MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 20TH JULY, 2017

AT 9.00 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	Dawn Wakeling	Councillor Reuben Thompstone
Dr Andrew Howe	Councillor Sachin Rajput	Selina Rodrigues
Chris Munday	Ceri Jacob	Chris Miller
Kay Matthews	Dr Clare Stephens	

Substitute Board Members

Julie Pal	Councillor Richard Cornelius	Dr Ahmer Farooqui
Elizabeth Comley	Councillor David Longstaff	Dr Barry Subel
Helen Petterson	Bernadette Conroy	Mathew Kendall
Ben Thomas	Dr Jeffrey Lake	

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 17 July. Requests must be submitted to Salar Rida at 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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1.	Minutes of the Previous Meeting	5 - 12
2.	Absence of Members	
3.	Declaration of Members' Interests	
4.	Report of the Monitoring Officer (if any)	
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15.	Any Items the Chairman decides are urgent	

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Decisions of the Health & Wellbeing Board

9 March 2017

Board Members:-

AGENDA ITEM 1

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

* Dr Charlotte Benjamin	* Chris Munday	* Cllr Reuben Thompstone
* Cathy Gritzner	* Cllr Sachin Rajput	* Dawn Wakeling
* Dr Andrew Howe	* Dr Clare Stephens	*Julie Pal
Chris Miller	Ceri Jacobs	

* denotes Member Present

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

The Chairman of the Health and Wellbeing Board, Councillor Helena Hart welcomed all attendees to the meeting.

Mr Michael Rich has now left his role at HealthWatch Barnet for a new role as Chief Executive at Epilepsy Research UK. The Chairman, on behalf of the Health and Wellbeing Board, congratulated Mr Rich on his new appointment and extended her sincere gratitude and appreciation of all the sterling work that he had done both as Head of Healthwatch Barnet and as an extremely active and committed Member of the Health and Wellbeing Board.

It was noted that Ms Julie Pal was attending the Health and Wellbeing Board, representing Healthwatch Barnet.

RESOLVED that the minutes of the previous meeting held on 19th January 2017 be agreed as a correct record with all necessary actions having been taken forward.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from:

- Mr Chris Miller (Independent Chairman, Adults and Children's Safeguarding Boards)
- Ms Ceri Jacob (NHS England)

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

Dr Debbie Frost made a joint declaration on behalf of Barnet CCG Board members, Dr Clare Stephens, Dr Charlotte Benjamin and herself, in relation to agenda item 7 by virtue of being impacted by proposals through their respective GP practices and as part of a GP Federation.

Councillor Helena Hart declared a personal 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 reforms.

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

None.

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

None were received.

6. MOTION FROM FULL COUNCIL - VOLUNTEERING IN CARE HOMES (Agenda Item 6):

The Chairman introduced the Report which informed the HWBB of a Motion on Volunteering in Care Homes which was referred from Full Council on 31 January 2017. The Chairman referred to the Report and expressed her own personal support for the sentiments expressed in the Motion. She noted the importance of effective communication between staff and residents at care homes, especially those residents suffering from Dementia very often reverting to their native tongues.

The Commissioning Director for Adults and Health, Dawn Wakeling informed the Board that the Motion and amendment were initially reported to Full Council on 31st January 2017 and referred to the Health and Wellbeing Board in accordance with Council Procedure Rule 23.5.

Ms Wakeling informed the Board about the various volunteering activities taking place in care homes across the Borough. These are organised through a number of community, voluntary and charitable bodies such as Barnet Mencap, Dementia Club UK, Jewish Care, Vintage Volunteering, Advocacy in Barnet and other organisations.

In response to the item, Ms Wakeling briefed the Board about Groundwork, which provides the Council funded volunteering brokerage service between volunteers and organisations. The service is called Volunteering Barnet. She stated that Volunteering Barnet have now been asked to expand the current application form to capture additional information about individual applicants' language skills. This would allow for specific language skills to be recorded by Groundwork and to be considered by care organisations when seeking to recruit volunteers. The Council also provides a Care Quality team which offers advice, guidance, training and support to care and nursing homes. The Volunteering Barnet service will be promoted to local care homes by the Care Quality team.

Dr Debbie Frost, Chairman of Barnet CCG made a request which was supported by the Board to invite a speaker at a future HWBB meeting to provide a verbal update on volunteering in care homes. (**Action: FWP**)

The following motion was seconded and agreed by the Board:

That the Board agrees with the actions noted above, namely that language skills are captured on volunteering application forms and that volunteers are signposted to relevant care homes.

It was therefore **RESOLVED:**

That the Health and Wellbeing Board's instructions in relation to this item are that - the Board agreed with the actions noted above, namely that language skills are

captured on volunteering application forms and that volunteers are signposted to relevant care homes.

7. CARE CLOSER TO HOME (Agenda Item 7):

The Chairman welcomed the report which provides an update on the Care Closer to Home (CC2H) proposals and its aims to improve services in Barnet.

She noted that the Council and CCG have for some time been working on bringing "Care Closer to Home" with the emphasis being re-positioned from patients receiving defined and rigid in-hospital treatment and services to more individually tailored out of hospital health care provision. She re-iterated the HWBB's focus on trying to prevent people from becoming ill in the first place and where that was not possible then preventing them from becoming more unwell. Progress along these lines so far had been through the Better Care Fund plan, the Joint Health and Wellbeing Strategy and a range of joint commissioning works, such as stroke rehabilitation and the community dementia pathway. The North Central London Sustainability and Transformation Plan (NCL STP) has developed a model for Care Closer to Home and this paper outlines the ambitions for Barnet in line with the NCL STP.

Upon invitation from the Chairman, John Ferguson Head of Primary Care Transformation / CC2H lead, Barnet CCG joined the table and presented the report. Mr Ferguson briefed the Board about the key areas of focus and developments so far.

In response to a query from the Board, Mr Ferguson stated that Care Closer to Home is driven by the principle of right care and the right place for patients. The Board heard about the importance of tailoring services around patients and patients' needs.

Dr Frost welcomed the paper and requested that an addition be made to include references to Reimagining Mental Health. (**Action**)

Dr Charlotte Benjamin highlighted the need to focus on needs at a local level. Ms Wakeling also welcomed the proposals and informed the Board about the framework which will be shaped based on local area needs in collaboration with other NCL areas.

Ms Wakeling stated that consideration will also need to be given about the impact of the proposals for all communities and age groups.

Julie Pal, CEO of CommUnity Barnet and representing Healthwatch Barnet, welcomed the proposals and noted the need for effective engagement with service users. Ms Pal requested that communication with residents be undertaken to develop informed and succinct understanding about CC2H proposals. (**Action**)

Cathy Gritzner, Accountable Officer CCG, requested that consideration be given to the way modern technology can be used as part of the development of the CC2H.

Mr Ferguson welcomed the comments and thanked the Board for their contributions.

RESOLVED :

1. **That the Health and Wellbeing Board noted and commented as above on the plans to implement Care Closer to Home.**

2. **That the Health and Wellbeing Board endorsed a shared approach between health and social care commissioners and providers to implement Care Closer to Home.**

8. PUBLIC HEALTH AND WELLBEING COMMISSIONING PLAN 2015 - 2020 ADDENDUM AND TARGETS (Agenda Item 8):

The Chairman introduced the report which sets out the Public Health and Wellbeing Commissioning Plan 2015-2020 and a detailed plan for delivery of the targets in 2017/18.

