MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 9TH MARCH, 2017

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

TO: MEMBERS OF HEALTH & WELLBEING BOARD (Quorum 3)

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

Dr Charlotte Benjamin	Councillor Sachin Rajput	Dawn Wakeling
Dr Andrew Howe	Cathy Gritzner	Chris Miller
Chris Munday	Dr Clare Stephens	Ceri Jacob
	Councillor Reuben Thompstone	

Substitute Members

Julie Pal	Dr Ahmer Farooqui	Mathew Kendall
Councillor Wendy Prentice	Dr Barry Subel	Dr Jeffrey Lake
Councillor David Longstaff		
Bernadette Conroy		

In line with the Constitution's Public Participation and Engagement Rules, public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is 10AM on Monday 6 March. Requests must be submitted to Salar Rida 020 8359 7113 salar.rida@barnet.gov.uk.

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

Andrew Charlwood – Head of Governance

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

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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Decisions of the Health & Wellbeing Board

19 January 2017

Board Members:-

AGENDA ITEM 1

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

* Dr Charlotte Benjamin	* Cllr Sachin Rajput	* Dawn Wakeling
* Cathy Gritzner	* Dr Clare Stephens	Dr Andrew Howe
* Chris Munday	* Cllr Reuben Thompstone	Ceri Jacob
		Michael Rich

Substitute Members:

* Dr Ahmer Farooqui	*Dr Jeff Lake	*Julie Pal

* denotes Member Present

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

The Chairman of the Health and Wellbeing Board, Councillor Helena Hart opened the meeting and welcomed all attendees. It was noted that the actions arising from the previous minutes have been taken forward under this agenda and the forward work programme.

The Chairman briefed the Board about the Motion which was passed at Full Council on 13th December 2016 calling for concerted local action to tackle the ever growing incidence of Diabetes in the Borough. Council has specifically requested that the Health and Wellbeing Board devises a local improvement strategy to try and mitigate this most worrying problem.

The Board heard that as part of the Annual Commissioning Plan, the Public Health team will provide an update to the Board on the work currently being delivered and the workstreams that are due to take place. Dr Jeff Lake (Consultant in Public Health) provided a brief update on some of the plans already underway. The Board received an update on local commissioned services for Diabetes and noted that a bid for funding had been submitted around Diabetes to expand structured education and a digital based offer. This includes working closely with partners to review the current mechanism in place to aid early diagnosis and the local commissioned services for Diabetes.

The Chairman thanked Dr Lake for the briefing and noted the update due to be reported to the Board at its meeting in March.

The Chairman then noted that colleagues at the Barnet Clinical Commissioning Group have been shortlisted for two national awards. The CCG has been nominated for two entries in the Health Service Journal Value Healthcare Awards - namely Medication Optimisation for Respiratory Conditions at Barnet CCG and Reimagining Mental Health in the Primary Care services category. The Chairman and the Board congratulated Barnet CCG colleagues on the nominations and their sterling achievements.

RESOLVED that the minutes of the previous meeting held on 10th November 2016 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from:

- Dr Debbie Frost, who was substituted by Dr Ahmer Farooqui
- Dr Andrew Howe, who substituted by Dr Jeff Lake
- Mr Michael Rich, who was substituted by Ms Julie Pal
- Ms Ceri Jacob (NHS England)

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

Dr Ahmer Farooqui made a joint declaration on behalf of Barnet CCG Board members, Dr Clare Stephens, Dr Charlotte Benjamin and himself in relation to agenda item 7 by virtue of offering immunisation services to children and membership of the GPs Federation through their respective GP practices.

Councillor Helena Hart declared a non-pecuniary interest in relation to agenda item 7 by virtue of her son being a Consultant at the Royal Free Hospital which in the future could be affected by any changes.

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

None.

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

The Board noted the details of the submitted public questions and the public answers which were provided for the meeting. Responses to the supplementary public questions were given verbally at the meeting.

Ms Mary O'Connor addressed the Board and made a public comment in relation to agenda item 12 (Forward Work Programme).

6. AGEING WELL REPORT AND REVIEW 2015/16 (Agenda Item 6):

The Chairman introduced the report which sets out the activities undertaken as part of the Ageing Well Programme. The Programme is an initiative aimed at reducing demand for adult social care service by supporting people to live independently in their own homes and communities for longer and to build support networks within local communities.

To present the report, the Chairman invited Zoë Garbett, Commissioning Lead Health and Wellbeing, Lisa Smith, East Finchley Altogether Better Officer and Nazra Zuhyle, Altogether Better Burnt Oak and Edgware and Stonegrove Altogether Better Officer.

Ms Garbett introduced the report and briefed the Board about the expansion of the project on a borough wide scale. It was noted that the project, which was initiated in 2013 has been progressing through a number of community activities.

The Board received a presentation from a resident who is a Community Friend at Altogether Better Burnt Oak. The resident shared her personal experience. She stated that her participation in the various community run activities had had a most positive impact on her and had prompted her to encourage other residents to participate in the activities.

In relation to a query about promotion of the Programme, Ms Smith noted that information about the activities is disseminated through various methods such as newsletters, publication in the local press and word of mouth.

Dr Jeff Lake, Consultant in Public Health highlighted the benefits of the Programme in helping to build connections with communities and noted that more leaflets will be distributed throughout the Borough.

The Board very much welcomed both the Presentation and the beneficial effects of the Programme. Dr Farooqui encouraged publicity of the Programme throughout the Borough and via GP practices.

The Commissioning Director for Adults and Health, Ms Dawn Wakeling requested that the synergies between various community development programmes be reviewed to make sure they are working together effectively for maximum impact – Altogether Better, Age UK Barnet Neighbourhood Model, Care Space and initiatives in Public Health.

The Chairman welcomed the discussion. Councillor Hart moved a motion which was seconded, to amend the wording of the recommendation to read:

The Health and Wellbeing noted and appreciates the progress made by the Ageing Well programme to reduce dependence on social care by facilitating community led activities for older people

The motion was declared carried and became the substantive motion. It was therefore **RESOLVED** that:

The Health and Wellbeing noted and appreciates the progress made by the Ageing Well programme to reduce dependence on social care by facilitating community led activities for older people.

7. BARNET CCG 2017/18 COMMISSIONING INTENTIONS (Agenda Item 7):

The Chairman introduced the report which sets out the Barnet CCG Commissioning Intentions for 2017-18.

She noted that in December 2016, the CCG agreed two year contracts with providers which reflect activity, workforce and performance assumptions within the vision of the local Sustainability and Transformation Plan (STP). Mr Neil Snee, Director of Integrated Commissioning, Barnet CCG joined the meeting.

Mr Snee presented the report and informed the Board about the focus of this contracting round. He noted that involvement of GP's, residents and service users in the process has been beneficial and a reduction in payments for over-performance had also been agreed. Mr Snee further briefed the Board about the intention to move services locally where they are needed, whenever this is possible. It was noted that the development and utilisation of the Finchley Memorial Hospital is at the centre of these plans.

The Commissioning Director for Adults and Health, Ms Dawn Wakeling welcomed the report and supported the commissioning intentions which fit in well with Care Closer to Home.

Board Members welcomed the report and highlighted the importance of engagement with residents, stakeholders and service users. Mr Snee welcomed the comments and informed the Board about future plans for resident engagement and patient representation - including carers.

Following sign off, it was noted that the Commissioning intentions will be published on the CCG website and issued throughout the Borough via service providers.

It was **RESOLVED:**

That the Health and Wellbeing Board noted Barnet CCG's 2017/18 Commissioning Intentions (see Appendices 1, 2 and 3) for each provider where it is the lead commissioner.

8. CHILDREN AND ADOLESCENT EMOTIONAL WELLBEING AND MENTAL HEALTH SERVICES - TRANSFORMATION AND PROCUREMENT (Agenda Item 8):

The Chairman noted that Child and Adolescent Mental Health Services have been an ongoing concern for the Board for some time. This has very much been reflected in the JHWB Strategy priority to improve mental health and wellbeing for **all** residents. She introduced the CAMHS Report and welcomed it both as an opportunity to shape the delivery of the joint programme as well as to focus on prevention.

The Commissioning Director for Children and Young People, Mr Chris Munday presented the item and briefed the Board about the service development and improvements. He noted that for 2017, there will be an additional service to provide targeted early intervention to vulnerable young people. This will be targeted for young people who are experiencing difficulties with anxiety, depression, and emotional distress but who are not yet at a diagnostic threshold for specialist CAMHS.

Mr Eamann Devlin CAMHS Joint Commissioning Manager (interim) joined the table and provided a presentation. Mr Chris Miller, Independent Chairman of the Barnet Adults and Children's Safeguarding Boards highlighted the need for specific care for children particularly in light of the population size in Barnet.

Mr Munday informed the Board about efforts to configure services appropriately and make services more accessible as well as increasing take up. Following a query from the Board, Mr Munday explained that schools are the heart of the development and implementation of the programme around the THRIVE model. So far, it has been well received within the schools where it had been piloted and the intention was to roll this out with other schools.

Mr Munday also noted that further work will be undertaken with schools to encourage young people to access services and tackle stigma around mental health.

It was **RESOLVED that**:

1. **The Health and Wellbeing Board noted and approved the progress made in jointly commissioning a new Emotional Wellbeing and Mental Health System for Children and Young People.**

2. **The Board noted and approved the commissioning intentions as planned with the procurement process based on the timetable Appendix A.**

3. **The Board noted and approved the monitoring of progress against milestones in the procurement plan Notes the successful funding bids received and progress toward improving local provision.**

4. **The Board noted that an update report on procurement is due to be provided to the HWBB in July 2017.**

9. REPORT ON THE UPDATE OF THE SHISHA CAMPAIGN (Agenda Item 9):

The Chairman welcomed the shisha update report and invited Ms Natalia Clifford, Consultant in Public Health to join the meeting. Councillor Hart introduced the report and thanked the Task and Finish Group for all their hard work on the Shisha campaign, particularly for the communication campaign and the posters. She re-iterated the very strong messages contained in these very well received posters that smoking Shisha could double your risk of Cancer, that Shisha contains tobacco and that Shisha had as much addictive nicotine as cigarettes.

In response to a query about addressing the increase in shisha usage, Ms Clifford stated that work has commenced with Environmental Health to consider options available taking into account legislation and licensing provisions.

She noted that shisha smoking itself is not a licensing activity however she informed the Board that the full range of levers available will be explored together with partners. Ms Clifford also stated that in-depth planning consultation will take time to achieve.

Following discussion, the Leader suggested that the Board make a submission to the Mayor of London as part of the Local Plan, which sets out the framework for how development and growth will be managed in the borough. (**Action**)

Dr Clare Stephens commended the work that had been done so far and welcomed the report. She noted that the Board could make a formal representation to the All-Party Parliamentary Group on Cancer to address the increase in shisha use. (**Action**)

Councillor Sachin Rajput queried the options available around curtailing visibility of shisha activity. Councillor Reuben Thompstone welcomed the suggestions to address the increase in shisha usage and associated health risks. Ms Wakeling welcomed the issues raised and noted that this will be considered as part of the options. (**Action**)

In relation to a query about enforcement, Ms Clifford noted that warning displays of shisha and smoking is an enforceable licensing activity.

The Board noted that an evaluation report will be brought to the June meeting of the HWBB.

The Chairman welcomed the comments from the Board Members and expressed support for taking the actions forward.

It was **RESOLVED:**

1. **That the Health and Wellbeing Board endorsed the next phase of the Shisha campaign (sections 1.2-1.4)**

2. **That the Health and Wellbeing Board approved and supports the distribution of campaign materials and proposed communications techniques aimed at all Barnet residents.**

10. SECTION 75 AGREEMENTS: ANNUAL REPORT (Agenda Item 10):

The Chairman welcomed the report which sets out the key achievements, risks, finance and commissioning intentions across the Section 75 agreements.

Ms Wakeling and Mr Munday presented the item and noted the overarching agreements and schedules in place as set out in the agenda report. The Board heard that the Section 75 Agreement mechanism has been used in Barnet for both adults and children services and the delivery of the agreements is monitored through the JCEG.

The Board welcomed the update and it was **RESOLVED:**

That the Health and Wellbeing Board noted the impact of the Section 75 agreements in delivering improved outcomes for Barnet's residents.

11. MINUTES OF THE HEALTH AND WELLBEING BOARD WORKING GROUPS - JCEG (Agenda Item 11):

The Commissioning Director for Adults and Health presented the standing item on the agenda which includes the minutes of the JCEG meetings held on 24th October 2016 and 23rd November 2016.

Ms Wakeling noted that, although it was expected in early December, the guidance and policy framework in respect of the BCF has not yet been published by NHS England. Ms Wakeling stressed the importance of the BCF being linked to the North Central London (NCL) Sustainability and Transformation Plan (STP) with clear governance.

RESOLVED:

That the Health and Wellbeing Board approved the minutes of the Joint Commissioning Executive Group meetings of 24 October 2016 and 23 November 2016.

12. FORWARD WORK PROGRAMME (Agenda Item 12):

The Board noted the standing item on the agenda which lists the work programme for 2017.

It was **RESOLVED**:

1. **That the Health and Wellbeing 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 Wellbeing Board Members continue to propose 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 Wellbeing Board continue to align its work programme with the work programmes of the 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).**

13. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 13):

None.

The meeting finished at 11.30 am

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AGENDA ITEM 6

	Health and Wellbeing Board **9 March 2017**
Title	**Motion from Full Council, Volunteering in Care Homes**
Report of	Head of Governance
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Salar Rida – Governance Officer salar.rida@barnet.gov.uk 0208 359 7113

Summary

The report informs the Health and Wellbeing Board of a Motion on Volunteering in Care Homes which was reported to Full Council on 31 January 2017. In accordance with Council Procedure Rule 23.5, if a Member's Motion is not dealt with by the end of a Full Council meeting, it will be referred to the appropriate committee for consideration and any necessary action. An opposition amendment Motion on Volunteering in Care Homes has also been referred to the Health and Wellbeing Board under this rule. Details of the original motion and the amendment are set out in this report.

Recommendations

1. **That the Health and Wellbeing Board's instructions are required in relation to this item.**

1. WHY THIS REPORT IS NEEDED

1.1 On Tuesday 31January 2017 Councillor Lisa Rutter submitted an Administration Motion to Full Council as follows:

1.2 Volunteering in Care Homes

1.2.1 Care homes have limited resources and there are specific areas of staffing where volunteers help and can help further. Thank you to all those who volunteer in Barnet. As our population grows more diverse there are language difficulties as people age. They prefer to use their original language or may become unable to communicate in English.

1.2.2 *Council wishes to encourage volunteering and specifically those who might help with other languages. Council call on officers to create a register of volunteers with language skills who might be able to assist and make this list available as required.*

1.2.3 Councillor Gill Sargeant submitted an Opposition amendment to the Motion, to Full Council as follows:

1.2.4 Care Homes are under increasing pressure to deliver services to a growing elderly population. Underfunding, at both government and local level, has left staff stretched and with little time to engage residents.

1.2.5 Care homes have limited resources, and there are specific areas of staffing where volunteers help and can help further. Thank you to all those who volunteer in Barnet. As our population grows more diverse there are language difficulties as people age. They prefer to use their original language or may become unable to communicate in English.

1.2.6 We have a large number of Chinese and Asian residents in the borough - many of whom are elderly and vulnerable for whom culturally specific services are not an option but a necessity, and it is essential that the council listens to those from these communities, and other communities, who understand their own cultural and linguistic needs best.

1.2.7 Unfortunately, recent cuts by this Conservative administration to social care organisations providing services to these residents undermine the importance of independence and user-led services, and represent an attack on grassroots voluntary and community services in Barnet who often do fantastic work in supporting and standing up for the local community.

1.2.8 The stark reality is that the Conservative-led council refused in their last budget, despite repeated representations from Labour councillors, to apply the full social care precept which could have mitigated the impact on these groups.

1.2.9 This is being compounded by a legacy of successive cuts passed on to local government services by a Conservative national government that has consistently refused to fund social care properly.

1.2.10 Council wishes to encourage volunteering and specifically those who might help with other languages. Council call on officers to create a register of volunteers with language skills who might be able to assist and make this list available as required. Council will support the individuals and organizations on the list.

1.3 Council's Constitution, Full Council Procedure Rule 23.5 states that:

If the Member's Motion is not dealt with by the end of the meeting, it will be referred to the appropriate Council Committee or sub-Committee for consideration and any necessary action. (However, if the proposer has specifically asked in his or her notice for the Motion to be voted on at that Council meeting it will be voted on without discussion).

1.4 The motion was not discussed or voted on at the Full Council meeting. Therefore the Health and Wellbeing Board are requested to consider the contents of the motion as set out in section 1.2 of this report and give instruction.

2. REASONS FOR RECOMMENDATIONS

2.1 No recommendations have been made. The Health and Wellbeing Board are therefore requested to give consideration to the motion and provide instruction.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Post decision implementation will depend on the decision agreed by the Board.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 If the Board propose to action in relation to this motion, any actions arising will need to be evaluated against the Corporate Plan and other relevant policies such as the Health and Wellbeing Strategy.

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

5.2.1 None in the context of this report.

5.3 **Social Value**

5.3.1 None in the context of this report.

5.4 **Legal and Constitutional References**

5.4.1 Council Constitution, Full Council Procedure Rules (section 23.5) states if the Member's Motion is not dealt with by the end of the meeting, it will be referred to the appropriate Council Committee.

5.4.2 The Council's Constitution, Responsibility for Functions (Annex A) sets out the terms of reference for the Health and Wellbeing Board which includes:

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of service for users and patients

- 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

- 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. To explore partnership work across North Central London where appropriate.

- Specific responsibilities for:
    - Overseeing public health
    - Developing further health and social care integration.

5.4.3 There are no legal references in the context of this report.

5.5 **Risk Management**

5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**

5.6.1 None in the context of this report.

5.7 **Consultation and Engagement**

5.7.1 All of these issues must be considered for their equalities and diversity implications.

5.8 **Insight**

5.8.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 Motion to Full Council, 31 January 2017:

https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=162&MId=8818&Ver=4

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AGENDA ITEM 7

	Health and Wellbeing Board **9 March 2017**
Title	**Care Closer to Home**
Report of	Director of Commissioning Barnet CCG
Wards	All
Date added to the forward plan	September 2016
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1 – 2017/18 outline work programme
Officer Contact Details	John Ferguson, Head of Primary Care Transformation / CC2H lead, Barnet CCG Email: john.ferguson@barnetccg.nhs.uk Tel: 020 3688 2299

Summary

Barnet Health and Social Care commissioners are looking at different ways that services could be provided in the future. In line with the aspirations already set out in the Barnet Better Care Fund plan, and the Integration Concordat, NHS Barnet CCG aims to shift the balance from the current situation where most funding goes into hospital services to a greater emphasis on care provided by out of hospital service providers. There will also be a much greater focus on preventing the public from getting ill or not becoming more unwell if they have a long-term condition, such as diabetes. This means care will be tailored to individual needs as well as bringing it closer to where people live. To achieve this, it will require existing practitioners such as doctors, community nurses, therapists to work in multi-disciplinary teams alongside new dynamic managed-care skills based roles delivering services closer to people's homes, preventing people travelling any further than necessary to receive the necessary care. We are calling this Care Closer to Home (CC2H), and it forms a key workstream of the North Central London STP (NCL STP).

The purpose of the report to the Health and Wellbeing Board is to:

- Outline the rationale to implement care closer to home, which will cover all age groups
- Provide an outline of the planned programme of work for care closer to home for 2017/18

- Provide an opportunity to comment / discuss the outlined approach.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the plans to implement Care Closer to Home.**
2. **That the Health and Wellbeing Board endorses a shared approach between health and social care commissioners and providers to implement Care Closer to Home.**

1. WHY THIS REPORT IS NEEDED

1.1 The sustainability of the current model of health and social care is now being questioned, prompting unprecedented ambitions of productivity aligned to the development of transformational, whole-system plans designed to create a sustainable health and social care system. This challenge for Barnet Health and Social Care is encapsulated in the North Central London (NCL) Sustainability and Transformation Plan (STP).

1.2 The scope of STPs is broad. Initial guidance from NHS England and other national NHS bodies set out around 60 questions for local leaders to consider in their plans, covering three headline issues: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. Health and Care system leaders (Health commissioners, local authorities and NHS providers) were asked to identify the key priorities needed for their local area to meet these challenges and deliver financial balance for the NHS. The plans needed to cover all aspects of NHS spending, as well as focusing on better integration with Local Authority services including social care. They also needed to be long term, covering October 2016 to March 2021.

1.3 Central to these sustainability plans is the need to radically change, enhance and provide care closer to home (CC2H). CC2H builds on the delivery of the borough's Health & Social Care Integration (HSCI) aspirations for Tiers 1-4 of Barnet's Better Care Fund service model: Developing greater self-management (Tier 1), promoting health and wellbeing and building the capacity of individuals and communities (Tier 2), 'No Wrong Door' approach to access services (Tier 3), investing in community intensive support (Tier 4).

1.4 Developing this approach of working and commissioning of services will lead to a step change in levels of self-care, earlier intervention supported by risk stratification and population segmentation and enhanced access to integrated services, particularly for the frail, those with long term conditions and those with mental ill-health. For residents, this will mean:

- Positive change
- A reduction of complexity of services
- Giving control and strengthening capacity to care for ourselves and each other. Delivering quality care values that the public believe in

- Care and treatment will be accessible closer to home and in the most appropriate primary care and community setting
- Reduce need to visit A&E due to alternatives available locally
- Greater understanding of which health service to use and when, due to clear signposting and easier access
- Multidisciplinary teams for people with complex needs, including social care, mental health and other services
    - Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
- Creating services that offer an alternative to hospital stay
- Building an infrastructure to support the model based on these components including,
    - Using outcome measures to incentivise and pay for services.
    - Develop new capabilities for existing resources and harness the power of the wider community.

1.5 The Better Care Fund plans include details of the jointly commissioned NHS community services and social care services to reduce the risk of individuals entering the health and social care system through a non-elective admission. The alignment with the CC2H model is evident: self-care, earlier intervention supported by risk stratification; and enhanced access to integrated services, particularly for the frail, those with long term conditions.

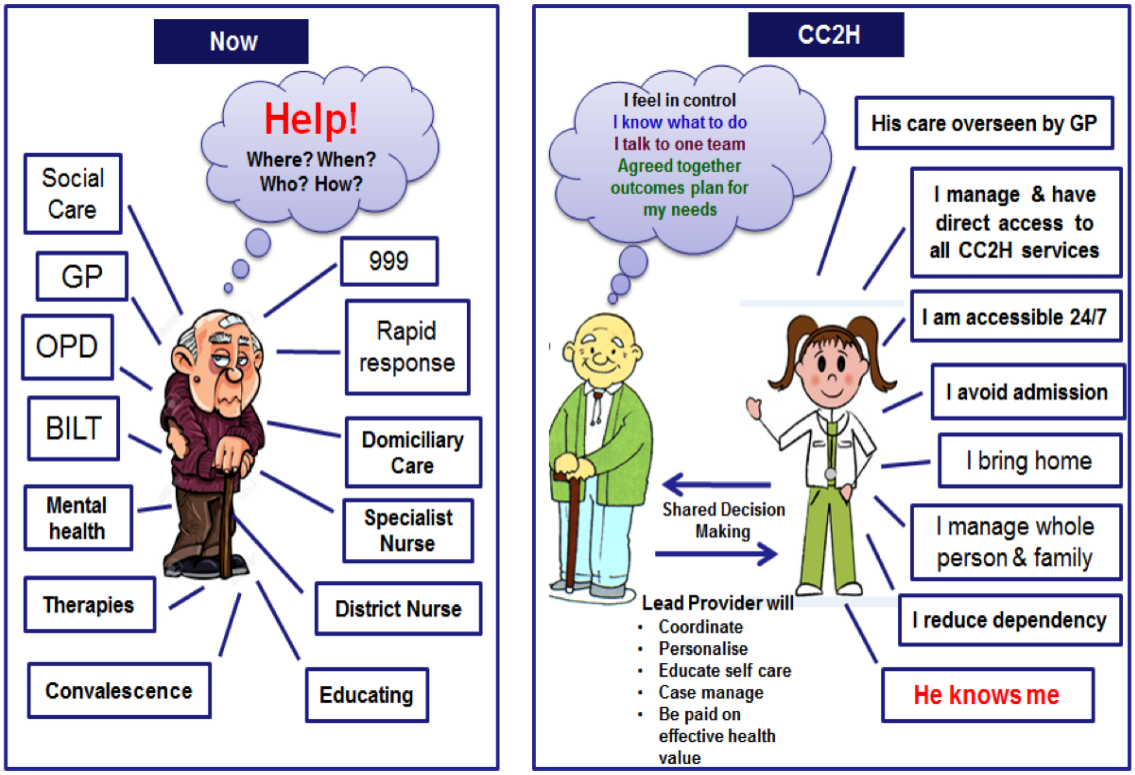
1.6 CC2H allows the borough to fulfil aspirations of the Joint Health and Wellbeing Strategy (2015 – 2020). In particular, the Care When Needed theme of the Strategy has integrating health and social care as a priority and details that programmes will be develop teams across primary and community health and social care to support people with complex long term conditions. This commitment has been met through the development of BILT as a borough wide service, supported by the use of the risk stratification tool and rapid care. In November 2016, the Health and Wellbeing Board refined the focus for the second year of the strategy's delivery which included Care Closer to Home as a priority.

1.7 The CC2H approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services. CC2H is used to extend a strengths based practice model into NHS primary and community care services. This would enable a fundamental shift from a 'treatment' model of care to co-production with patients.

1.8 CC2H is an emerging commitment and the joint governance of its delivery is still being developed to align with BCF and STP governance and will include roles for the Joint Commissioning Executive Group and the Health and Wellbeing Board.

Figure 1:

What a Care Closer to Home commitment will feel like for the public



1.9 In Barnet, the NHS and local authority will develop a series of care closer to home service initiatives and developments. To enable progress a joint approach to the following transformational steps will be developed.

- A shared strategic approach
- The alignment and combination of budgets
- Rethinking and redesigning the commissioning of acute primary, community, mental health, voluntary and social care services
- Implement care models/pathways at scale through a lead provider contracted approach to include access to specialist support and diagnostics
- Creating a strong integrated care platform liked to measureable outcomes (reporting and payment)
- Implementation of affordable and evidence based new technology.

2. REASONS FOR RECOMMENDATIONS

2.1 The purpose of the paper is to provide the Health and Wellbeing Board with the opportunity to comment on the plans to implement services closer to home. The paper:

- Outlines the rationale to implement care closer to home.
- Seek support regarding the transformational steps required.
- Outlines the immediate transformation and developments in 2017/18 across key themes so care close to home can be a reality.

- Describes the planned management approach to implement the care closer to home initiatives.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The alternative to this integrated approach and commitment is to maintain the status quo. Currently the pressures on current systems and ways of working are not meeting the public's needs and requirements.

3.2 Furthermore, by drawing on all resources across health, social care and public health in a unified way this fundamental change in approach for a more integrated health and care system under the principles of care closer to home will bring benefits to many people. In particular it will make a real difference to older people, those with long-term conditions like diabetes and to carers. People don't want health care or social care; they just want the best care in their own environment. The care closer to home vision is a vital step in creating a truly joined up system that puts people first and real innovation could also bring efficiency and financial benefits.

4. POST DECISION IMPLEMENTATION

4.1 Progress continues in delivering this shared strategic approach across Barnet health, social care and public health which articulates the vision, the ambition and the task in hand.

4.2 Agree on a delivery roadmap incorporating timelines for full implementation of Care Closer to Home. This roadmap will take into account the levers to deliver to outcome such as de-commissioning, re-commissioning, and contracting processes.

4.3 A number of immediate projects, tasks and service developments have been identified from local and NCL STP strategies for delivery in 2017/18. Collaborating across health and social care these programmes of work will help create founding principles of care closer to home and contribute directly to the vision. See appendix 1 for further detail.

4.4 A key Barnet development in 2017/18 is the roll out of Care Closer to Home Integrated networks (CHINs) and Quality Improvement Support Teams (QISTs). These models build on the work already underway across Barnet (i.e. BILT) but will aim to significantly move much further towards developing integrated working and person centred care. Adopting a consistent approach to CHINs and QISTs in Barnet will drive improvement and reduce the variation that we currently see in people's health outcomes and quality of life. See appendix 1 for further detail.

4.5 Larger and more fundamental initiatives need to be developed further, with appropriate resident, patient and service user consultation at the appropriate time.

4.6 Through the creation of an inclusive Barnet Care Closer to Home programme management approach, the schemes will be grouped and prioritised. This

committee will oversee a number of task and finish groups to progress operational delivery.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The 'Five Year Forward View' (NHS England, 2014) and GP Forward View (NHS England, 2016) and The Councils Corporate Plan (2015-2020) sets out the vision why change and a transformational approach is required for public sector services to become more integrated, intuitive and efficient. Care closer to home is fully aligned to these strategies.

5.1.2 Barnet's Joint Health and Wellbeing Strategy (2015 – 2020) outlines the borough's focus on health and social care integration. Care Closer to Home is a priority of the strategy as agreed by the HWBB in November 2016.

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

5.2.1 The partnership across health, social care and public health will provide the initial project support to deliver on the programmes of work.

5.2.2 The transformation of existing models of delivery through existing contracts with providers will support the vision and ambition. Where investment is required to support this transformation additional funding will be sourced through the STP.

5.3 Social Value

5.3.1 Before any procurement process is entered securing the benefits required will be clearly established in the preceding business case.

5.4 Legal and Constitutional References

5.4.1 Under the Council's Constitution – Responsibility for Functions (Annex A) the terms of reference of the Health and Wellbeing Board includes the following responsibilities:

a) To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
b) To directly address health inequalities through its strategies and have a specific responsibility for regeneration and development as they relate to health and care.
c) To champion the commissioning of services and activities across the range of responsibilities of all partners to achieve this.
d) 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.

e) To explore partnership work across North Central London where appropriate.
f) Specific responsibilities for:
    - Overseeing public health
    - Developing further health and social care integration

5.5 **Risk Management**

5.5.1 There is a risk that the sustainability of the current model of health and social care is now being fundamentally questioned. Currently the pressures on current systems and ways of working are not meeting the public's needs and requirements. The risks associated with not transforming services will remain and the health and social care concerns will not have been addressed. Managing these risks will have oversights at an STP level and Barnet level through the Health and well-being board.

5.6 **Equalities and Diversity**

5.6.1 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 eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010, advance equality of opportunity between people from different groups and foster good relations between people from different groups. Both the local authority and the CCGs are public bodies. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Equality impact assessments will be carried out on specific schemes and proposals.

5.7 **Consultation and Engagement**

5.7.1 To further support the evidence base a public consultation programme will be established. Events are being planned with the first taking place w/c 27/2/17.

5.8 **Insight**

5.8.1 Local intelligence has been principally been drawn from the Council's and Health data bases.

6. BACKGROUND PAPERS

6.1 North Central London Sustainability and Transformation Plan Update, Health and Wellbeing Board, 10 November 2016, item 7: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8715&Ver=4

6.2 NHS five year forward view. https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/

6.3 Barnet Council Corporate Strategy 2015 - 2020
https://barnet.moderngov.co.uk/documents/s22195/Appendix%20A.pdf

Appendix 1

A. 2017/18 Work plan linked to the Care Closer to Home (CC2H) principles

Scheme	CC2H Objectives	Timeline to start
Extending GP access 8-8, 7 days	Widening primary care access	Work commenced
Development of GP Federation	Provider delivery redesign Sustainability of primary care practices Back office sharing	Work Commenced
Pharmacists in GP practices and Nursing homes	Scheme developed with national programme	June 17
Development of Finchley memorial Health & Wellbeing centre (hospital)	Re-imagining form and function GP practices to relocate GP admit and manage beds	Work commenced
Self-management scheme	Patient self-care, self-management programme	April 17
LCS & Improving quality incentive scheme (One Hackney Model)	Variety of new interventions and activity shift to community / CC2H aligned programmes. QIST[1] brings up the minimum, improving raises to a higher level.	April 17
Recruit iGPs	Form a cohort of "future leaders in primary care"	Sep 17
CEPN[2] education programme and workforce development	Workforce skills development, support sustainability, reduce variance, care navigation, sign-posting, medical assistants	April 17
Urgent care and Frail elderly fellows	CC2H	June 17
Primary care workforce review	Linked to sustainability, workforce planning	April 17
Practice nurse development scheme Increasing practice nursing numbers scheme	Workforce skills development, support sustainability, reduce variance	April 17
Pharmacists training on minor illness mgmt	GPFV[3], workforce development	May 17
GP staff training on self-care, self-mgmt	CC2H, GPFV work streams	April 17
Practice based mental health therapist development scheme.	CC2H, GPFV work streams	May 17
Develop idea of accountable care model for 30-50k population groups	Develop an approach to move from CHIN model to accountable care models.	TBA
Other CCG business cases being developed to support CC2H	Wound care, Urgent care, Frailty, Diabetes, Cardiology, Musculosketal, Urology, Children. Resource & funding needs to transform to meet objectives.	Work commenced

[1] QIST - Quality Improvement Support Teams
[2] CEPN – Community Education Providers Network
[3] GPFV – GP Forward View

B. CHIN development plan for Barnet implementation in 17/18

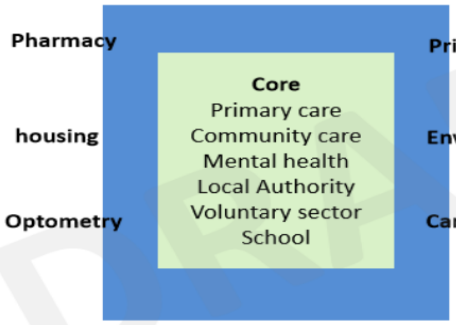
Model presented at the "lock in"

Care closer to home integrated networks (CHIN)

Principle

Network/hub does commissioning and providing

- Network has a multidisciplinary teams – pulled from core group supplemented by locally determined key players



Covers a meaningful population size e.g. 50-80K

Commissioning

- Needs analysis (public health and outcomes)
- Agree care pathways that are in scope
- Delegated budget
- Set an agreed commissioner plan
- Review aim to reduce variation – to achieve upper 25% across key players

Providing

- Acute reactive – clinician agnostic
- LTC chronic – clinician specific
- Rehabilitation
- Admission prevention
- Discharge facilitation

CHIN delivery plan for CHIN 1 (Barnet CCG) CHIN 1

Phase	CHIN development domain	Date	Activities
CHIN Development phase	**CHIN expression of interest**	Mar 17	• Engage and identify practices interested in taking part in the CHIN • Identify the support requirements needed by the CHIN to develop domains 1-4 • Identify clinical and managerial leads for the CHIN
	1. Build collaborative leadership around a shared vision		• Develop clinical leadership needed for the CHIN • Develop the leadership and partnership from across health and social care and establish CHIN management board • Develop the CHIN approach to co-production and activation of community resources to support local engagement
	2. Establish a transparent governance structure		• Develop the governance structure for the CHIN • Establish CHIN approach to managing conflicts of interest • Establish CHIN approach to data sharing and IG between providers
	3. Understand the different needs of the CHIN population		• Work with partners from public health to understand the specific needs of the CHIN population • Map the workforce pressures and create a workforce strategy for the CHIN with support from the CCG • Map the current IT infrastructure and with support from the CCG, set out the IT roadmap for the CHIN
	4. Develop logic models to explain how the transformational work will meet the outcomes of the CHIN		• Identify the outcomes the CHIN aspires to improve • Set out logic model for achieving the desired outcome
CHIN delivery phase	**CHIN Operating Plan**	May 17	• Utilise the logic model to present the financial and non-financial benefits of the CHIN • Set out the proposed CHIN governance • Present the CHIN needs assessment and approach to engaging with local people
	Design and document each of the specific component parts of the care redesign		• Identify and redesign pathways based on the needs of the local population • Where required, work with the CCG to re-specify services around the needs of the CHIN
	CHIN Delivery	June 17	• Mobilise changes identified to key pathways

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AGENDA ITEM 8

	Health and Wellbeing Board **9 March 2017**
Title	**Public Health & Wellbeing Commissioning Plan- 2017/18 addendum and targets**
Report of	Dr Andrew Howe, Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1: Public Health & Wellbeing Commissioning Plan - 2017/18 addendum and targets
Officer Contact Details	David Fabbro Public Health Business Support: david.fabbro@harrow.gov.uk

Summary

In March 2015, the Health and Wellbeing Board approved a five year Commissioning Plan for the period 2015-20, which sets out the Board's priorities and outcome performance measures across its core areas of responsibility. All Theme Committees agreed their five year Commissioning Plans.

