of considerations that will support the Board to manage and update its forward work programme effectively. These considerations are:

- The statutory responsibilities and key priorities of the Health and Well-Being Board
- The work programmes of other Strategic Boards in the Borough
- The significant programmes of work being delivered in Barnet in 2015/16 that the Board should be aware of
- The nature of agenda items that are discussed at the Board

Recommendations

1. **That the Health and Well-Being Board notes the Forward Work Programme and proposes any necessary additions and amendments to the forward work programme (see Appendix 1).**
2. **That Health and Well-Being Board Members proposes updates to the forward**

work programme before the first day in each calendar month, so that the work programme can be published on the Council's website more efficiently, with the most up to date information available.
3. That the Health and Well-Being Board aligns its work programme with the work programmes of the new Council Committees (namely the Adults and Safeguarding Committee, and the Children's, Education, Libraries and Safeguarding Committee), Health Overview and Scrutiny Committee, and Barnet CCG's Board. (see Appendix 2)

1. WHY THIS REPORT IS NEEDED

1.1 At the Health and Well-being Board meeting on 13th November 2014 the Board committed to monthly updates of the forward work programme in alignment with other council committees.

1.2 The current forward work programme has been designed to cover both the statutory responsibilities of the Health and Well-Being Board and the key projects that have been identified as priorities by the Board at its various meetings and development sessions. The current work programme covers items until the end of September 2015; an updated 12 month work programme will be presented at the next Health and Well-Being Board in March 2015.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented on the 13th November 2014 to the Board, and suggests a refreshed schedule of reports and items for the following 10 months, reflecting the Board's statutory requirements, (see below), agreed priorities, and objectives set out in the Health and Well-Being Strategy.

1.4 In January 2015, Zoë Garbett, started in the role of Commissioning and Policy Advisor (Public Health and Wellbeing). The Commissioning and Policy Advisor (Public Health and Wellbeing) will be the key contact for the Board and for receiving any items for the forward work programme. The post holder will meet with relevant (CCG) colleagues and stakeholders to ensure that the work programmes of the Council and CCG are aligned and reflected in the Health and Well-Being Board forward plan.

1.5 In June 2014, the Council moved to a Committee Structure of governance. In the Committee system, decisions will be taken by all-party, decision-making Committees, themed around the key areas of Council business. The new themed Council Committees are: Policy and Resources; Housing; Adults and Safeguarding; Assets; Regeneration and Growth; Environment; Community Leadership; and Children's, Education, Libraries and Safeguarding. The Health and Well-Being Board has been designated responsibility to approving the commissioning plans for public health. The principles of these committees are as follows:

- Only one Committee can make a decision; the decision cannot be taken by more than one Committee

- If it is not clear whose responsibility an issue comes under, it will be taken by Policy and Resources Committee
- Broadly, Policy and Resources will be supported by the Council's Strategic Commissioning Board; Performance and Contract Management by Delivery Board; and the Themed Committees by the Commissioning Board
- The number and themes of each Committee has been Member led.

1.6 The Health and Well-Being Board must ensure that it's forward work programme is compatible with the forward work programmes of the new Adults and Safeguarding and Children's, Education, Libraries and Safeguarding Committees. The Board also needs to seek alignment with the work programmes of the Council's Health Overview and Scrutiny Committee, and Barnet CCG's Board, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate. Updated forward work programmes for each of these Boards are attached at Appendix 2 to support the Board plan its work programme effectively.

1.7 There are a number of work programmes being delivered in 2015/16 that will be of interest to the Health and Well-Being Board, and should be reflected in the Board's forward plan. These work programmes include, but are not limited to, the health visiting and school nursing review, delivery of the Children and Families Act and the Care Act, and the acquisition of Barnet and Chase Farm NHS Trust by the Royal Free NHS Foundation Trust.

1.8 The Health and Well-Being Board has a varied and demanding programme of work to cover over the next 12 months. At the Health and Well-Being Board meeting on the 21st November 2013, the Board discussed the high number of agenda items and papers regularly presented at Board meetings and suggested that some of this work could be delegated to other Boards. It was also suggested that items which the Board was only required to note be considered in a different way. The Chairman noted that the Board need to factor in reasonable time for full discussions where agenda items require input from NHS England or other external partners and Members will wish to ensure that agendas do not contain more reports than the Board has time to properly consider.