The Chairman noted that Public Health continues to deliver vital projects and activity supporting the delivery of the Joint Health and Wellbeing (JHWB) Strategy. She welcomed this report as an opportunity for the Board to discuss the delivery of Public Health services in the Borough. The Chairman particularly welcomed the fact that Barnet will be able to continue to provide services beyond the statutory requirements in 2018/19 and thanked both Dr Howe and the rest of the Public Health team for all their efforts in securing this result.

The Board noted that many of the indicators reported are showing as green meaning that they are either on or above target.

Dr Andrew Howe, Director of Public Health presented the report. Dr Jeff Lake, Consultant in Public Health joined the table.

The Chairman stated that she was particularly pleased at the positive impacts of the Shisha campaign as highlighted in the Key Successes on page 9 of the appendix.

In relation to the indicators for PH/S3 and PH/S11 regarding excess weight, the Chairman expressed her disappointment on the very high proportion of both 10-11 year olds and adults who were overweight and asked for an update on the progress of the Obesity Plan.

In response, Dr Andrew Howe, acknowledged the challenges around tackling obesity and setting realistic and ambitious targets. Dr Howe noted that this was a national issue and that work has been undertaken to improve food labelling and encourage physical activity.

He updated the Board on two projects which centre around obesity in families and schools. It was noted that outcomes show that there have been positive changes as part of the referrals to the excess weight support service for children and their families. However, Dr Howe also recognised that further work is needed to tackle this important issue in a sustainable way, involving partner agencies and engaging with local residents.

Dr Lake provided an update to the Board about the NHS Diabetes Prevention Programme which aims to educate residents about lifestyle choices to reduce the risk of developing Type 2 diabetes.

Councillor Reuben Thompstone informed the Board about the success of the Mayor of Barnet's Golden Kilometre initiative – which encourages primary schools in Barnet to help their pupils take part in a daily 1km walk, jog or run around their school or local green space.

The Chairman thanked Board Members for their comments.

It was **RESOLVED**:

That the Health and Wellbeing Board reviewed and approved the addendum to the Public Health & Wellbeing Commissioning Plan for 2017/18 (Appendix A).

9. SCREENING UPDATE (Agenda Item 9):

The Chairman introduced the report and noted that screening has been a priority area for improvement in the Joint Health and Wellbeing Strategy since its refresh in 2015.

NHS England were not present at this meeting, which the Chairman regretted as she stated that attendance by NHSE would have been most valuable particularly in light of the ongoing grave concerns around low screening uptake and inconsistent reporting. The Chairman expressed her own deep concern regarding this in the light of effect it could have on the vitally important early cancer diagnosis necessary for successful cancer treatment.

The Chairman indicated the need to escalate the HWBB's concern over ongoing failures to establish clear reporting arrangements and the need to address low cancer screening uptake.

Dr Lake updated the Board regarding the delay in a screening report returning to the HWBB awaiting an annual report from NHS England. An annual report was produced and shared with the Joint Health Overview and Scrutiny Committee in February but concerns remained both over its format and plans to address areas of poor performance. Dr Lake noted that the Committee has asked for an update to be reported back in six months' time.

It was noted that in summary, good performance was shown for some areas of screening, particularly diabetic eye screening and screening for Abdominal Aortic Aneurysm. However there were ongoing concerns about low uptake for breast, cervical and bowel screening.

To help improve support to NHSE in producing a report to address Local Authority needs, an NCL adult screening assurance group has been set up and is chaired by Dr Lake. Efforts are underway to establish how it can best operate to support NHSE. Ms Julie Pal also expressed interest in joining the group.

Dr Frost noted the importance of closer working between partners and GP's to help improve uptake and potentially exploring the use of IT technology and mobile apps.

Dr Benjamin welcomed the report and noted that inclusion of partners is key to encourage more screening. In order to identify the groups where uptake was low, Dr Lake noted that further scrutiny of the data would need to be undertaken.

In order to improve screening uptake, Dr Stephens requested that the Board join the national call for lowering the screening age for bowel cancer from 60 to 50. She noted the importance of early screening for bowel cancer particularly for the age group 50-60.

Ms Wakeling welcomed the comments and proposed to move two additional recommendations (numbered 4 and 5) which were seconded and agreed.

4- That the Health and Wellbeing Board asks the Communities Together Network to consider the need for and develop proposals accordingly for increased screening uptake (including amongst BME communities and faith groups in Barnet).

5- That the Health and Wellbeing Board asks Council Officers and CCG colleagues to develop proposals for a local communication campaign with an aim to increase screening uptake in Barnet.

It was therefore **RESOLVED:**

1. **That the Health and Wellbeing Board noted 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 asked that the Director of Public Health seek assurance from NHSE 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.**

4. **That the Health and Wellbeing Board asked the Communities Together Network to consider the need for and develop proposals accordingly for increased screening uptake (including amongst BME communities and faith groups in Barnet).**

5. **That the Health and Wellbeing Board asked Council Officers and CCG colleagues to develop proposals for a local communication campaign with an aim to increase screening uptake in Barnet.**

10. JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION PLAN PERFORMANCE REPORT INCLUDING CAMHS TRANSFORMATION PLAN (Agenda Item 10):

The Chairman introduced the report which sets out the progress delivered against the set priorities as agreed by the Board in November 2016. She noted that following the agreement of the JHWBS in November 2015, colleagues across the partnership have been working to deliver the actions set out in the Strategy's implementation plan.

Ms Dawn Wakeling presented the report and Mr Eamann Devlin, CAMHS Joint Commissioning Manager (interim) joined the table. Ms Wakeling updated the Board on the progress made against each of the four themes within the Strategy. The Board noted the development of the Reimagining Mental Health Programme as part of the progress update since November 2016.

Mr Munday noted that good progress has been made in respect of the CAMHS Transformation Plan to improve children's health services. He also noted that further work is needed to increase capacity and reduce waiting times which will help to improve CAMHS Tier 4 and Early Years standards.

The Chairman welcomed the discussion and commended the joint working on behalf of children in Barnet.

It was **RESOLVED:**

1. **That the Health and Wellbeing Board noted and commented as above on progress to deliver the Joint Health and Wellbeing Strategy (2015-2020). (Appendix 1)**

2. **That the Board approved the refreshed CAMHS Transformation Plan (2015 – 2020) part 1 (Appendix 2) and noted the refreshed Plan for NCL, part 2 (Appendix 3).**

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

The Board noted the standing item on the agenda which includes the minutes of the JCEG meeting held on 4th January 2017.

It was **RESOLVED:**

That the Health and Wellbeing Board approved the minutes of the Joint Commissioning Executive Group meeting of the 4 January 2017.

12. FORWARD WORK PROGRAMME (Agenda Item 12):

Ms Dawn Wakeling presented the report which sets out the business items for 2017. Ms Wakeling noted that the Board has requested to receive an update on volunteering in care homes.

RESOLVED:

That the Health and Wellbeing Board considered and commented during the meeting on the items included in the Forward Work Programme (see Appendix 1).

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

The Chairman and Vice-Chairman invited Mr Adrian Phelan and Ms Robyn Sandler to join the Board. Mr Phelan provided an update on the progress of the CCG Annual Report and Accounts.