This report presents updated targets for 2017/18 in an addendum to the Commissioning Plan (Appendix 1).

Recommendations

1. **That the Health and Wellbeing Board review and approve the addendum to the Public Health & Wellbeing Commissioning Plan for 2017/18 (Appendix A).**

1 WHY THIS REPORT IS NEEDED

1.1 The council's **Corporate Plan** 2015-20 was agreed by Full Council in April 2015. It sets the strategic priorities and direction for the council to 2020 and targets against which progress is measured. Each year, the priorities and targets are refreshed to ensure they remain focused on the things that matter most to the council. The 2017/18 addendum will be presented to Full Council on 7 March 2017 and will include the new priority on delivering quality services:

- **Delivering quality services –** we strive to deliver services to the highest possible standard and to continuously improve this standard. We are committed to high quality customer service and being as transparent as possible with the information we hold and our decision-making.
- **Responsible growth, regeneration and investment** – in an era of reduced Government funding, growth is necessary for councils to increase the local tax base and generate income to spend on public services. The council has an ambitious programme of regeneration, which aims to create new homes and jobs, and the proceeds of this growth will be reinvested in the borough's infrastructure and essential community facilities.
- **Building resilience in residents and managing demand** – we will focus on the strengths and opportunities in our communities and target resources at those most in need. The council will support residents to stay independent for as long as possible through equipping people to help themselves and intervening early to address issues as they arise rather than waiting until they reach a critical stage.
- **Transforming local services –** as a Commissioning Council our focus is on reaching the best outcomes for our residents whilst delivering value for money to the taxpayer. This means delivering differently and working with a range of public, private, and voluntary sector organisations to ensure we can meet our priorities.
- **Promoting community engagement, independence and capacity –** we want to support residents and the wider community to become more independent and self-sufficient. This means residents having more of a say in the future of their local area, and where appropriate, taking on more responsibility for local services.

1.2 In 2015/16, each thematic Committee agreed a 5 year Commissioning Plan. The Health & Wellbeing Board agreed in October 2014 that the critical outcomes are as set out in the following table:

Priority	Key Outcomes
Giving children the best start in life	• Support for first time mothers. • Women are encouraged to breastfeed their babies and feel confident to do so. • Every woman is supported to avoid alcohol and stop smoking in pregnancy. • Support is provided for mothers experiencing peri/postnatal depression • Children, young people and their families are supported to be physically, mentally and emotionally healthy
Enable all children, young people and adults to maximise their capabilities and have control over their lives	• People are discouraged from taking up smoking in the first place, and encouraged and supported to quit should they wish to. • Children and adults who are overweight and obese are encouraged and supported to lose weight. • Children and adults are discouraged from misusing alcohol and drugs, and encouraged and supported to quit • Children and young people feel supported to achieve and engage, while developing their identities and resilience. • Working age adults and older people are well-connected to their communities and engage in activities that they are interested in, and which keep them well.
Create fair employment and good work for all, which helps ensure a healthy standard of living for all	• Those furthest from the labour market are supported to access training and employment opportunities, retain job opportunities, and return to employment. • Employers in Barnet are encouraged to promote healthy workplaces that make it easier for their employees to make healthy lifestyle choices.
Create and develop healthy and sustainable places and communities	• The built environment is conducive to healthy living choices such as walking and the accessibility of safe open spaces. • The range of green spaces and leisure facilities in the Borough are used more extensively, there is more active travel and levels of physical activity increase. • Social isolation, especially amongst older people, is reduced through schemes that enable the sharing of skills and experience. • Working age adults and older people live a healthy, full and active life and their contribution to society is valued and respected. • Sexual ill health and alcohol/substance misuse are treated early and effectively by robust services delivered in partnership across the voluntary sector, the Council, the NHS and other statutory organisations. • People are given many opportunities for volunteering, which increases inclusion into local communities, overcome language barriers and develop stronger intergenerational support.

Strengthen the role and impact of ill health prevention	• People aged between 40 and 74 years are offered and take-up health and lifestyle checks in primary care to help reduce risk factors associated with long term conditions. • People with a long term condition are encouraged and supported to self-manage their condition, resulting in a delayed/reduced demand for crisis response. • Older people are supported to stay well during winter months. • All people are supported to identify the warning signs of cancer and are encouraged to adopt behaviours that may help to prevent the onset of cancer.

1.3 Each Theme Committee is now being asked to agree a 2017/18 addendum to their plans, which sets out the Q2 position against 2016/17 targets and updated targets for 2017/18. This will give Committees the opportunity to review and consider their priorities for the year ahead and the associated targets against which progress will be measured. The addendum to the Public Health & Wellbeing Commissioning Plan for 2017/18 is provided at Appendix A.

1.4 Overall Public Health performance in Q3 2016/17 was very good. Public Health reports on 24 indicators and 25 key actions across the Commissioning intentions addendum for 2016/17 and the Management Agreement for 2016/17.

1.5 87% of the indicators were in the Green and Green/Amber categories with approximately the same percentage of key actions falling within the Green and Green/ Amber categories. Action plans are in place to address the small number of areas where performance improvement is required.

1.6 Over the next two years the Public Health grant will be directed towards the protection of statutory services and investments to influence the wider determinants of health, ensuring costs are contained within the available financial envelope.

1.7 The addendum to the Public Health & Wellbeing Commissioning Plan focuses on the following priorities:

- Investing in demand management to put all statutory services – Health Checks, National Child Measurement Programme, Health Visiting, School Nursing, sexual health (GUM) – on a secure footing for the future
- Ensuring that additional investment in non-statutory but priority services – e.g. drug and alcohol, smoking cessation, winter-well, mental health, self-care, sport and physical activity – are targeted to achieve the best possible health outcome
- Influencing the priorities of internal and external delivery partners so that they help to improve the health of Barnet residents

- Helping residents to engage with their own health and wellbeing by investing in community assets to promote health

1.8 The proposed addendum to the Public Health & Wellbeing Commissioning Plan, including updated targets for 2017/18, is set out in Appendix A. Members are invited to review and agree the document.

1.9 Following agreement, the Board will receive a progress report during the year against this Plan and associated in-year targets. The Board will be asked to agree updated targets for 2018/19 in March 2018 and this process will continue through to 2020.

1.10 The Performance and Contract Management Committee will continue to review progress against the council's Corporate Plan, and overview of the performance of both internal and external Delivery Units. This Commissioning Plan will enable Performance and Contract Management Committee to focus on the key areas of performance for different service areas.

2 REASONS FOR RECOMMENDATIONS

2.1 A key element of effective strategic and financial management is for the council to have comprehensive business plans in place that ensure there is a clear strategy for addressing future challenges, particularly in the context of continuing budget and demand pressures (resulting from demographic and legislative changes), delivering local priorities and allocating resources effectively.

2.2 The Public Health commissioning intentions have been directed by the priorities identified in the Joint Health and Wellbeing Strategy 2015-2020. Funding for tiers 1 and 2 of the Better Care Fund work/Health and Social Integration strategy (self-care and health and wellbeing) have been protected.

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is no statutory duty to publish Committee Commissioning Plans but it is considered to be good practice to have comprehensive business plans in place for each Committee – which set out priorities and how progress will be measured – to ensure that the council's vision for the future is clearly set out and transparent.

4 POST DECISION IMPLEMENTATION

4.1 Revisions to the Commissioning Plan will be communicated internally and with key stakeholders.

5 IMPLICATION OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This report invites Members to review and approve the addendum to the Commissioning Plan for 2017/18.

5.2 Resources

5.2.1 In addition to continuing budget reductions, demographic change and the resulting pressure on services pose a significant challenge to the council. The organisation is facing significant budget reductions at the same time as the population is increasing, particularly in the young and very old population groups.

5.2.2 The Public Health grant allocation to Barnet Council was reduced by a 6.2% in-year cut in 2015-16 and subject to on-going reductions in addition to that. The ring-fenced public health grant allocation for Barnet for 2017 - 18 totals £17.609m. Further reductions are expected in the years to April 2020, and could be in the region of 2.65% per annum. The Spending Review 2015 made a number of further commitments including a commitment to retain the public health grant for 16-17 and 17-18 in order to complete the transition of 0-5s and an indication that the public health grant will be replaced potentially by a model based on retained business rates, and will be subject to full consultation. A pilot is being run in 2017-18 with 10 local authorities in Manchester using the retained business rate model.

5.2.3 The commissioning plan will need to be managed within the financial envelope available to meet public health outcomes and has been informed by the Budget and Medium Term Financial Strategy, agreed by Council on 3 March 2015. This included a savings target of £90.8m required by 2019-20 and a capital investment programme through to 2019-20.

5.3 Social Value

5.3.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 All proposals emerging from the business planning process must be considered in terms of the council's legal powers and obligations, including its overarching statutory duties such as the Public Sector Equality Duty.

5.4.2 Under the Council's Constitution, Responsibility for Functions (Annex A) the terms of reference of the Health and Wellbeing Board includes the following:

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
- 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.

- 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. To explore partnership work across North Central London where appropriate.
- Specific responsibilities for:
  Overseeing public health
  Developing further health and social care integration.

5.5 Risk Management

5.5.1 Statutory service provision and key strategic areas of discretionary spend have been protected. There is a risk that discretionary investments may not deliver enduring system change. The potential for sustainability of services and/or mainstreaming of innovation has been prioritised in funding decisions.

5.5.2 The council has an established approach to risk management. Key corporate risks are monitored regularly and reported to Performance and Contract Management Committee on a quarterly basis.

5.6 Equalities and Diversity

5.6.1 The general duty on public bodies is set out in section 149 of the Equality Act 2010.

5.6.2 A public authority must, in the exercise of its functions, 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; and
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.6.3 Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

5.6.4 The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

5.6.5 Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, the need to tackle prejudice; and promote understanding.

5.6.6 Compliance with the duties in this section may involve treating some persons more favourably than others but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

5.6.7 The relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

5.6.8 It also covers marriage and civil partnership with regard to eliminating discrimination.

5.6.9 In agreeing the Corporate Plan, the council is setting an updated strategic equalities objective and reiterating our commitment to delivering this. The strategic equalities objective is as follows:

- Citizens will be treated equally, with understanding and respect, and will have equal access to quality services which provide value to the tax payer.

6 Consultation and Engagement

6.1 The original Corporate Plan and Commissioning Plans were informed by extensive consultation through the Budget and Business Planning report to Council (3 March 2015).

6.2 The consultation aimed to set a new approach to business planning and engagement by consulting on the combined package of the Corporate Plan, Commissioning Plans, and budget. In particular it aimed to:

- Create a stronger link between strategy, priorities and resources
- Place a stronger emphasis on commissioning as a driver of the business planning process.
- Focus on how the council will use its resources to achieve its Commissioning Plans.

6.3 To allow for an eight week budget consultation, consultation began after Full Council on 17 December 2014 and concluded on 11 February 2015. Further consultation on the budget for 2017/18 has been undertaken following Policy and Resources Committee on 1 December 2016.

7 BACKGROUND PAPERS

7.1 Health and Wellbeing Board, 13 March 2014, Public Health Commissioning Plan 2015-2020: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7783&Ver=4

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Public Health & Wellbeing Commissioning Plan 2015 – 2020

2017/18 addendum & targets

This document is an addendum to the **Public Health & Wellbeing Commissioning Plan 2015 – 2020**, which sets out a revised narrative and updated indicators/targets for 2017/18. The full Commissioning Plan can be found here: https://www.barnet.gov.uk/citizen-home/council-and-democracy/policy-and-performance/corporate-plan-and-performance.html

1. CONTEXT FOR COMMISSIONING PLAN (SUBJECT TO CHANGE)

Delivering quality services

Barnet is growing, with the highest population of any London borough. Our vision is for a council that works to ensure everyone can benefit from the opportunities that growth and investment will bring. This means helping people to help themselves whilst still protecting what people value in Barnet – its excellent schools, its parks and open spaces, and the character of the borough.

We will need to change the way we work over the next few years to ensure we remain in a stable financial position, while delivering the savings required. We will take this opportunity to do things differently so that we achieve better outcomes for residents and become more efficient.

Barnet is an ambitious council, and we strive to continuously improve the quality of our services. Delivering services that our residents value most to a high standard will ensure that Barnet continues to be a great, family friendly, place to live.

In practice, this means keeping our neighbourhoods and town centres clean and safe, maintaining our parks and open spaces, ensuring that our roads and pavements are well looked after and that we are reaching the highest possible standards of air quality – all whilst ensuring value for money for the Barnet taxpayer.

To support this, we are taking a strong enforcement approach against those who litter and fly-tip. We will ensure that developers pay for any damage that they cause to our roads and pavements through a deposit scheme. We will also outline an approach to vehicle fees and charges based on environmental impact to help us improve our air quality.

Responsible growth, regeneration and investment

As the funding we receive from the government reduces to zero, growth is necessary to increase the local tax base and generate income to spend on local services.

The council's regeneration programme will see £6bn of private sector investment over the next 25 years, which will create around 20,000 new homes and up to 30,000 new jobs. It will also generate £17m of additional income annually for the council by 2020, with one-off income of £55m.

Through our capital investment programme we will invest £772m in the borough between now and 2020. We will use the proceeds of growth to re-invest in infrastructure, not only delivering quality housing – including affordable homes – but also providing essential community facilities such as community hubs and transport.

We will work to ensure that our residents and businesses get the most out of the opportunities presented by growth. We will do this by improving our town centres, supporting small businesses to thrive, and bringing more jobs and easier access to skills development.

We have already put in place services to support our residents into work, for example, the Burnt Oak Opportunities Support Team (BOOST) which has helped nearly 200 people into work since its launch in June 2015.

Building resilience in residents and managing demand

Barnet council is facing a £61.5m savings gap to 2020, and this is not simply due to continued reductions in Government funding. Changing demographics, a growing population – particularly increased numbers of children and young people and older people – and a rising cost of living are putting pressure on the public services we offer.

We will always protect our vulnerable residents. Our aim is to target our resources at those most in need, and support residents to stay independent for as long as possible. In Children's and Adults' social care where there is significant pressure due to increasing numbers of vulnerable residents, we are focusing on building on strengths and opportunities to improve outcomes.

This means equipping residents to help themselves and intervening early to address and respond to issues as they arise, rather than waiting until they reach a critical stage. We are working with other parts of the public sector to achieve this through more joined up services that will deliver better outcomes for residents, as well as costing less by working together more efficiently.

An example of this is the Barnet Integrated Locality Team which is being trialled in the west of the borough and which coordinates care for older adults with complex medical and social care needs. This integrated health and social care approach helps vulnerable adults to stay well and living in their own home, easing demand for costly residential care and reducing pressure on the NHS.

Transforming local services

For all of our services, we are considering the case for delivering differently in order to meet our priority outcomes. As a Commissioning Council our focus is on reaching the best outcomes for our residents whilst delivering value for money to the taxpayer through working with a range of public, private, and voluntary sector organisations.

For some services, this has meant a partnership with the private sector, for example our contracts with Capita to provide our back office and customer services.

We have also recently entered into a partnership with Cambridge Education, a specialist education company, to deliver our Education and Skills services. By 2019/20 this partnership is guaranteed to save the council £1.88 million per year through marketing and selling services to more schools and other local authorities, which will create income.

Through our Customer Access Strategy we are aiming to move towards a 'digital by default' approach, with a target of 80% of contact with the council being online or through other digital means by 2020. This is more efficient and flexible for the customer, and saves the council money. The money saved through moving towards digital by default allows us to free up resource which we can target at our customers who are most in need.

This will be underpinned by a Digital Inclusion Strategy which aims to help all those in the borough who are willing and able to get online, and ensure that there are special access arrangements for those who cannot.

We are also transforming the way we work within the council to allow staff to do their jobs more effectively and to make the council more accessible to those who use its services. The office move to Colindale is a key part of this and will support the ongoing regeneration in the west of the borough as well as bringing us closer to the community and reducing the amount we spend on accommodation.

Promoting community engagement, facilitating independence and building community capacity

We want to support residents and the wider community to become more independent, healthy and self-sufficient. This means residents having more of a say in the future of their local area, and where appropriate, taking on more responsibility for local services.

Our Community Participation Strategy will play a key role in this. We will increase our support for those residents and groups who want to take on a more active role in their community, and will work with them to make the best possible use of their knowledge and skills to deliver what is needed.

2. OUR APPROACH TO MEETING THE 2020 CHALLENGE

The council's Corporate Plan sets the framework for each of the Theme Committees' five year commissioning plans. Whether the plans are covering services for vulnerable residents or about universal services such as the environment and waste, there are a number of core and shared principles, which underpin the commissioning outcomes.

The first is a focus on fairness: Fairness for the council is about striking the right balance between fairness towards the more frequent users of services and fairness to the wider taxpayer and making sure all residents from our diverse communities – young, old, disabled and unemployed benefit from the opportunities of growth.

The second is a focus on responsibility: Continuing to drive out efficiencies to deliver more with less. The council will drive out efficiencies through a continued focus on workforce productivity; bearing down on contract and procurement costs and using assets more effectively. All parts of the system need to play their part in helping to achieve better outcomes with reduced resources.

The third is a focus on opportunity: The council will prioritise regeneration, growth and maximising income. Regeneration revitalises communities and provides residents and businesses with places to live and work. Growing the local tax base and generating more income through growth and other sources makes the council less reliant on Government funding; helps offset the impact of budget reductions and allows the council to invest in the future infrastructure of the borough.

Planning ahead is crucial: The council dealt with the first wave of austerity by planning ahead and focusing in the longer-term, thus avoiding short-term cuts and is continuing this approach by extending its plans to 2020.

3. CORPORATE PLAN PRIORITIES

The **principles** of **Fairness**, **Responsibility** and **Opportunity** are at the heart of our approach. We apply these principles to our **Corporate Plan priorities** of: **delivering quality services**; **responsible growth, regeneration and investment**; **building resilience in residents and managing demand; transforming local services;** and **promoting community engagement, independence and capacity**.

These priorities are underpinned by a commitment to **continual improvement in our customer services** and to be **as transparent as possible with the information we hold and our decision-making.**

Fairness
• fairness for the council is about striking the right balance between fairness towards more frequent users of services and to the wider taxpayer • **building resilience in residents and managing demand** – between 2011 and 2016 we've successfully saved over £112m through effective forward planning. In order to meet the £61.5m budget gap to 2020, we will target resources on those most in need and support residents to stay independent for as long as possible • this will require a step change in the council's approach to early intervention and prevention, working across the public sector and with residents to prevent problems rather than just treating the symptoms.
Responsibility
• the council will focus not only on getting the basics right, but also **delivering quality services**, and striving to continuously improve the standard of services • **promoting community engagement, independence and capacity -** as the council does less in some areas, residents will need to do more. We're working with residents to increase self-sufficiency, reduce reliance on statutory services, and tailor services to the needs of communities • in doing so, the council will facilitate and empower residents to take on greater responsibility for their local area.
Opportunity
• the council will capitalise on the opportunities of a growing local economy by prioritising regeneration, growth and maximising income • **responsible growth, regeneration and investment** is essential for the borough – by revitalising communities and providing new homes and jobs whilst protecting the things residents love about Barnet such as its open spaces. New homes and business locations also generate more money to spend on local services, which is increasingly important as the money received directly from government reduces to zero • we will use the proceeds of growth to invest in local infrastructure and maintain Barnet as a great place to live and work as we continue to deal with budget reductions to 2020 • we will explore the opportunity this presents to **transform local services** and redesign them, delivering differently and better • we will focus on making services more integrated and intuitive for the user, and more efficient to deliver for the council and the wider public sector.

The Equality Act 2010 and the Public Sector Equality Duty impose legal requirements on public organisations to pay due regard to equalities. The Corporate Plan is fundamental to the council's approach to deliver equalities. It enables the principles of equalities and valuing diversity to be reflected and mainstreamed into all council processes. It also outlines the council's Strategic Equalities Objective (SEO) that citizens will be treated equally, with understanding and respect, and will have equal access to quality services which provide value to the tax payer.

Through the SEO, Barnet aims to provide the best start for our children and access to equal life chances to all our residents and taxpayers who live, work and study in Barnet. Progress against the SEO is monitored annually in an Annual Equalities Report which is publicly reported to Council and the SEO is also reflected through our Commissioning Plans and priorities for each Theme Committee. Management Agreements with our Delivery Units have a number of commitments which reflect the importance of equalities and how the Commissioning Plans will be achieved in practice, and performance indicators have been set and published for each Delivery Unit.

4. VISION FOR PUBLIC HEALTH & WELLBEING

- The people of Barnet are generally healthy but the borough is not without health challenges
- We have a large and growing elderly population, which makes promoting physical activity and tackling issues such as social isolation more important
- We commission services to address these challenges, while continuing to deliver our statutory functions and ensuring that Barnet's population is as healthy as it can be by integrating public health as a priority theme across all services.
- The development of new communities in Barnet offers opportunities to integrate health outcomes such as the design of buildings, the assessment of new developments for heath impact and the structure of communities to promote health.

- Our aim is to encourage an engaged population that is supported to take responsibility for health and wellbeing individually and collectively by means of targeted early intervention and integrated services.

5. COMMISSIONING PRIORITIES

Summary

We're investing in demand management to put all of our statutory services – Health Checks, National Child Measurement Programme, Health Visiting, School Nursing, sexual health (GUM) – on a secure footing for the future**.**

- We're ensuring that additional investment in non-statutory but priority services – e.g. drug and alcohol, smoking cessation, winter-well, mental health, self-care, sport and physical activity – are targeted to achieve the best possible return on investment in terms of health outcomes and demand for services**.**
- We are influencing the priorities of our internal and external delivery partners so that they help to improve the health of Barnet residents.
- We're helping residents to engage with their own health and wellbeing by investing in community assets to promote health.

Background

- Public Health in Barnet has two main roles:
    - Spending the approximately £17 million public health grant to provide statutory and discretionary services for maximum health gain
    - Co-ordination of council delivery units and partners to ensure that the health of the people of Barnet is prioritised in commissioning and delivery of services
- The Public Health grant has been reduced. There was an in-year reduction of 6.2% in 2015-16, made recurrent in all following years to 2019-20 (a total of 8.4%). In addition there has been a reduction in grant of 2.2% in 2016-17, and an estimated reduction of 2.6% in 2018-19 and 2019-20.
- This reduction in funding will constrain delivery of services by 2018/19. Therefore, we're investing money now to affect systemic change which will manage future demand for statutory services, for example by transforming delivery of services such as employment and mental health from acute to community settings and by working with all London boroughs to change how sexual health services are structured and delivered.

Giving children the best start in life

Children, young people and their families are supported to be physically, mentally and emotionally healthy.

- Responsibility for commissioning Health Visiting was transferred from the NHS to local authorities in 2016. This includes responsibility for antenatal health, new baby reviews, six to eight week assessments, one year assessments and two to two-and-a-half year reviews. Public Health in Barnet receives an additional circa £4.5m to fund this.
- We are integrating Health Visiting within Early Years provision in Children's Centres, enhancing promotion of healthy behaviours and school readiness. We are working closely with the Early Years Review to support better integration between health and social care and to embed an early years resilience model, targeted at vulnerable families.
- Health coaches: We have commission Family Health and Perinatal Health coaches to work with troubled families, and those suffering pre/post natal depression through to March 2018 as a system innovation to contain demand and improve outcomes.
- Childhood obesity: Maintain childhood obesity and nutrition investment via a tier 2 weight management programme to the Healthy Schools Programme.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Physical activity and healthy diet: complete the tender process and implement the weight management offer for adults in 2017-18
- Mental health: continue to build capacity of the community centred practices programme in practices in identifying and referring to community resources to support patients. Also, expand digital based resources available for residents with common mental illness.
- Consider the most effective and cost efficient way to reduce smoking in the population through redesign of the current smoking cessation service offer and working with partners on wider tobacco control issues including use of shisha.

Create fair employment and good work for all, which helps ensure a healthy standard of living for all

- Employment support: continuing investment in employment support programmes improving local pathways and support for clients with motivational, mental health and alcohol/substance misuse issues.
- Workplace health promotion: Achieving London Healthy Workplace Charter accreditation and sharing models of good practice with businesses across the borough.

Healthy and sustainable places and communities

The built environment is conducive to healthy living choices such as walking and the accessibility of safe open spaces.

- The council is investing £30 million in redeveloping two leisure centres at New Barnet and Copthall, and implementing our Sport and Physical Activity strategy, to ensure that all Barnet residents have access to high quality health and fitness facilities, particularly in areas where the local population is projected to grow. Public Health in response have invested in

more facilities for communities to look after their own health and wellbeing, such as outdoor gyms and sporting equipment, in our parks and open spaces

- We are helping to plan communities and ensure that where necessary assessments can be made of new developments for the health outcomes they promote. We are looking to further partner with planning, regulation, licensing and regeneration to ensure integration of health outcomes in these decisions.

Ill health prevention

Public Health commissioned services are a very small part of the health and social economy and of the wider social and environmental determinants of health and wellbeing. Public health's primary concern is to inform and influence decision making across LA, NHS and other partners for the benefit of population health.

- Health and lifestyle checks help reduce the risk factors associated with long-term conditions, and people with a long-term condition are supported to self-manage their condition. We are developing a more targeted Health checks programme to align to a reducing budget.
- We're working towards an integrated and sustainable sexual and reproductive health services model by commissioning collaboratively with all London Boroughs as part of the London Sexual Health Transformation programme to procure both an e-service portal which will allow residents to self-manage their sexual health and access home testing kits, where appropriate, and commissioning new sexual and contraceptive health services. An integrated and sustainable sexual and reproductive health services model will help to ensure a consistent pan-London service while maximising return on investment through economies of scale and reduce the onward transmission of infections.
- We have invested in our discretionary provision and re-commissioned drug and alcohol services with a single lead organisation. Now we're improving treatment outcomes, and managing demand drug and alcohol misuse creates elsewhere in the system. For example, in support of the Barnet Early Intervention and Prevention strategy where drug and alcohol misuse is recognised as one the drivers in poor family outcomes. It also supports safeguarding through the Hidden Harm Service which works collaboratively with a range of professionals as part of the team to manage the risk posed to children and young people within identified families. Similarly the Young Peoples Substance Misuse Service aims to reduce medium term demand by preventing escalation of use and harm rather than it continuing into adulthood.
- Self-care: Promotion of self-management and living well through innovative service development such as structured education and health champions, social prescribing and, Making Every Contact Count.
- We have extended the Winter Well programme which now incorporates access to low income and vulnerable people for whom fuel poverty is an issue and are working closely with the private sector rental team to take this forward.
- Assurance of immunisations and health screening: we also work to promote the long term health of the population by supporting immunisations and various health screening activities in an assurance role. We are in the final stages of establishing a local Health Protection Forum to provide oversight on health protection arrangements and promote local resilience and health protection through the Borough Resilience Forum. We work closely with the NHS England immunisation lead and Public Health England and contribute to and assure local CCG awareness raising and screening initiatives in relation to cancer, TB and hypertension for example.

- The borough has been successful in its bid to enter the second wave of the National Diabetes Prevention Programme. Public health worked with Barnet Clinical Commissioning Group (CCG) and with colleagues in LB Enfield to develop the proposal. The intention is to commission the service in the first half of 2017-18. Public Health is with the CCG to develop a local commissioned service for GP practices to ensure that there is a robust process for identification and management of pre-diabetes including brief intervention to encourage behaviour change. Public health is also giving attention to a campaign both to raise awareness of diabetes in the borough, protective health behaviours and local provision and services.

6. KEY SUCCESSES IN PAST YEAR

Giving children the best start in life

- All 10 Children's Centres in Barnet have been awarded 'Healthy Children's Centre' status to recognise their hard work and dedication in helping to improve the health of children and families in Barnet
- The Public Health team continues to identify Barnet schools with the highest levels of obesity, based on evidence from the National Child Measurement Programme, and ensures that the tier 2 service targets and works with these schools.
- Barnet was ranked one on the highest boroughs in London for achievement of Barnet Healthy Schools Award.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Engaged with GP and pharmacy practices on smoking cessation programme, including Stoptober.
- Launched a new shisha campaign.

Create fair employment and good work for all, which helps ensure a healthy standard of living for all

- Achieved good results for employment outcomes following successful completion of treatment for opiate clients (part of the Barnet Adult Substance Misuse Service): the percentage of clients who, on exit from the service, were working more than 10 days in the last 28 days continues to be higher than the national average.
- Both mental health employment support services (for people with common mental health issues and people with severe mental health problems) met their annual targets with clients gaining jobs in a wide range of sectors and employers. Both services received a visit from the DWP's Work and Health Unit in August 2016. A total of 12 from the unit came to learn from the success of these services. They were impressed with how successfully multi-agency working has been embedded to help residents.

Healthy and sustainable places and communities

- Public health contributed to the development of the new leisure contract through input to the requirements documentation and input to the tender assessment documentation.

Ill health prevention

- The Public Health team has continued to work in collaboration with other boroughs and partners to design and deliver better, more cost-effective sexual health services for the North Central London sub-region.
- Barnet Adult Substance Misuse Service's proportion of clients in structured treatment who are reported to be living with children is lower than the national average.
- Much good inter agency liaison work has been undertaken which is leading to the creation of borough Protection Forum that will provide oversight on health protection arrangements and promote local resilience.

7. STRATEGIC PARTNERSHIPS

Public Health engages with a number of strategic partnerships in order to improve the health of residents. Working with the Clinical Commissioning Group we promote health initiatives and work to influence local health priorities. Across North Central London work has been on-going to develop the NHS Sustainable Transformation Plan. We work closely with colleagues in Adult Social Care and the Children & Families services to inform system transformation and sustainability across the health and social care economy. We also work with colleagues across the council wherever there are opportunities for public health gain such as through environmental services, planning and regeneration and enterprise.

Close liaison is maintained with National Health Service England to provide assurance to the Local Authority on local population screening and immunisation programmes and ensure, alongside local partners, robust local resilience planning and health protection.

Public Health has been actively engaged in the London Sexual Health Transformation Programme. This initiative will deliver changes to the way the current treatment system works across London and will help to contain demand and deliver more cost efficient services locally.

8. INDICATORS FOR 2017/18

The tables below outline how the Committee contributes to achieving the priorities of the Corporate Plan: **Delivering quality services** (Responsibility); **Responsible growth, regeneration and investment** (Opportunity); **Building resilience in residents and managing demand** (Fairness); **Transforming local services** (Opportunity); and **Promoting community engagement, independence and capacity** (Responsibility).

Key:
CPI = Corporate Plan Indicator
SPI = Commissioning Plan Indicator

Transforming local services (Opportunity)

GIVING CHILDREN THE BEST START IN LIFE - Children, young people and their families are supported to be physically, mentally and emotionally healthy.

Ref		Indicator	2016/17 Target	2016/17 Q2 Result	2017/18 Target	2019/20 Target	Service
SPI	PH/S2	Excess weight in 4-5 year olds (overweight or obese)	21%	19.92%	21%	21%	Public Health
SPI	PH/S3	Excess weight in 10-11 year olds (overweight or obese)	32%	32.58%	32.6%	32.6%	Public Health

HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES - The built environment is conducive to healthy living choices such as walking and the accessibility of safe open spaces.

Ref		Indicator	2016/17 Target	2016/17 Q2 Result	2017/18 Target	2019/20 Target	Service
SPI	PH/S11	Excess weight in adults	56.8%	56.75%	57.8%	57.8%	Public Health

Building resilience in residents and managing demand (Fairness)

ILL HEALTH PREVENTION - Health and lifestyle checks help reduce the risk factors associated with long-term conditions, and people with a long-term condition are supported to self-manage their condition.

Ref		Indicator	2016/17 Target	2016/17 Q2 Result	2017/18 Target	2019/20 Target	Service
SPI	PH/C7	Percentage of people with needs relating to STIs who are offered an HIV test at first attendance (excluding those already diagnosed HIV positive).	97%	97.2%	97%	97%	Public Health
SPI	PH/C8	Percentage of people with needs relating to STIs who have a record of having an HIV test at first attendance (excluding those already diagnosed HIV positive).	80%	88%	80%	82%	Public Health
SPI	PH/C6	Percentage of people with needs relating to STIs contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service.	98%	100%	98%	98%	Public Health
SPI	PH/S12	Percentage of women accessing Emergency Hormonal Contraception (EHC) within 48 hours	80%	100%	80%	80%	Public Health
SPI	PH/S13	Percentage of new attendances of all under 25 year olds tested for chlamydia	70%	77.1$	70%	70%	Public Health
SPI	PH/C10	Successful treatment - opiate users	8%	8.3%	7.3%	8%	Public Health
SPI	PH/C11	Successful treatment - non-opiate users	33%	36.1%	32.7%	34%	Public Health
SPI	PH/C12	Successful treatment - alcohol users	42%	48.4%	37.3%	38%	Public Health
SPI	PH/C13	Successful treatment - non-opiate and alcohol users	32%	34.7%	30.7%	38%	Public Health
SPI	NEW - TBC	Number of people engaged or supported by Winter well	1,200	Reported annually as it is a seasonal service	1,200	1,200	Public Health

AGENDA ITEM 9

	Health and Wellbeing Board **9 March 2017**
Title	**Screening update**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: NCL Joint Health and Oversight Scrutiny Committee - Review of Adult Immunisation and 7a Screening Programmes.
Officer Contact Details	Jeffrey Lake, Consultant in Public Health Medicine Email: jeff.lake@harrow.gov.uk, Tel: 020 83593974

Summary

The Health and Wellbeing Board has previously expressed concerns about inconsistent reporting of screening performance data and low uptake, particularly for cancer screening programmes.

An annual reporting cycle has been suggested and what was intended as the first annual report was presented to the North Central London Joint Health Overview and Scrutiny Committee on 2nd February 2017.

The Joint Health Overview and Scrutiny Committee asked for another report in 6 months time providing a summary of performance, actions to address areas of concerns and a clear schedule for improvement. It also requested that NHS England work in partnership with the boroughs (through the North Central London Adult Screening Assurance Group) to develop this.

Screening uptake in Barnet remains below national targets in cervical, breast and bowel screening.