2. REASONS FOR RECOMMENDATIONS

2.1 To maintain a programme of agenda items that will aid the Board in fulfilling its remit.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Following approval of the recommendations in this report, Board Members will be asked to update the forward work programme.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Health and Well-Being Board needs a robust forward work programme to ensure it can deliver on the key objectives of the Health and Well-Being Strategy, including the annual priorities within the Strategy that were agreed at the November 2014 Board meeting.

5.1.2 Successful forward planning will enable the Board to meet strategic local and national deadlines for each organisation represented at the Board and transformational changes required to meet the savings targets for both the Council and the CCG.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 Currently, all items on the forward work programme of the Health and Well-Being Board will be managed within existing budgets.

5.3 **Legal and Constitutional References**

5.3.1 Health and Well-Being Boards have a number of statutory duties designated through the Health and Social Care Act (2012) that will inform what items should be taken to the Health and Well-Being Board meetings.

5.3.2 The work programme should ensure that the Health and Well-Being Board is able to deliver on its terms of reference as set out in the Council's Constitution Responsibility for Functions- Annex A, which are set out below:

*(1) To jointly **assess the health and social care needs of the population** with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.*

*(2) To **agree a Health and Well-Being Strategy** for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.*

*(3) To work together to **ensure the best fit between available resources to meet the health and social care needs of the population of Barnet** (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.*

*(4) To **consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures** to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.*

*(5) To **receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services** for users and patients.*

*(6) To **directly address health inequalities** through its strategies and have a **specific responsibility for regeneration and development as they relate to health and care**. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.*

*(7) To **promote partnership and, as appropriate, integration, across all necessary areas**, including the use of joined-up commissioning plans across the NHS, social care and public health.*

*(8) **Receive the Annual Report of the Director of Public Health** and commission and oversee further work that will improve public health outcomes.*

(9) Specific responsibilities for:
- ***Overseeing public health***
- ***Developing further health and social care integration.***

5.4 **Risk Management**

5.4.1 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.

5.5 **Equalities and Diversity**

5.5.1 The Public Sector Equality Duty at s149 of the Equality Act 2010 will apply to CCGs and local authorities who as public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the 2010 Act and advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

All items of business listed in the forward programme and presented at the Health and Well-Being Board will be expected to bear in mind the health inequalities across different parts of the Borough and will aim to reduce these inequalities. Individual and integrated service work plans sitting within the remit of the Health and Well-Being Board's work will need to demonstrate how the needs analysis contained in the Joint Strategic Needs Assessment (JSNA) has influenced the delivery options chosen, including differential outcomes between different communities.

5.6 **Consultation and Engagement**

5.6.1 The forward work programme will be set by the Members of the Health and

Well-Being Board but the Health Overview and Scrutiny Committee also has the opportunity to refer matters to the Board.

5.6.2 The twice yearly Partnership Board Summits, and the meetings of the Partnership Board co-chairs, will provide opportunity for the Board to engage with each of the Partnership Boards on the forward work programme.

6. BACKGROUND PAPERS

6.1 None.

Health and Well-Being Board Work Programme

January 2015 – October 2015

Contact: Zoë Garbett
Commissioning and Policy Advisor (Public Health and Wellbeing)
zoe.garbett@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
29 January 2015			
Health and social care integration (update on the Better Care Fund and approach to risk pooling)	**The Board is asked to comment on the progress made**	Adults and Communites Director	**TBC**
Annual public health report	**The Board is asked to note the report**	Director of Public Health	**Consultant in Public Health**
Early Years Sub-Group – update on progress	**The Board is asked to comment on the progress made**	Director of Public Health/ Strategic Director for Communities	**Family and Community Wellbeing Lead Commissioner**
Dementia Manifesto	**The Board is asked to approve the recommendations**	Adults and Communites Director	**Later Life Lead Commissioner, LBB**
Healtwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
12 March 2015			
Feedback from consultation on Public Health Commissioning Plan	**The Board is asked to discuss the report**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Opportunities to align the Public Health and Planning teams – progress report	**The Board is asked to note the progress that has been made locally to align the work of the public health and planning teams**	Director of Public Health	**Consultant in Public Health**