Mr Phelan invited the Board to submit their comments and suggestions for areas of focus which can also be made outside of the meeting. It was noted that the final draft of the Annual Report will be submitted to NHSE on 31st May. Mr Phelan noted that the Board will be updated on the final draft prior to submission and on the final version following submission to NHSE.

Following discussion the Board made the following requests for reference and inclusion within the Annual Report:

- CAMHS Transformation Plans and consultation feedback from children and young people

- Children's Continuing Care and collaborative working towards a shared pathway for vulnerable children and young people
- Childhood Immunisations and initial health assessments for Looked After Children
- The Mayor of Barnet's Golden Kilometre Award
- Community Dementia Services and the joint working arrangements
- Acute admission and continued pressures in health and social care system
- Shisha communication campaign
- Councillor Hugh Rayner and Councillor Agnes Slocombe have been appointed as joint Diabetes Champions.
- Concerns about low level of funding for Primary Care.

Ms Julie Pal indicated that she had submitted her comments on behalf of Healthwatch Barnet.

The Chairman welcomed all the submissions made by Board Members and requested that further issues and comments be sent directly to Mr Adrian Phelan.

In response to a query from the Chairman, Dr Andrew Howe confirmed that the budget for Public Health was ring-fenced for 2018/2019.

The meeting finished at 11.45 am

AGENDA ITEM 6

	Health and Wellbeing Board **20 July 2017**
Title	**Barnet Family Nurse Partnership**
Report of	Strategic Director for Children and Young People
Wards	All
Date added to Forward Plan	November 2016
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 – Case study 1 Appendix 2 – Case study 2
Officer Contact Details	Collette McCarthy, Head of Joint Children's Commissioning Unit collette.mccarthy@barnet.gov.uk Tunde Adewopo- Senior Joint Commissioning Lead Tunde.adewopo@barnetccg.nhs.uk Donna Thornley- Supervisor FNP Central London Community Hospitals Trust Donna.thornley@clch.nhs.uk

Summary

Early intervention and prevention is a key priority of the Children and Young Peoples Plan 2016-2020 and Joint Health and Wellbeing Strategy 2015-2020. It is particularly important in pregnancy and in the early years for young families. In Barnet, young first-time mothers receive extra support throughout their pregnancy and up until their child reaches two years of age. The Family Nurse Partnership (FNP) is one of the evidenced based programmes that is commissioned by the London Borough Barnet (LBB) and delivered by Central London Community HealthCare Trust (CLCH). The delivery of FNP actions the Barnet child health needs.

Recommendations

1. **That the Health and Wellbeing Board notes the ongoing work of the FNP Programme Board and the long term benefits to young people and their babies across Barnet, recognising the benefits and long term cost avoidance when considering future commissioning plans.**

1. WHY THIS REPORT IS NEEDED

Background

1.1 The Family Nurse Partnership (FNP) programme sits at the intensive end of the preventative care pathway for more vulnerable children and families working within our local safeguarding policies and procedures. It is an intensive home visiting, evidenced based preventative programme offered to young mothers having their first baby and until the child turns two years old. It begins in early pregnancy and is orientated to the future health and well-being of the child which sits within the continuum of the progressive Healthy Child Programme.

1.2 The FNP programme enables and promotes multi-professional relationships and working to improve outcomes for young people and their babies.

1.3 The FNP Programme is a good fit with national and local priorities. As It:

- Provides prevention and early intervention for vulnerable teenage mothers and their children), and also leaving care clients up to age of 24years
- Works to improve access and engagement with other services (e.g. social care and children's centres)
- Works to improve child health and development (e.g. school readiness) so that children develop in line with expectations for this age group
- Works to improve the life chances for mother and child by breaking cycles of disadvantage (e.g. focusing on supporting mothers to get back into education, employment or training)
- Delivers the Healthy Child Programme to first-time teenage mothers
- Addresses the six early years high impact areas - transition to parenthood, maternal mental health, breastfeeding, healthy birth weight and nutrition, managing minor illness and reducing accidents, and supporting child development
- Supports resilience building enabling young mothers, their partners and children to continue achieving good outcomes following the Programme.

1.4 The Programme costs £3,200 per year per client (mother and baby) per year which equates to £6,400 over two years. The contract started as a national pilot programme in 2013 and a full national review is currently being undertaken to assess its effectiveness.

1.5 The team work remotely and meet weekly at base. The team run parenting groups in Children's Centres (CC) to bring more young parents into CC's as

these mums will often not attend the young parents groups in CC as they are 25 years and under.

1.6 The overview of 2016 activity of the Barnet FNP programme clearly demonstrates that the FNP Service with 5.1 WTE staff and a £300k plus budget has had a caseload capacity of 100, over 477 referrals into the service since 2011 to present. This further supports the outcome based on strong links with social care, housing and maternity services as the numbers of clients leaving prematurely in 2015/16 has reduced.

Outcomes and benefits

1.7 The Dartington Social Research Unit's Investing in Children[1], estimate that for every £1 invested in the FNP programme, society obtains £1.94 return. Therefore, for 100 clients and babies this equates to cost avoidance over 2 years of £601,600.

1.8 The efficiency cost avoidance come from less use of health services, reductions in child abuse and social care needs, better school achievement, reduced involvement with criminal justice services, improved mental health and increased earnings. By reducing these costs the multi-agency stakeholders can concentrate their work on more vulnerable high risk cases.

1.9 For high risk families the costs were recovered by the time the children reached 4 years due to reduced use of health services and avoided costs.

1.10 The figures below outline two case studies from Barnet's FNP programme demonstrating the potential cost avoidance achieved from intensive support of two clients (social care reference costs from 2015):

[1] http://investinginchildren.eu/interventions/family-nurse-partnership

Case study 1 - G 2011-2013 age 17

CASE Study 1	Costs to LA	Interventions
Petty crime and police involvement	£14,762	Stopped any offending
Drug use	£215	Referral to drug services
Non attendance at school	£28,136	Re-engaged with school on reduced timetable
Health	£494	Attending ANC appointments with FN
Social care	£37, 726	After initial assessment – not escalated to CP, as long as worked with FNP
Domestic violence (Brother and grandfather)	£23,315	Engaged with DV services and relationship programmes
Housing and rent arrears		Referred to housing welfare and agreed Payment plan and benefits reviewed
	£89,886.00	
FNP intervention	£6000 (2 years)	Engaged with FNP
Savings	£83,886.00	

Case study 2- L . 2012-2014, Age-16 years

	Cost to LA	Intervention
Petty crime	£14,762	Engaged with FNP
Non attending health appointments	£494	Attended appointments and agreed to meet with Youth worker
LAC in LAchildren's home (3rd generation LAC)	£185 ,412 year (£3181 week)	Referred to welfare rights and benefits team/ housing
Not engaging with Social care or youth services Unborn assessment	 £37,726	Social worker invited to FNP meeting Unborn on CP plan- stepped down at 6 months
Not attending school	£28,136	Engaged on reduced timetable, and post delivery voluntary work
Mother and baby unit 12 weeks	£40,212	FNP continued to visit during placement and weekly visits on return to Barnet
		At 2 years- breast feeding. 100% immunisation uptake Working/ Partner working Accessing early years funding
	£286,742.00	
FNP	£6000 + placement	
Savings	£240,520.00)	Mother and baby unit enabled L to return to Barnet and parent. Therefore reducing cost of foster placement or of new-born requiring additional services)

1.11 Further successes from the Barnet programme include the uptake of early years funding and the number of young mothers in Education, Employment and Training; 63.2% at 2 years following the birth of their children.