Recommendations

1. **The Health and Wellbeing Board notes the NHSE Annual Report on screening programmes that was presented to Joint Health Overview and Scrutiny Committee on 2nd Feb 2017.**

2. **That the Health and Wellbeing Board seeks assurance that a clear reporting cycle is established with a clear implementation date.**
3. **That the Health and Wellbeing Board seeks assurance that a recovery plan setting out clear actions and schedule to improve performance against screening uptake targets.**

1. WHY THIS REPORT IS NEEDED

1.1 Cancer screening aims to identify early signs of a disease in otherwise healthy people before symptoms become apparent. Screening helps to detect physiological changes that may lead to cancer if not treated and to identify existing cancer as early as possible when the options for effective treatment are greatest. Cancer screening both prevents cancer and extends survival.

1.2 There are three cancer screening programmes; Breast, Cervical and Bowel. All three programmes are commissioned by the NHS England.

1.3 The local authority, through its Director of Public Health, has responsibility for assurance of these programmes.

1.4 The Health and Wellbeing Board reviewed performance of adult screening programmes in September 2014. The Board requested further updates and referred the report to the Health Overview and Scrutiny Committee to ensure that performance concerns are adequately addressed through the work of the London Screening Board. A scheduled update in 2016 was delayed in expectation of an annual report. An annual report was completed in January 2017 and presented to the North Central London Joint Health Overview and Scrutiny Committee.

1.5 Whilst the Abdominal Aortic Aneurysm and Diabetic Retinopathy Screening programmes appear to be performing well and are meeting targets, cancer screening performance remains a significant concern with approximately one third of eligible patients for breast and cervical screening and over a half of patients eligible for bowel screening not being screened.

2. REASONS FOR RECOMMENDATIONS

2.1 Robust reporting of screening performance for local authority assurance has not yet been established.

2.2 In response to the failure to achieve national targets for cancer screening coverage/uptake, a longstanding issue for London, a London Coverage Technical Group was established by NHS England in 2014 to ensure commissioning and implementation of best practice services across London. The performance concerns are persistent though.

2.3 The North Central London Joint Health Overview and Scrutiny Committee, recognising common concerns across the North Central London Boroughs requested an annual report to address the issues. Whilst the report produced failed to do this, some coordination across North Central London does have

the potential to both reduce replication in requests to NHS England and to coordinate support from partners.

2.4 It is suggested that a North Central London Adult Screening Assurance group, which was formed by the Directors of Public Health, work with partners to help support NHS England in developing an annual report incorporating plans for recovery of under performance.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 We have previously looked to NHS England to resolve these reporting and performance issues. Given the persistence of these issues, recognising the limitations of resources available to NHS England, and the challenges of serving 33 Health and Wellbeing Boards and Health Overview and Scrutiny Committees across London, the prospect of any resolution appears slim.

4. POST DECISION IMPLEMENTATION

4.1 The lead consultant in Barnet (Jeffrey Lake) has taken over chairing the North Central London Adult Screening Assurance group and is currently seeking agreement for a way forward with NHS England before revision of Terms of Reference which will then be shared with Directors of Public Health and partner agencies for agreement.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Joint Health and Wellbeing Strategy (2015-2020) makes a commitment to reducing premature mortality due to cardiovascular disease and cancers.

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

5.2.1 Funding for cancer screening programmes sits primarily with NHS England although some elements are commissioned by CCGs.

5.3 Social Value

5.3.1 Not applicable, as this is not a procurement activity.

5.4 Legal and Constitutional References

5.4.1 The Terms of Reference of the Health and Wellbeing Board are contained within the Council's Constitution (Responsibility for Functions, Annexe A) Specific Responsibilities include: *To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients*.

5.4.2 Under paragraph 8 of the Local Authorities Regulations 2013, made under section 6C of the National Health Service Act 2006, local authorities have a duty to provide information and advice to relevant organisations to protect the population's health; this can be reasonably assumed to include screening and immunisation. Local authorities also provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers to ensure all parties discharge their roles effectively for the protection of the local population.

5.4.3 It is NHS England's responsibility to commission screening programmes as specified in the Section 7A agreement: public health functions to be exercised by NHS England . In this capacity, NHS England will be accountable for ensuring local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels, as specified in the Public Health Outcome Indicators and KPIs. NHS England will be responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

5.5 **Risk Management**

5.5.1 We do not have access to NHS England's assessment of risks and mitigations. At the population level, we would expect a higher rate of delayed diagnoses amongst those who have not accessed screening.

5.6 **Equalities and Diversity**

5.6.1 Very limited data is available on access to screening amongst protected groups. The North Central London Joint Health Overview and Scrutiny Committee noted its concern over this in discussion of the annual report and asked that it be given closer attention.

5.7 **Consultation and Engagement**

5.7.1 We are not aware of any consultation or engagement work has taken place in relation to screening beyond work with practices to examine variation in screening uptake and promotional activities.

5.7.2 Healthwatch have indicated that they are giving some attention to this area.

5.8 **Insight**

5.8.1 Data presented is the annual report is provided by NHS England.

6. BACKGROUND PAPERS

6.1 Health and Wellbeing Board, 18th September 2014. http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7782&Ver=4

6.2 NHSE Annual Report on screening programmes that was presented to Joint Health Overview and Scrutiny Committee on 3rd Feb 2017. http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=360&MId=8804&Ver=4

NCL Joint Health and Oversight Scrutiny Committee

Review of Adult Immunisation and 7a Screening Programmes

3rd February 2017

The immunisation section of this report has been omitted

Adult Screening Programmes

Purpose

The purpose of this paper is to provide an overview of uptake, coverage and performance of the Adult Screening Programmes, namely Diabetic Eye Screening and Abdominal Aortic Aneurysm Screening Programmes for the North Central London patch.

Diabetic Eye Screening Programme

The paper will present data from the period between 1st of December 2015 and 30th November 2016, for all the five CCGs which make up North Central London (Barnet, Camden, Islington, Enfield and Haringey. However, reference will be made, where applicable, to data before this time period.

The source of data to prepare this report has been OptoMize reporting tools as well as writing specific SQL queries to obtain data from OptoMize. Furthermore QMS GP data extraction information has been used to complement the ethnicity of the invited population where there were no specific data was available on OptoMize.

Estimated Diabetes Prevalence: NCL DESP

Estimates of the number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation.

Region/ CCG	2013	2015	2016	2017	2018	2019	2020
England	TBC	3,921,071 (8.4%)	3,976,419 (8.5%)	4,032,506 (8.5%)	4,089,864 (8.6%)	4,147,109 (8.7%)	4,204,334 (8.7%)
London	TBC	664,041 (8.9%)	677,273 (8.9%)	690,782 (8.7%)	703, 916 (9.0%)	716,906 (9.1%)	730,575 (9.1%)
NHS Barnet	23,364 (8.5%)	27,073 (8.6%)	27,670 (8.6%)	28,300 (8.7%)	28,871 (8.7%)	29,540 (8.8%)	30,140 (8.9%)
NHS Camden	13,757 (6.2%)	14,871 (6.7%)	15,252 (6.7%)	15.565 (6.7%)	15,959 (6.8%)	16,355 (6.8%)	16,693 (6.9%)
NHS Enfield	19,174 (8.4%)	23,480 (9.4%)	23,931 (9.5%)	24,461 (9.5%)	24,867 (9.6%)	25,409 (9.7%)	25,824 (9.7%)
NHS Haringey	13,666 (7.6%)	22 411 (9.3%)	22,950 (9.4%)	23,470 (9.5%)	24,019 (9.6%)	24,484 (9.6%)	24,957 (9.7%)
NHS Islington	10,491 (6.5%)	15,032 (7.6%)	15,419 (7.6%)	15,725 (7.7%)	16,067 (7.7%)	16,422 (7.7%)	16,748 (7.8%)
NCL Total	80,452	80,456	105,222	91,972	109,783	112,210	114,362

Table 7 Source: APHO Diabetes Prevalence Model section of the YHPHO website (www.yhpho.org.uk)

Context

The National DESP screens all diabetic patients aged 12 + annually, with the aim of preventing sight loss from preventable retinopathy.

Following a successful re-procurement of the London Diabetic Eye Screening programmes in London are now delivered by five Provider organisations, to an eligible population of approximately half a million people.

The Programme in NCL is delivered by North Middlesex University Hospital, who are responsible for delivering screening service to approximately people living with diabetes across North Central London. Programmes are contracted to deliver a national service specification, containing nationally agreed Key Performance Indicators and Programme Quality Standards.

In London, commissioners have developed a set of enhanced indicators that Providers will be measured against in subsequent contract years.

The eligible population is identified through data extraction solutions from GP registers that aim to update monthly.

Oversight of performance

NHS England (London) Commissioners deliver the oversight and performance management function for the DESP contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads
- Local Authority Public health strategists
- Clinicians
- Hospital Eye service managers and failsafe leads

NCL-DESP uptake

Below is a table (table 8) summarising uptake of Diabetic Eye Screening Services across NCL between 2012 and 2016

Year	Uptake
2012- 2013	74.5%
2013-2014	78.9%
2014-2015	85.0%
2015-2016	85.1%

Table 8

a. Indian population seem to have the highest rate of uptake and attendance at 91.2%.
b. All known ethnicities have an uptake of 80% or above.

c. As in the previous health equity audit, undertaken in July 2013, uptake skews down in the groups with no ethnicity data, as the programme is less likely to have seen the patient to collect that information. However, the extent of this is now much less as NCL-DESP has collected data on the ethnicity for 90.4% of the invited population within the reporting period.

NCL DESP is currently working with QMS to facilitate a more accurate upload of ethnicity data. However, the programme is continuously trying to improve intake in groups identified through methods like DNA Audits to have a low uptake. Provision of translation services have been proved to increase uptake in the Turkish Community, however the cost of providing such services, makes it difficult for the programme to invest in long term language and geography.

Uptake by Gender (table 9)

Gender	#invited	#screened	uptake
Unknown	39	23	59.0%
F	30681	25916	84.5%
M	36667	31250	85.2%
Total	**67387**	**57189**	**84.9%**

NCL-DESP Uptake by Ethnicity

Table 10 shows uptake by Ethnicity, where this was recorded:

Ethnicity	#Invited	#Screened	Uptake
A: British	18710	16379	87.5%
B: Irish	1277	1088	85.2%
C: Any other White background	10478	8943	85.4%
D: White and Black Caribbean	308	253	82.1%
E: White and Black African	246	198	80.5%
F: White and Asian	205	171	83.4%
G: Any other Mixed background	513	424	82.7%
H: Indian	5237	4776	91.2%
J: Pakistani	997	843	84.6%
K: Bangladeshi	2515	2172	86.4%
L: Any other Asian background	4093	3627	88.6%
M: Caribbean	3834	3298	86.0%
N: African	5255	4235	80.6%
P: Any other Black background	1559	1297	83.2%
R: Chinese	841	752	89.4%
S: Any other Ethnic group	4857	4010	82.6%
Unknown	2269	1459	64.3%
Z: Not stated	4193	3264	77.8%
Total	**67387**	**57189**	**84.9%**

Table 10

Where ethnicity data was not recorded on OptoMize, it was supplemented from QMS; there are still some patients where it's not recorded either with the programme or the GP.

Uptake by Age

Age Group	Invited	Screened	uptake
0-14	113	96	85.0%
15-19	345	287	83.2%
20-24	513	412	80.3%
25-34	1947	1523	78.2%
35-44	4875	4086	83.8%
45-54	11730	9863	84.1%
55-64	16652	14140	84.9%
65-74	15964	13660	85.6%
75+	15248	13122	86.1%
Total	**67387**	**57189**	**84.9%**

Table 11 Source: NCL DESP

a. 88.4% of NCL-DESP diabetic patients (59,594) are over 45 years old and 85.2% of this population has attended screening.
b. Of note is that uptake in the 25-34 age group is78.2%. This might be an area that can receive some focus and may be extra phone call reminders.
c. Previous analysis of DNA data showed lower uptake in the working age population which was vastly improved by an increase in out of hours and weekend clinics.

Uptake by Index of Multiple Deprivations (IMD)

IMD Quintile	Invited	Screened	uptake
Unknown	146	106	72.6%
1 (most deprived)	24652	18634	75.6%
2	19148	15467	80.8%
3	11817	11438	96.8%
4	8378	8325	99.4%
5	3246	3219	99.2%
Total	**67387**	**57189**	**84.9%**
1 (most deprived)	**24652**	**18634**	**75.6%**
Quintiles 2-5	**42589**	**38449**	**90.3%**

Table 12 Source: Official Statistics; English indices of deprivation 2010

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010
http://dclgapps.communities.gov.uk/imd/imd-by-postcode.html
http://www.apho.org.uk/resource/view.aspx?RID=111277

Each patient is mapped via their postcode to the LSOA (local small output area) used in the national dataset. Data from the London Health Observatory was then used to identify which quintile of deprivation each LSOA falls into.

a. IMD has divided the whole country in to five levels in terms of level of deprivation. 1 is the most deprived (20% of the country), then 2 (the next 20%), 3, 4 and 5 (the final 20% which are the most affluent).
b. In the cohort of patients invited for screening in this reporting period, 24,652 (36.6%) live in the most deprived areas of England. The uptake in this cohort is 75.6%.
c. The uptake in the less deprived group (quintiles 2-5) is 90.3%.
d. It is apparent that level of deprivation is directly correlated with uptake.
e. During a HEA conducted by NCL-DESP in July 2013 it was established that uptake of the screening test in the Most Deprived Quintile was 73.8%, compared with 76.6% in the non-deprived group. Therefore whilst we have managed to increase the uptake of the non-deprived group to 90.3% from 76.6%; the deprived Quintile has been increased by a much smaller margin.

Uptake by CCG

NCL-DESP has achieved an uptake of over 80% for all CCGs

CCG	Invited	Screened	Uptake
Barnet	17862	15605	87.4%
Camden	8420	6984	82.9%
Enfield	17410	15080	86.6%
Haringey	14021	11638	83.0%
Islington	9670	7880	81.5%
Total	**67383**	**57187**	**84.9%**

Table 13 Source: OptoMize PPR

DNA rates by CCG

CCG	Total No of Appointments due	Total Number of DNA Appointments	DNA Rate
Barnet	24645	8470	34.4%
Camden	13023	5795	44.5%
Enfield	24534	8857	36.1%
Haringey	20088	8083	40.2%
Islington	14571	6461	44.3%
Total	**96861**	**37666**	**38.9%**

Table 14 Source: RDS Operational Performance Report on OptoMize

a. Booking appointments: The high DNA rate is the result of patients being offered multiple appointments in a year when they DNA (for example, in Barnet, there were 8470 DNAs, relating to 4607 patients: 1011 patients DNAd between 3 and 7 appointments in the

reporting period, 1057 patients DNAd 2 appointments, and the remaining 2539 DNAd a single appointment).

b. Clinic efficiency and slot utilisation: In order to reduce wastage of clinic slot resources, NCL-DESP overbooks the clinic according to the historical DNA analysis of each of the clinics. This has meant that according to a detailed audit conducted in October 2016 looking at a three month data from 1st April 2016 to 30th September 2016, the overall clinic slot utilisation at 13 clinic sites and our Mobile Screening Unit (MSU) is over 95%. This point to a highly efficient usage of available clinic slots.
c. Actual uptake: In terms of uptake and reaching to the "hard to reach" patients, since the overall annualised uptake is around 85%, the proportion of those who were invited and not screened is around 15%.

GP practice

NCL-DESP operates using a single collated list for call and recall. In order to facilitate the maintenance of an accurate Single Collated List, NCL-DESP successfully engaged the 227 GP practices within its catchments to sign up to the QMS Electronic data transfer service. The Electronic Data Transfer service does not nullify the routing referral methods used by GPs to refer diabetic patients into the programme, but it acts as a failsafe mechanism to ensure that all patients with diabetes are referred to the programme. In addition to this, NCL-DESP actively cleanse data every month using the national SOP and also actively compares its data with CQRS although this is only done annually as CQRS is not updated regularly.

In light of learning from incidents, relating to the Single Collated List, an escalation protocol has been developed to support process of ensuring all stakeholders submit lists in a safe and timely manner. The Escalation Protocol is endorsed by PHE and the Medical Directorate provides a clear and standardised escalation process for all to follow and is being implemented successfully across the NCL patch and London.

The NCL-DESP maintains regular contact with GPs through a range of forums, including the

- Programme website
- Routine GP mailing
- Access to GP meetings to raise specific issues or to alert of new developments.

Uptake by GP practice for each CCG in NCL is shown in Appendix 1

Inequities and inequalities in uptake

The retinal screening programme is an important means to reducing eye complications among people with diabetes and consequently, ensuring universal equity of access to the programme is a key government priority.

Uptake in NCL DESP is currently at 55232 over 64872, making it 85.1%. NCL-DESP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups.

Patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. Appendix 2 shows a recent patient satisfaction survey report by the NCL DESP.

NHSE has recommended quarterly Patient Experience Surveys, with findings and analysis shared at Programme Board Meetings. Developing a strategy for public engagement:

Work in Progress

Screening in Prisons and secure units

NHS E L is currently developing protocols for the screening of people with diabetes who are in prison and secure settings, working in conjunction with Prison health officers, NHSE commissioners and DESP programme leads

The programme is trying to establish the numbers and location of 'halfway houses' or hostels run by the Probation Service, for prisoners preparing for release into the community.

London referral pathway for pregnant women with diabetes:

Commissioners for Adult screening and ANNB screening have worked with service providers to design and deliver a pathway that ensures women with diabetes are referred for enhance screening, as per national guidance. The teams are currently trying to identify the right links to support implementation – i.e. diabetes midwives in all London maternity units

An Implementation action plan will be developed by commissioners and to be circulated to wider stakeholders before the end of September

Co-commissioning of Optical Coherence Tomography (OCT)

DESP providers across London are seeking support from CCGs for the development and implementation of OCT within the DESP. This is in response to the ongoing issues with capacity, in many Hospital Eye Services.

OCT is an enhanced form of imaging which can help to cut the amount of patients who are referred into HES to access enhanced imaging where images taken in the programme are deemed unclear for screeners to conclude a safe outcome. It is possible to implement OCT cameras within the Screening Programmes and in programmes where this has been available, it helped to cut the amount of referrals into HES and also improved patient experience, as it meant the enhanced images can be taken on the same day without patient having to make a separate trip to a hospital site.

Diabetic Eye Screening Programme Leads met in October 2014 and developed an OCT Protocol. Most are working towards developing Business Cases in order to present to CCG HES Commissioners and HES Eye Service Managers, in order to gain their support to agree to fund the specialist OCT Cameras. NHS England feels that although the purchase of Cameras involves an initial Capital outlay, this will provide future cost savings by cutting the large amount of referrals into the HES specifically for OCT only.

An equity analysis which describes the differential uptake of adult screening .

This report will look at the data provided by NCL DESP for routine digital screening uptake during the period between 01/12/2015 to 30/11/2016

Abdominal Aortic Aneurysm Screening (NAAASP)

Purpose

The National Aortic Abdominal Aneurysm Screening Programme (NAAASP) aims to reduce deaths from ruptured aneurysms through early detection of men at risk. The UK National Screening Committee (UKNSC) recommended implementation of a systematic population screening programme, in March 2009, following evidence that ultrasound screening of men in their 65th year could reduce the rate of premature death from ruptured AAA by up to 50 per cent.

Context

The North Central London (NCL AAASP) was implemented in 2010. The London AAA Programmes are aligned to the Strategic Planning Groups structure. Currently, the five London AAA screening programmes are delivered by NHS Trusts that are also vascular network centres or hubs. All aspects of the service, both clinical and administrative, are coordinated by these Trusts.

All London programmes use the nationally commissioned IT system, Surveillance Management and Referral Tracking (SMaRT), to manage the eligible cohort population. Each local service coordinates screening for the population in its area and organises invitation letters, screening and surveillance clinics, results letters and referrals to the appropriate vascular network. The local screening services ensure GPs are informed when men from their practice have been screened and of the outcomes of their screening test.

Men with a screen detected aneurysm of 5.5 cm and above are referred into the vascular centre for surgery, whilst those with aneurysms measuring between 4.5 and 5.4 cm are put on quarterly surveillance; those with aneurysms measuring between 3.0 and 4.4 cm are recalled for surveillance on an annual basis.

Throughout England, each commissioned Provider is responsible for delivering a service to the local population that delivers against the Public Health England (PHE) Service Specification (No.23), Ref[1], and other agreed national quality requirements.

Oversight of performance

NHS England (London) commissioners deliver the oversight and performance management function for the AAA contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Local Authority Public health strategists
- Clinicians
- Vascular Service Managers
- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads

Health Equity Audit

A Health Equity Audit which was recently conducted by NHS England (2016) to support the London AAA Re-procurement process, had limitations due to poor data to facilitate some analyses. The Head of Screening at NHS England is cited as stating that, whilst it is not possible to form a comprehensive picture of all factors that influence AAA screening uptake or to comment on the relative influence of demographic and programme factors, there is a clear variation in screening uptake that is associated with deprivation and geography. Recommendation is that, Programmes should consider the clear variation by location and deprivation in their plans for improving uptake and implications for future service provision (NHSE, 2016).

Gender and age

The AAA Screening Programme in the UK is restricted to men aged 65years old within the year of screening. Men over the age of 65, who missed out on screening at 65, can attend for screening as a self- referral. There are currently no plans to screen women.

Ethnicity

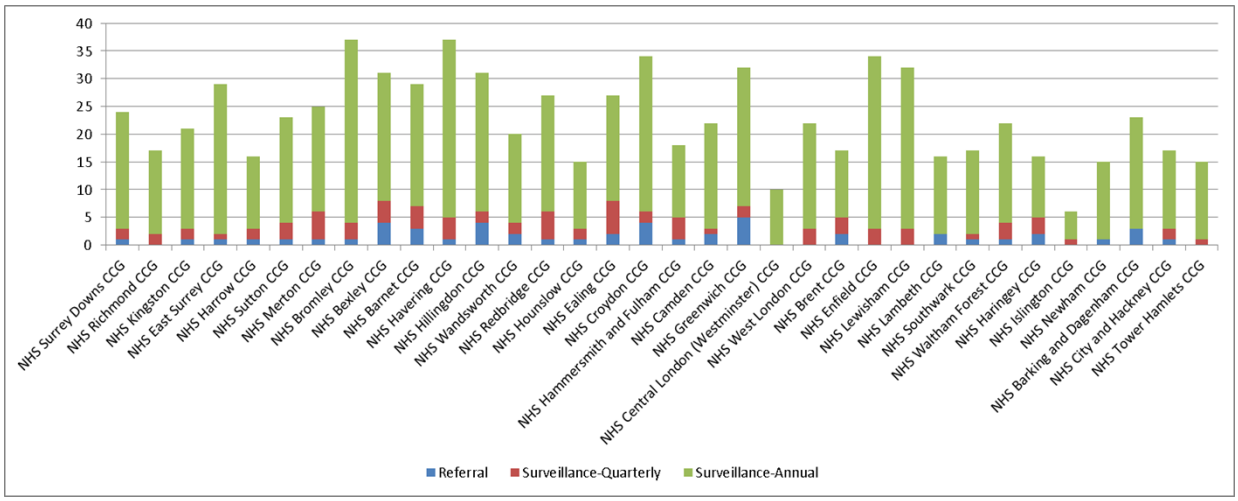
The health equity audit conducted by NHSE (2016) for the procurement, shows differences in uptake by ethnicity are also presented, this data needs to treated with caution because of concerns about data quality. Ethnicity was only available for those who attended as it is only requested and recorded at the point that men attend. Therefore for all who did not attend and some people who attended, ethnicity was not stated.

Ethnicity was estimated by using the ethnicity breakdown of the local authority from the 2011 Census and comparing that to the proportion of the same ethnic group in those who attended. The North Central London programme had a particularly high proportion of people who did not state their ethnicity (72%).

Deprivation

There is an established link between uptake of AAA Screening and deprivation and also the incidences of AAA in relation to deprivation, with deprived communities bearing an increased burden of abdominal aortic aneurysms in association with high rates of DNAs. The geographical variations in uptake of AAA screening across London that, are similar to those seen in other screening programmes. It also shows the association between uptake and deprivation scores.

Screening outcome (referral and surveillance) ordered by CCG average deprivation score (least deprived to most deprived) for years 2013/14 to 2015/16



Graph 1

Ward of residence

There is currently only CCG level data rather than Ward of residence level data. Islington is the lowest performing CCG. Factors contributing to this include:

- low GP engagement
- high level of homeless people in the borough. Suggestions have been made for the programme to look at issues affecting uptake in Islington and the NCL AAA propose, amongst other actions:
    - Mapping of locations with high % of patients with no fixed abode to see if this accounts for lower performance in a particular borough (Islington).
    - Mapping non-attendance in Islington by geography, to identify if there are areas with poor access to the Kings Cross screening venue that show higher rates of non-attendance.

Issues affecting service delivery

Towards the end of 2014-15, the NCL AAA Programme was experiencing difficulties with it's screening workforce. This led to concerns over their ability to screen the cohort during that year. The matter was escalated to NHS England and the Trust Governance Team, resulting in an Action Plan being drafted and being put in place to address the issues that were identified.

Commissioners' tight monitoring of performance along with the Trust's and Programme's commitment to addressing the identified issues has led to a transformation in how the service is delivered resulting in an increase in the uptake. NCL AAA is now a more stable and a well performing service. Uptake for 2015-16 is 77%, above the acceptable level of 75%.

Performance

Table 15 shows performance during 2016-17, against the only National Key Performance Indicator for the NAAASP. Quarterly figures are aggregated from Q1 with approximately 25% of the cohort expected to be offered screening per quarter although this will vary between local screening programmes, depending on the screening model

Regional Summary	Numerator	Denominator	Performance (%) Acceptable =/ >90% Achievable =/ > 99%
North Central London	5,224	5,267	99.2
England	281,989	285,287	98.8
London	33,631	34,406	97.7

Table 15

Patient satisfaction

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. No recent reports on patient satisfaction surveys by NCL AAA. However, moving forward, the NHS England Commissioners have recommended that Programmes carry out Patients Experience Surveys on a Quarterly basis and share findings with the Programme Board.

Inequities and inequalities in uptake

Breakdown of performance by CCG area is shown in table 16

CCG	**PERFORMANCE =/> 85%**	**PERFORMANCE =/>75% AND <85%**	**PERFORMANCE < 75%**	**OVERALL UPTAKE PER CCG 2015-16**	**NON-PATICIPATING PRACTICES**
BARNET	18	13	27	79.32%	9
CAMDEN	6	9	19	75.91%	2
ENFIELD	13	10	23	79.73%	3
HARINGEY	17	7	16	79.14%	6
ISLINGTON	5	4	23	71.28%	2

Table 16

Whilst overall uptake for the NCL AAA Programme 2015-16 Cohort was 77%, it is clear from the data presented in the table above that, the CCG with the lowest uptake also contains the largest number of poorly performing GPs. Below is work in progress to try and tackle some of the inequalities and inequities that still exist.

Work in progress

Re-procurement and reconfiguration of the London AAAA

NHSEL commissioning intentions in 2016/17 included the intention to re-procure London NAAASP to improve the resilience of administrative functions and the screening workforce. Following a lengthy options appraisal, it was agreed that two new services, for south and North London, would be commissioned against the national specification and a London wrap-around to ensure appropriate levels of cross border cover, and the capacity to screen in any convenient location, the Re-Procurement is currently underway. Invitation To Tender will go live in February 2017, with contracts awarded in May with a four month mobilisation period beginning on 1st June 2017 and the new contracts in place by October 2017. Contracts for all current London programmes have been extended by 6 months due to some inevitable delays.

All prospective bidders will be kept up to date about the Re-Procurement Process via the designated portal.

Promoting GP Engagement

There is an appreciation within the NCL Programme that, achieving any response to an invite for screening was reliant on strong relationships with the GP practices and support from them in engaging the patients. This is something the service is trying to develop. There is ongoing work in the Programme around engagement with GPs using a range of strategies including:

- Identify poorly performing practices and investigate possible reasons as to why they may not be performing well.
- Sending pre-invitation letters in advance of drop in clinics. Based on findings so far, GP endorsement of letters seems to encourage uptake of screening.
- Ad-hoc clinics at GP Practices with historical low attendance. Recently, the programme ran 4 clinics at Faversham Practice and 7 out of the 99 patients who attended tested positive to an abdominal aortic aneurysm. They will continue to engage practices with low uptake.
- Looking at the feasibility of using use the television screens in GP premises where other to publicise the NAAASP. This would provide an opportunity to capture patients' attention whilst they are in the practice for other reasons.
- Accessing educational or training forums for doctors, for instance those arranged by the Royal College of Medicine and discuss AAA screening.
- Working with Pharmacy and GPs to raise awareness of the screening Programme and support improved uptake NCL AAA.
- Discussions with EMIS about generating alerts on eligible men's records, when they attend for GP appointments, so GPs can promote attendance.

Promoting Career Development of Clinical Skills Trainers (CST)

The programme intends to host CST workshops, as well as reviewing a programme of audits which they are looking to deliver across London.

Screening in prisons and secure units

There are a small number of patients that have been identified as eligible for screening across two secure units in North Central London. NHSE has developed some guidance for Programmes and will be appointing a Commissioning Lead for Prison screening who will help the Programmes to establish a way of working with the cohort.

Targeted work in areas of low uptake

The NCL AAA Programme has an ongoing action plan to increase uptake in areas with low uptake by using a range of strategies including:

- Identify weak spots and look at possible new clinic locations.
- Look at required versus actual capacity at clinic sites
- Increase the number of Hospital screening clinics.
- Contact Chase Farm, Barnet and Edgware hospitals and Identify contacts for hiring treatment rooms at each hospital site.
- The Programme had held a promotional event in the RFH main hospital, with 10 eligible men agreeing to be screened on the day (self-referrals)
- Maintain Saturday clinics as they are doing well with a reduced number of DNAs.
- A Men's Health Initiative, working in collaboration with Spurs Football Club to raise awareness of the AAA Screening Programme. The programme has also contacted men's clubs and societies and next step will be to arrange drop in clinics to offering opportunity to screen men in places where they socialise.
- The clinical lead for the AAA Screening Programme is planning to target marginalised communities such as, the Turkish community to promote uptake. Related to this is information that has come to light, regarding the fact that, National AAA Programme Literature does not routinely get translated into Turkish.

External Quality Assurance Visit

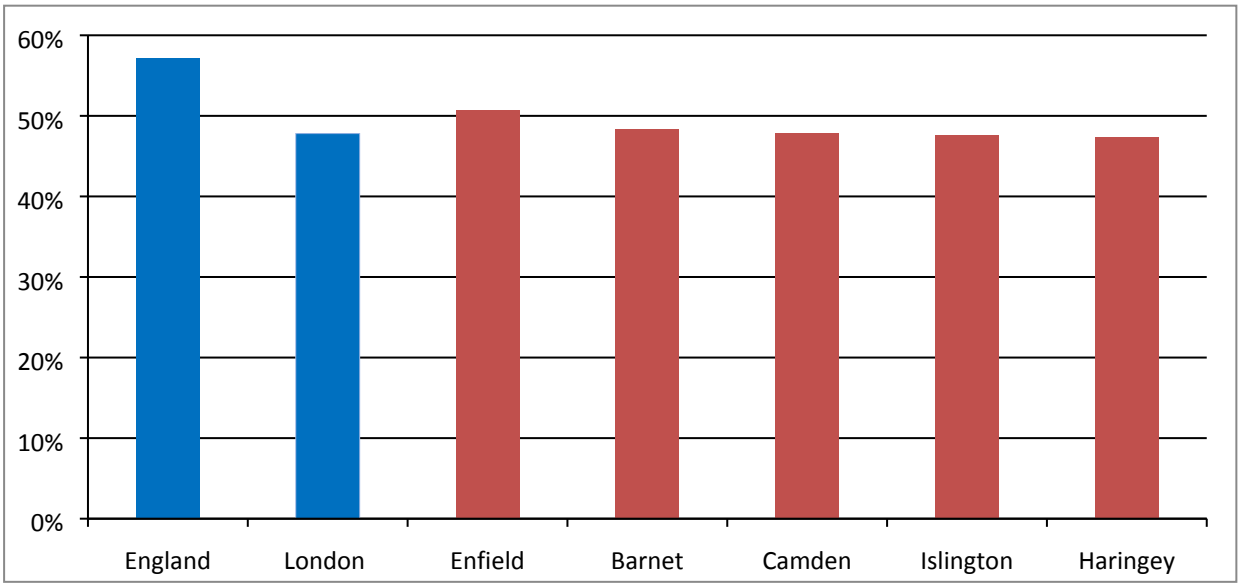
The Proposed date for the NCL AAA Screening Programme External Quality Assurance Visit is 22nd of February 2016.

Bowel Cancer Screening Programme

Coverage

Coverage is the percentage of people adequately screened in the last 2.5 years out of those who are eligible for gFOBt screening. Latest published data (up to end of March 2015) shows North Central London performs significantly below the national average for this measure; 48.34% compared to 57.1%. Performance is slightly better when compared to the London average of 47.8%. Variation in coverage across North Central London CCGs is minimal, ranging from 47.3% in Haringey to 50.7% in Enfield.

Cancer Screening –Bowel Cancer Coverage March 2015 (60-74 years) across NCL CCGs



Graph 2 Data from Public Health Profiles available at http://fingertips.phe.org.uk/profile/health-profiles

2.20iii - Cancer screening coverage - bowel cancer 2015

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	4,406,923	57.1	57.1	57.1
London region	407,429	47.8	47.7	47.9
Barking and Dagenham	6,481	39.7	38.9	40.4
Barnet	20,934	48.3	47.9	48.8
Bexley	15,566	51.8	51.2	52.3
Brent	15,339	47.4	46.8	47.9
Bromley	23,103	53.5	53.0	54.0
Camden	10,234	47.8	47.1	48.5
City of London	415	46.1	42.8	49.3
Croydon	22,073	51.1	50.6	51.5
Ealing	17,648	47.8	47.3	48.3
Enfield	17,967	50.7	50.2	51.2
Greenwich	11,421	46.2	45.6	46.8
Hackney	7,285	39.1	38.4	39.8
Hammersmith and Fulham	7,549	43.9	43.2	44.7
Haringey	11,195	47.3	46.7	47.9
Harrow	16,304	52.5	51.9	53.1
Havering	17,182	50.6	50.1	51.2
Hillingdon	16,929	52.1	51.5	52.6
Hounslow	13,039	46.9	46.3	47.5
Islington	8,692	47.6	46.9	48.4
Kensington and Chelsea	7,565	42.5	41.8	43.2
Kingston upon Thames	10,893	55.5	54.8	56.2
Lambeth	9,742	39.8	39.1	40.4
Lewisham	10,536	43.3	42.7	43.9
Merton	11,329	51.0	50.3	51.6
Newham	8,694	38.2	37.6	38.8
Redbridge	13,383	44.0	43.4	44.5
Richmond upon Thames	14,235	57.2	56.6	57.8
Southwark	9,109	39.8	39.1	40.4
Sutton	13,680	56.2	55.6	56.8
Tower Hamlets	5,698	37.3	36.6	38.1
Waltham Forest	10,835	44.5	43.9	45.2
Wandsworth	13,034	49.4	48.8	50.0
Westminster	9,340	41.8	41.2	42.5

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Table 17

Published data is only available at Practice level for the age range 60-69 years. There is significant variation for coverage between practices across the North Central London footprint, ranging from 27.4% to 62% as seen in the table below. NHSE are working with Primary Care Commissioners and CCGs to address variations in coverage at a practice level.