Subject	Decision requested	Report Of	Contributing Officer(s)
Strategic approach to obesity	**The Board is asked to discuss the report and approve the recommendations contained within**	Director of Public Health	**Consultant in Public Health**
JSNA refresh	**The Board is asked to approve the refresh of the JSNA**	Director of Public Health	**Consultant in Public Health**
6 month update- Domestic Violence and Violence Against Women and Girls Action Plan	**The Board is asked to comment on the progress made**	Strategic Director of Communities	**Domestic Violence Coordinator**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Adults and Communites Director	**TBC**
May 2015			
Draft Health and Wellbeing Strategy refresh	**The Board is asked to comment on the draft Health and Well-Being Strategy**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Draft substance misuse strategy	The Board is asked to comment on the draft substance misuse strategy	Director of Public Health	**Consultant in Public Health**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Adults and Communites Director	**TBC**

Subject	Decision requested	Report Of	Contributing Officer(s)
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
July 2015			
Report on the Partnership Boards/ Health and Well-Being Board catch up	**The Board is asked to comment on the report and take forward any delegated actions that arise out of the report**	Adults and Communities Director	**Customer Care Service Manager, LBB**
Healtwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**
Update- implementing recommendations from the TB situational report	**The Board is asked to comment on the progress made**	Director of Public Health	**Consultant in Public Health**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Adults and Communites Director	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
September 2015			
Health and Wellbeing Strategy (2015-20)	**The Board is asked to approve the Health and Well-Being Strategy**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**

Subject	Decision requested	Report Of	Contributing Officer(s)
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Adults and Communites Director	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director of Communities	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
TBC 2015			
Report of the Tobacco Control Alliance	**The Board is asked to comment on the progress made by the Alliance**	Director of Public Health	**Consultant in Public Health**

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Appendix 2 - Forward Work Programmes of Strategic Boards (January 2015 - May 2015)					
Calendar month	Strategic Board	Agenda Item	Nature of item (if known)	Report of	Contributing Officers(s)
January 2015	Children, Education, Libraries & Safeguarding Committee (12 January 2015)	Education and Skills- Future Delivery of Services	To approve Outline Business Case for Education and Skills related services	Schools, Skills and Learning Lead Commissioner	Education and Skills Director
		Nursery school review- update	To agree the next steps for the nursery school review.	Family and community Wellbeing Lead Commissioner.	Education and Skills Director
		Early Help (Early Intervention) Offer for Children and Families in Barnet	To review services and outcomes for Barnet's Children and Young People (referral from Education OSC)		
		Preparing to Meet Future Need For Children with Special Educational Needs	To agree a commissioning strategy for services to support children with special educational needs.		
	CCG Board (22nd January) - Lisiting special business items only	None Listed			
	Safer Communities Board (30 January 2015)	Annual update on the performance and delivery of the SCPB			
		Refresh of the strategic crime needs assessment			
		Forward plan and key SCPB priorities for 2015/16			
		Agree dates, refresh membership, review terms of reference of SCPB for 2015/16			
		Standing agenda items			
		Update from 'Youth Matters'- (Barnet Youth Offending Board)			
		Performance Dash Board			
	Adults and Safeguarding Committee (26 January 2015)	Corporate Grants Programme, 2014/15 - Grant Applications	Committee to consider assessments of two grant applications.	Deputy Chief Operating Officer	
		The Implications of the Commissioning Plan	Committee to receive a report covering the implications of the Commissioning Plan and The Care Act for Adults Social Care in Barnet.	Strategic Director for Communities	
		Implementation of the Care Act - Adult Social Care Deferred Payments Policy	To approve an updated Deferred Payments Policy to meet the requirements of The Care Act 2014.	Adults and Communities Director, Later Life Lead Commissioner	
February 2015	Health Overview and Scrutiny Committee (9 February 2015)	Annual report of the Director of Public Health	To consider the 2014 Annual Report of the Director of Public Health; and to consider an update on the 2013 Annual Report (to include update on Call to Action on Physical Activity)	Director of Public Health (Barnet and Harrow)	
		North London Hospice: Working with Hospitals	Committee to receive a report from the North London Hospice on the work that they are undertaking with five North London Hospitals in relation to end of life care		
		Central London Community Healthcare: Progress to Becoming an NHS Foundation Trust	Committee to receive a report on Trust's strategy for the next five years and to the progress being made towards becoming an NHS Foundation trust		
		Update Report: Royal Free London NHS Foundation Trust	Committee to receive an update report from the Royal Free London NHS Foundation Trust to cover: Response to the removal of the Liverpool Care Pathway Winter Pressures: to report on winter pressures, including Accident and Emergency and bed Capacity. Parking at Barnet Hospital		