2. REASONS FOR RECOMMENDATIONS

2.1 Barnet FNP is commissioned by LBB and delivered by CLCH. The paper informs the Board of the contribution of FNP makes to the strategic priorities of the HWBB and the difference the programme is making to key outcomes for vulnerable mothers and their young children across Barnet and the long term savings.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 FNP is an internationally recognised evidence based programme which LBB is committed to provide. It will form part of the 0-19 early years services review to ensure future sustainability and integration with other services.

4. POST DECISION IMPLEMENTATION

4.1 FNP will continue to deliver the programme across Barnet with the enhanced referral criteria and continue to collect evidence of successes and cost savings and the Family Nurse Partnership Board will continue to manage the implementation and delivery of the programme

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The implementation of the FNP priorities aims to improve the health outcomes of Children and Young People 2016-2020 in Barnet and delivers the priorities of the Joint Health & Well Being Board Strategy 2015-2020.

5.1.2 The Service supports the Council's Corporate Plan 2015-2020 in ensuring that the services deliver efficient, quality and transparent services which will result in better value for money for the taxpayer and good outcomes for children and young people by ensuring the following below:

- According to FNP National Unit, FNP is often cited as the most effective programme for preventing child abuse and neglect and reducing childhood injury and this is where some of its strongest evidence lies. Outcomes of the programme in this area include:
    - Reductions in verified child abuse and neglect
    - Reductions in health care encounters for injuries
- In Barnet the number of initial assessments has remained static at 19% however the number of children placed on Child Protection Plans within FNP has reduced from 8.3% in 2015 to 2.8% 2016.
- Supporting mothers back into employment/ study- Barnet FNP has over 63% of mothers in employment or education at 2 years.
- Children with 100% immunisation uptake, 88% FNP babies' breastfed and 27% still breastfeeding at 6 months and education re: healthy lifestyle choices and diets.
- Vulnerable children starting school being on a equal reading and maths level to their peers.- gathering long term FNP Barnet data following these children through KS1- KS4.

5.1.3 The FNP programme delivers against the four themes of the Joint Health and Wellbeing Strategy throughout the duration of the programme to young pregnant teenagers and supports these mothers into parent their children well and achieve positive outcomes.

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

5.2.1 The FNP in Barnet costs £300k a year and is funded by Public Health grant.

5.2.2 The structures and arrangements in place over the five years has ensured effective leadership, financial effectiveness, support and management of our FNP team who have achieved programme targets and goals year on year.

5.3 **Legal and Constitutional References**

5.3.1 The FNP Service is commissioned within the relevant contract rules and regulations of the London Borough of Barnet and Barnet Clinical Commissioning Group.

5.3.2 Compliance with FNP licensing agreement to replicate FNP programme delivery and obtain best outcomes possible. The FNP Advisory Board is chaired by the Local Authority Barnet Senior Children's Commissioner. The Board meet monthly to monitor progress of the service, address concerns, and review progress against service improvement action plan.

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

- 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.
- Specific responsibilities for: overseeing public health and developing further health and social care integration.

5.4 **Social Value**

5.5 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.

The developments within the FNP programme approach ensure that the service provides a efficient wellbeing, health and social care for children and families whilst ensuring that it delivers benefits to individuals in a much more coordinated fashion, supporting young mothers when they need it and providing the right amount of support to ensure individuals develop the skills they need to make choices for their own well-being in the future. Services

working together derive social capital from each other and this in turn supports a collaborative approach towards sustainability within an ever-changing economy.

5.6 **Risk Management**

5.6.1 This is managed as part of the governance arrangements and monitored through the relevant Programme Management Office and the Family Nurse Partnership Board.

5.7 **Equalities and Diversity**

5.7.1 The Public Sector Equality Duty at s149 of the Equality Act 2010 will apply to CCGs and local authorities who as public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the 2010 Act and advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The protected characteristics are - age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.7.2 FNP Barnet offers the programme to all young persons across the borough, who fit the referral criteria. This is a privilege and enables the Borough of Barnet to offer the service to all pregnant teenagers in Barnet. Section 149 of the Act imposes a duty on 'public authorities' and other bodies when exercising public functions to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.8 **Consultation and Engagement**

5.8.1 Barnet FNP service has a strong client representation, both locally and at Board level. There is continued client evaluation and feedback, patient stories to feedback, support service modifications and adaptations to the delivery of FNP.

5.8.2 This includes

- The team holding three client events annually to celebrate successes and involve stakeholders.
- Running of a mother and baby FNP group within Children Centres, which has increased young people accessing CC.
- Clients present at FNP Advisory Board and the Children's Trust.
- Clients also represented on interview panels during recruitment process.

5.9 **Insight**

5.9.1 Barnet FNP has been commissioned for 5 years, and has had many successes for both parents and young children. The first cohort of FNP children have commenced school in September 2016 and will be tracked to enable more Barnet specific data to be collected.

6. BACKGROUND PAPERS

6.1 None.

Case Study: expelled year 11 left without maths and English. Physical and Mental health issues. Estranged from Family. History of physical, sexual and emotional abuse Fled Domestic violence. Social care involvement from age 4. Multiagency working managed on CAF and CIN no need for CP. Client now in Education and Therapy Sensitive parenting to child. Child in nursery.

Both parents engaged well.
Multiple needs made it hard to deliver programme.
Numerous referrals led to CAF and multiagency work
Issues re ID and UK status affected benefits
MH issues caused panic attacks

Intervention
Stick with the programme not allow issues to overshadow it.
Multiagency working and referrals to share load & CAF and support mental and physical health issues
Smart choices, Pipe etc
Good communication Skills
Nurturing and increasing self-esteem and self-worth
Practical support
Continuity of FN especially through relocation.

Breastfed until 18 months
Domestic violence
Isolation no support
Rehoused three times this affected benefits and continuity of care and community support
Protective and attentive to child.
Supported by Foodbank
Disconnected from Mental and physical support due to move out of area.

Intervention
Multiagency support
Parenting skills
Empowerment and encouragement.
Goal setting
Using all FNP programme materials
Agenda matching
Enabling her skills for daily living eg cooking
Consistent and persistent Family Nurse

Back in Education
Child in nursery and no longer CIN reaching milestones
Immunisations up to date
NO A&E attendances for child
Mum managing anger issues
More aware of controlling behaviour. Left Partner but is managing contact with child.
Using LAC Implant
Re-establishing relationship with parents and siblings on HER terms. Sharing her knowledge and experience and empowering others.

Without FNP: Client likely to have enduring mental health issues which could impact on her child. Possible suicide. Child could end up in care. Mum could have been lost in system. Questionable UK status. Could have been deported or denied access to Public Funds. Tolerated DV as no one to turn to. Unlikely to be in education or have secure tenancy. Poor physical health due to long term issues. Poor relationship with child.