CCG	Lowest	Highest	Percentage of Practices ≥ England Average (57.8%)
Barnet	31.7% (Alder JS (The Surgery	61.9% (Oakleigh Road Health Centre)	1.34%
Camden	36.8% (Somers Town Medical Centre	56.5% (West Hampstead Medical Centre)	0%
Enfield	33.5% (East Enfield Practice)	62% (Abernethy House)	3.43%
Haringey	27.4% (West Green Road Surgery)	61.7% (The Muswell Hill Practice)	1.8%
Islington	33.4% (Archway Medical Centre)	57.8% (The Miller Practice)	0.36%

Table 18 Data extracted from National General Practice Profiles available at ***https://fingertips.phe.org.uk/profile/general-practice***

Bowel Cancer Screening Service for NCL

NHSE commissions UCLH to deliver bowel cancer screening to the NCL population. Performance against KPIs (national standards) is monitored on an ongoing basis with reports submitted quarterly to the London Bowel Cancer Screening Programme Board. KPIs are generally met by UCLH with a minimal numbers of breaches. In line with all London Screening Centres, uptake continues to fall significantly below the national average for the NCL population. Additionally UCLH, along with the majority of London centres, regularly breaches the target for colonoscopy uptake (the percentage of participants with an abnormal gFOBt who then go on to have a colonoscopy). The majority of breaches are for patients who do not attend an initial SSP assessment. For those who do, according to an internal audit conducted by UCLH, co morbidities are the most significant reason for declining colonoscopy.

The national Bowel Cancer Screening System facilitates a service user questionnaire completed 30 days post screening. In addition the centre provides a service user feedback report to the quarterly London Bowel Cancer Screening Programme Board. The majority of feedback is positive with minimal numbers of complaints. Feedback is discussed at the quarterly Programme Board meetings providing an opportunity for learning across the London programme.

Bowel Scope

University College London Hospitals NHS Trust is currently rolling out bowel scope screening to the populations of North Central London. Bowel scope is offered as a one off screen at 55 years when participants are invited to attend an accredited screening centre for a flexible sigmoidoscopy. Roll

out is being implemented in a phased approach that includes delivery at satellite sites to improve accessibility for those invited to attend. Roll out for UCLH has been slow with only Haringey currently live for bowel scope. Within Haringey 18 practices out of 45 are currently live. This population is served by a satellite service at the Whittington Hospital. Delay to roll out has largely been as a result of the loss of JAG (Joint Advisory Group) accreditation at UCLH, which has prevented this site from going live with bowel scope in line with national standards. Additionally failure to recruit further accredited scopists to operate at the Whittington site has prevented faster roll out for the population of Haringey. JAG accreditation was reinstated at UCLH at end of November 2016 and revised plans for roll out for this site are now being developed with the aim of starting invitations to the Islington population by Spring 2017.

Coverage and Uptake

Data on ethnicity and socio economic status is not routinely collected as part of the national bowel cancer screening system. However in line with other screening programmes uptake tends to be lower in those from more deprived backgrounds along with those from particular minority ethnic groups. In addition there is evidence that uptake tends to be higher in those who attended a previous screening episode. The likelihood of uptake in those who have completed one previous screening episode for bowel cancer screening is almost double than for those who have received an invitation for the first time (prevalent round).

NHSE hosts a Task and Finish Group, which includes Transforming Cancer Services Team, Researchers at UCL, Screening Centres and the London Hub. This group works on a Pan London level to plan the delivery of evidence-based activities across the bowel cancer screening pathway

- to increase the uptake of bowel cancer screening in London
- to reduce inequalities in bowel cancer screening uptake between and within London boroughs, and by different communities

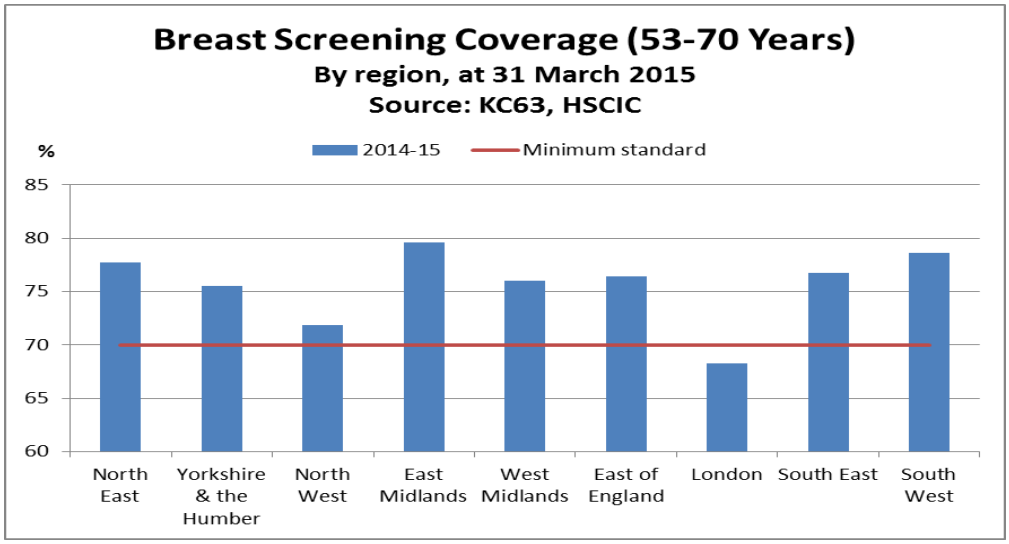
Current initiatives include General Practice Endorsement of pre invitation letters along with enhanced reminder letters. A randomised controlled trial by University College London highlighted the effect of GP endorsement of bowel cancer screening in improving uptake.[1] The addition of GP endorsement to the standard bowel cancer screening invitation letter increased the odds of participation in the gFOBt screening programme by 7%. This translates into a 1.7% relative increase in the probability of screening and a 1% absolute increase. Although the intervention significantly affected uptake overall, no effect was seen between socio-demographic groups.

A recent London Trial of FIT (Faecal Immunochemical Test) demonstrated an increase in uptake of 8.3% overall and this was across all population groups with a greater increase seen in the most deprived compared to the least deprived. Following a ministerial announcement in Spring 2016 FIT will replace the current gFOBt as the primary test for bowel cancer screening in Spring 2018.

[1] Raine R, Duffy SW, Wardle J, Solmi F, Morris S, Howe R, Kralj-Hans I, Snowball J, Counsell N, Moss S, Hackshaw A, von Wagner C, Vart G, M McGregor L, Smith SG, Halloran S, Handley G, Logan R F, Rainbow S, Smith S, Thomas M C and Atkin W *Impact of general practice endorsement on the social gradient in uptake in bowel cancer screening* British Journal of Cancer 114, 321-326 (02 February 2016) | doi:10.1038/bjc.2015.413

Breast Cancer Screening Programme

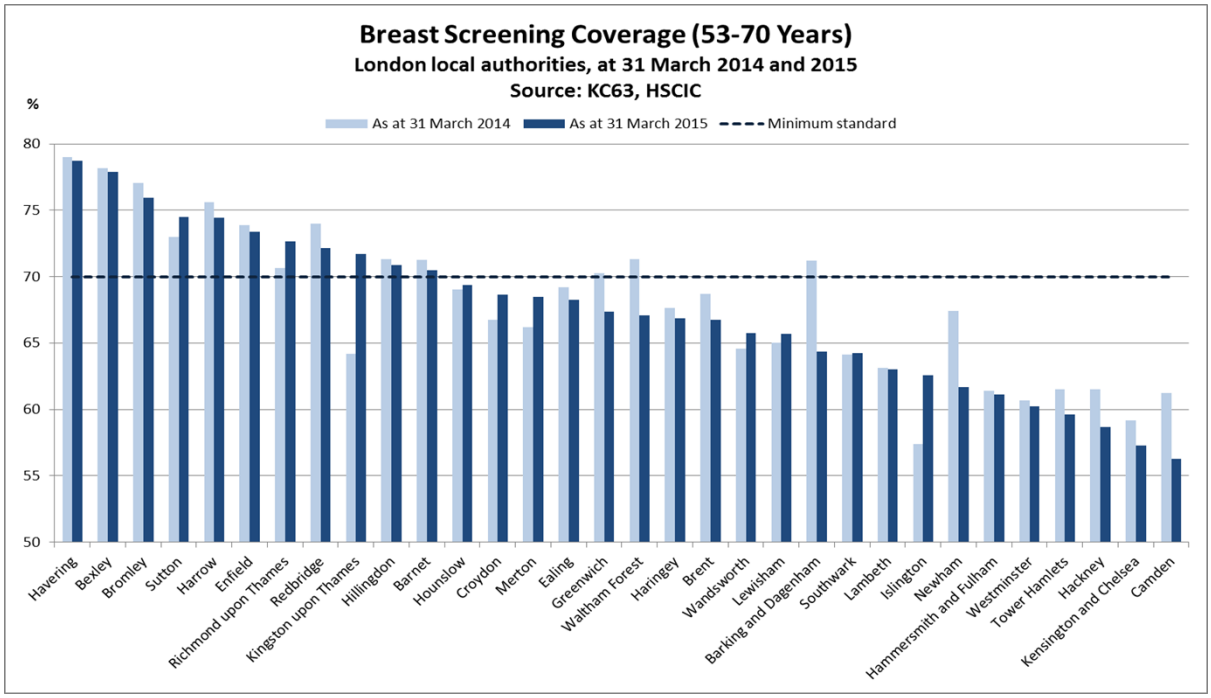
Coverage



Graph 3

Breast screening coverage in London was 68.3% (at 31 March 2015) the lowest of the regions in England. From 2010/11 the coverage in London is fairly stable, closely matching the overall trend in England.

Breast screening coverage nationally has fallen for the last four years. Barnet and Enfield have coverage over the minimum standard



Graph 4

Comparative Coverage by CCG 2013 - 2015

	2013-2014			*2014-2015*			
Local authority	**Eligible pop**	**Women screened**	***Coverage***	**Eligible pop**	**Women screened**	***Coverage***	***Difference***
Barnet	**32,764**	**23,349**	***71.3***	**33,991**	**23,963**	***70.5***	***-0.8***
Camden	**16,131**	**9,880**	***61.2***	**16,728**	**9,416**	***56.3***	***-4.9***
Enfield	**27,879**	**20,600**	***73.9***	**28,790**	**21,119**	***73.4***	***-0.5***
Haringey	**19,566**	**13,234**	***67.6***	**20,534**	**13,727**	***66.9***	***-0.7***
Islington	**14,182**	**8,140**	***57.4***	**15,156**	**9,484**	***62.6***	***5.2***
Source KC63, HSCIC							

Table 19

Table 19 above shows that apart from Islington all other authorities have experienced a decline in coverage.

Improving Uptake

The breast screening units in North London (NLBSS) hosted by Royal Free Hospital and Central and East London (CELBSS) hosted by Bart's Health are responsible for screening women in North Central London. Table two below shows the uptake for each breast screening service. Uptake looks at the percentage of women who attended for breast screening from the total of women invited to attend.

Uptake	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Barking, Havering, Redbridge & Brentwood	75.4	70.4	73.3	73.0	66.6	75.3	72.9	66.0	73.3	67.0	63.3	
Central & East London	48.4	52.8	52.5	52.5	55.6	53.1	61.1	60.6	56.7	57.3	58.0	
North London	61.6	62.7	59.3	59.0	59.9	62.2	64.6	65.2	66.7	66.4	64.7	
South East London	..	..	..	..	..	..	..	64.1	62.9	61.2	65.8	
South East London (Kings College Hospital)	59.3	62.2	61.6	59.3	60.9	60.5	59.8	..	..	..	..	
South East London (Queen Mary's Sidcup)	67.1	65.6	70.8	67.7	64.9	69.5	64.6	..	..	..	..	
South West London	67.4	65.4	61.7	64.5	64.5	62.2	66.4	64.9	64.4	66.7	61.6	
West of London	56.1	58.4	53.9	56.0	56.5	56.4	58.9	58.4	57.4	58.4	61.5	
Whipps Cross	70.2	..	..	..	..	..	..	..	..	..	..	

Table 20 Source: KC62, NHS Digital

.Both breast screening services have implemented 3 uptake initiatives to improve uptake and these have been mainstreamed into regular practice.

- Pre-invitation letters
- Text message reminders
- Second timed appointments

Over the last 10 years, the administration of the breast screening service had been identified as a weakness, both through QA processes and clinical incidents/SIs. As a result, there have been discussions about how the configuration of the breast screening programme in London could be changed to strengthen the administrative function and ensure equity across the service. As part of the new model of service for breast screening across London from March 2017, the administration for the service has transferred to the London Breast Screening Hub hosted by the Royal Free Hospital. This means a centralised administration unit for the whole of London. It also means a single point of contact for women and better access through extended opening hours. Women may not realise any change in the service as the screening will remain provided by CELBSS and NLBSS. What they may notice is a new telephone number and the opportunity to make an appointment outside of

NC London more easily than had previously been the case. The Breast Screening Hub is also looking at other opportunities to increase the uptake. There are planned initiatives with the hub to improve uptake through extending opening times of the call centre. The Hub will be working closely with GP practices, reintroducing information packs for GPs and creating a website.

In 2015/16 NHSE commissioned Community Links, a voluntary organisation, to promote uptake through community engagement in 3 boroughs in London. The work involved telephoning women who had received an invitation to attend for breast screening. One of the boroughs included was Camden. The work has seen an increase in uptake for Camden during 2016/2017. This can be seen below in table 21 and table 22.

Overview of Coverage and Uptake in April2015

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	25	10	12	40
Camden	39	0	35	3	26
Enfield	55	24	5	17	20
Haringey	54	7	15	1	31
Islington	38	0	21	0	26

Table 21 Source Open Exeter via NHS England cube

Overview of Coverage and Uptake in March 2016

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	19	10	1	41
Camden	39	0	21	0	19
Enfield	55	23	7	14	17
Haringey	54	2	17	2	29
Islington	38	0	31	2	24

Table 22 Source Open Exeter via NHS England cube

A feasibility study will be undertaken shortly to determine whether extending the work telephoning women invited for mammography across London to improve uptake

Performance

In July 2013 CELBSS were instructed by NHS England (London) Head of Screening and the Director of Quality Assurance, London, to implement a managed slow-down of invitations to 50% to redress issues of quality within the service. It was also recommended that the Trust commissioned a management team from the North London Breast Screening Service to improve administrative functions within the breast screening service. There was a managed slowdown of the round length and monthly assurance meeting to monitor performance. There was a need to recruit locum radiologists and for substantive posts to be advertised. By October 2015 2016 the minimum standard for round length had been achieved.

In quarter two, three and four of 2015/2016 CELBSS did not meet the screen to assessment KPI. This was due to a large volume of women pulled back to meet the round length target. This was addressed by balancing screening activity with assessment capacity and putting a demand and capacity model in place.

Failure to meet the minimum standards has meant that CELBSS has not taken part in the age extension trial. This is taking place in NLBSS where women aged 47-49 and women aged 71-73 are invited within a randomised trial

In quarter two NLBSS also did not meet the minimum standard for screen to assessment. This was due to staff capacity issues and an increase in workload due to an increase in women screened. This was resolved by optimising clinic slots and filling radiography and radiology posts.

Patient Surveys

Each breast screening services submits a quarterly report of how many complaints and compliments they have received. A comment form is available to clients when attending for a mammogram. These can be completed anonymously if the client prefers to not complete her personal details. The client can also submit a comment independently and through the local PALS department. Each service also offers the opportunity of communication from clients via their websites. On an annual basis each service runs a patient survey.

The compliments far outweigh the complaints that are submitted. The common themes with the complaints were the manner and negative attitude of the staff, customer care, and availability of appointments, the painful experience of mammogram, unclear signage, unhygienic changing rooms and problems parking. Each complaint was looked into and addressed and where necessary an apology was given. All were discussed at team meeting so there was shared learning. The common themes with the compliments were friendly and helpful staff and an excellent service provided.

There is no analysis available which looks at the differential uptake by age, ethnicity learning disabilities deprivation or ward of residence.

Future actions

At the moment women are invited in NLBSS by GP practice and in CELBSS by area and GP practice. In July 2016 the computer system used to produce breast screening batches was replaced with a new system called BS Select. The introduction of BS-Select has had an unanticipated (negative) impact on the Round plans of both breast screening services in North Central London. It is anticipated that in one of the London breast screening services 9-25% of the cohort will be called/recalled either early or late (reduced or increased Round length for the affected cohort by a few months or up to two years or more in some cases). This has been raised with the National Office and guidance has been sought to determine what action can be taken to mitigate the effects. An independent consultant is working with the breast screening units to quantify the impact.

There is a desire to move to delivering the breast screening programme using the next test due date, this would reduce the negative impact of BS Select it would also result in women being called at the correct time exactly three years form their last test. For services involved in the age extension trial it would not be possible to transfer to next test due date without using further software. For NLBSS

using mobile breast screening units there would have to be a move to static sites before transferring to next test due date.

Cervical Screening

Overview

The NHS Cervical Screening Programme invites women between the ages of 25 and 64 are invited for regular cervical screening under the NHS Cervical Screening Programme. Women aged 25 to 49 are invited every 3 years. After that, women are invited every 5 years until the age of 64. This is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

Coverage

Coverage of cervical screening is an effective indicator of judging the success of the Cervical Screening Programme. It measures the percentage of women in the target age group (25–64 years) who have been screened. Nationally there has been a downward trend in coverage from 2013/14 which is reflected across London. North Central London coverage is in line with the London average but lower than the national minimum standard of 80% coverage (Table 23).

NHS Cervical Screening Programme: Age appropriate coverage by age band and NC London Boroughs, 2015-16

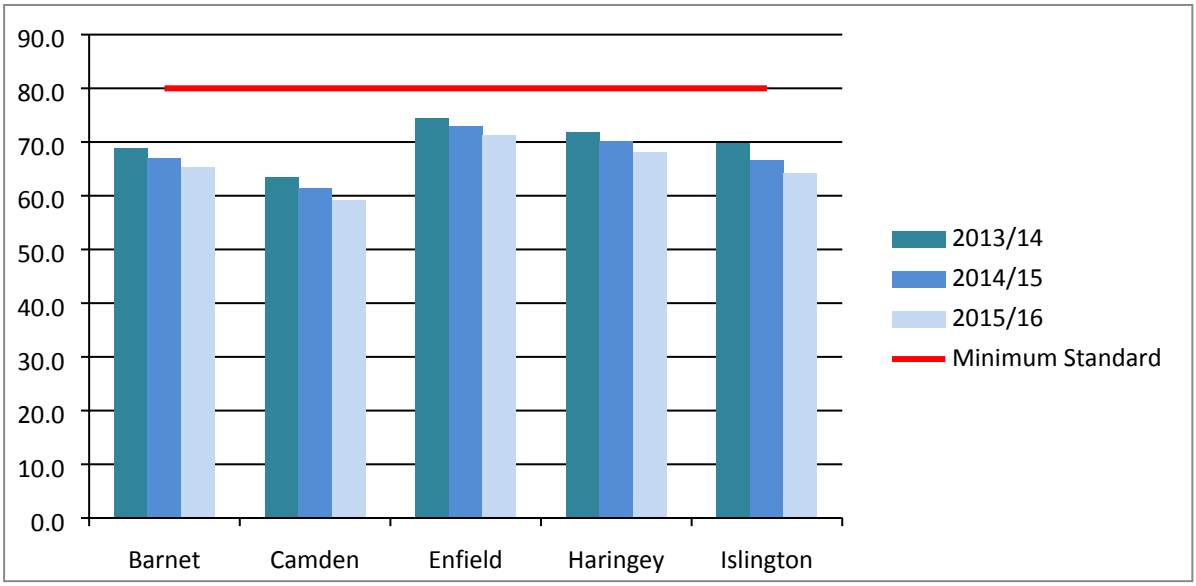
Region & Local Authority		2015-16						
		Eligible population [1]				Age appropriate coverage		
		Thousands				Percentages		
		25-49	50-64	25-64		25-49 (less than 3.5 yrs since last adequate test)	50-64 (less than 5.5 yrs since last adequate test)	25-64
	ONS Code	(000's)	(000's)	(000's)		*(%)*	*(%)*	*(%)*
London	**E12000007**	**2,002.8**	**652.8**	**2,675.3**		***63.7***	***76.3***	***66.7***
Barnet	E09000003	81.6	30.9	112.5		*61.9*	*74.4*	*65.3*
Camden	E09000007	59.6	15.6	75.1		*56.1*	*71.3*	*59.2*
Enfield	E09000010	67.4	27.4	94.8		*68.0*	*79.2*	*71.2*
Haringey	E09000014	69.2	21.0	90.2		*65.0*	*78.1*	*68.1*
Islington	E09000019	62.7	15.1	77.8		*61.5*	*74.9*	*64.1*

[1] This is the number of women in the resident population less those with recall ceased for clinical

Table 23: Source: Open Exeter system (Health and Social Care Information Centre), PHOF report.

Cervical screening coverage has worsened for all Local authorities in North Central London from 2013/14 to 2015/16 (Graph 1). There are no Boroughs in North Central London that are achieving the minimum standard of 80%. In NC London, Enfield has the highest uptake (71.2%) which is higher than London average (66.39%) with Camden having the lowest (59.2%); trends in coverage figures reflect a similar pattern across London with a slight drop in coverage rate of 1.7% from 2014/15 to 2015/16 and remain lower than the national minimum standard of 80% coverage.

Cervical Screening Age Appropriate Coverage: 25-64 Age Cohort
(3.5 years for 25-49 and 5.5 years for 50-64)



Graph 5: Source**:** Health and Social Care Information Centre

Although coverage shows a downwards trend since March 2014, both Enfield and Haringey have performed above the London average but both have also shown a reduction from March 2015 to March 2016 (1.7%) and (1.9%) respectively.

There are no Boroughs in London that are achieving the national minimum standard of 80% for coverage. However, Enfield (71.2%) and Haringey (68.1%) coverage remains higher than the London average (66.7%) in March 2016.

- Boroughs in NC London continue to not to meet the standard for cervical screening coverage and all show some deterioration in 2015/16.
- NC London coverage is in line with London's performance but shows a downward trend in 2015/16

NC London Boroughs receive their colposcopy service from six providers namely; Barnet Hospital, Chase Farm Hospital, North Middlesex Hospital, The Royal Free Hospital, Whittington Hospital and University College London Hospital. All six providers are meeting the following targets: high grade waiting times, DNAs for new patients and communication of results letters within 8 weeks.

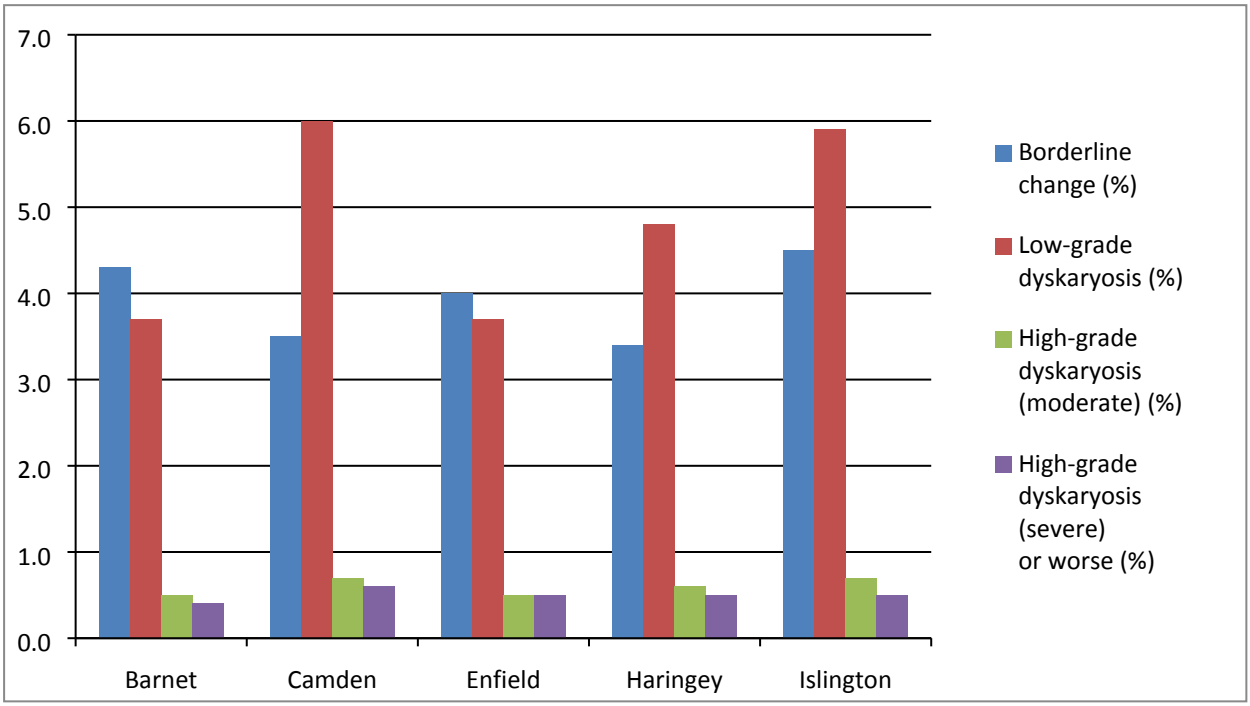
Table 24 below includes data for NC London Boroughs on the screening samples examined by the Health Services Laboratory (HSL) and Chase Farm Hospital on referrals to colposcopy units. Of samples submitted by GPs and NHS Community Clinics across NC London, the percentage of test results returned Negative ranged between 88.3% and 91.4%, the London average is 92.8% of test results returned Negative. Test results returned as High-grade dyskaryosis (severe or worse) and or High-grade (moderate) were less than 0.7%, Low-grade dyskaryosis results are highest in Camden (6.0%) and Borderline change results are highest in Islington (4.5%) see Graph 6 below.

NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16

	Negative	Borderline change	Low-grade dyskaryosis	High-grade dyskaryosis (moderate)	High-grade dyskaryosis (severe) or worse
	(%)	*(%)*	*(%)*	*(%)*	*(%)*
London	***92.8***	***2.9***	***3.3***	***0.5***	***0.5***
Barnet	*91.1*	*4.3*	*3.7*	*0.5*	*0.4*
Camden	*89.2*	*3.5*	*6.0*	*0.7*	*0.6*
Enfield	*91.4*	*4.0*	*3.7*	*0.5*	*0.5*
Haringey	*90.8*	*3.4*	*4.8*	*0.6*	*0.5*
Islington	*88.3*	*4.5*	*5.9*	*0.7*	*0.5*

Table 24: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

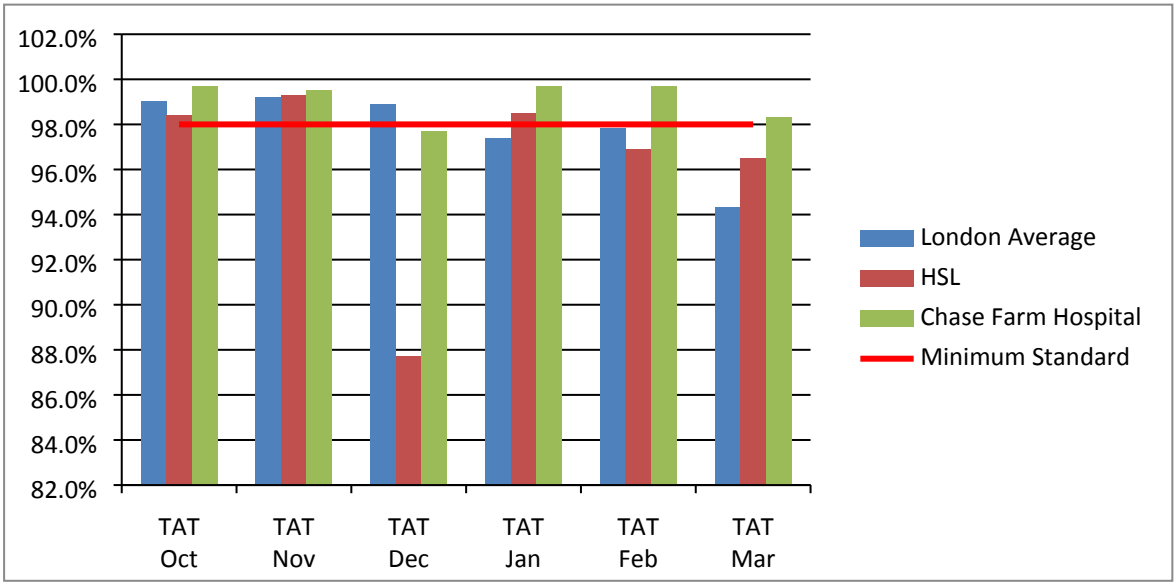
NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16



Graph 6: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

Cervical screening Turnaround Times (TATs) the national minimum standard is 98% of women receive their cytology result within 14 days from the date of primary screen. The cytology laboratories covering NC London Boroughs regularly achieve the minimum standard, however, in November 2016 HSL breached the target (97.7%) but the London average remained at 99% see Graph 7 below.

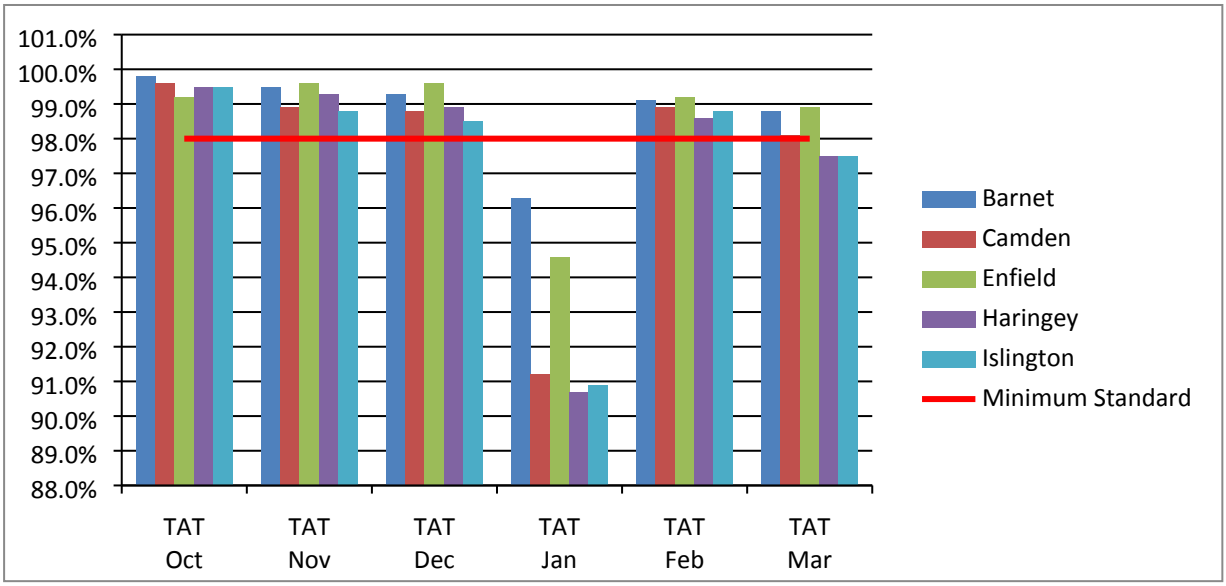
NHS Cervical Screening Programme: Turn Around Times (TATS) by Cytology Laboratory, October – March 2015-16



Graph 7: Source**:** Open Exeter

The performance in cervical screening Turnaround Times (TATs) at Borough level has seen a decline in performance since December 2015 (98.7%) of results were estimated to be delivered within 14 days achieving the national standard (98%). In March 2016 the overall TATs for London had dropped to 95.7% with only 3 of the NC London Boroughs meeting the national standard of 98% see Graph 8 and Table 25 below.

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16



Graph 8: Source: Open Exeter

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16

	Oct	Nov	Dec	Jan	Feb	Mar
London	99.0%	99.2%	98.9%	97.4%	97.8%	95.7%
Barnet	99.8%	99.5%	99.3%	96.3%	99.1%	98.8%
Camden	99.6%	98.9%	98.8%	91.2%	98.9%	98.1%
Enfield	99.2%	99.6%	99.6%	94.6%	99.2%	98.9%
Haringey	99.5%	99.3%	98.9%	90.7%	98.6%	97.5%
Islington	99.5%	98.8%	98.5%	90.9%	98.8%	97.5%

Table 25: Source: Open Exeter

From April 2016, Primary Care Support England (PCSE) has taken over the responsibility for the primary care support services delivered by NHS England. PCSE's priority is to ensure the safe and secure delivery of existing services, whilst introducing new arrangements to help create a national easy to use service for all customers. The closure of the support services based in London has resulted in an increase in the number of both laboratories and CCGs failing to meet the minimum standard.

HSL are currently conducting an audit to understand delays with results to Primary Care Support England (PCSE) since centralisation of services in Leeds. Initial investigations show that files sent at 8am and should be received and posted on that day are not being processed (i.e. results letters sent) until the following day so adding an extra day to our TATs.

Learning disabilities

Unfortunately, the screening programmes do not routinely collect data regarding numbers of patients with learning disabilities accessing the services due to the software not being programmed to collect such data.

Deprivation

The screening programmes do not routinely collect data for deprivation; this data is held by Local Authorities

GP practice

NHS England will engage with CCG commissioners to develop actions to support GP practices with low uptake of service. We will also actively participate in Strategic Transformation Plan working groups looking at cancer commissioning and prevention

Females 25- 64 yrs, attending Cervical Screening within target period 3.5 or 5.5 year coverage % (2014-15)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.4	41.5	78.3
Camden	59.4	27.7	73.2
Enfield	72.8	62.3	82.2
Haringey	70.8	54.2	80.5
Islington	67.1	61.3	74.4

Table 26: Source: QOF

Ward of residence

There is currently only CCG level data rather than Ward of residence level data.
Camden is the lowest performing Borough

Service delivery issues

All services breaching national performance targets are asked to provide an exception report highlighting the reasons for the breach and remedial actions taken to prevent reoccurrence. At the Cervical Screening Programme Boards the Hospital Based Programme Coordinators (HBPC) provide an exception report on performance and alert NHSE to any issues concerning performance. When a trust breaches the same target in two consecutive quarters NHSE commissioners review the exception reports and make a decision on the issuing of contract performance notices.

North Middlesex Hospital (January 2016)

Contract performance letter sent to Chief Executive

- Consistently failed to meet the target DNA rate for follow up patients. Performance data for Quarter 2 2015/16 shows the DNA rate for follow up patients to be well above the recommended 15% at 32.38%, we note this is a rise of 12.3% on the previous quarter which is a real cause for concern and which needs to be addressed immediately.

The Trust has implemented a number of changes to address the poor performance. Reminder letters and phone calls were implemented early December 2015. Text reminders have also been reintroduced; the implementation of phone calls and letters has already had an impact on performance and DNA rates are significantly reduced.