	CCG Board (26th February) - Listing special business items only	None Listed			
March 2015	Children, Education, Libraries & Safeguarding Committee (9 March 2015)	Preparing to Meet Future Need for Children with Special Educational Needs	To agree a commissioning strategy for services to support children with special educational needs.	Education and Skills Director	Education and Skills Director
		Business Planning	To approve five year commissioning priorities, proposals for meeting financial targets set out in the MTFS	Strategic Director for Communities	Commissioning Director (Children and Young People)
		Independent schools seeking maintained status	To approve a framework for decision making for applications from individual faith schools to join the maintained sector	Commissioning Director (Children and Young People)	Commissioning Director (Children and Young People), Education and Skills Director
	Adults and Safeguarding Committee (19 March 2015)	Your Choice Barnet Task & Finish Group	To consider a six-month update report from Officers on the approved recommendations of your Choice Barnet Task and Finish Group.	Housing and environment lead Commissioner, Later Life Lead Commissioner	
		Commissioning priorities	To agree commissioning priorities for 2015/16	Family and community Wellbeing Lead Commissioner, Later Life Lead Commissioner	
		Implementation of the Care Act	To receive an update on progress with the implentation of the Care Act	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the care Act- Remodelling Adult Social Care	To agree changes to the ASC process that will enable it to comply with the Care Act 2014. To agree a new a policy arising from the Care Act 2014 formalising the new duties of the council where a care provider falls. To agree an approach to how councils can develop a sustainable social care market place to meet the new duties of the Care Act 2014	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the care Act- Prevention, Information & Advice Policy	To agree an approach to Information & Advice and Advocacy services in relation to the requirements of the Care Act 2014	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the Care Act- Prevention policy	To agree new policies in line with the requirements fo the care act.	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the Care Act - Eligibility and Contributions	To agree new policies in line with the requirements fo the care act.	Adults and Communities Director, Later Life Lead Commissioner.	
		Management Agreements	To review management agreements for the commissioning and delivery of Adult Social Care services	Adults and Communities Director, Later Life Lead Commissioner.	
	Health Overview and Scrutiny Committee (30 March 2015)	Update Report from NHS England: Immunisations Task and Finish Group	Committee to receive an update report from NHS England on the work of the Task and Finish Group undertaken in relation to immunisations		
		Healthwatch Barnet Enter and View Visits- Update Report	Committee to receive an update on the visits to Barnet Hospital as reported to committee at their meeting in December 2014		
		Royal Free London NHS Foundation Trust Acquisition- Update Report (to Include Ambulances)	Committee to receive an update report from the Royal Free London NHS Foundation Trust provide an update report on the topic of Ambulances.		
		GP/ Primary Care Services at Finchley Memorial Hospital- Update report	Committee to receive an update from NHS England and Barnet Clinical Commissioning Group on GP/ Primary Care Services at the Finchley Memorial Hospital Site.		
April 2015	Adults and Safeguarding Committee (23 April 2015)	Your Choice Barnet Task & Finish Group	To consider a 12-month update report from Officers on the approved recommendations of the Your Choice Barnet Task and Finish Group	Adults and Communities Director.	

		Implementation of the Care Act	To review progress made against the implementation plan	Adults and Communities Director, Later Life Lead Commissioner.	
		Healthwatch Barnet Enter & View Reports	To receive Enter & View reports from Healthwatch Barnet which relate to the provision of the adult social care services	Adults and communities Director	
	Children, Education, Libraries & Safeguarding Committee (20 April 2015)	Naom conversion to Voluntary Aided Sector	To approve the granting of voluntary aided status to Noam primary School	Education and Skills Director	Education and Skills Director, Schools, Skills and Learning Lead Commissioner
		Looked after children	To note progress made in developing services for looked after children and agree priorities for 15/16	Commissioning Director (Children and Young People), Family Services Director	Commissioning Director (Children and Young People), Family services Director
		Health Visiting Transfer	To agree the transition plan and commissioning priorities for 15/16	Director of Public Health (Barnet and Harrow), Commissioning Director (Children and Young People)	Director of Public Health (Barnet and Harrow), Commissioning Director (Children and Young People)
May 2015	Health Overview and Scrutiny Committee (11 May 2015)	NHS Trust Quality Accounts (11th May)			
unallocated items	Health Overview and Scrutiny Committee	Public Health Commissioning Intentions		Director of Public Health (Barnet and Harrow)	

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