Impact:

Mum engaging with support for physical and mental health issues
She has broken the cycle of deprivation and is insightful how to parent differently.
Managing Family relationships in the best interest of herself and child
Good bonding and attachment
Child development & school readiness
No repeat pregnancy. Secure tenancy
Confident dealing with services
NEET to EET now in education

Potential Savings to:

Mental Health services

Children Services

Police

Welfare benefits

Case Study: Mum completed school year 11. MH issues. Personality Disorder, eating disorders and history of suicide attempts. Father was in looked after system and heavy cannabis user. Father did not engage with FNP until Child protection plan at the end of pregnancy. MH issues. Bipolar. Attempted Suicide. Police history for Burglary, Drug and driving offences.

Mum engaged well, once located

Focus on bonding & attachment

Improved diet no further concerns re eating disorders

Stopped smoking cannabis, cigarettes and drinking alcohol

Facilitated access to antenatal care via liaison with Acacia team

Mum proactive re housing and benefits

Intervention

PIPE with dolly especially cues

Smart Choices (1 step removed) improved communication skills with partner and parents

Facilitators (used knowledge from Childcare at school)

Referral to IAPT and CBT helped to lower anxiety and depression scores

Power and Control Wheel for healthy relationships

Term delivery, good birth wt

Quickly settled into routine

Reliable contraception – Depo

Intuitive to child's needs

Strong attachment

Life style changes maintained.

Relationship with parents and partner improved

Parents taking turns in working or education

Intervention

Smart Choices and work around relationships and communication especially dealing with anger re SW involvement

Understanding teenage brain. Compassionate minds

Praise and encouragement.

Goal setting

Joint work with SW

Consistent and persistent FN

Sensitive parenting

Fully immunised Child

Development top of ASQ range

Safe and stimulating home

Housing – secured tenancy

Mum working Dad smokes miminal cannabis

Good family relationships all generations

Both parents discharged from Complex care and are well

Without FNP: . Poor engagement in antenatal care. Client unlikely to have returned to work. May not now have secure tenancy. Likely to still be under care of Complex care team and parents relationship unlikely to have survived stress of parenthood. Dad could still be offending to fund habit. Lack of grand parents support if dad was still offending. Child unlikely to be securely attached if both parents still had MH issues.

Impact:

Cessation of involvement of police and YOT

Good bonding and attachment

No repeat pregnancy

NEET to EET – Mother (dad looking for work)

Grandparents now involved

Both parents discharged from mental health services

Potential Savings to:

Children's Services

Education & Health Services including mental health

Police and Youth Offending Service

AGENDA ITEM 7

	Health and Wellbeing Board **20th July 2017**
Title	**North Central London Sustainability and Transformation Plan Update**
Report of	Strategic Director - Adults, Communities and Health LBB Chief Operating Officer, NHS Barnet CCG
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A: North Central London Partners in Health and Care: Sustainability and Transformation Plan – DRAFT April 2017
Officer Contact Details	Dawn Wakeling, Strategic Director Adults, Communities and Health Email: dawn.wakeling@barnet.gov.uk Tel: 0208 359 6474

Summary

This is an update on the progress of the North Central London Sustainability and Transformation Plan (NCL STP) which covers five of the London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the North Central London Sustainability and Transformation Plan.**

1. WHY THIS REPORT IS NEEDED

1.1 In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. Every health and care system has been working together to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

1.2 Local health and care systems have come together in STP 'footprints' with Barnet included in the North Central London sub-regional area. The twenty-

one health and care organisations within these geographic footprints are working together to improve the health of local people, narrow the gaps in the quality of care and establish financially sustainable local Health and Social economies.

1.3 Appendix A provides an updated plan for transforming the health and social care economies across North Central London. This document reflects the work undertaken over the last twelve.

2. REASONS FOR RECOMMENDATIONS

2.1 The STP guidance is clear about the crucial role of Health and Wellbeing Boards, highlighting that success requires the engagement of all partners across a local system. The guidance goes on to encourage STPs to build on the work of the local Health and Wellbeing Board, including local needs assessments and Joint Health and Wellbeing Strategies.

2.2 The Board has received updates on the progress to develop the NCL STP in July, September and November 2016.The NCL STP was submitted to NHS England on the 21 October 2016 and has been published on the Council's website.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1 The Health and Wellbeing Board will receive further progress update reports at future meetings.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The requirement for STPs came out of the NHS shared planning guidance 16/17 – 20/21 and supports the delivery of the Five Year Forward View.

5.1.2 The STP reflects local and regional need and builds on local strategic plans (such as the Corporate Plan, Joint Health and Wellbeing Strategy and CCG Operating Plan).

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

5.2.1 The NCL STP (appendix A) outlines that there is a substantial financial challenge facing health organisations in NCL and outlines the STP plans to reduce this gap.

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 Under the Council's Constitution, Responsibility for Functions, Annex A, 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 (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 wellbeing. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; the Better Care Fund; and Section 75 partnership agreements between the NHS and the Council.

- 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 N/A.

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.

5.7 **Consultation and Engagement**

5.7.1 A public consultation event was held on the 27 September in Barnet.

5.7.2 A programme of further public consultation is being developed.

5.8 **Insight**

5.8.1 The STP has used local Joint Strategic Needs Assessments and Case for Change information.

6. BACKGROUND PAPERs

6.1 Health and Wellbeing Board, 10th November 2016,: NCL Sustainability and Transformation Plan update: https://barnet.moderngov.co.uk/documents/s35924/HWBB%20Nov%202016%20-%20NCL%20STP.pdf

6.2 Health and Wellbeing Board, 15 September 2016, Agenda item 11: NCL Sustainability and Transformation Plan update: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8714&Ver=4

6.3 Health and Wellbeing Board, 21 July 2016, Agenda Item 12: NCL Sustainability and Transformation Plan: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8713&Ver=4

NORTH LONDON PARTNERS in health and care

June 2017

Working together for better health and care: our sustainability and transformation plan

Contents

Foreword

Welcome to our plan for health and care in North London.

Health and social care services in North London have become 'partners in health and care' to improve the access and quality of services, and to make the system more efficient. As partners, we serve a population of more than 1.5 million people from the London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

This is our plan for changing the way the health and social care services in North London work, to bring them together to provide the entire local population with access to the best possible health, care and wellbeing services, and to make North London a place where no-one is left behind.

We have a proud history of providing high quality health and care services. We have an important role to play in delivering the **NHS Five Year Forward View** and other national health and social care policy. We need to ensure our services can adapt to meet future needs and are financially sustainable against a backdrop of increasing demand. In particular, we need to support services work better together, both in hospital and the community, to keep people well and independent and to help them recover when they are unwell.

On 31 March, NHS released the **Five Year Forward View Next Steps**. This update provides us with an opportunity to relook at our local plan and to make some adjustments so that our focus remains aligned to the national priorities while delivering at local level.

Our current system is unsustainable. The health and social care needs of our local people are changing and the way we are currently organised means that waiting times for some services, as well as the health outcomes vary. As our population ages, we now need to consider how people will receive care and what that care may look like. We believe there is the scope to provide more services closer to people's homes. Working alongside local authorities, we can design and deliver the right care in the right setting so that everyone can live and age with dignity. We need to do more to recognise the mental health as well as the physical health needs of our population. We want the standard of care and people's experience of health and social services to be of the highest quality.

Our financial situation remains challenging as the demand for health and social care continues to grow year on year, exceeding any increase in funding.