Data validation issues caused by the interface between Medway and Compuscope, impacted on indicators reported via Cyres. There were discrepancies between the two systems which meant KPIs could not be tracked and figures reported via KC65 (extracted from Cyres) were inaccurate. The trust have now implemented a new computer system for the colposcopy department to resolve this issue

Barnet and Chase Farm (December 2015)

Despite initiatives in place to reduce follow up DNA, including texts and reminder letters, rates at Barnet and Chase Farm Hospitals breached the standard (<15%) for quarter 3

Following the acquirement of BCFH by RFH in July 2015, the PAS systems at Hampstead site and at Barnet & Chase Farm site were merged on 1st November 2015. This involved allocating new hospital numbers to most of Barnet & Chase Farm patients. As a result of the merge, old appointment history on PAS and appointments for direct referrals booked on the system for patients that had not been seen prior to the merge (approx 6 weeks) were lost.

The issue was declared a serious screening incident to ensure the Trust had taken the appropriate actions to resolve the incident and have escalated to the highest level within the organisation. Following assurance that all data had been restored on the PAS system and submission of a concise Root Cause Analysis, the incident was closed.

The Whittington Hospital (November 2016)

A Contract Performance Notice issued because the Trust had consistently failed to meet Colposcopy performance targets in Q1and Q2 2016/17. A meeting between NHSE and the Trust has taken place and a number of recommendations with timescales have been agreed to improve performance. NHSE will continue to monitor performance and take appropriate action if performance breaches continue.

Information on patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board (NC London vacancy)
- routine monitoring of compliments and complaints
- to implement required improvements patients

Adverts for Patient Public Voice (PPV) representatives for Cervical Screening Programme boards have been sent out.

NC London-wide and borough specific action plan to address:

- **non-achievement of national minimum standards in the programme**
    - breaches will be managed through NHS performance frameworks

- **inequities and inequalities in uptake**

- NHSE/PHE Uptake and Coverage Manager to be appointed (social marketing)
- Commissioning CASH clinics to provide cervical screening for women who do not respond to invitation
- NC London CSP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups
- Engagement with pharmacies
- Integration of screening and/or screening awareness raising in other community settings
- NHSE/PHE working with Local authorities and CCG commissioners to develop a joint understanding of local population needs leading to a shared set of priorities

Table 5: Female patients (25 – 64yrs) on the Mental Health register who had cervical screening test in the preceding 5 years (2015-16)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.6	27.3	100
Camden	69.2	45.5	95.5
Enfield	70.4	47.1	100
Haringey	72.5	42.9	100
Islington	68.2	41.7	100

Source: QOF

- **identified issues with service delivery**
  - monthly delayed sample reports by CCG and GP practice
  - monthly sample handling errors reports by CCG and GP practice

- **identified issues with patient experience**
  - management cervical screening incidents affecting patient or service delivery

Other actions to improve uptake and coverage:

- Introduction of Primary HPV screening
  - HPV self-testing subject to National approval
- Working with Primary care commissioning to develop action plans and ensure that private and overseas samples are recorded appropriately
- Working with Sustainable Transformation Plans (STPs) planning groups

Appendices omitted

AGENDA ITEM 10

	Health and Wellbeing Board **9 March 2017**
Title	**Joint Health and Wellbeing Strategy (2015 – 2020) progress update including CAMHS Transformation Plan**
Report of	Commissioning Director – Adults and Health, LBB Commissioning Director – Children and Young People, LBB Director of Public Health – Barnet and Harrow Public Health CCG Accountable Officer – Barnet CCG
Wards	All
Date added to Forward Plan	November 2016
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: JHWB Strategy Progress Report Appendix 2: CAMHS Transformation Plan (Part 1 - Barnet) Appendix 3: CAMHS Transformation Plan (Part 2 – NCL)
Officer Contact Details	Zoë Garbett, Commissioning Lead, Health and Wellbeing Email: zoe.garbett@barnet.gov.uk, Tel: 020 8359 3478

Summary

In November 2015 the Health and Wellbeing Board (HWBB) approved the Joint Health and Wellbeing (JHWB) Strategy 2015 – 2020. The HWBB has received regular updates on progress to deliver the JHWB Strategy.

In November 2016 the HWBB reviewed Barnet's Health Profile (as produced by Public Health England), reviewed progress to deliver the JHWB Strategy and agreed revised areas of focus for the next year. This report provides a progress update, against the revised areas of focus.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on progress to deliver the Joint Health and Wellbeing Strategy (2015-2020). (Appendix 1)**
2. **That the Board approves the refreshed CAMHS Transformation Plan (2015 – 2020) part 1 (Appendix 2) and notes the refreshed Plan for NCL, part 2 (Appendix 3).**

1. WHY IS THE REPORT NEEDED

1.1 Background

1.1.1 On 12 November 2015, the Health and Wellbeing Board approved a new Joint Health and Wellbeing (JHWB) Strategy (2015 – 2020)[1] for Barnet. The JHWB Strategy has four themes – Preparing for a healthy life; Wellbeing in the communities; How we live and Care when needed. JHWB Strategy has a section on each theme which describes progress to date (since the last strategy), key data from the updated JSNA, and most importantly the planned activity to meet our objectives as well as specific targets.

1.1.2 The JHWB Strategy is the borough's overarching strategy which aspires to improve health outcomes for local people and aims to keep our residents well and to promote independence. The JHWB Strategy focuses on health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of prevention, early intervention and supporting individuals to take responsibility for themselves and their families. The JHWB Strategy also addresses wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing.

1.1.3 Actions in the JHWB Strategy have and will be included in other key strategies and action plans such as the Primary Care Strategy, Better Care

[1] The final Joint Health and Wellbeing Strategy (2015 – 2020) can be found here: home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html

Fund plans and the Children's and Young People's Plan to ensure delivery across the health and social care system in Barnet. The actions detailed in this implementation plan focus on the priorities that require a partnership approach. The Plan indicates where an action or target is aspirational. The plan has no new financial resources to support its implementation but provides a framework and direction for focus of existing resources to have a significant impact on the health and wellbeing of the borough.

1.1.4 The Implementation Plan was presented to and agreed by the Health and Wellbeing Board in January 2016. The Implementation Plan is structured around the four theme areas of the JHWB Strategy: Preparing for a healthy life; Wellbeing in the community; How we live and Care when needed. For each theme area, the priorities are highlighted.

1.1.5 In November 2016, using borough's Health Profile produced by Public Health England, the HWBB reviewed the progress made to improve health and wellbeing in Barnet and agreed revised areas of focus for the next year – these are shown in table 1.

Table 1: Barnet's Joint Health and Wellbeing Strategy areas of focus

Vision	To help everyone to keep well and to promote independence			
Themes	*Preparing for a healthy life*	*Wellbeing in the community*	*How we live*	*Care when needed*
Objectives	Improving outcomes for babies, young children and their families	Creating circumstances that enable people to have greater life opportunities	Encouraging healthier lifestyles	Providing care and support to facilitate good outcomes and improve user experience
What we will do to achieve our objectives (2015 – 2020)	Focus on early years settings and providing additional support for parents who need it	Focus on improving mental health and wellbeing for all	Focus on reducing obesity and preventing long term conditions through promoting physical activity	Focus on identifying unknown carers and improving the health of carers (especially young carers)
		Support	Assure	Work to

		people to gain and retain employment and promote healthy workplaces	promotion and uptake of all screening including cancer screening and the early identification of disease	integrate health and social care services
Priorities for November 2016 – November 2017	Improve the health and wellbeing of Looked after Children	Focus on improving mental health and wellbeing for all – through redesign of mental health provision including CAMHS	Reduce excess weight in children and adults	Care closer to home – earlier intervention supported by risk stratification and population segmentation for those with long term conditions
	Increase the uptake of childhood immunisations	Support people with disabilities to gain and retain employment	Increase screening uptake	Carers (including young carers)
	Review early years provision			

1.1.6 Within the nine priorities listed in table 1, there are 11 areas of focus as two priorities (mental health and excess weight) are priority areas for children and young people and adults requiring separate work streams.

1.1.7 The Health and Wellbeing Board have received progress reports at each meeting, the progress reports have highlighted key achievements, concerns and remedial action and provide the Board with an opportunity to review and comment on the progress to deliver the JHWB Strategy.

1.1.8 Each November the Board agreed to receive a full annual report on progress including targets, indicators and activity which allows the Board to review

progress and refine priorities for the coming year, feeding into the business planning processes.

1.1.9 The JHWB Strategy provides focus for the HWBB, a number of the priority areas are substantive items at each Board. Where an area is being presented to the HWBB at the same meeting in a substantive item this is highlighted.

1.2 **Progress against the Joint Health and Wellbeing Strategy Implementation plan**

1.2.1 The following Red, Amber and Green (RAG) status criteria have been applied to progress made:

- Red: requires remedial action to achieve objectives. The timeline, cost and/or objective are at risk
- Amber: there is a problem but activity is being taken to resolve it or a potential problem has been identified and no action has been taken but it being closely monitored. The timeline, cost and/or objectives may be at risk
- Green: on target to succeed. The timeline, cost and/or objectives are within plan
- Grey: completed

1.2.2 Since November 2016, against the priority areas in table 1, progress is reported as:

- Green – 36% (4 areas)
- Green / amber – 9% (1 area)
- Amber – 36% (4 areas)
- Red – 18% (2 areas)

1.2.3 Appendix 1 provides a full report of the progress against these 11 priority areas.

2. REASONS FOR RECOMMENDATIONS

2.1 The production of a (Joint) Health and Wellbeing Strategy is a legal requirement of the Local Government and Public Involvement in Health Act (2007). Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint duties to prepare a JHWB Strategy, through the Health and Wellbeing Board.

2.2 The annual report allows a review of process to ensure that we deliver the JHWB Strategy and meet its targets and gives the Board the opportunity to review and refine the priorities for the coming year.

2.2.1 The Implementation Plan enables the Health and Wellbeing Board to monitor progress and success in the short, medium and long terms. The Health and Wellbeing Board will receive regular progress reports which will allow the

Health and Wellbeing Board to continue to develop its work programme.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is a legal requirement to draft a Joint Health and Wellbeing Strategy. Not producing a JHWB Strategy implementation plan would create a risk of non-alignment across the Health and Wellbeing Board membership, could result in decisions being made either in silos or based on sub-optimal evidence and intelligence, and increase the likelihood of unnecessary duplication and overlap of public sector spend.

4. POST DECISION IMPLEMENTATION

4.1 The implementation plan will be developed with and agreed across the partnership.

4.2 JCEG will receive detailed activity updates and escalate any concerns to the Health and Wellbeing Board.

4.3 The Board will receive a progress report after 6 months (around May 2017) and an annual report in November 2017.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The JHWB Strategy (2015 – 2020) supports evidence-based decision making across the Health and Wellbeing Board and its partners. The JHWB Strategy has been developed to align and bring together national and local strategies and priorities including Barnet Council's Corporate Plan 2015-2020 and BCCG's strategic plans.

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

5.2.1 The JHWB Strategy directs the Health and Wellbeing Board priorities for the period 2015 – 2020, building on current strategies and focusing on areas of joint impact within current resources. The priorities highlighted in the JWHB Strategy will be considered by all the relevant organisations when developing activities. The JHWB Strategy will support the work of all partners to focus on improving the health and wellbeing of the population. It emphasises an effective and evidence-based distribution of resources for efficient demand management. Each project will be individually funded using the existing resources of the participating organisations.

5.2.2 No additional resources from within Barnet are required to deliver the updated aims of the CAMHS Local Transformation Plan (LTP). Additional funding as described in the LTP is coming from NHS England and other central government funding to deliver the plan. Barnet financial commitment for 2016-17 is as follows'

Barnet CAMHS Budget (including Transformation) 2016-17

	£'000
Barnet CCG	**4,800**
London Borough of Barnet: Children and Family Services Barnet Public Health	 **0.770** **0.250**
NHSE Transformation Funding	**1,000**
Other funding awards from central government departments	**0.260**
Total	**7,080**

5.3 **Social Value**

5.3.1 The JHWB Strategy focuses on the health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of addressing wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing. The JHWB Strategy will inform commissioning.

5.3.2 The Public Services (Social Value) Act 2013 requires those who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 Producing a JHWB Strategy is a legal requirement of the Local Government and Public Involvement in Health Act (2007). Local authorities and CCGs have equal and joint duties to prepare JSNAs and JHWSs, through the Health and Wellbeing Board. The Board must have regard to the relevant statutory guidance – Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - when preparing the JSNA and JHWS.

5.4.2 The Council's Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health and Wellbeing Board which include:

- 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.
- 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.
- 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 JHWBS and refer them back for reconsideration.
- 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.
- To promote partnership and, as appropriate, integration, across all necessary areas, including the joined-up commissioning plans across the NHS, social care and public health.
- Specific responsibilities include overseeing public health and developing further health and social care integration.

5.5 **Risk Management**

5.5.1 There is a risk that if the JSNA and JHWB Strategy are not used to inform decision making in Barnet that work to reduce demand for services, prevent ill health, and improve the health and wellbeing and outcomes of people in the Borough will be sub optimal, resulting in poorly targeted services and an increase in avoidable demand pressures across the health and social care system in the years ahead.

5.5.2 The Joint Commissioning Executive Group (JCEG) manage the delivery of the JHWB Strategy and review detailed activity and targets (when available) at each meeting (every two months). Risk is managed by JCEG and escalated to the HWBB as necessary.

5.6 **Equalities and Diversity**

5.6.1 The JHWB Strategy has used evidence presented in the JSNA to produce an evidence based resource which has equalities embedded at its core, explicitly covering the current and future needs of people in Barnet from each equalities group.

5.6.2 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 eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010, advance equality of opportunity between people from different groups and foster good relations between people from different groups. Both the Local Authority and the CCG are

public bodies. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.7 **Consultation and Engagement**

5.7.1 A number of partners have been involved in the development of the JHWB Strategy including a public consultation which ran from 17 September – 25 October 2015 which included an online survey and workshops.

5.7.2 Feedback from the consultation has informed the final JHWB Strategy 2015-2020. Overall there was support for our vision, themes and areas of priority focus. A full consultation report was presented to the HWBB in November 2015.

5.7.3 The implementation plan has been developed with a number of partners to ensure the plan is universally agreed and embedded across the public sector.

5.7.4 The HWBB works closely with the Voice of the Child Strategy, Adults Engagement Structures and Patient and Engagement to ensure that the voice of residents feed into the development of services and activities. Individual programmes will consult during development.

5.8 **Insight**

5.8.1 The JSNA is an insight document and pulls together data from a number of sources including Public Health Outcomes Framework, GLA population projections, Adults Social Care Outcomes Framework and local analysis. The Joint HWB Strategy has used the JSNA as an evidence base from which to develop priorities.

6. BACKGROUND PAPERS

6.1 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020) annual report, Health and Wellbeing Board 10 November 2016, item 6: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8715&Ver=4

6.2 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020) progress update, Health and Wellbeing Board 15 September 2016, item 12: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8714&Ver=4

6.3 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020) progress update, Health and Wellbeing Board 21 July 2016, item 11: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8713&Ver=4

6.4 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020) progress update, Health and Wellbeing Board 12 May 2016, item 9: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8712&Ver=4

6.5 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020) progress update, Health and Wellbeing Board 10 March 2016, item 9: https://barnet.moderngov.co.uk/documents/s30322/JHWB%20Strategy%20implementation%20plan%20March%202016.pdf

6.6 Joint Health and Wellbeing Strategy (2015 – 2020) including Public Health report on activity 2014/15 and the Dementia Manifesto, Health and Wellbeing Board, 12 November 2015, item 6: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8387&Ver=4

6.7 Draft Joint Health and Wellbeing Strategy (2016 - 2020), Health and Wellbeing Board, 17 September 2015, item 8: https://barnet.moderngov.co.uk/documents/s25837/Draft%20Joint%20Health%20and%20Wellbeing%20Strategy%20HWBB%20September%202015.pdf

Appendix 1: Joint Health and Wellbeing Strategy progress report, November 2016 – February 2017

This progress report provides an overview of progress to deliver against the Joint Health and Wellbeing Strategy (2015 – 2020)

Theme	**Preparing for a healthy life**	
Objectives	**Improving outcomes for babies, young children and their families**	

Area of focus (1)	**Improving the health and wellbeing of Looked after Children**
	• Target
	  ○ All initial health assessments completed within time frame (20 working days / 28 calendar days)
	  ○ Review Health assessments for children looked after for a year or more
	  ○ Increase the proportion of locally placed looked after children – to at least 46% (2017/18) to 53% (2019/20)
	• Continue to closely monitor the provider including staff vacancies.
		RED
		Date of substantive report to HWBB:
		TBC

Progress since November 2016	**Health and wellbeing of looked after children (LAC)** • Initial health assessments are to be completed within 20 days (statutory period) for all children coming into care. Data from the end of 2015/16 and the beginning of 2016/17 showed that this was only the case for 30% of children coming into care. To rectify this, three new GP registrars have been trained across the borough and the pathway has been reviewed to reduce delay. • There are now four GP practices contributing to the provision of appointment dates, and currently the supply is adequate. The incidence of children failing their first appointment is being addressed by social care. • In January, 5 out of 9 (56%) of children who required an assessment were seen by a GP within 28 calendar days. Two children who have not had assessments are still within the 28 days, if they attend this will bring the percentage to 78%. However there are still delays in completing the whole process within 28 days. • Consent is being sought and appointments are being arranged for the children who have entered care in February.	
Planned activity	• There is still improvement required with the LAC pathway, this is being addressed by the CCG: ○ Practice Managers are now ensuring that contributing GPs return paperwork within the timescales • There are 20 appointment slots available with Barnet GPs in March; three have been booked with a	

	further four to be booked therefore 13 slots remain available for March appointments. • All partners contributing to the pathway have been contacted and are committed to working together to improve outcomes. The pathway is as follows: consent within 7 days, IHA completed within 15 days and report returned for recording in the database for children's social care within 6 days (= 28 calendar days) • The adequacy of resources in the LAC health team is being considered, and retendering for a lead provider will be progressed for implementation early in the 17/18 financial year. • The Children, Education, Libraries and Safeguarding (CELS) Committee signed off the Care Leavers Strategy on 21 February, following consideration by Corporate Parenting Advisory Panel. The third strategic priority – "We will help you to be well in body and mind" – includes commitments to improve the physical and mental health of Barnet's care leavers. A Terms of Reference is being established for the Corporate Parenting Officers' group, which will launch in March 2017 to progress the corresponding action plan.	
Area of focus (2)	**Increasing the uptake of childhood immunisations** • Target – Increase uptake of childhood immunisations to be above the England average	**AMBER** **Date of substantive report to HWBB:** June 2017
Progress since November 2016	Increasing uptake of immunisations is a key indicator in the Healthy Early Years standards in Children Centres. Seven out of nine Children Centres have achieved the standards to date. Public Health is working with Public Health England to deliver a Train the Trainer model in Children Centres on tackling myths around immunisations and increase uptake Following a discussion with NHS England at the HWBB in November 2016, Public Health is working with NHS England to prepare GP league table of immunisations to support the performance improvement piece with GPs.	
Planned activity	The two remaining Children Centres are working to meet the Healthy Early Years standards by March 2017. A training session on Childhood Immunisation is being arranged for the children's centre staff by Barnet Public Health Team with the support of Public Health England. The purpose of the training is to increase take-up of childhood immunisation and ensure coverage across the demographic groups in Barnet, using the train the trainer model. NHS England will bring a thorough update as a substantive item to the HWBB in June 2017.	

Area of focus (3)	**Early years review** The council (including Public Health) and Barnet CCG are working together to further integrate service offer of health-related services in early years settings improving service delivery for families. Objectives of the Early Years review: • To deliver the best outcomes possible for children and families in the early years with the resources available • To enable vulnerable families with children under five years old to build their resilience • To provide integrated services so that they are joined up around the needs of families and feel seamless to users • To support meeting the duty to provide sufficient, high quality childcare for eligible 2, 3 and 4 year olds • To develop a sustainable model for early years services.	**GREEN** **Date of substantive report to HWBB:** TBC Report to LBB Children Education Libraries and Safeguarding Committee (CELS) June 2017
Progress since November	The 0 – 19 project includes the Early Years Phase 2 Review – one of the main objectives of the Early Years Phase 2 review is to increase the integration of Early Years' services so to provide integrated services that are joined up around the needs of families and feel seamless to users. This workstream is being called the Leading Integration in the Early Years and is developing an integrated model for Health services in the Early Years and Early Years services in Children's Centres. A stakeholder group has been set up, made up of representatives from Health and Early Years from the council (Head Teachers, Public Health, Commissioners, Family Services), CLCH and Royal Free. This group will meet regularly to make operational improvements to the current model to move towards more integration and develop ideas for the strategic alignment of budgets, organisations and management. The group had a successful first meeting to review current context and identified opportunities for improved integrated working. Analysis of data to determine need and associated budget (needs based funding formula) is currently being developed.	
Planned activity	There will be a workshop with Head Teachers of Children Centres in February 2017 where Head Teachers will	

	present proposals for their locality Leading Integration in the Early Years workshop with stakeholders from Health and Children Centres in February 2017 to build on what the integrated model for health and early years could (and should) look like in Barnet Development of Outline Business Case which will be presented to Children, Education, Libraries and Safeguarding Committee in June 2017.	
Theme	Wellbeing in the community	
Objectives	Creating circumstances that enable people to have greater life opportunities	
Area of focus (4a)	**Mental health** remains a priority, as reflected in the NCL STP, with a focus on service redesign **Child and Adolescent Mental Health Services (CAMHS)** • In order to improve CAMHS provision, Barnet CCG and Barnet Council agreed to jointly recommission CAMHS at the HWBB in September 2016 • Public health are supporting the redesign of CAMHS; developing a programme of work that is based on the Thrive Model. The new approach will improve access to services by improving sign posting, self-management and enabling one off contact in order to improve coping mechanisms in children and young people.	**GREEN** **Date of substantive report to HWBB:** March 2017
Progress since November	**Child and Adolescent Mental Health Services (CAMHS)** • In order to improve CAMHS provision, Barnet CCG and Barnet Council agreed to jointly recommission CAMHS at the HWBB in September 2016. • The CAMHS procurement is proceeding and consultation events with Children and Young People (25+ schools and a 'Youthorium' Conference-250 young people have been taking place throughout January 2017 and February 2017). • Public health are supporting the redesign of CAMHS; developing a programme of work that is based on the Thrive Model. The new approach will improve access to services by improving sign posting, self-management and enabling one off contact in order to improve coping mechanisms in children and young people. A resilience planning group has been established to review the best practice models for supporting Barnet schools in a solution focused approach to young people's mental health.	
Planned activity	The CAMHS transformation plan is being presented to the HWBB in March 2017 (appended to this report).	

	GPs, Social care and Clinical professionals will also be consulted on what the new service model should look like. A resilience coordinator is being recruited to lead on this programme.	
Area of focus (4b)	The vision for **adult mental health** is designed to achieve a number of strategic goals: • Achieve effective and proactive service delivery plans in a more collaborative approach • Move away from 'Mental Health professional led' models of care towards more primary care, community, and peer-led models of support • Reinforce relationships and community connections • Rebalance the model and orientate professionals towards prevention and early intervention for both carers and users • Deliver potential to integrate community and peer groups into specialist care to foster effective 'Step Down care' back into primary care and community settings • Help providers, users and carers to be better at long-term planning, managing and supporting demand rather than rationing supply • Focus on the quality of relationships (between users and those who support them) and depth of our knowledge about users' needs and assets for example developing peer models.	**GREEN** **Date of substantive report to HWBB:** TBC
Progress since November	**Adults mental health services** The Reimagining Mental Health Programme led by the CCG and endorsed by the council at the HOSC in October 2017 continues to deliver a whole system transformation approach to mental health Phase 2 reimagining, pilot delivery Wellbeing Hub and Primary Care link working: • Organisations are working collaboratively, with minimal investment in transformation, to deliver improvements for individuals, with dedicated Mental Health linkworker support in primary care, and community services following a social prescribing model. • There have been fewer referrals to secondary care, especially to crisis care and mental health liaison. • Linkworkers are embedded in the new Wellbeing Collaborative delivering wellbeing services to people across Barnet. Organisations are working closely with commissioners to ensure that social prescribing sits alongside clinical and social care support. o Initially six practices provided space for the Linkworkers and this quickly increased to over 30 practices. o Coverage has been rolled out across all Barnet localities and referrals have been received from all	

	62 practices o GP Practitioners promote the direct benefits of the Linkworker and integrated service to their colleagues o Linkworkers attend locality meetings to promote the service o Patient feedback is positive – "it was the best assessment I have ever had in many years of using services!" The Network have developed stronger links with the Wellbeing Hub and have established a weekly joint referral meeting and a drop in session for the Wellbeing centre at the Network building. The Wellbeing Hub had its official launch at the reimagining mental health meeting on 8th February 2017. Most significant and measurable results: 1. Achieved 40% reduction in referrals to secondary care from South Barnet since commencement of linkworker service (first quarter) 2. Did not attend rate below 10% target (Aug 16 - 4.23%, Sep 16 - 3.63%) 3. Average of 94% of a total 225 referrals to linkworkers were acknowledged within 24 hours and were contacted within 5 working days in the first qtr of operation 4. 92% of all referrals had a comprehensive care and support plan created within 15 working days (including primary care and third sector support) Emotional health checks are being delivered across Barnet following staff training
Planned activity	A multi-agency training plan has been commissioned, the training will started in February 2017 and will continue through to May 2017, this will help to embed the new enablement model across the key stake holder organisations. Evaluation of the Primary Care Linkworker and Wellbeing Hub models – Dr Mike Scanlan is working with services to embed evaluation tools. An initial report will be available by end April 2017. Follow up to be determined. Wellbeing Hub is working to join up services with IPS and MAPs. Services moving to phase 3 redesign and procurement of integrated Wellbeing Services through integrating IAPT, Wellbeing Hub and services and Talking Therapies.

Area of focus (5)	**Employment** • Increase the proportion of adults in contact with secondary mental health services in paid employment. • Increase the proportion of adults with learning disabilities in paid employment Target • Proportion of adults in contact with secondary mental health services in paid employment - 6.1% at the end of quarter 3 (2016/17) against a target of 6.8% for the quarter (2016/17 target is 7.2%) • Percentage of adults with learning disabilities in paid employment – 9.4% at the end of quarter 3 (2016/17) against a quarter target of 10.4% (10.8% for 2016/17)	**AMBER** **Date of substantive report to HWBB:** TBC

Progress since November	**Employment and healthy workplaces (good progress)**
	• Individual Placement and Support (IPS): From the onset, since January 2015 to the end of December 2016, Twining received 356 referrals from the mental health teams. 257 of those referred are assessed and 211 engaged and received the service. Twining moved 70 residents into employment. 33% job outcome rates compare favourably against national benchmarking.
	• Motivational and Psychological Support (MAPS): From November 2014 – December 2016, engaged 458 people and 168 people into employment
	• The council's BOOST community support between March 2015 – December 2016 has engaged 728 people and supported 270 people into work.
	
	Employment for people with disabilities (gaps)
	• Proportion of adults in contact with secondary mental health services - the increase this is due to a reduction in the overall cohort size rather than an increase in the numbers employed
	• There is now significantly more mental health provision with a focus on DWP client groups but less focus on those only in contact with adult social care
	• Some gaps in provision have been identified as:
	  ○ Specialist employment support for ASC learning disabilities clients (IQ under 70)
	  ○ Supporting mental health clients to retain employment	

	○ Job Brokerage at scale.
Planned activity	A data audit is being undertaken to establish the number of adults with learning disabilities in paid employment to attain an accurate reflection of our current activity such as the seven individuals placed in employment through the YCB transformation programme. Developing the market and engaging with providers not yet operating in the borough and procuring an approved list for supported employment by April 2017. Embed employment in care plans – develop the role for brokerage in securing employment pathways, embedding strengths based practice and continue to develop the Mental Health Enablement model Raising quality of provision within existing day-care – including the Your Choice Barnet transformation and hold Job Coaching and Brokerage Skills (delivered by British Association for Supported Employment). London has secured devolution of the Health and Work Programme investment. This is the DWP employment support that will replace the Work Programme. Barnet will work with West London boroughs to develop a specification and select a provider in partnership with DWP. The council is working with the Learning and Work Institute to evaluate the project, this will include the impact of the service on resident wellbeing. The council is also replicating the model in another unemployment hotspot in the south of the borough. As with BOOST this new location will make links with local health services to support health and work outcomes side by side. The council as a public sector leader - leverage to create job opportunities through contracting and becoming a disability confident employer The council to attain Disability Confident Employer level 2 status.

<table>
<tr><td>Theme</td><td colspan="2">How we live</td></tr>
<tr><td>Objectives</td><td colspan="2">Encouraging healthier lifestyles</td></tr>
<tr><td rowspan="2">Area of focus (6)</td><td>Reduce excess weight in children (10 – 11 years old) (overweight and obese)

<table><tr><td>Year</td><td>Target</td><td>Reported</td></tr><tr><td>2016/17</td><td>32%</td><td>Current (2016/17 quarter 2) – 32.58%</td></tr><tr><td>2017/18</td><td>32.6%</td><td rowspan="2"></td></tr><tr><td>2019/20</td><td>32.6%</td></tr></table></td><td>GREEN</td></tr>
<tr><td>Reduce excess weight in adults (overweight and obese)

56.8% 2016/17

<table><tr><td>Year</td><td>Target</td><td>Reported</td></tr><tr><td>2016/17</td><td>56.8%</td><td>Current (2016/17 quarter 2) – 56.75%</td></tr><tr><td>2017/18</td><td>57.8%</td><td rowspan="2"></td></tr><tr><td>2019/20</td><td>57.8%</td></tr></table></td><td>GREEN / AMBER

Date of substantive report to HWBB:

July 2017</td></tr>
<tr><td>Progress since November and planned activity</td><td colspan="2">Tier 1: Universal population based interventions and programmes
Tier 2: Help for people who need it who meet criteria
Tier 3: More Specialist assistance for people who struggle and meet more stringent criteria
Tier 4: Bariatric surgery. High requirements are in place nationally.

<table><tr><td>Area of focus</td><td>Tier 1</td><td>Tier 2</td><td>Tier 3</td><td>Tier 4</td></tr></table></td></tr>
</table>

Develop and agree an Obesity Strategy and Action plan **Next Step:** to finalise and agree draft strategy March 2017	Y	Y	Y	Y	
Focus on the built environment and how we can maximise the built environments role in encouraging healthy lifestyles for all residents **Next Step:** working with planners and planning commissioners to integrate health outcomes into planning decisions, regeneration and growth (ongoing)	Y	Y	Y		
Establish the Fit and Active Barnet (FAB) Partnership **Next Step:** The FAB Framework is being presented to the Adults and Safeguarding Committee in March 2017 for sign off and adoption. Following this Committee, the first FAB Partnership meeting will be held. The vision for collaborative work has been tested through the development of a future Active Ageing Barnet project.	Y	Y	Y		
Develop the Healthier Catering Commitment in Barnet. Successful award ceremony took place in the autumn. **Next steps:** An award ceremony to be held in Spring for new providers. Current area of focus are Finchley Church End, Burnt Oak (to correspond with the Town Centres Strategy) and hard to engage fast food outlets (Ongoing).	Y	Y	Y		
A new leisure management contract has been developed with an increased focus on public health outcomes. A formal procurement process commenced in October 2016, a successful bidder will be	Y				

	appointed in August 2017 and the new contract will commence on 1 January 2018. **Next Step:** procurement in process and due to complete this summer.(Sept 2018)					
	Specific to Children				N/A	
	Through a multi-agency approach (Saracens Sport Foundation, England Athletics, LBB, Barnet Partnership for School Sport and MDX University) primary schools are encouraged to increase physical activity levels by participating in the Mayors Golden KM Challenge encouraging 15 minutes of physical activity every day. Seven schools engaged with pilot phase and currently recruiting more primary schools focusing on recruiting PH 'priority schools' (schools with the highest prevalence of overweight and obese children according to the National Child Measurements Programme) **Next Step:** The group will be meeting with the founder of the Daily Mile (Elaine Wyllie) in Feb 2017 to discuss ways of improving marketing of the project, engaging with schools more and learning from good practice across the UK. Engagement with schools continue, utilising Cllr Stock and Healthy Schools partnership coordinator and Saracen's lead for the project.	Y	Y			
	Tier 2 child weight management programme: During the summer holidays no School Time Obesity Programmes (STOP) were delivered Weight loss results for the summer term were lower than previous quarters. This could be due to various reasons (please note that summer programmes have not been delivered before): the children were out of their usual routine without structured meal times (as they would have during school time); a lot of children missed		Y			

	some sessions as they were away on holidays; the summer Alive n Kicking (ANK) programmes ran for 6 weeks rather than 12 weeks. **Next Step:** ANK continue to receive referrals from Healthy Weight Nurses (one to one element of the Tier 2 service); family support workers and GP's. Between October 2016-December 2016 48 referrals were made to ANK • 32.35% of completers (n=11) achieved a decrease in waist circumference • 70.00% of completers (n=24) achieved a decrease in BMIz score • 13.33% of the completers (n=5) maintained their BMIz score • 64.71% completers (n=22) achieved maintenance or reduced their weight During the same period STOP programme was delivered in three primary schools. 186 children were weighed and measured at week one and week twelve of those 44 children were identified as being overweight or obese at week one. 41% of children either lost or maintained their weight and the average BMI z score was -0.58					
	Specific to Adults					
	Commissioning of commercial weight management providers, initial procurement failed and a second attempt in now in place **Next Step:** to finalise commissioning of service to implementation		Y			

	(feb 2017).				
	Review of Tier 3 services undertaken with reference to national picture and how some particular examples of services commissioned by CCGs. **Next Step:** to work with CCG to consider the elements of Tier 3 provision in Barnet (tba).			Y	
	Review of bariatric service provision in Barnet and comparison with national and other local provision. **Next Step:** to communicate findings to NHS commissioning colleagues (tba)				Y

Area of focus (7)	**Increase screening uptake** • Target: increase screening uptake	**RED** **Date of substantive report to HWBB:** March 2017
Progress since November	The most recent data from NHSE (for internal management only) shows declining performance across all cancer screening programmes. The annual report was presented to Joint Health Overview Scrutiny (JHOS) Committee. An uptake on screening is presented to the HWBB as a substantive item (March 2017).	
Planned activity	Report back to JHOSC in six months' time.	

	It has been suggested that a North Central London (NCL) adult screening assurance group (which Dr Lake will chair) work with NHS England and partners to help develop this report and incorporate plans for recovery of under-performance. Actions from HWBB March 2017 to be picked up.

Theme	**Care when needed**	
Objectives	**Providing care and support to facilitate good outcomes and improve user experience**	
Area of focus (8)	**Care closer to home** Targets and outcomes TBC	**AMBER** **Date of substantive report to HWBB:** March 2017
Progress since November	Barnet CCG is developing a programme of work designed to radically enhance the delivery of appropriate Care Closer to Home. A number of projects and service developments have been identified from local and national strategies from the Five Year Forward View (NHS England, 2014), GP Forward View (NHS England, 2016), CCG commissioning intentions & NCL Sustainability and Transformation Plan (STP). In order to develop a new Care Closer to Home approach a key requirement is to create a major shift of balance from avoidable hospital admissions to integrated health, social care and third sector models delivered in community and primary care settings.	
Planned activity	A multi-agency stakeholder forum will also need to be established to enable cross-sectorial inputs and oversight, and it may be that the recently revamped Health and Social Care Integration Board could be used for this purpose. In collaboration across the local health economy and STP footprint Barnet CCG will commence an intensive, focussed and directed programme of work around a number of prioritised initiatives which will deliver on the vision.	

Area of focus (9)	**Carers (including young carers)** Delivering the Carer and Young Carer Strategy – • Focus on identifying unknown carers • Improving the health of carers (especially young carers)	**AMBER** **Date of substantive report to HWBB:** TBC
Progress since November 2016	The current number of carers registered with Barnet Carers Centre are 6484 (5821 adults and 663 young people) which has increased by 8% since 2014/15 (5951 carers). This falls slightly short of the target to increase the number of carers by 10%. Good progress is being made on the Carers and Young Carers Strategy Action Plan. Key achievements in 2016/17 include:- • An annual training programme being put into place for all adult social care staff detailing specific learning (covering identification, whole family approach, assessments and support available for carers of all ages) and being delivered on a monthly basis Successfully implementing new commissioned integrated support services for carers and young carers. • New aspects of service delivery include:- ○ A newly integrated offer which allows for a whole family approach to be applied ○ Carrying out statutory carers assessments ○ Delivery of the Carers Emergency Card Scheme ○ Developing an alternative respite offer using befriending - service to go live ○ March 2017 (increase in scale during 2017/18) ○ Implementing a hospital support service for carers – service to go live by end of March 2017 increase in scale during 2017/18) • Refreshing and improving online resources for carers on the LBB website https://www.barnet.gov.uk/citizen-home/adult-social-care/welcome-to-carers.html LBB joining the Employers for Carers Scheme (membership no. #EFC1588) which allows all LBB employees and SME's in the borough (businesses who employ less than 250 staff) to access resources such as:	

	• Supporting working carers – a carer's guide • Supporting carers in your workforce – an employer's guide • Supporting carers in your workforce – a manager's handbook Adults and Communities developing and embedding a new Specialist Dementia Support Service. The Service delivers a specialist programme of support to carers of people with dementia through assessments, support planning and a targeted training programme Promoting and supporting carers week 2016 with the Lead Provider to ensure that the EFC Scheme was promoted and to help support raising awareness of and championing carers, highlighting the challenges that they face and the contribution they make families and communities and promoting local support available to carers. The current lead provider for carers and young carers support services continues to engage with carers and young carers regarding the quality of services and considering gaps in service provision. This includes the provider engaging with carers whilst developing the new befriending service and carrying out engagement with carers and young carers as they further develop their hospital support service.
Planned activity	Training will be delivered to young carers in quarter 4 of 2016/17. Training will be carried out with the Adults and Communities Enablement Provider in quarter 4 regarding identification of carers and young carers and support available Working to embed the concept of being a carers champion into targeted settings including within the council working in partnerships with the commissioned provider for carers and young carers support services to help increase identification of carers and young carers and ensure that carers and young carers have access to good support. To develop a new service with our Commissioned Provider for carers support services to help carers and young carers share their experiences and knowledge with one another to help support them in being sustained in their caring role and achieving the outcomes that they desire. To carry out further work with faith groups and community based organisations to increase identification of and engagement with carers of hard to reach groups The results of the bi-annual carers survey will be available at the end of February 2017.

	Carers and Young Carers Strategy action plan is being reviewed for 2017/18.

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Appendix 2

Barnet Child and Adolescent Mental Health and Emotional Wellbeing Transformation Plan 2015-2020: Refresh 2016

Contents

Part 1: Barnet Focus

1.1 Introduction

The Barnet CAMHS Transformation plan refresh is set out in two parts. Part 1 reflects the priority areas with a Barnet focus and the strategic vision we have established. It deals primarily with community CAMHS provision, commissioning intentions and refresh local priorities. Part 2 has been developed with NCL wide partners and sets out our joint transformation planning for those areas with high interdependencies, opportunities for increased efficiency or which are jointly commissioned across the STP

footprint. We have updated local needs assessment data where this is available or was not included in the original plan. We have not undertaken a redrafting of the whole transformation plan. The refreshed Barnet CAMHS LTP will be presented for approval at the Health and Wellbeing Board on 9th March 2017 and as such will be published online on Barnet Council and CCG websites.

1.2 Executive Summary

Barnet has made progress in a number of priority areas which we identified in the Child and Adolescent Mental Health Service Transformation Plan 2015-2020 published in February 2016. An update of progress and is set out in section 1.3 of this plan. Key areas of progress include

- Embedded our strategic approach to Family Friendly Barnet
- Established resilience based practice at the heart of vision for children and young people
- New CAMHS satellite provision at Pupil Referral Units
- Significant reduction in waiting times for the Eating Disorders Service
- Improved performance management of services and new targets
- Participation with NCL partners in a successful bid for Child House Model
- Successful funding bids for additional capacity to reduce waiting times, develop CAMHS for Young Offenders, employ four trainee Psychological Wellbeing Practitioners and develop a new perinatal Mental Health Service

Whilst some progress has been made to date we feel that the challenges and vision described in 'Future in Mind' 2015 to transform services requires a more 'whole system' remodeling approach. Therefore we have decided to jointly re-commission Community CAMHS services within a Section 75 agreement. We will redesign our services based on the concepts and principals of our resilience based model using the THRIVE approach (see page 9). We have begun a wide ranging review of our needs assessment, mapping of provision and development of a new model of services. We will consult widely as part of a procurement process running for one year (1st October 2017 completion). Our goal is to achieve a more balanced provision of services in order to improve service user experience and achieve a long term sustainable Emotional Wellbeing and Mental Health System for children and young people.

We will use transformation funding and existing local resources to achieve the vision set out in 'Future in Mind' 2015 by focusing on developing open, responsive and outcome orientated services based on evidenced based resilience focused practice. Through innovative approaches to delivering high volume/low unit cost support for example via web based delivery and an increased emphasis on population wide needs we will take a different approach to emotional wellbeing of Children and Young People. We will do so while improving the quality and efficiency of specialist clinical services.

We will publish a refreshed needs assessment alongside this plan. We have included key highlights and findings from the updated needs assessment to support the new priorities identified in this plan.

In support of the remodeling process we will direct additional one off NHSE funding to reduce waiting times in Barnet and take the pressure of the 'front door' while CAMHS is redesigned and transformation is embedded. We will initiate a performance improvement plan with BEH-Community CAMHS as part of this process.

Barnet aims to increase the number of children and young people receiving a 'new treatment episode' from locally commissioned services by over 125% by 2019/20 with an overall increase in the total number of young people receiving support of 80%+ (see modelling document attached as appendix 8)

Financial planning to deliver local priorities

Barnet will be undertaking an ambitious and complex recommissioning and procurement process. Therefore we will not be publishing a detailed allocation of spend against our priorities listed as this may negatively impact upon the procurement process and transgress procurement regulations. Barnet will continue increasing investment in children's mental health and emotional wellbeing services and we fully anticipate delivering increased value for money across the system.

1.3 Progress Update on CAMHS Transformation Priorities 2015-16

Activity Data 2015.16*

Referrals	2382
Initial Assessments	1386 of which 963 Tier 3
CYP in Treatment	TBC
Discharges	1621 of which 1175 Tier 3
Waiting Times	TBC

*As recorded on local performance reports

Schools, promoting mental health and wellbeing, resilience, PSHE and counselling services in schools.	*Resilience based approach - THRIVE in Schools-Jointly managed with Public Health, plan under development* *New satellites at PRU and named CAMHS link workers for schools*

Enhancing existing maternal, perinatal and early years health services	*Partnership bid submitted- see Part 2* *Additional £25k invested in psychiatry sessions at maternity services*
Supporting self-care utilising evidenced based apps and digital tools;	*Review of options under way and new work strand in place.*
Moving away from the current tiered support	*New resilience based Model of practice with services under development based on THRIVE and flexible, responsive services*
Eating Disorders: Reduce Waiting Time, increase workforce and progress toward meet NICE Guidelines (also see Part 2)	***Performance*** *2015.16 Q3 <4 weeks = 32.5%* *2015.16 Q4 <4 weeks = 78.6%* *2016.17 Q1 <4 weeks = 85%*
Vulnerable Groups: ***Improve engagement of vulnerable groups with behavioural problems New Pupil Referral Unit (PRU).***	*CAMHS satellites set up psychologist input, group and 1-1 sessions and parental support. 25 CYP engaged and 12 Parents*
Commissioners and providers across education, health social care and youth justice sectors working together to develop appropriate and bespoke care pathways	*New PRU satellites established –see above* *CAMHS Health and Justice Proposal drafted*
Progress Mental Health Crisis Care Concordat	*A specification and tender pack have been developed to procure a new nurse led Out of Hours CAMHS Crisis Service to help support crisis and reduce admissions to hospital and long term residential placements*

Improving communications, referrals and access to support through and CAMHS in Schools	*Barnet CAMHS offer a named Primary Mental Health Worker to all schools. New model now under consideration* *Improved data reporting confirms 190 CYP engaged per year 150 appoints attended per month.*

Co-Design and Participation including Co-design film project under way	*CYP Participation films have begun production* *We have an CYP CAMHS Service User Group* *New service model will have extensive input from Voice of The Child CYP Groups*
Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services Performance Management and Targets;	*New targets agreed for < 8 weeks Referral to Assessment and < 13 Weeks Referral to Treatment (see also Section 5.2). A new standardized reporting template has been agreed across NCL*
Reduce Waiting Times	*Waiting Times reduction plan now in place*

Development of Drop-In:	*Barnet will be progressing this objective in the new service model*

Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.	*New BEH CAMHS Website almost completed-Soft Launch December 2016 and full launch January 2017*

Improving Follow Up of CYP who do not attend appointments	*New access policy in place for BEH CAMHS as of September 2016. Evidence of improvement not yet confirmed*

Comprehensive assessment and referral to appropriate evidence-based services for Children Sexually Abused	*New hub in Place and Child House model funding secured*

and or Exploited	
Making the investment of those who commission children and young people's mental health services fully transparent.	*CAMHS Funding has been published on CCG and Council websites*
Improve understanding of the CAMHS funding flows across health, education, social care and youth justice	*Funding arrangements now clear and coordinated across partners* *Agreement reached for Section 75 pooled Budgets to begin 1st October 2017*
Improving commissioning	*Additional commissioning capacity in place. Improved performance management, commissioning systems and coordination with other commissioners*
Extending the CYP-IAPT curricula and training	*Additional training places have been recruited to CYP-IAPT* *Planning has not been coordinated and a new steering group will being in November 2016 which will include more input from the voluntary and social care sector.*
Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.	*Some services mapped but not yet completed.* *Workforce plan not yet fully in place*

1.4 Governance, Commissioning and Overview of Needs Assessment

Barnet, through its Children and Young People's Plan 2016-2020 sets out a clear aspiration to make Barnet the most Family Friendly Borough by 2020 where all children and young people flourish. At the heart of this vision is the development of a consistent model of work which builds resilience in our communities, our families and our children and young people. 'Future in Mind 2015' identified the growing levels of emotional

problems among young people and that fundamental change in CAMHS and emotional wellbeing services more generally were required to meet these emerging needs.

Children's Mental Health is identified as a priority area with the North Central London Sustainability and Transformation Programme (STP). CAMHS Commissioners across NCL have identified eight priority areas for development across the STP footprint and these are covered in Part Two of the plan. Some of these priorities are also elaborated on in the Barnet specific section of this document.

Governance arrangements are now in place with a Children's Mental Health and Wellbeing Transformation Governance Board. This is chaired by the Director of Children's Service and includes Barnet CCG Director of Commissioning, BCCG GP Clinical Lead for Mental Health and the lead Public Health Consultant. (See Appendix 1 for governance and membership). Children and Young People discussed this plan at the Barnet Children's Partnership Board and extensive consultation is taking Place January/February 2017 on proposed plans for the new service.

On 15th September 2016 Barnet Joint Health and Wellbeing Board received a report jointly sponsored by the respective commissioning directors of Barnet Council Children and Family Services and Barnet CCG. This paper proposed that Barnet move to a more transformative approach to redesigning services to support emotional wellbeing for children and young people in the locality. The JHWB agreed the following recommendations:

- Alignment of all commissioned contracts and pooling of budgets across Barnet under a Section 75 arrangement with oversight from the governance board
- Re-commissioning of children and young people's mental health and emotional wellbeing services, as a whole system under the leadership of London Borough of Barnet
- A Barnet specific process for re-modelling Community CAMHS starting Autumn 2016 for implementation by 1 October 2017
- Additional investment to be made in prevention, resilience based practice and early intervention based around THRIVE 'Coping' and 'Getting Help' segments-see below.
- Embedding of CAMHS into the wider children's service system including schools, primary care and children and family services

To initiate this process Barnet is:

1. Refreshing our Children and Young Peoples Mental Health Needs Assessment (by 1st December 2016),
2. Undertaking an extensive stakeholder consultation on provision and delivery of service (by 1st December 2016)
3. Process mapping of all local capacity (1st December 2016)

4. Demand modelling of services (November 2016)
5. Engaging Public Health (October 2016-completed)
6. Increasing dedicated commissioning capacity for one year (October 2016-in place)
7. Develop a Procurement Plan and Timetable (December 2016)

Overview of Needs Assessment

It is now recognized that the level of mental health need among young people has increased significantly over the last 20 years. Levels of anxiety and depression among young people nationally have increased by 70% in the last 25 years and presentations to A+E for psychiatric symptoms doubled between 2009 and 2013.14 (Future in Mind 2015).

Therefore we must increase access for young people with emerging low and moderate level mental health needs who may deteriorate further if not supported. A review /critique of previous needs assessments is that they focus on already pathologised populations to design services. Barnet JSNA and national data suggest that 26% of young people in the UK experience suicidal thoughts (2). When applied to Barnet with a U18 yrs population of 94,000 this suggests that currently 24,684 children and young people in Barnet are at risk of experiencing suicidal thoughts. By 2018 this will rise to 26,774. This paints a picture of significant distress that will require a shift in the provision of services to meet needs.

It is estimated that 30% of children and young people are experiencing low grade (sub clinical) mental health problems (3). This indicates that currently in Barnet 28,482 are experiencing a level of distress that can in time become a more significant condition. This will rise to 36,293 by 2030. A future service will need to innovate and use a range of technological high volume/low intensity to meet this need.

We believe that this calls for a coherent and systematic response by all stakeholders. We feel that the challenges presented are best addressed by a joint approach to commissioning support for children's mental health and wellbeing. We wish to design efficient, responsive, integrated and outcome focused services into a coherent system. We will redesign community CAMHS provision within the borough on a whole system basis. In addition we will ask our specialist providers for Eating Disorders (Royal Free London) and Specialist Therapies (Tavistock and Portman) to participate in this process and review provision alongside the core community redesign process. In eight key North Central London priorities detailed in Part 2 of this plan we have aligned developments with our Barnet focused process to ensure robust pathways and sustainable services.

An extensive range of stakeholders have been consulted by teleconference and face to face meetings in order to gain a better understanding of what our new priorities should be, including:

Organisation	Who	How	When
Barnet CAMHS Providers	BEH NHS Trust lead clinicians and local senior management	Face to face/Telephone	Sept/Oct 2016

	Royal Free Hospital Lead Clinicians and Management Tavistock and Portman – Lead Clinican		
Barnet Council	Director of Children and Family Services 2 x Assistant Directors and 3 Heads of Service Voice of The Child – Strategic Lead	Face to face	October 2016
	Public Health Consultant and 2 PH Strategists	Face to face	October 2016
Education	Pupil Referral Unit Head Teacher	Telephone	September 2016
	Northgate Schools Alliance-14 head teachers	Face to face	July 2016
	Cambridge Education-head of Education Psychology	Face to face	September 2016
Vol Sector	Community Focus Manager Raphael House-CEO Community Barnet - CEO The Young Barnet Foundation – Lead manager	Face to face	September 2016
Children and Young People	Barnet Children's Board Extensive consultation planned January and February 2017		See attached Children and Young People consultation plan appendix xxx

Aims and Objectives of Service Redesign

The core objective of this process is to improve patient and family experience by better prevention, resilience building, and early intervention, reducing waiting times, and making accessing support less stressful. We will commission services with targets based more on outcomes and that are co-designed with Children, Young People and Families/Carers. We will achieve the objectives described by redirecting more of our resources to prevention, early intervention and in-reach to non-clinical settings. We are reviewing options for commissioning high volume digital support such as KOOTH, Silent Secret etc. We will design this procurement process to be co-produced with young people in Barnet.

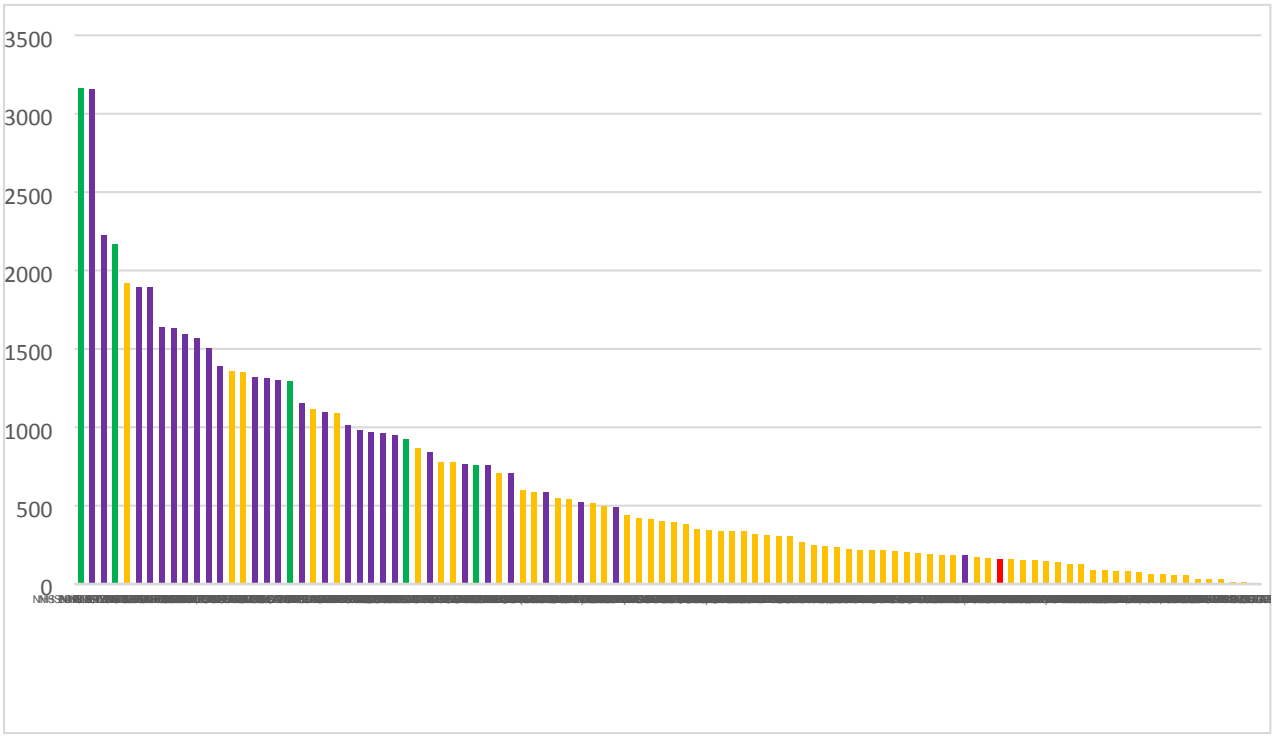
In 2016 The Care Quality Commission undertook a review of BEH Community CAMHS in Enfield and Haringey. While Barnet CAMHS was not specifically inspected it was recognised that the findings of this report related across the services. Local data from our updated needs assessment indicates that young people wait an average of 9 weeks for Referral to Assessment (RTA). The findings of our demand modelling process and needs assessment confirm an average wait for Referral to Treatment of 131 days. CAMHS local reporting in Barnet indicates waiting times of 6 months+ for Psychology Referral to Treatment (RTT) with over 55 CYP waiting for neurodevelopmental assessments for up to 6 months. CAMHS clinical services are receiving on average 2350 referrals in Barnet per-year. Demand modelling indicates that less than 50% make it into treatment. While there are likely to be a number of causes there is some evidence that productivity could be improved across CAMHS services in Barnet to reduce waits.

The updated needs assessment confirms that 'non pathologised' cohorts of young people with moderate level depression, anxiety and self-harm are poorly served by the current system and account for a substantial proportion of the 50% of CAMHS referrals that do not make it into treatment. Therefore a priority for Barnet is to significantly develop and extend CYP-IAPT services and increase capacity further upstream. This should in turn reduce front door pressure on complex care CAMHS.

The under provision of CAMHS early intervention is possibly contributing to excess demand for specialist clinical services and the high attrition rate across entry pathways. We will continue this analysis to support service improvement. Residential CAMHS admissions are among the highest in England and typically double our neighbouring boroughs. It is likely that delays in accessing specialist community support may in turn be exacerbating demand at Tier 4-see below .

Table 1: CAMHS admissions to London Based Residential Units (including Eating

Disorders)



	NCL CCGs
	Rest of London CCGs
	Outside of London CCGs
	Unknown Invalid CCG

Provision of Crisis support requires further development. At present Barnet CAMHS provide day time self-harm rota (Mon-Fri) cover whereby the local CAMHS clinicians will respond within 2 hours to a self-harm crisis presentation. In addition a psychiatric liaison service (Monday-Thursday day time hours only) and an on call consultant led rota responds to crisis Out of Hours including Early Intervention in Psychosis (EIP). An onward pathway including assessment and referral for EIP into community or Tier 4 hospital provision exists. However this does not provide a full comprehensive pathway for EIP and requires further development.

Two strands of work are progressing for enhancing CAMHS Crisis care. Barnet with NCL partners wishes to develop a long term sustainable North Central London wide Crisis Service covering both day time and 'Out of Hours' provision. This involves resolving a complex set of interdependencies and while it is hoped we can achieve a deliverable plan in 2017 (see Section 2 Priority 5). As an enhancement of interim arrangements we are in discussion with the Royal Free London NHS Foundation Trust to extend local provision at Barnet Hospital to 9am-9pm 7 days per week from April 2017 and we will seek continue the Out of Hours Rota until an NCL wide service is in place.

Services in Barnet have not been designed as a whole system to meet the changing

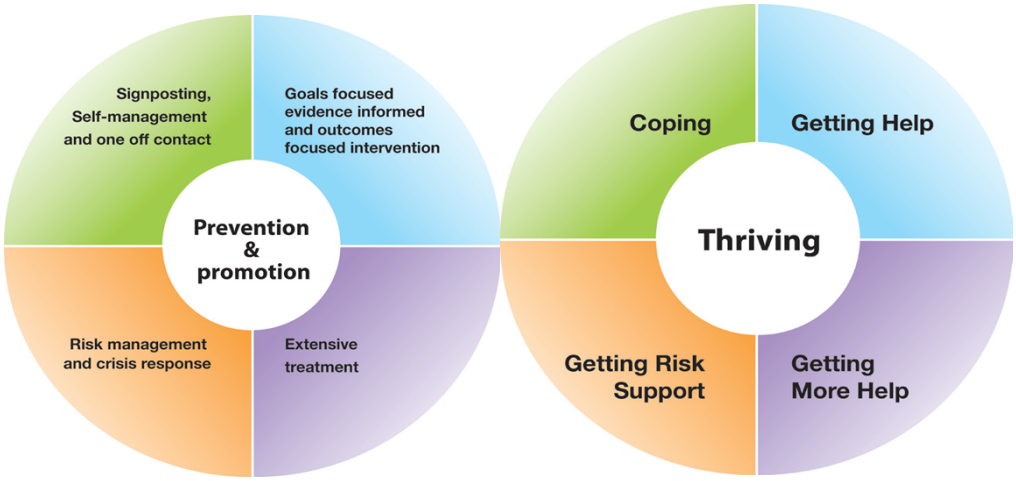
needs of the population. The system requires more of a public health focus. The non-specialist workforce including schools, social work and primary care staff must be offered extensive training and liaison support to enable them to identify problems earlier and support those not yet in need of clinical interventions by building resilience. We must re-commission services to meet needs earlier in the pathways. Support must be embedded in the community and among services for vulnerable groups e.g YOS, PRU's, LAC at the same time as flowing into specialist CAMHS. Some of this development has been achieve in the last year. However to radically overhaul the system we recognize that many challenges will need to be overcome. We will work in collaboration with partners, clinicians, providers and families/CYP to re-commissioning CAMHS toward a CYP Mental Health and Wellbeing System based on the principles of resilience based practice using the THRIVE approach and with an outcomes focus.

We aim to create a culture of high expectations, ambition and forward thinking services that attract a multi-skilled and motivated workforce. We will establish challenging performance targets for our providers and ourselves as commissioners and will invite and priorities service users, young people and families to participate in this process and challenge us to do better.

Resilience is the state we are seeking to achieve when we provide support for children and young people in relation to their emotional wellbeing through THRIVE. Services should be helping with prevention, promotion, awareness raising work in the community to support the ability of children and young people to be resilient and to thrive. An important underpinning of this process is a person's level of resilience. Therefore an emotional wellbeing system must not only provide treatment but also support to build resilience. This will involve consultation, advice, training and influencing the environment that children inhabit in order to promote a healthy emotional wellbeing culture. Support should not just be focused on particular children or families.

The THRIVE framework supports building resilience and conceptualises five needs-based groupings for young people with mental health issues and their families (see below). The image on the left describes the input that is offered for each group; that on the right describes the state of being of people in that group – using language informed by consultation with young people and parents with experience of service use.

INPUT **STATE**



Current Barnet Provision based on 5 THRIVE segments

- Limited levels of CAMHS Prevention, Promotion and Resilience Building
- 85% of local CCG CAMHS resources go into specialist clinical services (Extensive Treatment)
- The workforce is skilled but does not reflect a balanced system
- Schools based work is not geared toward prevention and culture change
- CYP-IAPT has delivered limited additional capacity and access and needs to be given more focus to deliver additional evidenced based support
- Lack of provision at the THRIVE Coping and Getting Help segments is placing unnecessary demand on clinical community CAMHS (Getting More Help) and Crisis/Tier 4 (Getting Risk Support)
- A lack of proper provision of home/community based crisis support across NCL is placing a strain on Tier 4 services and acute hospitals.

Toward THRIVE in Barnet

In the future we will take a more public health orientated perspective regarding the need to improve the mental health and wellbeing of children and young people in Barnet. A review /critique of previous needs assessments is that they focus on already pathologised populations in order to design services. This approach has limitations and contributed to the absence of a strategic approach to commissioning.

Based on national research we estimate that in Barnet

- Around 25,000 children and young people in Barnet are experiencing suicidal thoughts.

- 28,000 are experiencing a level of distress that can in time become a more significant condition. This will rise to 36,000 with increase in the local population is

- It is estimated that in Barnet 5,146 16-24 yr olds have two or more indicators of an Eating Disorder that would require further investigation ((Adult Psychiatric Morbidity Survey 2007 http://www.ic.nhs.uk/pubs/psychiatricmorbidity07).

A future service will need to innovate and use a range of technological high volume/low intensity to meet this need.

Aims

- Towards the a THRIVE model that offers greater choice and shared decision making principles aimed at providing improved services for children and young people with learning disabilities and mental health difficulties to build resilience
- Towards a greater emphasis on resilience
- Towards much greater use of technological modalities that fit with the way that young people get and use information
- Towards further self-referral options in order to really enable young people to access help when they need it
- Towards support schools and families in encouraging a compassionate culture among children and young people to promote resilience
- Toward an expanded and more flexible workforce provision

Developing a CYP-IAPT Hub and Network

The new Barnet model under development will include an extended range of CYP-IAPT provision across NHS, Barnet Council, Schools/Colleges and Voluntary Sector providers. A single lead provider will be chosen by procurement to coordinate this network and be responsible for coordinating training, governance, capacity building, outcomes monitoring/reporting and pathways development. All funded CYP-IAPT providers will be required to sign a Memorandum of Understanding agreeing to work within the network.

Part of this new network will be developed using recently confirmed funding including the four HEE funded Psychological Wellbeing Practitioner trainee's. These trainee's will be recruited by London Borough of Barnet and will be managed within the Family Support Service. Each practitioner will initially be offered a 1 year fixed term contract to run over the course of the training programme. They will be embedded within Children and Family service structures. Barnet CCG will fund one additional senior practitioner/team leader (B7 or equivalent) who will be employed in LB Barnet to create a Children and Young People Psychological Wellbeing Team. This and other aspects of the new model being developed in 2017 will be designed to then plug into the new Hub when it goes live later in the year.

Workforce Development and Capacity Building

In our view the workforce for children's mental health presents one of the biggest challenges to real transformation of the system. There is abundant evidence of both a workforce shortage in certain key professions (Clinical Psychology and Psychiatry) and a broader skills deficit among the wide. These factors are exacerbated by recruitment barriers related to cost of living in London and the rapidly growing U18 yrs population of Barnet. We are therefore developing a four year workforce development plan to address this. Our initial analysis is that

- Increased capacity will need to largely come from CYP-IAPT workforce of between 30-40 additional staff by 2020/21
- This workforce expansion should be generally deployed outside of existing CAMHS service location but be integrated with it. Locations will focus on Schools, Primary Care and Children and Family Services
- CYP-IAPT practitioners must be supported and work alongside specialist senior clinicians, social workers and school staff
- Knowledge exchange, clinical supervision and career progression must all be at the heart of these developments in order to attract the new workforce for the future
- Salary support will be funded by the CCG transformation funding to support development
- Barnet will invest in training and liaison support post training for non-specialist staff in order to support young peoples mental health needs

The workforce development plan is still under development and will be widely consulted on before publication in April 2017.

Health in the Justice System

Barnet has been awarded additional funding to support the needs of CYP at risk of offending or already committing crime. We plan to develop new capacity with the Youth Offending Service:

Areas under consideration for Barnet Model for Health and Justice CAMHS

Aspects of new service model
• Mental Health Assessment at diversion stages • Single point of access for YOS/CAMHS referrals • Service design based on in-reach to YOS and strengthening pathways into community and specialist CAMHS • YOS CAMHS capacity as part of the new Gangs Unit in Barnet • Early intervention for Sexually Harmful Behaviours • Support for transition from secure settings into community CAMHS • Development of Specialist Child and Adolescent Mental Health Services for

High Risk Young People with complex needs and/or involved in Gangs

1.5 Barnet Transformation Priorities: Refreshed 2016-2018

Priority	KPI's	Deadline	RAG
Re-commissioning	Needs Assessment Completed	Dec 2016	
Procurement	Procurement Plan Confirmed	Jan 2017	
Service model	Develop a new model for services	April 2017	
Service model consultation	Consult with key stakeholder primarily CYP/Families, education and social care partners	Jan-March 2017	
THRIVE in SCHOOLS	Piloting of high volume/low input digital support such as Kooth, Silent Secret, Big White Wall and linking with evidence based initiatives such as Action for Happiness (Q4 2016.17)- http://www.actionforhappiness.org/10-keys-to-happier-living A comprehensive and standardised provision of training and engagement with schools, youth services and children centre's (Q4 2016.17) Specific provision for support around reducing the impact and occurrences of bullying, support around exam stress, depression/anxiety and eating disorders (Q1 2017.18)	January 2018	
THRIVE in the Community CYP-IAPT	Breaking Down the Barriers' training for schools and primary care health workers. Set up LB Barnet/CAMHS Psychological Wellbeing CYP-IAPT service from NHSE funding stream Building CAMHS Pathways into CAF process/Family Support Model	January 2018	
Enhanced support for Vulnerable Groups	Submission of a joint CCG/YOS proposal to NHSE Health and Justice for specialist CAMHS/Criminal Justice provision (December 2016)-see attached appendix 7	September 2017	

	Joint work between CAMHS and Adult MH services to support children and parents where the child is on the 'edge of care' (Q1 2017.18)		
Accessing	**Re-direction of resource towards a Primary Care Link Worker model that embraces THRIVE and provides a conduit between, schools, social care, primary care and CAMHS clinical services**	**April 2018**	
Access	**Reduce waiting times in key bottlenecks based on the findings of the demand modelling process (**	**April 2017**	
Extending Crisis Service	**Deliver OOH Crisis Service January 2017**	**April 2017**	
Transition pathway for 17/18 year olds	**Co-production of transition pathways with Adult MH commissioners**	**April 2017**	
NCL wide redesign of services	**Actions set out in Part Two of this plan on the eight STP priorities**	**See attached section 2**	
Workforce	**Workforce Development and Capacity Building Plan**	**April 2017**	

Appendix (1)

CYP MENTAL HEALTH & WELL BEING GOVERNANCE BOARD

STRUCTURES AND TERMS OF REFERENCE

PURPOSE OF THE GOVERNANCE BOARD

- To provide oversight and lead the remodelling of Mental Health and Emotional Wellbeing Services
- To provide oversight of the re-commissioning of CAMHS
- Agree and sign off the service specification
- To set up S75 arrangements and pooled budgets
- To monitor progress and delivery of the above
- To provide oversight of provider performance outcomes and to provide remedial direction and intervention when required
- To report to the H&WB Board on progress and issues
- To be responsible for monitoring resource allocation for emotional health and well Being services

The Board will also:

- Sign off and provide oversight of the CAMHS Transformation plan and associated funding allocation to ensure the transformation money is targeted effectively
- To approve reporting of the CAMHS Transformation Plan tracker prior to submission to NHSE.

MEMBERSHIP

- Director of Children's Services, LBB (Chair)
- Director of Commissioning, Barnet CCG
- Assistant Director Family Services, LBB
- Head of SEN/Principle Psychologist, LBB
- Head of Children's Joint Commissioning, LBB/BCCG
- Public Health Consultant, LBB
- CAMHS Commissioning Transformation Manager, LBB/CCG
- Clinical Lead for mental health
- Mental Health & Wellbeing/CAMHS expert
- CYP service user

Core members are required to ensure delegated representation is maintained in their absence as key decisions will not necessarily be deferrable.