We have worked hard to identify challenging but achievable opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can make. However, the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes that we plan to deliver over the next few years.

We know that this is probably not be enough to bring our plan into financial balance. To support our need to achieve financial balance, we will continue to work with NHS England and NHS Improvement as part of the Capped Expenditure Process to help us to produce a set of affordable NHS plans 2017/18, which potentially includes difficult choices. This aims to help us deliver the best possible clinical outcomes for local people within the limited funding available.

Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services, is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. Our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people, communities and our staff when deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.

Executive summary

It has been over a year since we came together as a partnership of 21 health and social care organisations in North London. During this time, we have invested time, energy and resources into building strong relationships with each other and developing a shared vision for a health and care system that can deliver high quality services to our community where and when they need, while becoming more sustainable.

We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. We agree on the nature and scale of the challenge described in our **Case for Change** (published September 2016).

Creating a healthier population is at the heart of our plan. Our vision is for our community to be happier, healthier and to live longer in good health. To do this we must embrace the opportunities that working together can deliver. We must look to emerging technologies and finding new and better ways of working that can eliminate duplication and waste and we must develop and support a motivated, highly skilled and professional workforce to serve North London.

As partners we have a shared vision, a collective agenda and the commitment to transform the health and care services of North London.

Every day the media report on the pressure experienced by the health and social care system. We know that to meet the demands of our population now and into the future we must do things differently. We have already invested time and resources into finding new ways of working. Our community has told us they want a more joined up and integrated health and care system, they want care closer to where they live and work, delivered by professional and compassionate health and care workforce. Some of our boroughs, such as Islington and Haringey, already have a strong history of working together and we know there some similarities in the health and care profile of the North London populations. We want to use this collective knowledge to deliver better health and care services to the North London community and to ensure we have a system that is efficient, effective and sustainable.

To build a better health and care system we must also look at the social determinants of health and wellbeing. There are high levels of poverty, mental ill health and employment insecurity. In general, life expectancy is increasing, but for many people, the last 20 years of their life is lived in poor health. As a result, older people often require a lot of support from health and care services.

Working together presents an opportunity for our health and care services to focus on the people we commission and provide services for. We want to share the collective responsibility for meeting the mental and physical health and care needs of the North London community and to help make our community more resilient.

Our greatest aim is to help people to be, stay or regain good health and wellbeing. To do this we must take a preventative approach, build strong community services and improve health and care outcomes for people. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our vision is for North London to be a place where our people experience the best possible health and wellbeing. North London is a place where no-one is left behind.

To achieve our vision, this plan must result in real and demonstrable improved health and care outcomes for the people. Our community will experience the benefits of improved health and wellbeing, better services delivered within the available resources for our health and care system.

We currently project a financial deficit across the NHS organisations in North London of £234m in 2016/17. If we do nothing, by 2020/21 we project this financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m. Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services.

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this

We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap and this includes working with NHS England and NHS Improvement as part of the Capped Expenditure Process to help the NHS produce a set of affordable plans for 2017/18.

We have in place a governance structure to enable NHS and local government organisations to work together in a new way to deliver our plan. It is crucial that whole system is aligned and committed to the delivery of this Sustainability and Transformation Plan (STP) and we have ensured the two year health contracts that are in place for 2017/18 - 2018/19 are consistent with the plan's strategic framework (outlined below).

Much work and effort has taken place to provide more detail about our proposals. We have begun to engage with those who use health and care services and we invite the public to work with us to test our thinking and validate that our plans truly reflect their needs.

We are committed to being innovative in our approach; to focusing on improving the health and wellbeing of our community and delivering the best care not only in London, but nationally. Local people deserve to be supported to live happier, healthier and longer lives, and we are fully committed to making this vision a reality.

Our vision: A place where no-one is left behind

We want to transform North London into a place where no-one is left behind. We are united in our commitment to transforming care to deliver the best possible health outcomes for our local population. This will be done by shifting our model of care so that more people are cared for in 'out of hospital' settings, and through prevention, more proactive care, and new models of care delivery, we can reduce the reliance on secondary care and improve the way people access and receive care.

To deliver on our bold vision, we have designed a programme of transformation with four fundamental elements:

- **Prevention:** We know that many of the health challenges facing our population arise from preventable conditions. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation**: We know that there are emerging technologies and new and better ways to deliver services. To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We know that there is duplication and waste that can be eliminated by working together. We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We know that there may be untapped resources that can be put to work to improve our capacity. We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Developing our vision in North London has taken time. We have harnessed high quality clinical and practitioner leadership at every stage of the process. The vision for North London initially drew on existing local engagement work which was underway before the STP process started – putting the needs and expectations of the public at the heart of the plan. Leaders across the system agreed the vision in September 2016. This process, alongside more local engagement events, has ensured that our vision is collectively owned across the health and care partnership. We will continue to engage with our population and develop the plan with them throughout the process.

By establishing North London 'Partners in health and care' we will work together to deliver our Sustainability and Transformation Plan (STP) and realise our vision for North London. Our core principles to support our ambition are:

Our core principles

- We will put the health and wellbeing of our population at the heart of our plan;
- We will work in a new way as a whole system; sharing risk, resources and reward. Health and social care will be integrated as a critical enabler to the delivery of seamless, joined-up care;
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research-based delivery models that move innovation in laboratories to frontline delivery as quickly as possible;
- We will make the best the standard for everyone, by reducing variation across North London;
- In terms of health, we will give children the best start in life and work with people to help them

remain independent and manage their own health and wellbeing;
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible;
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate;
- To do all of this we will do things radically differently through optimising the use of technology;
- This will be delivered by a unified, high quality workforce for North London.

We are continuing to include staff and residents in the development of our plan. We will continue to engage with people and groups throughout the process so that our conversation with our local community continues to develop and mature alongside our proposals. Each organisation in the partnership is committed to delivering the right service, at the right time, in the right place.

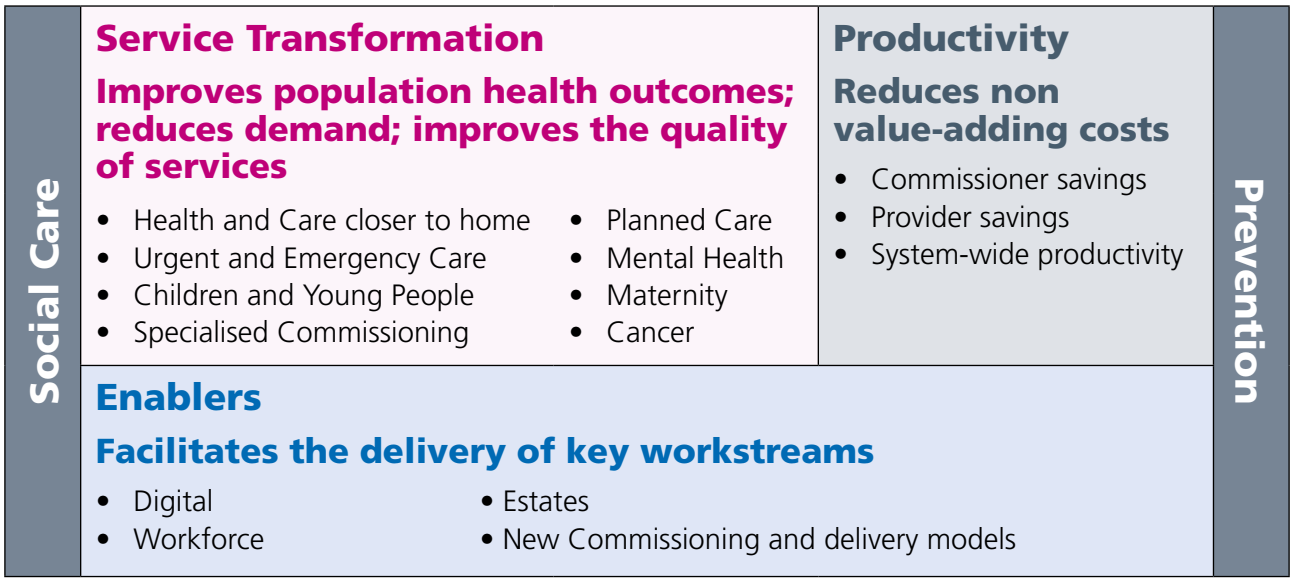
Further detail about how we plan to engage with our patients and residents can be found in the Communications and Engagement section of this document.