PAPERS

- Agenda items may be nominated by the membership no later than 2 weeks prior to the meeting.
- Agenda and papers will routinely be emailed one week prior to the date of scheduled meetings. Hard copies may be requested in advance.
- Minutes of each meeting will be issued within 2 weeks or 10 working days.
- Papers will be circulated and read in advance where possible in order to effectively utilise the meeting time

FREQUENCY OF MEETINGS

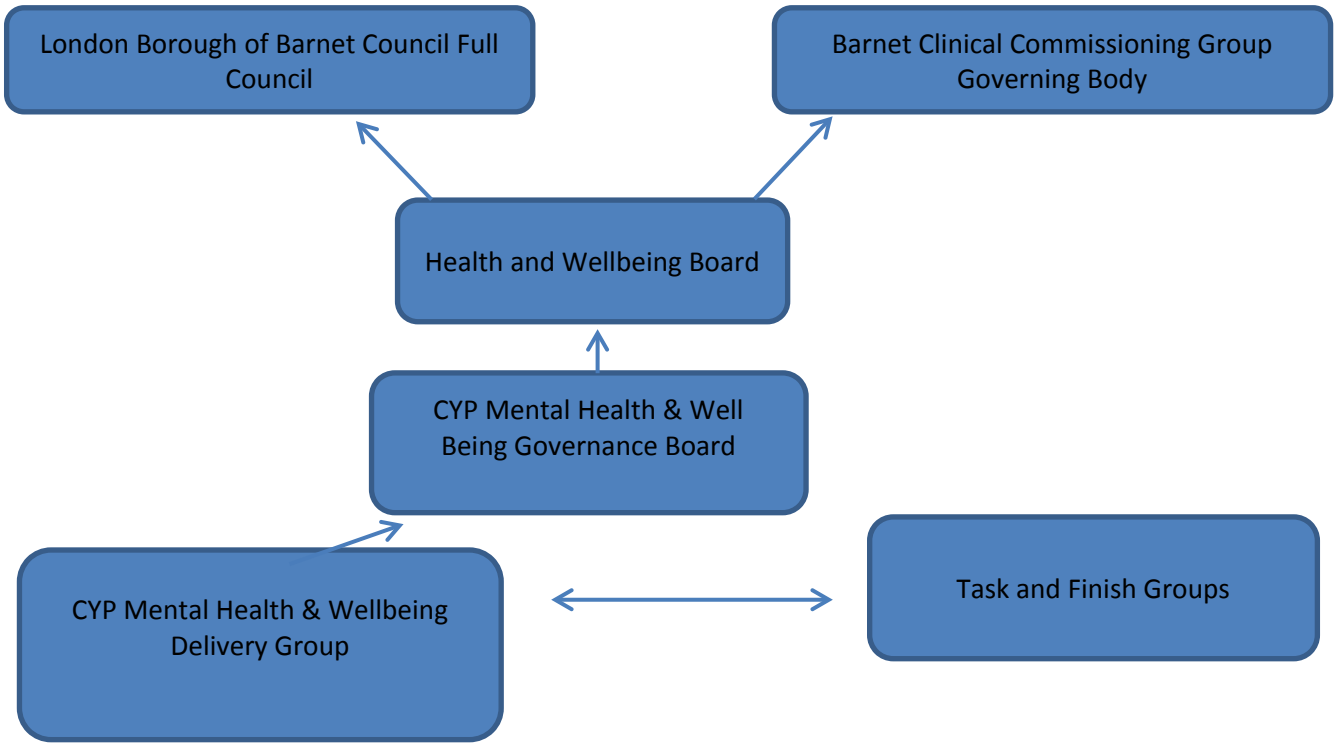
- The Governance Board will meet monthly

CONFLICTS OF INTEREST

Declarations of Interest will be recorded at the start of every meeting, and members will recuse themselves from any agenda item in which they have a conflict of interest.

GOVERNANCE & REPORTING MECHANISMS

- This group reports into HWBB and will provide regular updates and will escalate issues and disputes as necessary.



Appendix (2)

Key findings from local Needs Assessment

1. **Looked After Children and children on the edge of care**

We have audited cases of children who entered care over 2015-16 in which we identified that parental mental health was a factor in 60% of cases **(Ref Resilient Futures 2016**). A sample of 10 cases were reviewed in more detail for additional learning. In 9/10 parental mental health as assessed as the key risk factor and contributed to the child becoming looked after. The quality of the multi-agency interventions was found to be 'variable', with limited evidence of early help. Early intervention for parents with mental health needs should be improved.

2. **Children At Risk of Offending**

The 'Health and Justice Specialised Commissioning of Children and Young People's Mental Health Services' transformation work stream aims to address this gap. Barnet has conducted a local review of needs within the YOS caseload (see appendix 1) which confirms the high level of mental health needs among young offenders. Barnet will prioritise the following in line with NCL partners

- Single point of access for all YOS/CAMHS referrals
- Service design based on in-reach to YOS and strengthening pathways into community and specialist CAMHS
- Measure outcomes using YJS performance monitoring and CAMHS minimum data set
- Support for individuals involved in gangs who have MH needs
- Benchmarking reported outcomes across NCL by 2017.18
- Early intervention for Sexually Harmful Behaviours
- Self-Harm and Crisis Care
- Transition from secure settings into community CAMHS

Figure 1: Barnet YOS cases with mental health needs 28-09-15 to 28-09-16

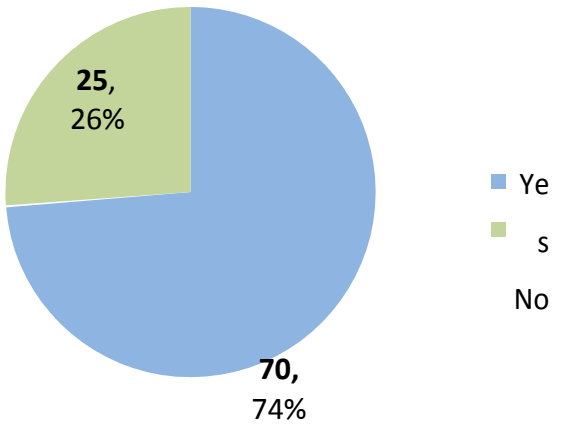


Figure 2: Referrals to CAMHS of those with known MH need 28-09-15 to 28-09-16

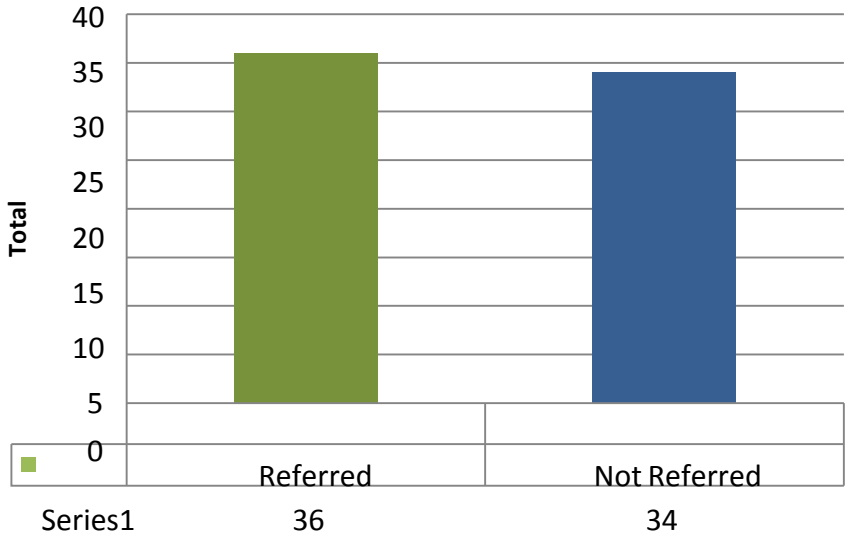
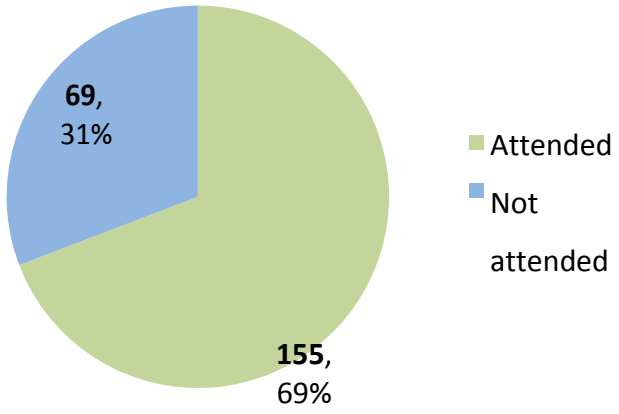


Figure 3: Appointment attendance YOS cases referred to CAMHS 28-09-15 to 28-09-16



APPENDIX (3)

BEH-MHT Barnet CAMHS Workforce (August 2016)

	Barnet CAMHS Tier 3				Barnet CAMHS Tier 2		Adolescent Pathway	ACCESS
	CAMHS West	CAMHS East	SCAN	LAC/ Adoption	Paed Liaison	Primary/ Secondary	BAS	
Registered Mental Health Nurse	0.6	1.2	0.4		0.6		1.0	0.15
Consultant	1.195 *	0.7*	0.5	0.5	0.4*		0.7	0.05
Trainee Psychiatry	1.1							
CT1-3	0.7	0.7					0.7	
Non Trainee Medical								
Clinical Psychologist	1.2	2.4	1.0	0.6				
Counselling Psychologist								
Child & Adolescent Psychotherapist	1.4	1.4	0.5	0.4	0.2		1.4	
Family Therapist	1.0	1.5	0.3	0.5			0.5	0.3
Art Therapist	0.25			0.6				0.15
Adolescent/Primary Care Mental Health Worker	0.5					7.9**	1.6	0.3
Dance Movement Therapist							0.5	
CAMHS Social Worker	1.0	1		0.5				
Clinical Total (wte)	8.945	8.9	2.7	3.1	1.2	7.9	7.4	0.95
BARNET CAMHS CLINICIAN TOTAL	41.095							
Trainees (non-medical)								
Clinical Psychology Trainee	1.2		0.6	0.6				
Psychotherapy Trainee	0.46							
Art Therapy Trainee	0.3			0.1				
Trainee Total (wte)	1.96		0.6	0.7				
CYP IAPT	0.9							

Assistant Psychologist				0.1		1.0		
CAMHS Admin	**2.1**	**2.6**				**1.0**	**1.0**	**1**
CAMHS ADMIN TOTAL	**7.7**							

Total .5 FTE included in the above totals.

1 WTE Consultant Psychiatry vacancy/0.4 maternity leave Band 6 nurse/ 0.7 Clinical psychology maternity leave Vacant posts: 2.8 WTE PMHW/0.7 Asst Psychologist Vacant 0.4 WTE MHW (reduced hours return to work) - 0.5 Psychology/0.8 long term sick Band 6 nurse

Rate (per 10,000) for ALL WTE staff	**5.26**
Rate (per 10,000) for CLINICAL WTE staff	**4.41**

Appendix (4)

Barnet CAMHS Finance Outturn 2015.16

Barnet CCG	4,598,000
London Borough of Barnet	970,000
Transformation Funding	696,000
Total	**6,264,775**

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PART 2

North Central London
CAMHS Transformation Plan Priorities

1.1 Mental Health is identified as a priority area in the North Central London (NCL) STP Case for Change. This has resulted in the development of the NCL Mental Health Programme as part of the NCL STP, which covers mental health support for all age groups. The programme currently has seven identified initiatives: community resilience, primary care mental health, acute pathway, female psychiatric intensive care unit, CAMHS and perinatal, liaison psychiatry, and dementia.

1.2 The CAMHS Transformation Plan Priorities are focussed on producing improved outcomes for children and young people, and on ensuring the best use of resources to generate those good outcomes. The transformation of children and young people's mental health and wellbeing services, and of perinatal mental health services, will not necessarily bring savings during the time period of the STP, but have been prioritised because of their future positive impact on the need for services. 50% of all mental illness in adults is associated with mental health needs that begin before 14 years of age, and 75% are associated with needs that are expressed by age 18[1]. Similarly, the negative impact on a child's mental wellbeing[2] associated with perinatal mental ill health confirms that these are two key service areas for ensuring improved long term mental health outcomes for our population.

Borough	Population aged 5-16	Est. prevalence of any MH disorder, aged 5-16 (2014)	
		Count	Percentage
Barnet	56,063	4,691	8.4%
Camden	27,904	2,546	9.1%
Enfield	52,460	5,195	9.9%
Haringey	37,905	3,745	9.9%
Islington	23,981	2,417	10.1%

Source: Fingertips, 2014

1.3 Across the 5 boroughs of NCL (Barnet, Camden, Enfield, Haringey and Islington) there are varying rates of mental ill health prevalence, and varying services and outcomes across the 5 boroughs; such as:

- Three of our boroughs have the highest rates of child mental health admissions in London (Fingertips, 2014/15)
- There is limited perinatal community service in NCL, with no specialist team in the North and in the southern boroughs the service does not meet national standards (Maternal Mental Health Everyone's Business)
- Most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight (Mental health crisis care ED audit, NHS England (London), 2015).

[1] Cavendish Square Group

[2] Centre for Mental Health and London School of Economics

1.4 In order to address variation and improve care for our population, as well as to meet the requirements set out in the Five Year Forward View and Future in Mind, the 5 NCL Boroughs will be working together on 8 areas as part of the NCL STP CAMHS and Perinatal initiative.

1.5 These are:

1. **Shared Reporting Framework** - to enable comparison and shared learning across the 5 boroughs
2. **Workforce Development and Training** - planning for the workforce in order to meet the mental health and psychological well-being needs of children and young people in NCL; including CYP IAPT workforce capability programme
3. **Specialist Community Eating Disorder Services** - dedicated eating disorder teams in line with the waiting time standard, service model and guidance
4. **Perinatal Mental Health Services** - to develop a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
5. **Crisis and Urgent Care Pathways** - 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis; this includes local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136 facilities for children and young people.
6. **Transforming Care** - supporting children and young people with challenging behaviour in the community, preventing the need for residential admission
7. **Child House Model/Child Sexual Assault (CSA) Services** - following best practice to support abused children in NCL
8. **Young People in the Youth Justice System** - working with NHS E to develop co-commissioning model for youth justice

1.6 In the development of the NCL CAMHS work, the principles of THRIVE will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

Priority 1: Shared Reporting Framework

Rationale for Joint priority across NCL:

2.1 In order to better plan across a broader NCL footprint we are working with providers to develop a minimum data set for local reporting on key indicators including quality indicators such as DNA rates and clinical outcomes. Importantly, we also wish to embed approaches such as the Thrive model with evaluation embedded in the process.

Our Ambition

- To better understand activity, performance and quality through the use of a set of metrics that support us to benchmark and combine consistently measured data
- To drive significant improvements in performance, requiring providers to demonstrate the production of better outcomes for children and young people, and holding them to account where they are failing to meet agreed outcome, output and quality targets.

Current picture

2.2 Across NCL there are currently a range of providers including:

- Barnet and Enfield Mental Health NHS Trust
- Tavistock and Portman Foundation Trust
- Whittington Health NHS Trust
- Royal Free NHS Foundation Trust
- Voluntary Sector Organisations unique to each Borough

2.3 Each provider uses a different Electronic Patient Record (EPR) system and has different reporting and monitoring arrangements with commissioners.

What we are aiming to achieve across NCL:

2.4 Currently we have a range of providers both within the NCL Boroughs and across them. We are working with all providers to agree a data set using definitions from the mental health minimum data set where available to ensure consistency. This will provide a mechanism for local reporting that will pick up a set of basic indicators to better monitor activity and performance across multiple providers, both for each borough and across the broader STP footprint.

- Agree a dataset with providers for more consistent and comparable monitoring
- Agree a methodology for recording RTI and RTT waiting times from the perspective of the Child/Young Person based on NICE Guidelines

2.5 Improving access is a key driver for us. In order to better ensure that access is improving we are working on waiting time standards and an agreed methodology for measuring waiting times which takes into account the wait from the perspective of the family. Waiting times will be measured from the first point of contact with the system, rather than from the first point of contact with a particular service. This will ensure that people being redirected or passed to an alternative provider are not disadvantaged.

Key Milestones

- Development of Dataset (Completed)
- Agreement of Dataset with Providers (Partially Completed)
- Implementation of Dataset (2016/17)

- Reporting on Dataset (2017/18)

Funding

2.6 The changes to reporting do not require any additional funding and will be managed through the contracts.

3 Linked to key policies and initiatives

Future in Mind	• Mental Health Minimum Dataset (CAMHS) • Children and Young People's IAPT Programme

Priority 2: Workforce Development and Training

Rationale for Joint priority across NCL:

3.1 Across NCL, there are three mental health trusts that provide CAMHS services for the 5 boroughs. In addition, the specialist Eating Disorder Service for the 5 boroughs is provided by Royal Free London NHSE Trust. Due to the shared provider landscape, along with the migration of our population within the NCL patch, it has been agreed to conduct workforce mapping across the entire patch as this is seen as the most beneficial and efficient method of doing so, while also allowing for local variations in workforce need. The result will be a multiagency strategy to develop the workforce for the NCL STP footprint.

Our Ambition:

3.2 To review the current workforce provision which will enable the planning for the workforce requirements in order to meet the mental health and psychological well-being needs of children and young people in NCL; including the CYP IAPT workforce capability programme. It is anticipated this will result in more children and young people being able to access support, with more professionals able to support children and young people with mental ill health.

What we are aiming to achieve across NCL

3.3 From undertaking the mapping of the current workforce, we will be able to identify what changes to the NCL CAMHS workforce will be required in order to deliver the new model of care and support contained in the 8 sections of the NCL CAMHS and Perinatal STP initiative, and achieve the ambitions of the Five Year Forward Plan, the Mental Health Taskforce and Future in Mind. Questions to be addressed are: what additional staff are required, and how will we recruit these; what new roles are required; what alternative ways of delivering support are required; and what training is required to ensure the workforce is adequately skilled to deliver the support required by children and young people with mental health needs. The mapping will also inform plans and commissioning intentions.

3.4 This multiagency workforce plan will be developed across partners and wider stakeholders, looking at how care can be delivered to maximise support. This may result in care and support being delivered in alternative ways to how it is delivered currently, such as increasingly through the voluntary sector, school and colleges. We do not envisage moving to a single workforce model for each area but will share ideas, expertise and learning across the area in order to produce a more efficient CAMHS system.

Key Milestones

- Secure funding – September 2016
- Appoint resource to conduct mapping – October 2016
- Completed mapping to be reviewed and next steps agreed – November 2016
- Wider stakeholder engagement – January 2017
- Completed workforce plan – March 2017

Funding

3.5 Commissioners are seeking funding for initial mapping work from NCL MH STP Programme funding.

Linked to key policies and initiatives

Linked to key policies and initiatives:	Aims
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Roll out CYP IAPT – incl. training via CYP IAPT for staff under 5, autism, and LD • Make MH support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH

Priority 3: Specialist Community Eating Disorders Services

Our Ambitions

4.1 All NCL CCG's submitted plans for improving provision for eating disorders across the area in our Local Transformation plans 2015 / 16. NCL jointly commissions the specialist Eating Disorders Service at the Royal Free Hospital, Barnet CCG is the lead commissioner. The services comprise of the Intensive Eating Disorder Service (IEDS) and the Community Eating Disorder Service. Priorities we identified in Transformation Plans 2015.16 included

- Increase capacity and reduce waiting times to meet key requirements of NICE Guidance
- Outreach education training for eating disorders to primary care health and education staff
- Offer telephone support for General Practitioners
- Improved performance monitoring and management

4.2 Baseline performance for referrals under 4 weeks was 54% 2014.15. NCL and RFL agreed milestone for improvement at 60% Q4 2015.17, 80% 206.17

Progress against Ambitions

4.3 Overall the number of referral in 2015.16 (181) increased by 50% since to 2012-13 (119) and increased 26% compared to the two previous years. 94.5% of referrals received were accepted in 2015.16.

Referrals for all five boroughs for 2015.16		
CCG	**Number of referrals received**	**Number of referrals accepted**
Barnet	63	60
Camden	35	33
Enfield	22	21
Haringey	32	31
Islington	29	26
TOTAL	181	171

4.4 Waiting times for first appointment for ED patients seen in 2015/2016: In 2015/2016, 69.2% of patients were seen within 3 weeks and 6 days of referral and 97.5% within 6 weeks. This was a significant improvement from previous year (54%).

CCG	Waiting Times to first face to face contact (weeks)	Number of patients (Percentage of patients)
All NCL CCGs	**0 - 3**	69.2%
	4 - 6	28.3%
	7 - 9	2.5%
	10 - 12	0%
	13 – 18	0%
	18+	2.2%

4.5 The table below shows the waiting times for first appointment for patients referred in Q4 of 2015/2016 which evidences progress in the first period after the additional investment was made. At this time referrals were not categorised in the RFL reporting system as 'urgent' or 'non-urgent'.

	Waiting Times Q4	Performance
All NCL CCGs	**0 - 3**	36 (75.6%)
	4 - 6	9 (22.2%)
	7 - 9	1 (2.2%)
	10 - 12	0 (0%)
	13 – 18	0(0%)
	18+	0 (0%)

4.6 NCL led by Barnet CCG initiated performance monitoring meetings in Q1 2016.17 with a new set of targets and data reporting. RFL began reporting urgent and non-urgent referrals separately and further progress was made in reducing waits with 100% of urgent referrals seen with 1 week and 85% of non-urgent with 4 weeks so a total of all referrals seen with 5 weeks of 97%

		Waiting Times Q1 2016.17	***Waiting Times Q1 2016.17***
All NCL CCGs		**Urgent**	**Non-Urgent**
	0 – 1	4 (100%)	2 (7.4%)
	1 – 2	0 (0%)	8 (29.7%)
	2 – 3	0 (0%)	7 (25.9%)
	3 – 4	0 (0%)	6 (22.2%)
	4 – 5	0 (0%)	3 (11.1%)
	5 – 6	0 (0%)	0 (0%)
	6 – 12	0 (0%)	1 (3.7%)
	12+	0 (0%)	0 (0%)

Workforce Capacity NCL/RFL Eating Disorders Services: Roles	***Grade***	***Existing funding WTE CAMHS and Eating Disorders***	***+Transformation Funding additional WTE Eating Disorders***
Clinical Psychologist	***7***	***1.4***	***1***
Clinical Psychologist	***8a***	***1.2***	
Clinical Psychologist	***8c***	***1***	
Psychotherapist	***8d***	***.6***	
Psychotherapist	***8a***	***1.9***	***.4***
Family therapist	***8a***	***.8***	
Family therapist	***8b***	***.6***	
Family therapist	***8c***	***.4***	
Psychotherapist	***7***		***.8***
Family therapist	***7***		***.8***
Assistant Psychologist	***4***	***4.6***	
Health Care Support Worker	***3***	***1***	
Reception/Med sec	***3-5***	***3.1***	***.4***
Dietician	***7***	***.4***	***.6***
Consultant		***4.4***	
Junior Medical Staff		***1***	***.6***
Nursing outpatient	***6***	***1***	***.87***
Nursing outpatient	***7***	***1***	
Nursing	***8a***	***2***	
Nursing	***7***	***1***	
Nursing	***6***	***2***	
Nursing	***5***	***7***	

Next Steps	Targets	Performance milestones
Service Improvement	RTT Non-Urgent < 4 weeks Urgent < 1 week	90% 2017.18 95% by 2018.19
Performance Management	Quarterly reports and Meetings Change from Reporting RTA to RTT (Referrals to Treatment)	Ongoing By Q4 2016.17
Workforce Capacity	Recruit to vacancies	Ongoing
Transformation and Development	RFL Service Review More community based work and prevention Community facing training events in place for school and primary care practitioners starting 18th November 2016.	Q4 2016.17 Q4 2016.17 Q3 2016.17

Linked to key policies and initiatives:	Aims
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Make support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH
NCL Sustainability and Transformation Programme	

Priority 4: Perinatal Mental Health Services

Rationale for Joint Priority across NCL

5.1 The population of NCL is approximately 1.4 million people. There are 4 acute Trusts, three mental health Trusts and a range of community providers. In 2014-15 there were approximately 20,000 births to NCL residents and 24,000 births delivered by the local Trusts. Within this provider geography are specialist maternity services centred around a single tertiary level neonatal unit, as well as a number of midwifery led units and home births.

5.2 This is a population with high levels of risk and vulnerability to mental health problems. The population is diverse and growing and experiences significant churn as people using health and care services move in and out of the city. The network covers areas of deprivation and includes women who are older, more likely to be overweight and obese and to experience gestational diabetes during pregnancy when compared with national averages. There are high numbers of households in temporary accommodation across the patch and around a quarter of the population in NCL do not have English as their main language.

5.3 Suicide is one of the leading indirect causes of death (CMACE 2011). In a recent audit by BEH Mental Health Trust there were two maternal suicides in 2014/2015.

Our Ambition

5.4 Our ambition for 2020 is to improve the care pathways so that there is better continuity of care. This may involve redesign and investment. As part of the redesign services should be co-located with maternity services e.g. IAPT, drug and alcohol services. All CCGs will have parent infant services.

5.5 There is an NCL working group led by the Tavistock and Portman Clinic. The work of this group is informed by stakeholder involvement e.g. Cocoon, the NCL maternity services participation groups, the Family Nurse Partnership in the Maternity Services Liaison Committee.

Current picture

5.6 There is no specialist community mental health service in NCL despite having some good parent-infant and psychology services. The majority of the local maternity services have perinatal mental health specialists. The continuity of care and the care pathways is very complex across several mental health providers and local community services. In Barnet, Enfield and Haringey Mental Health Trust there is no specialist perinatal mental health service and BEHMHT is one of two mental health trusts in London without a dedicated service.

5.7 The availability of services for families affected by perinatal mental illness in North Central London is dependent on where a woman lives and where she chooses to have her baby. Only women who choose to give birth at the Whittington can expect to have access to a comprehensive, specialist perinatal mental health service. Services are in effect provider delivered, rather than effectively commissioned.

5.8 NCL partner organisations have calculated that 1,200 women a year will be supported by a proposed perinatal mental health service model. This is equivalent to 5% of all women giving birth in NCL and includes women that have a previous history of serious

illness, those experiencing psychosis, serious depression or other complex difficulties. The service will focus resources and develop approaches to engage people who find help harder to access including teenagers and mothers from some BME groups including those for whom English is not their first language.

5.9 Outlined below are the rates of perinatal psychiatric disorder per thousand births and the numbers that would be expected by borough.

2014 births ONS			Barnet 5244	Enfield 4824	Haringey 4006	Camden 2700	Islington 2879
Disorder	Established rate per 1000 births	% women affected	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases
Postpartum psychosis	2/1000	0.2%	10	10	8	5	6
Chronic serious mental illness	2/1000	0.2%	10	10	8	5	6
Severe depressive illness	30/1000	3%	157	145	120	81	86
Mild-moderate depressive illness	100-150/1000	10-15%	524-786	482-724	400-601	270-405	287-431
Post-traumatic stress disorder	30/1000	3%	157	145	120	81	86

Birth Data: ONS, July 2015

What we are aiming to achieve across NCL

5.10 This ambition is dependent on additional funding. An NCL application has been submitted to NHS England by Islington CCG and clinically led by the Tavistock and Portman Trust.

5.11 We are proposing a hub and spoke model for North Central London. The hub will be primarily administrative with a central meeting place for training and to oversee and maintain quality and equity across the patch and co-ordinate activity and outcome data. Accommodation has already been provisionally identified on both the St Ann's and Whittington sites. There will be five spokes each relating to one of the five maternity units in NCL so that each maternity unit has clinicians with whom to make effective relationships but facilitating cross cover and a capacity to respond to urgent referrals. Although the maternity units are best placed to identify early vulnerability throughout pregnancy and the early post-natal period, we anticipate that many women will be identified by other professionals including GPs, adult MH workers including IAPT, HVs, CAMHS, Children's Centre staff, etc. The work strand will overlap with, and be included in, work being undertaken on pathways.

Key Milestones

5.12 In addition to the proposed implementation plan submitted as part of the NCL application, the key milestones have been identified:

1. Continue to develop NCL Perinatal Mental Health partnership and workstream
2. Secure additional NHSE funding for community based perinatal mental health service
3. Continue mapping of care pathways
4. Continue improving communication between providers
5. Continue improving care pathways from pre-conception to one year after birth
6. Continue NCL/Pan London perinatal training programme
7. Continue NCL/Pan London perinatal mental health champions programme
8. Ensure each service provider has perinatal mental health champions

Funding

5.13 Below are the proposed costs for implementing the community perinatal health services within NCL.

	2016/17		**2017/18**		**2018/19**	
Costs Staffing, building, equipment and training	£163k		£1,233k		£1,218k	
Existing and proposed North Central London annual resource	Barnet Camden Enfield Haringey Islington	- - - - -	Barnet Camden Enfield Haringey Islington	£ 50,000 £ 40,000 Resource to be identified through redesign of existing services. £ 80,000 £ 150,000	Barnet Camden Enfield Haringey Islington	£ 100,000 £ 40,000 Resource to be identified through redesign of existing services. £ 80,000 £ 150,000

Note: There are other costs associated with the care pathways and part of the NCL Perinatal Mental Health Group will be to identify existing services, current expenditure and gaps.

Linked to key policies and initiatives

- NCL Perinatal Mental Health Strategy
- Healthy Child Programme
- NICE Guidance on Perinatal Mental Health

Priority 5: Crisis and Urgent Care Pathway and Collaborative Commissioning proposal of Tier 4 beds.

Rationale for an NCL wide approach

6.1 Local management of CAMHS beds and the development of 24/7 community based rapid response service for children and young people experiencing mental health crisis are national and regional priorities. The North Central London Sustainable Transformation Plan, mental health work stream, includes out of hours crisis response for children and young people across all boroughs. Our ambition to deliver this will work best across NCL wide population to deliver economies of scale and an effective, efficient service.

Aim

6.2 We will develop a local integrated pathway for CYP requiring beds that includes rapid community based response to crisis. This will result in admission prevention, reduced length of stay and support appropriate and safe discharge and a reduction of admission to acute paediatric beds across the footprint. We will work closely with Specialised Commissioning and jointly with Health and Justice Commissioners to develop local integrated pathways including transitioning in or out of secure settings, SARCs plus liaison and diversion provision.

I. Local management Tier 4 beds (Collaborative Commissioning)

6.3 The Tavistock and Portman NHS FT is co-ordinating a provider led bid to NHSE to manage inpatient stays of children and young people across NCL. The stakeholder partnership includes Barnet, Enfield and Haringey Mental Health NHS Trust, Whittington Health, Royal Free NHS Foundation Trust, CAMHS commissioners from all boroughs. The data we have on admissions and length of stay in CAMHS beds across NCL is shown on the next page.

NCL Tier 4 CAMHS Admissions

Data Source	NHS E	NHS E	NHS E	NHS E	NHS E	HLP	HLP	HLP
Year	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 total	15-16 HLP London	15-16 HLP Out of London	15-16 HLP total
Barnet est popn 2016 aged 0-18 **48,471** (GLA, 2015)								
Admission	33	39	34	7	41	35	6	41
LOS London	1,923	2,220	2,740	749	3,489	2,852	735	3,587
Cost	£958,686	£1,007,955	£1,595,878	£467,354	£2,063,232	£1,597,062	£459,307	£2,056,369
Av Cost	£499	£454	£582	£624	£591	£560	£625	£573
Camden est popn 2016 aged 0-18 **22,597** (GLA, 2015)								
Admission	5	19	9	14	23	11	10	21
LOS London	650	1,218	701	1,064	1,765	1,049	1,021	2,070
Cost	£143,739	£601,102	£630,340	£663,904	£1,294,244	£631,263	£645,020	£1,276,283
Av Cost	£221	£494	£899	£624	£733	£602	£632	£617
Enfield est popn 2016 aged 0-18 **44,312** (GLA, 2015)								
Admission	20	23	5	6	11	4	5	9
LOS London	1,187	1,165	185	213	398	473	207	680
Cost	£663,675	£625,566	£291,389	£132,906	£424,295	£291,389	£174,103	£465,492
Av Cost	£559	£537	£1,575	£624	£1,066	£616	£841	£685
Haringey est popn 2016 aged 0-18 **31,504** (GLA, 2015)								
Admission	22	16	10	4	14	9	2	11

LOS London	1,331	1,532	435	151	586	833	148	981
Cost	£679,371	£821,833	£500,394	£94,219	£594,613	£500,394	£90,018	£590,411
Av Cost	£510	£536	£1,150	£624	£1,015	£601	£608	£602
Islington est popn 2016 aged 0-18 **21,344** (GLA, 2015)								
Admission	13	17	7	2	9	7	3	10
LOS London	697	1,591	857	81	938	1,234	81	1,315
Cost	£142,332	£810,165	£786,502	£50,542	£837,043	£786,502	£53,600	£840,102
Av Cost	£204	£509	£918	£624	£892	£637	£662	£639
NCL est popn 2016 aged 0-18 **168,226** (GLA, 2015)								
Admission	93	114	65	33	98	66	26	92
LOS London	5,788	7,726	4,918	2,258	7,176	6,441	2,192	8,633
Cost	£2,587,803	£3,866,621	£3,804,503	£1,408,924	£5,213,427	£3,806,609	£1,422,048	£5,228,657
Av Cost	£447	£500	£774	£624	£727	£591	£649	£606

Note

- 15-16 out of London cost base assumed at £623.97 per unit
- Data excludes ED, CLD, PICU, Low Secure, Medium Secure, Daycare, SCAAND (GOSH, Ellern Mead excluded)
- For HLP OOA where NHS E had provider cost as £0, updated to £623.97
- Before managing tertiary budget locally, would need support from NHS E to validate data as variances between data sets
- Due to LOS and cost coming from different sources for in London placements, cannot be 100% sure that the LOS and costs align. Admissions and costs do align.

II. Community based rapid response to young people experiencing crisis

6.4 A mental health crisis is defined as when someone is in an emotional or mental state where they need urgent help. A mental health crisis can be unpredictable. A person in crisis may need support at any time of day or night. They may seek help from a GP, or medical attention from a local hospital, or the crisis may result in an intervention by the police.

6.5 We are in the process of gathering data about the numbers of children and young people presenting to emergency departments and those being admitted in all boroughs.

6.6 The picture at the moment is that at least **350** children and young people were admitted to acute paediatric wards in 15-16. However at this stage the data is incomplete. We are also consulting with children and young people to inform both proposals for the local management of inpatient beds and development of crisis care provision.

III. Crisis Concordat and young person appropriate Place of Safety

6.7 Crisis Care Concordat planning is taking place across North London Central (NCL) with local forums developing action plans for Camden & Islington and for Barnet, Enfield & Haringey. This has led to work on revising local S136 pathway protocols and exploration of options to further young person appropriate develop local place of safety provision.

6.8 Simultaneously work is being undertaken by the NCL stakeholder partnership group to review places of safety currently provided across NCL, focussing on the appropriateness of provision for children & young people.

Key Milestones

1. Project plan locally to pilot extended hours for community based out of hours crisis response across NCL. November 2016
2. Recruitment plan with identified provider Trust December 2016
3. Proposed go live date of April 2017
4. NHSE approval to develop local management of provider led CAMHS inpatient beds
5. Project plan to implement local management of inpatient beds. January 2017

Summary

1. NCL boroughs will develop jointly a whole system pathway to respond to children and young people experiencing mental health crisis as required. This will include primary care.
2. The system wide pathway includes local management of inpatient beds for children and young people as required
3. Outcomes will include reduced attendance and admissions to acute hospital beds; reduced admissions and length of stay to T4 beds; improved patient experience and patient outcome measures
4. The timescale for delivery of 24/7 response is by 2020.

Priority 6: Transforming Care Programme

Rationale for Joint priority across NCL

7.1 Transforming Care is a nationally driven programme to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

7.2 The Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

7.3 We are working together across North Central London, and in collaboration with Local Authority Children and Young People's Services, in order to deliver this programme and have identified a number of areas in common for joint work.

Our Ambition

- To keep Children and Young People with their families through commissioning an appropriate range of community and respite provision that reduces the need for residential and inpatient admissions.

What we are aiming to achieve across NCL

I. Care and Treatment Reviews (CTRs) and Admission Avoidance Register

7.4 When someone is identified as being at risk of admission they are placed on an 'admission avoidance register'. This enables professionals to arrange a Care and Treatment Review meeting with the child/young person and/or their parent/carer to think about what can be done to support them in the community and to retain oversight and regular review of the case. In NCL we are working towards a single process for this. Guidance is being completed for professionals to support the identification of those at risk and how to seek consent from the family to join the register. We are also looking at how we can also support those at risk of requiring a residential placement, through additional support to enable families to stay together.

II. Early support for behaviour

7.5 There are different models for delivering behaviour support across NCL. We intend to undertake a sufficiency audit to look at those different models, and numbers of children and young people accessing this support against identified need.

III. Intensive Family Support

7.6 Enfield are currently developing an intensive family support model based on the Ealing model, using positive behaviour support. The proposal is for an Intensive Behaviour Therapeutic & Assessment Service (IBTAS) to develop a viable local alternative to for a cohort of young people with challenging behaviours so that they are intensively supported preventing such behaviours deteriorating to the point where external placement become the only solution. The new service aims to avoid permanent residential accommodation for approximately four children / young people per year

through a combination of timely and intensive therapeutic support and the provision of regular, planned short breaks. With small numbers such as these across each of the Boroughs consideration is being given to the possibility of a jointly commissioned service, or roll-out of a single model across the five CCGs.

IV. Shared Learning to inform Commissioning

7.7 The Care and Treatment Review process enables colleagues across NCL to share learning about what is helpful in both preventing the need for Tier 4 services, including hospital admissions, and for expediting step down. We aim to monitor the approaches tried across NCL to inform future commissioning intentions. For example we are looking at the possibility of mentors who visit the young person in hospital and then support them when they return to area. As admissions are very small numbers, this is an area which would be better considered across the larger NCL footprint.

V. Improving Pathways and Models of Care

7.8 We are currently working across adult's and children's services to look at the pathways for ASD, from pre-diagnosis to post-diagnosis support, looking at any opportunities for joint working. Additionally we will be considering the different models of CAMHS delivered to those with learning disabilities and/or ASD. There are a number of teams across NCL using different models, we will be working closely to review these models in order to take a view as to which functions are better delivered locally (for example support into special schools) and which could create improved quality and efficiency through jointly planning for (for example specialist assessments).

VI. Workforce

7.9 Integral to the pathway review outlined above is the workforce. This will be reviewed in the context of the pieces of work to look at current services and pathways and in the context of the HEE and CYP-IAPT opportunities for staff development. Some of the presenting issues which our teams support are quite rare, providing an ability to call on a wider workforce mean that specialist expertise are available to a larger range of families, reducing the need for high cost specialist assessment and treatment services which may currently be contracted on a cost per case basis, and enabling that resource to be used to invest in local services.

VII. Market Development

7.10 In order to deliver a flexible model of community provision to avoid admission to hospital or residential units, we need to develop the market across the sector. This will involves stimulating the market and working jointly to attract providers who can provide innovative solutions. Commissioning intentions will be led by the outcomes of the sufficiency audit around early help, and the learning from CTR processes.

VIII. Capital and Housing

7.11 NCL will have a representative on the pan- London Capital and Housing sub-group to support the development of capacity on a regional basis.

Key Milestones

- Establish consistent process for admission avoidance register
- Improve data through work with providers to record LD/ASD and through better use of and profile of admission avoidance register
- Develop a clear engagement plan to ensure patient/family rep are engaged as partners at all stages and levels of decision making

- Complete sufficiency audit of current behaviour support and complete any required business cases for funding
- Market Testing
- Develop a new service model (avoidance of admission)
- Develop a new service model (moving individuals back to the community)
- Reduce the use of hospital beds in line with the TC assumptions from 43 in April 2016 to no more than 21 in March 2019

Funding

7.12 We will be seeking to bid for Transforming Care funding in order to support this area of transformation. We will also be looking locally at developing business cases to support this work through the reduction of costly residential placements.

Linked to key policies and initiatives:

- Transforming Care: A National Response to Winterbourne View - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
- Care and Treatment Review: Policy and Guidance - https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf

Priority 7: Development of local Child Sexual Assault (CSA) Services / Child House Model

Our ambitions

8.1 This priority area sets out the work to date at a pan-London level and locally in North Central London to progress towards the Child House model for victims of child sexual abuse (CSA), including sexual exploitation. The 2015 "Review of the pathway following Children's Sexual Abuse in London" recommended the Child House model based on the Icelandic Barnahus[1]. This model has been subsequently been supported by Children's Commissioner for England, Home Secretary and the London Mayor.

8.2 It was estimated by the NSPCC study[2] that 9.4% of 11 to 17 year olds had experienced sexual abuse (including non-contact) in the past year. The same incidence as childhood asthma (9%) and more common than diabetes (2.5%), and yet these children are hidden from sight. When they do come forward, the minimum that all children and young people that experience sexual abuse should expect includes:

- A safe place to live
- Being listened to and believed
- Ability to develop a narrative
- Early emotional support is available before therapeutic interventions start e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on returning to normal daily life – such as night terrors, flashbacks, self-harm
- Reducing risk of further abuse

8.3 Following the publication of the Review of services in London, a North Central London sector steering group was established, one of 5 across London, to look at the outcomes of the review and take forward recommendations across a sector wide partnership. CAMHS services are central to this piece of work and NCL CAMHS Commissioners have come together to support this initiative and ensure the sector wide work is reflected in CAMHS transformation plans as well as being linked into our NCL Sustainability and Transformation Plan.

- **A single pathway for C&YP across NCL who have experienced child sexual assault**

8.4 The partnership is working to bring clinicians together from existing services, identifying resources to ensure CAMHS and Advocacy support is available as part of the pathways, and agreeing access for young people is based on what makes sense for them rather than geographical boundaries. This is viewed as the first step in improving available support and initial funding has been made available from DH to support a 1 year pilot of providing CAMHS and Advocacy into these pathways.

- **Development of the Child House Model**

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[1] Link to Children's Commissioner report on Barnahus
https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[2] Radford L, Corral S, Bradley C et al. Child abuse and neglect in the UK today, 2010

8.5 Ultimately the ambition is to develop the Child House Model in NCL. Following the development of this initiative, we would envisage a reduction in service demand on tier III CAMHS, and reduced wait times, through early intervention to minimize the risk of severe and enduring mental health conditions. Safeguarding teams and children's social care teams will be supported by a streamlined process to access all health and police investigations immediately after disclosure, as well as through a case management and advocacy service in the Child House.

Current picture

8.6 NCL Commissioners previously invested CAMHS Transformation funding in a demand and capacity mapping project of CSA/CSE services. This work was commissioned to map current commissioning arrangements and service provision, estimate future demand, and provide an options appraisal and business case for the CSA hub and Child House model.

8.7 Early intervention emotional support services are being designed as part of the CSA Hubs in North Central and South West London, funded by the Department of Health and local CCGs respectively. This evidence-based support gives immediate access to CAMHS or advocacy services and is predicted to reduce progression to PTSD and the need for long-term CAMHS intervention.

8.8 In the North Central Sector:

- CSA medical examinations are being provided by two CSA Hubs at University College Hospital and St Ann's Hospital.
- The Department of Health has funded an early intervention emotional support service for all children and young people accessing the CSA Hubs. The service will be provided by the Tavistock and Portman and Solace Women's Aid, and will consist of 1 WTE CAMHS clinician and 0.8 WTE Child Advocate. The service is currently being designed and is due to launch in September 2016.
- 3 of the 5 North Central CCGS have funded demand and capacity mapping to be completed in August 2016
- A multiagency co-design workshop ran in March 2016 with more than 50 professionals attending. A smaller multiagency group is now working to develop the detail of the Child House model for the sector
- Engagement with children and young people is ongoing with consultations already conducted with Barnet Youth Board, Enfield Youth Parliament, and Islington In Care Council

8.9 Funding has been secured from MOPAC to support the development of two Child House Pilots in London. We are currently awaiting a decision as to where these pilots will be sited.

8.10 If successful in the first instance this will be done by looking to redesign existing resources and services to enable CAMH services to be delivered from a Child House to support C&YP across NCL accessing services here.

8.11 We will also be utilising the findings of the NCL mapping to consider the data and the projected numbers of C&YP expected to access services (it is thought this project will uncover current unmet need) and jointly consider commissioning arrangements to further support the model with CAMHS input

Benefits

- Clear pathway for children and families to use existing commissioned services in paediatrics, CAMHS and early help as well as third sector provision
- Reduced pressure on CAMHS specialist inpatient and outpatient services, through early emotional support and stabilisation of child and family, reducing the risk of progression to long-term mental health conditions and emergency presentations in mental health crises
- High quality medical examinations – sufficient throughput to meet the RCPCH guidelines in all boroughs
- Children and families less traumatized
- Doubling of conviction rates at trial [3] [4]
- Significant long-term savings for the health and social care economy through reduction in chronic mental health, drug and alcohol use, further abuse and sexual violence, school refusal and unemployment, dependency. NSPCC estimates London Alone spends £0.4billion on the outcomes of unsupported victims of CSA.

Next Steps

- October 2016 – Notification of decision re location of MOPAC funded pilot sites for Child House Model
- December 2016 – Discussion with existing providers re service reconfiguration to support implementation by April 2017 (if successful pilot area)
- April 2017 – Review and consider how the current CSA CAMHS and Advocacy services (1 year funding from DFE) are mainstreamed into our local pathways.
- December 2017 – review Child House reconfigured pilot and numbers of C&YP access data to consider additional funding to be made available across the sector for April 2018.

Funding

8.12 Commissioning intentions reflect a commitment to service redesign to reconfigure existing pathways in the first instance to support the Child House Model

8.13 We are awaiting the outcome of the funding decision by The Mayor's office regarding the location of the 2 proposed pilot sites in London.

8.14 Further funding decisions will then be made across NCL re identification of additional funding if and where required.

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promote early Intervention • Improving access and reducing waiting times • Make support more visible and easily accessible

[3] Link to Children's Commissioner report on Barnahus https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[4] http://www.bvs.is/media/barnahus/Dublin,-sept.-2013.pdf

NCL Sustainability and Transformation Programme	• MH Workstream

Priority 8: Pathways for Young People in the Youth Justice System

Our Ambitions

9.1 Future in Mind 2015 outlined the need to transform 'care for the most vulnerable' which includes mental health of children who come to the attention of criminal justice system. The 'Health and Justice Specialised Commissioning of Children and Young People's Mental Health Services' transformation work stream aims to address this gap.

9.2 We wish to ensure timely assessment and support for vulnerable young people with mental health problems before they become ingrained with offending culture. Since 2007, there have been 82% fewer young people coming into the formal Youth Justice System as a result of diversionary activity. Furthermore, the number of young people aged 10-17 years in custody has fallen by 70% over the last decade. Therefore we will develop an NCL offer that reaches young people in the early stages of contact and provide assessment and treatment where needed including those already in YOS caseloads.

Mental Health Needs of Young Offenders

Youth Justice Board research (2005) found that 31% of a 300 sample of CYP had mental health needs, which included:

- 18% having problems with depression
- 10% suffering from anxiety
- 9% reporting a history of self-harm within the last month
- 9% suffering from post-traumatic stress disorder
- 25% identified as having learning difficulties
- Individuals involved in gangs have higher chances of diagnosable difficulties and poorer general mental health than other young people (Coid, et al., 2013).

North Central London STP

9.3 NCL CCG's and YOS Managers are working with Health and Justice partners in the London region across their STP footprint to enhance the local health offer for CYP that come into contact with the justice system. We have agreed and signed a Memorandum of Understanding with the NHSE Health and Justice Team in relation to roles, responsibilities, funding and governance that jointly ensure a comprehensive local response is in place for CYP in the justice system. Detailed proposals for local service provision will be submitted by December 2016 for assurance in order to release resources for commissioning of new capacity

Priorities and Outcomes for the Health & Justice work stream

9.4 Due in part to the success of liaison and diversion schemes in keeping young people out of formal court proceedings we believe that additional capacity for mental health within youth justice must also extend to exploring options for pre-court interventions Our objective is to close the treatment gap and promote integrated commissioning in line with the national health and justice work stream priority areas:

- Development of Specialist Child and Adolescent Mental Health Services for High Risk Young People with Complex Needs
- Development of Collaborative Commissioning Networks between Health & Justice regional teams and CCGs

9.5 Across NCL STP we wish to achieve a reduction in variation in care for CYP in London in contact with the justice system. CYP Mental health pathways will seek to support diversion of individuals, where appropriate, out of the youth justice systems into health, social care, education and training, or other supportive services. We will offer a mental health assessment to every young person at second appointment to support a reduction in re-offending and/or escalation of offending behaviours.

9.6 Each CCG will develop KPI's with their local providers and YOS managers. Some of these will be congruent across the STP footprint while others will have a local focus to reflect the different starting positions of each area. NCL will aim to establish a greater level of consistency across the STP footprint by ensuring all areas have:

Principals of NCL CCG Model for Health and Justice CAMHS
• Single local point of access for all YOS/CAMHS referrals • Service design based on in-reach to YOS and strengthening pathways into community and specialist CAMHS • Measure outcomes using YJS performance monitoring and CAMHS minimum data set • Benchmarking reported outcomes across NCL by 2017.18 • Each YOS/CCG area to develop bespoke aspects of provision based on local needs

NCL also exploring options for STP wide work including:
• Early intervention for Sexually Harmful Behaviours • Self-Harm and Crisis Care • Transition from secure settings into community CAMHS

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Professionals who work with children and young people trained in child development and Mental Health
NCL Sustainability and Transformation Programme	• Efficient use of resources and provision with a view to future proofing local health services.

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AGENDA ITEM 11

	Health and Wellbeing Board **9 March 2017**
Title	**Minutes of the Joint Commissioning Executive Group**
Report of	Commissioning Director – Adults and Health CCG Accountable Officer
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1- Minutes of the Joint Commissioning Executive Group 4 January 2017
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report is a standing item which presents the minutes of the Joint Commissioning Executive Group (formerly known as 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. The Groups key areas of work include the Better Care Fund and Section 75 agreements.

Recommendations

1. **That the Health and Wellbeing Board comments on and approves the minutes of the Joint Commissioning Executive Group meeting of the 4 January 2017.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health and Wellbeing Board on the 26th May 2011 agreed to establish a Financial Planning group (now named the Joint Commissioning Executive Group) to co-ordinate financial planning and resource deployment across health and social care in Barnet. The Joint Commissioning Executive Group (JCEG) meets bi-monthly and is required to report back to the Health and Wellbeing Board (HWBB).

1.2 For 2016-2017 the overall Better Care Fund pot has increased by a £797,000 uplift to core the CCG allocation, £17,059 additional CCG funding and £100,000 increase in Disabled Facilities Grants (DFG) funding. Therefore, the Better Care Fund Allocation for Barnet in 2016/17 is £24,324,521, which includes the Barnet CCG minimum contribution of £22,336,331, additional CCG contribution of £17,059 and Barnet Council's Contribution of £1,971,131.

1.3 The budgets will be used to continue to support the delivery of existing initiatives, as well as any such new initiatives identified to support the delivery of Better Care Fund (BCF) outcomes and the appropriate protection of social care services.

1.4 Given changes in the operating context for the CCG and LBB, the Terms of Reference were updated and agreed in December 2015 (and updated and agreed in April 2016), giving the Joint Commissioning Executive Group main functions:

- To oversee the development and implementation of plans for an improved and integrated health and social care system (including Education where relevant) for children and young people, adults with disabilities, older people, those with long term conditions, and people experiencing mental health problems
- To oversee the delivery of the Better Care Fund including:
  - Holding Joint Commissioning Unit and partners to account for delivery
  - Making recommendations on the governance and legal functions required to develop and implement the Better Care Fund Pooled budget and manage risk and, where necessary, making recommendations on recovery plans
  - Monitoring expenditure for budgets for the Better Care Fund and for wider work to integrate care services.
  - Monitor progress in delivering Better Care Fund services and tracking benefits realisation against these budgets.
- To oversee all Section 75 agreements held between the London Borough of Barnet and NHS Barnet CCG to ensure that they are operating effectively and to bring them in line with overarching Section 75 agreements. Receiving performance reports on Section 75 agreements (at each meeting) and other relevant services/projects.
- To review all annual budget, additional budget, budget virement and all new expenditure commitment proposals relating to the Better Care Fund, or to other joint budget arrangements prior to these being taken through the approval processes required under each partner's own scheme of delegation.

- To approve the work programmes of the Joint Commissioning Units (adults and children).
- To develop and review the work programme for the Health and Wellbeing Board and make recommendations for amendments or additions.
- To review reports being considered by the Health and Wellbeing Board which have financial or resource implications.
- To receive financial reports (Better Care Fund and Section 75 reports).
- To recommend to the Health and Wellbeing Board, Council Committees and Barnet CCG's Finance Performance and QIPP Committee how budgets should be spent to further integrate health and social care.
- To ensure appropriate governance arrangements and management of additional budgets delegated to the Health and Wellbeing Board.
- To agree business cases arising from the Joint Commissioning Units for adults and children's, subject to both the Council and Barnet CCG's governance framework or Scheme of Reservation and Delegation
- To support the refresh of the Joint Strategic Needs Assessment and oversee the refresh and implementation of the Joint Health and Wellbeing Strategy.
- To develop and maintain a forward work programme to ensure strategic and operational alignment between the Council and Barnet CCG. All members will contribute to the work programme.

1.5 Minutes of the meeting of the JCEG held on the 4 January 2017 are presented in appendix 1. In January the Group –

- Discussed the content of the North Central London Sustainability and Transformation plan; ensuring that this is appropriate from a Barnet perspective
- Explored the role of JCEG given the changing local and national context since its inception; work will be undertaken to ensure the agendas and work programme are relevant and effective
- Agreed to take forward the quality assessment framework for care homes and for officers to further explore resourcing for the activity
- Reviewed BCF activity and asked for further work to analyse the extent to which the BCF activity is reducing demand in other parts of the health and social care system
- Approved the Section 75 Agreement annual report ahead of its presentation at the HWBB. JCEG requested a report on Community Equipment be presented to the next JCEG meeting in February

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Wellbeing Board established the Health and Wellbeing Financial Planning Sub-Group (now the Joint Commissioning Executive Group) to support it to deliver on its Terms of Reference; namely that the Health and Wellbeing 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 Joint Commissioning Executive Group, the Health and Wellbeing 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 Wellbeing Board is satisfied by the progress being made by the Joint Commissioning Executive Group to take forward its programme of work, the group will progress its work as scheduled in the areas of the Better Care Fund, Section 75 agreements and financial reporting.

4.2 The Health and Wellbeing Board is able to propose future agenda items for forthcoming group meetings that it would like to see prioritised.

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 and children and young people with special needs and disabilities, is a key ambition of Barnet's Joint Health and Wellbeing 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 Joint Commissioning Executive Group acts as the senior joint commissioning group for integrated health and social care in Barnet. The Groups functions relate to the management of local resources, as outlined at 1.4.

5.3 Social Value

5.3.1 Not applicable.

5.4 Legal and Constitutional References

5.4.1 The Health and Wellbeing 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.

5.4.2 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.

5.4.3 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. At Section 195 of the Health and Social Care Act 2012 there is a new duty, The 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.*

5.4.4 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.

5.4.5 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.

5.5 **Risk Management**

5.5.1 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. JCEG 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.

5.6 **Equalities and Diversity**

5.6.1 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.*

5.6.2 The protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

5.6.3 The MTFS has been subject to an equality impact assessment considered by Cabinet, as have the specific plans within the Priorities and Spending Review. The QIPP plan has been subject to an equality impact assessment considered.

5.7 **Consultation and Engagement**

5.7.1 The Joint Commissioning Executive Group will factor in engagement with users and stakeholders to shape its decision-making.

5.7.2 The Joint Commissioning Executive Group will also seek assurance from group members that there is adequate and timely consultation and engagement planned with providers as integrated care is implemented.

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

Minutes from the Health and Wellbeing Board – JCEG
Wednesday 4 January 2017
North London Business Park, Boardroom
10.00 – 11.30

Present:
(AD) Anisa Darr, Resources Director, LBB
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB
(MA) Muyi Adekoya, Joint Commissioning Manager Integration, LBB/BCCG
(JC) James Colledge, Associate Director of STP Interventions, BCCG
(JL) Jeff Lake, Public Health Consultant, Barnet and Harrow Public Health Team
(NH) Neil Hales, Assistant Director Commissioning Development, BCCG
(NS) Neil Snee, Director of Integrated Commissioning, BCCG (Chair)
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

(MJ) Marsha Jones, Darzi Fellow, BCCG (for item 4)

Apologies:
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(RH) Roger Hammond, Interim Chief Finance Officer, BCCG

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair, NS welcomed the attendees to the meeting. Apologies were noted as above. NS introduced JC who has joined Barnet CCG from Enfield to develop more collaborative work. JC will be working on service redesign, Care Closer to Home, data and contract management.	

Policy and strategy		
2.	**NCL Sustainability and Transformation Plan (STP)** NS invited DW to present the STP activity. DW described the project management work undertaken in early December which included work stream and programme reviews. In terms of governance, a Programme Board is replacing the Transformation Group. A Reference group, which will include lay members from Trusts and local politicians, will be set up. Alongside this, collaborative commissioning arrangements have been developed and the council has been asked to nominate people to be involved. **DW will circulate updated work stream and governance information when this is confirmed.** NS updated the group on the collaborative developments including the NCL Committees in Common and the NCL Accountable Officer post which had been advertised. NCL arrangements aim to be operating in shadow form by April 2017. NS described the CCG two year contracting round which was finalised on the 23 December which allowed for some positive developments such as potential pathway redesigns and improved models of payment. NS stated that there was a still work to do to reduce the financial gap. JL asked if there were any updates on the work streams and transformational funding with a particular interest in Prevention and Mental health. DW explained that programme budgets will largely come from existing resources. NS added that the STP Project Management Officer will be responsible for coordinating the NCL bid for national funding.	**DW**
3.	**Role of JCEG** NS introduced the item, noting the work that NH and ZG had undertaken prior to the meeting. NH described the opportunity to review the functioning of JCEG alongside the other joint groups to ensure that the group continues to add value. NH suggested that the group receives updates on the wider JCU work plan which will reflect strategic objectives of both organisations and joint working to allow for an oversight of joint work and the opportunity to direct this work. DW described the need for the group to evolve to respond to national and local changes such as the BCF and integration agenda. DW, speaking for adult services, stated that JCEG needs to be responsible for one plan for Barnet (locality plan) which incorporates the JHWB Strategy, Public Health plans, NCL plans and the BCF. CM added that childrens services and plans need to be included in the work plan particularly the work around resilience and the Children and Young People's Plan. The group agreed that the membership of the group was appropriate and the attendance was good and noted that this is not about updating the TOR but refining the groups work plan and relationship to other boards.	

	ZG to circulate slides. **JCEG to send comments to ZG by 19 January.** **NH/NS/DW/CMc to meet to discuss the role of JCEG.**	**ZG** **JCEG** **CMs/DW/NS/NH**
4.	**Quality assessment framework** *MJ attended for this item* MJ explained that the item had previously been discussed by JCEG in October and was well received with an update requested for this meeting. MJ stated that the care home risk management group, which includes colleagues from BCCG and LBB, has been meeting to develop the tool to allow for proactive improvement to care homes in the borough. MJ described the two options presented in the paper and recommended that: - BCCG second the team that works in the Local Authority - Additional resource would allow for this team to monitor health as well as social care aspects of care in care homes - The cost is estimated to be £170k The recommended model replicates the model used in Birmingham which has been successful. DW agreed that this was the right thing to do but asked for the funding to be discussed further. NS was interested to know how the tool would be targeted and whether there were any current resources which could be redeployed for this. JC added that there would be measurable cost avoidance from this work and that targets can be developed. **The group supported the item but asked for the funding / resourcing and targeting to be further developed.** *MJ left the meeting.*	**MJ/NH**
Performance and finance review		
5.	**BCF performance dashboard** MA summarised the current BCF activity. MA described that despite work to support BILT the impact and outcomes are not as expected. MA is addressing this with the provider through contract arrangement, the group agreed with this action. **MA to circulate BILT performance report.** **MA to draft communication to provider by 6 January (to be sent 13 January).** The group heard that rapid response was performing well. **DW would like to see measures of the prevention work (self-management, self-care, early support) added to the dashboard.** DW felt this is required to be	**MA** **MA** **MA / JL**

	able to assess the effectiveness of the prevention work to ensure that it is supporting BILT and rapid response. NS commented that BCF will be a key piece for the STP. NS agreed with DW and added that BCF needs to be more aligned with other programmes. NS would like more information about what the programmes are doing to positively impact to the indicators. **MA to look at the impact of BCF programmes on the following:** - **Pace and Treat** - **7 day social care** - **Extended hours hubs** - **Discharge to assess** - **Trusted assessor.** DW stated that there will need to be a focused piece of work for next BCF plan as LBB and the CCG need to be confident that the right services in place, targeting the right people and that services are joined up. NS asked for KPIs to be revisited. DW agreed and stated that the indicators need to include resilience, delayed transfers of care (DTOC) and A+E. NS added that he put forward LBB as the frailty work stream lead for the A + E Delivery Board. **NS and DW to discuss social care involvement.** DW questioned the presentation of the permanent admissions to residential care, **MA to add a note and narrative about the change in measure and performance.** DW raised ongoing concern with the reablement indicator. **MA to look at remedial action (either improving data collection or performance).** DW stated that DTOC is also a concern and is looked at in resilience meetings. The change with this indicator is that Barnet is now worse than comparators which was previously not the case. **MA to review BCF programmes for impact, revisit KPIs and ensure appropriate remedial action is in place.** **Finance** AD stated that the BCF finance for month 8 was broadly on track, the group noted the overspend on Community Equipment. DW stated that BCF only included the health contribution to Community Equipment NH described the action being taken to address the overspend including reviewing and challenging spending as well as improving processes and training staff. NH stated that it would be unlikely for the changes to impact this financial year. NS asked for **NH to bring a report to the next JCEG proposing how Community Equipment will be managed in 2017/18.** **The group asked for the papers (finance, performance and BCF plan) to be more clearly linked.**	**MA** **NS/DW** **MA** **MA** **MA** **NH** **MA / Finance**

	Pooling BCF budget AD presented the paper and the group agreed for LBB to lead and manage the pooled budget for BCF. The group agreed for work to progress. AD stated the need for further consideration of details. **The group agreed for AD, JC and RH to move forward with this as soon as possible.**	**AD/JC/ RH**
6.	**S75 Annual report** ZG provided an overview of the Section 75 agreement annual report ahead of the presentation of the report to the HWBB. Section 75 agreements have enabled improved outcomes for residents. ZG highlighted the community equipment overspend (noted by the group earlier) and slight overspend in the Learning Disability section 75. Risks and mitigations were noted by the group. **CM stated that the new Section 75 schedule for CAMHS is being developed.**	**CM**
Business		
7.	**Minutes of previous meeting – 23 November and action log** The action plan was updated. A number of actions were covered in the agenda, in addition: • CM updated the group on the recruitment to substantive posts in childrens joint commissioning which will be advertised soon • LG and DW had met to discuss the Care Closer to Home programme and agreed that it requires governance by a joint group including primary care (as providers and commissioners) as well as clear links to BCF and prevention activity. John Ferguson/NS/NH/DW to discuss incorporating the locality plan discussed today • Section 75 training was completed by 15 staff from BCCG and LBB at the beginning of December, feedback from attendees was positive • Quarter 2 BCF was updated following JCEG in November and submitted to NHS England.	
8.	**Health and Wellbeing Board (HWBB) – Forward Plan** The Group noted the forward work programme for the HWBB.	
9.	**AOB** None.	
	Next meeting (JCEG): Date of next meeting: 20 February 15.30 – 17.00 • STP • JHWB Strategy Implementation Plan • BCF Q3 • S75 progress report	

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AGENDA ITEM 12

	Health and Wellbeing Board **9 March 2017**
Title	**Forward Work Programme**
Report of	Commissioning Director Adults and Health
Wards	All
Date added to Forward Plan	January 2014
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1- Forward work programme of the Health and Wellbeing Board
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 359 3478

Summary

This report introduces the forward work programme for the Health and Wellbeing Board (the 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 Wellbeing Board
- The work programmes of other Strategic Boards in the Borough, thematic Committees and Health Overview and Scrutiny Committee;
- The significant programmes of work being delivered in Barnet in 2017/18 that the Board should be aware of
- The nature of agenda items that are discussed at the Board.

Recommendations

1. That the Health and Wellbeing Board considers and comments on the items included in the Forward Work Programme (see Appendix 1).

1. WHY THIS REPORT IS NEEDED

1.1 At the Health and Wellbeing 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 Wellbeing 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 a period until the end of September 2017.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented to the Board on 19 January 2017 and suggests a refreshed schedule of reports and items for the following eleven months, reflecting the Board's statutory requirements, responsibilities as the Commissioning Committee for public health and agreed priorities set out in the Joint Health and Wellbeing Strategy (2015 – 2020). The work programme will be regularly reviewed and updated.

1.4 Agendas are split into two sections. The first section will be decision and discussion items which will explore topical issues; this section will include external speakers (including residents) to speak at the Board to agree joint action. In the second section, the Board will consider and note papers.

1.5 The Health and Wellbeing Board must ensure that its forward work programme is compatible with the forward work programmes of the 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 Governing Body, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate.

1.6 There are a number of work programmes being delivered in 2017/18 that will be of interest to the Health and Wellbeing Board, and should be reflected in the Board's forward plan. These work programmes include, but are not limited to, Adult Social Care Alternative Delivery Model (ADM) project, Early Years ADM and work across North Central London.

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 Wellbeing Board needs a robust forward work programme to ensure it can deliver on the key objectives of the Joint Health and Wellbeing Strategy, including the annual priorities within the Strategy that were agreed at the November 2015 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 Barnet CCG.

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

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 Health and Wellbeing 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 Wellbeing 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. To explore partnership work across North Central London where appropriate.*

*(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 **Social Value**

5.4.1 N/A

5.5 **Risk Management**

5.5.1 A forward work programme reduces the risks that the Health and Wellbeing 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.

5.6 **Equalities and Diversity**

5.6.1 All items of business listed in the forward programme and presented at the Health and Wellbeing 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 Wellbeing 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.

5.6.2 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. The protected characteristics are - age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.6.3 This is particularly essential when addressing 5.3.2. (6) above regarding health inequalities.

5.7 **Consultation and Engagement**

5.7.1 The forward work programme will be set by the Members of the Health and Wellbeing Board but the Health Overview and Scrutiny Committee also has the opportunity to refer matters to the Board.

5.7.2 The bi-annual 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.

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

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Health and Wellbeing Board Work Programme

March 2017 – September 2017

Contact: Zoë Garbett
Commissioning Lead – Health and Wellbeing (LBB)
Zoe.garbett@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
9 March 2017				
DISCUSSION				
Care Closer to Home	**The Board is asked to consider and discuss the progress to implement care closer to home.**	Director of Strategic Development		No
Public Health Commissioning Plan 2015 – 2020	**The Board is asked to approve the revised PH commissioning intentions (2015-2020) in light of changes to the public health grant. This report will include how PH will contribute to the JHWB Strategy priority to improve mental health and wellbeing.**	Director of Public Health	**Consultant in Public Health**	Yes
Screening update	**The Board is asked to review and comment on the progress made to improve screening uptake in the borough.**	Director of Public Health	**Consultant in Public Health** **NHS England: London Regional Lead**	No
NOTE				
Joint Health and Wellbeing Strategy Implementation plan – performance report including CAMHS transformation plan	**The Board is asked to consider the progress made to deliver the Joint Health and Wellbeing Strategy.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People Director of Public Health CCG Accountable Officer	**Commissioning Lead – Health and Wellbeing**	Yes
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group	**The Board is asked to approve the minutes of the Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable Officer	**Commissioning Lead – Health and Wellbeing**	No

***A key decision is one which**: *Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
8 June 2017				
DISCUSSION				
Family Nurse Partnership	**The Board is asked to note and comment on the borough's Family Nurse Partnership.**	Commissioning Director – Children and Young People	**Head of Childrens Joint Commissioning Senior Commissioner**	No
North Central London Sustainability and Transformation Plan Update	**The Board is asked to review and note the progress to develop a NCL STP.**			
Annual Director of Public Health Report	**The Board is asked to note the report.**	Director of Public Health	**Consultant in Public Health**	No
Update from the Shisha Task and Finish group	**The Board is asked to review the progress made to explore local powers to minimise health harms associated with shisha.**	Director of Public Health	**Consultant in Public Health**	
Childhood Immunisations update including an updated action plan	**The Board is asked to review progress made by NHS England to improve uptake of childhood immunisations following actions given to NHS England at the HWBB in July 2016.**	NHS England – Director of Public Health Commissioning, Health in the Justice System and Military Health	**NHS England – Immunisation Manager**	No
NOTE				
Adults Engagement Strategy Update	**The Board is asked to comment on the progress of the Adults Involvement Board.**	Adults and Communities Director	**Engagement Lead**	No
Update on Substance Misuse services for Adults and Young People	**The Board is asked to note the progress made to deliver substance misuse services.**	Director of Public Health	**Head of Public Health Commissioning**	No

***A key decision is one which**: *Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group	**The Board is asked to approve the minutes of the Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable Officer	**Commissioning Lead – Health and Wellbeing**	No
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
20 July 2017				
DISCUSSION				
Tackling health inequalities in Barnet including suicide prevention	**The Board is asked to review and comment on the approach to tackling health inequalities in Barnet.**	Director of Public Health	**Consultant in Public Health**	
Tackling excess weight	**The Board is asked to note the progress made to tackle obesity in the borough.**	Director of Public Health	**Consultant in Public Health**	
CAMHS	**The Board is asked to comment on the progress to develop a joint children and adolescent mental health service (CAMHS) in Barnet.**	Interim Director of Commissioning Commissioning Director Children and Young People	**Head of Children's Joint Commissioning CAMHS Joint Commissioning Manager**	No
Care home development work	**The Board is asked to review and comment on the developments with care homes.**	Director of Integrated Commissioning	**Joint Commissioning Manager – Integrated Care**	No
NOTE				
Joint Health and Wellbeing Strategy Implementation plan – performance report	**The Board is asked to consider the progress made to deliver the Joint Health and Wellbeing Strategy.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People	**Commissioning Lead – Health and Wellbeing**	Yes

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
		Director of Public Health CCG Accountable Officer		
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes of the Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable Officer	**Commissioning Lead – Health and Wellbeing**	No
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
14 September 2017				
DISCUSSION				
Procurement of sexual health services	**The Board is asked to note the progress of the procurement of sexual health services**	Director of Public Health	**Head of Public Health Commissioning**	No
Update on creating healthy places with the Local Plan	**The Board is asked to note progress.**	Director of Public Health	**Consultant in Public Health**	No
NOTE				
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes of the Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable Officer	**Commissioning Lead – Health and Wellbeing**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
Unallocated				
Fit and Active Barnet - including leisure services and green spaces	**The Board is asked to consider and discuss the progress made to encourage healthier lifestyles.**	Commissioning Director – Adults and Health	**Strategic Lead – Sports and Physical Activity**	No
Health visiting and integration of health services	**The Board is asked to comment on the progress made in developing the Boroughs health visiting and integration of health services.**	Commissioning Director – Children and Young People	**Head of Joint Children's Commissioning**	No
Children's Continuing Care	**The Board is asked to comment on the progress to develop the model for children's continuing care.**	Commissioning Director – Children and Young People	**TBC**	No
Corporate Parenting	**The Board is asked to comment on the progress made to develop the borough's offer to children looked after.**	Commissioning Director – Children and Young People	**TBC**	No
Implementing Barnet's Carers' Strategy	**The Board is asked to comment on the progress made to implement the Carer's Strategy.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People	**Carer's Lead**	No
Devolution – estates	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	Commissioning Director – Adults and Health CCG Accountable Officer	**TBC**	No

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