Our Strategic Framework

To deliver on our vision and achieve an increase in health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency, we have designed our five year programme of transformation with four elements:

- **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in North London is preventable. We will increase our efforts on prevention and early intervention to improve both the physical and mental health and wellbeing of our whole population. This will reduce health inequalities, and help reduce the demand for more expensive health and care services in the longer term. Best of all, we can improve the quality of life of our residents and build a more resilient community;
- **Service transformation:** To meet the changing needs of our population and to respond to what people have told us they want from health and care services, we will transform the way that we deliver services. This involves taking a "population health" approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Working in partnership with local authorities, together we can provide a better health and care experience for people when they need it, and in a place that more conducive to recovery or longer term care, supported by caring and compassionate professionals;
- **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the **Carter Review** and working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** To increase our ability to provide health and care services for the future we have identified key areas that will support the delivery of transformed care across North London. To do this we must have the necessary architecture in place. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 1: The North London STP strategic framework



Programme governance to deliver the plan

In coming together as a collaborative, we have developed a governance structure, which enables NHS and local government partners to work together in new ways. The objectives of the North London STP governance arrangements are to:

- Support effective collaboration and trust between commissioners, providers, political leaders and the general public to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the North London system;
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the North London STP;
- Provide greater clarity on system level accountabilities and responsibilities for the North London STP;
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in North London; and
- Enable collaboration between partner organisations to achieve system level financial balance over the remaining 3 years of the Five Year Forward View timeframe and deliver the agreed system control total, while safeguarding the autonomy of organisations.

A detailed governance handbook including the terms of reference for all of the governance groups is available **here**. A summary of the programme governance is provided below.

The delivery of the plan is overseen by the North London Programme Delivery Board. This is an executive steering group made up of a cross section of representatives from across North London. This group is specifically responsible for providing accountability for the implementation of the workstream plans. Membership includes the Senior Responsible Officers (SRO) of each workstream and SRO leads for CCGs, Providers and Local Authorities. Two subgroups provide advice to the Programme Delivery Board: the Health and Care Cabinet (formerly the Clinical Cabinet) and the Finance and Activity Modelling Group.

The Health and Care Cabinet meets monthly to provide clinical and professional steer, input and challenge to each of the workstreams as they develop. Membership consists of the five CCG Chairs, the eight Medical Directors, clinical leads from across the workstreams, three nursing representatives from across the footprint, Pharmacy and Allied Health Professions representatives, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group currently meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The component workstreams feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

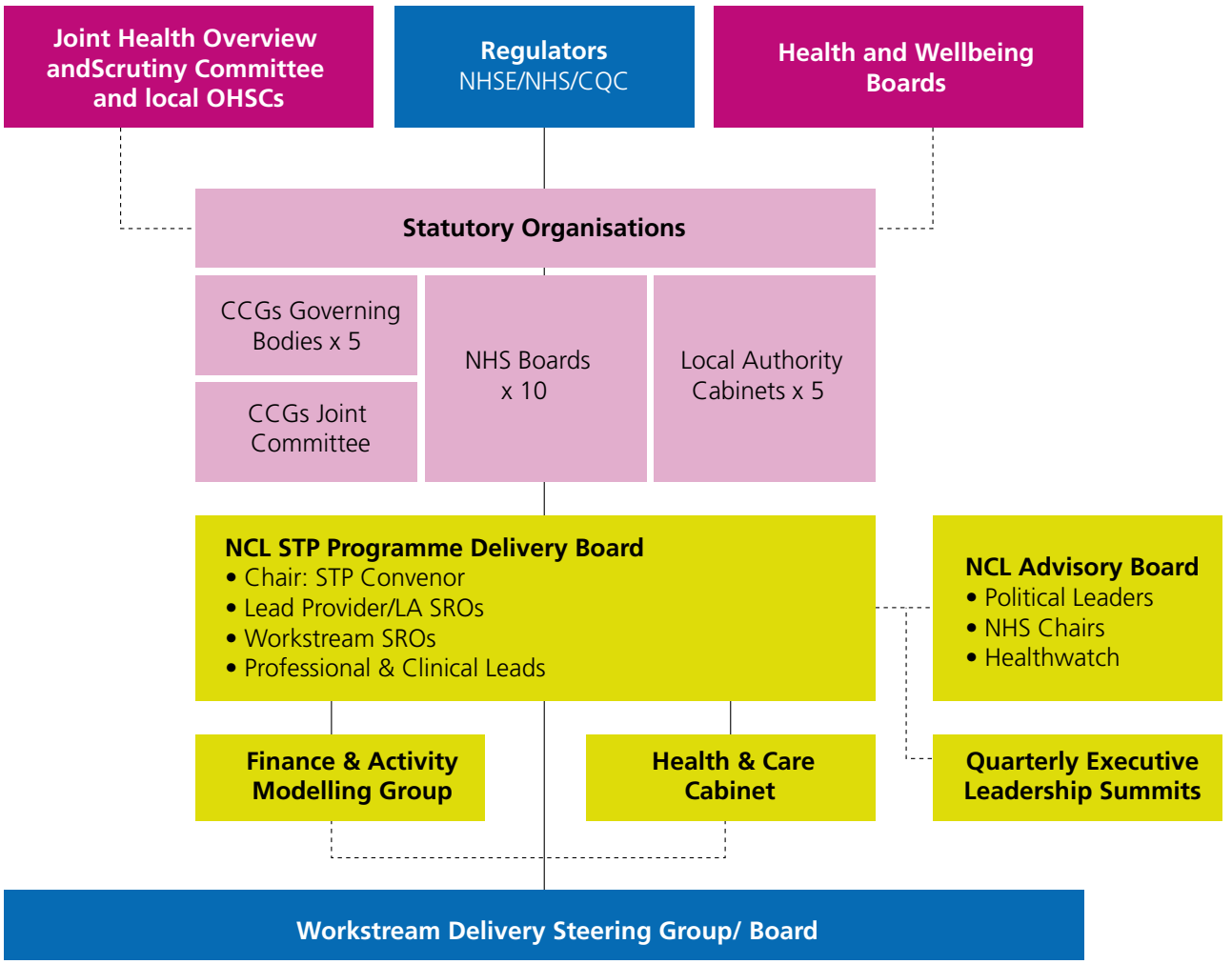
A new STP Advisory Board was established established in June 2017. This group will have an advisory role, enable a collective partnership approach, and act as the 'sounding board' for the implementation of the STP plans. The membership of this group includes Local Authority leaders, NHS Chairs, and Healthwatch. This will go some way to address the democratic deficit and representation of views of the local population, and ensure a better connection with the independent members of NHS boards/ governing bodies, local authority leadership, patients, and residents. This group will meet quarterly and a decision whether or not to appoint an Independent Chair will be discussed in due course.

In addition to the above governance groups, CEOs and other relevant executive directors and stakeholder representatives will meet quarterly for executive leadership events to enable continued engagement and momentum, regular communication, and to assist with resolving any programme delivery issues identified by the programme delivery board.

There has been the appointment of a single Accountable Officer for the five CCGs across North London. This will ensure a more collaborative commissioning approach across North London. The Governing Bodies of the five CCGs agree to establish a Joint Committee for some elements of commissioning in North London including:

- All acute services core contracts and other out of sector cute commissioning
- All learning disabilities contracting associated with the Transforming Care programme
- All integrated urgent care (through the Urgent & Emergency Care Boards including NHS 111/ GP Out-of-Hours services)

Exhibit 2: Agreed programme governance structure



Programme resourcing

The implementation of the STP is regarded as business as usual, so the majority of the capacity required to implement the plan will be found from within existing management and clinical capacity within the health & care organisations in North London. In addition we have established a Project Management Office (PMO) which facilitates and coordinates the meetings of the main governance groups, liaises with each of the workstreams to monitor and track delivery plans, as well as delivering communications and engagement support to the programme.

Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality.

Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, CCGs have engaged with HWBs as we developed the plan and will continue to do so as it is implemented.

Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health and care services in their local area. Local authorities themselves are scrutinised on the delivery of health and social care services for which they are directly responsible and accountable, but commissioners and providers of NHS services must also consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place for North London. The JHOSC undertook a review of the draft STP during November and December 2016 The JHOSC heard verbal and written evidence from local residents and a range of other stakeholders at specially convened meetings. This review has generated a report from the JHOSC setting out a number of key principles and recommendations across eight themes, which aim to support and inform the further development and delivery of the STP going forward. The JHOSC also reviewed governance and communications & engagement proposals in March 2017. We continue to work constructively with the JHOSC as the proposals are developed so we can plan ahead for any potential public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

The Plan

To meet the changing needs of our population we must transform the way that we deliver services and shift the nature of care from reactive to proactive. We will embed prevention in everything we do. This starts with giving children the best start in life and helping people stay healthy and well throughout their lives. We will develop our care closer to home model, and we will create a holistic approach to mental health services. We will improve urgent and emergency care, optimise the planned care pathway, consolidate specialties where appropriate and transform cancer services to improve the treatment and care experience for patients and their families.

Implementing our plans

This work began as an NHS directive. However, we are all committed to ensuring integrated health and social care is what we provide our population. Now health and social care are working together to join up the system. Our collaboration means more joined up health and social care services, this integration is a key success factor in the realisation of our plan.

A robust delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements, communication and engagement plans and the key risks to successful delivery.

The delivery plans are live documents and will continue to be reviewed and revised as the programme develops. Each workstream has developed a detailed delivery plan which will provide a reference point for the relevant governance structures and the central PMO to keep planned delivery on track, and to support the effective management of interdependencies between workstreams.

Social Care

Social care plays a crucial role in our plan and is reflected throughout this document. Sufficient, high quality and sustainable social care delivered directly by local authorities (e.g. via social workers) or commissioned through external providers (e.g. in the residential, nursing and home care markets) can deliver excellent outcomes for residents in North London and reduce the burden on health and care services.

However, adult social care faces similar funding challenges to the NHS, as the ageing population with more long term conditions begin to draw on adult social services in the same way they do the NHS. Put together with recruitment and retention issues and a social care provider market under significant pressure, it is important that we invest time and effort in social care and the NHS in equal measure.

Recent measures announced by the Government have begun to ease the financial pressure, but a significant financial gap remains.. In the 2017 Spring Budget, the Chancellor of the Exchequer announced an additional £2bn investment into adult social care from 2017/18 to 2019/20. This is on top of the £2.4bn announced as part of an improved Better Care Fund in the 2015 Spending Review and separately, powers for Councils to raise additional revenue for adult social care through applying a precept of up to 6% over the next three years. The additional £2bn investment equates to £28m for North London Councils in 2017/18 and £55.5m by the end of 2019/20. This is to be spent specifically on adult social care for the purposes of meeting adult social care needs, reducing pressures on the

NHS, including supporting more people to be discharged from hospital when they are ready, and stabilising the social care provider market. North London Councils will be working closely with NHS organisations to implement these measures during 2017/18, using guidance in the new Better Care Fund Policy Framework and Planning Requirements 2017-19. More detail on the financial position of local authorities on adult social care is reflected in the ' Addressing the financial gap' chapter.

Since the publication of the draft plan in October 2016 NHS organisations and local authorities in North London have continued to work together to ensure the STP addresses the challenges across health and social care. As such, many workstream delivery plans now seek to deliver benefits and outcomes from both a health and social care perspective. Directors of Children's Services (DCS) and Directors of Adults Services (DASS) across all five North London Councils have been contributing to the development of the delivery plans where there is an opportunity to work as a system across health and social care.

We have also undertaken some further analysis across North London to understand the nature and scale of the local social economy and pinpoint areas where the NHS and local authorities need to work together closely to deliver better health and care. These areas are summarised below.

Hospital admission avoidance and discharge

Councils' ability to arrange social care packages for adults in North London is a major contributing factor to delays in hospital discharge, albeit it is not the biggest cause. Latest data from NHS Digital shows that 55% of delays are caused by the NHS, 42% by social care and the remainder attributable to both parts of the system. Each Council in North London has a different approach to arranging packages of care and ensuring timely discharge from hospital, therefore there are variations in the length of wait to be discharged from hospital depending on where you live in North London. There are similar variations in the way each Council supports people to avoid unnecessary admission to hospital.

We will be working closely with NHS colleagues as part of the Urgent and Emergency Care workstream to ensure variation is minimised across North London.

The social care 'market'

Under the Care Act 2014, upper tier local authorities have a responsibility to manage and shape their local social care market to ensure the needs of users and carers are met. A significant proportion of social care packages are purchased from an external marketplace of large and small, profit-making and not-for-profit organisations some of which operate nationally and/or locally. Analysis shows that the 42% of delays transfers of care attributable to social care, the majority of these relate to difficulties in sourcing a suitable package of care in a residential or nursing home or in the person's own home with homecare. Analysis of 2016 data from NHS Digital suggests a growing trend in delays attributable to the sourcing of suitable home care vs bedded care, suggesting pressure on homecare market capacity. Local authorities in North London also pay different prices for residential, nursing and home care, even when purchasing the same package of care from the same provider.

High quality, sustainable capacity in these markets are critical to achieving the aims of the STP, both in order to prevent admission to hospital and help with timely discharge, but also in ensuring care can be delivered closer to home and in the community. North London local authorities will be working together to shape and manage the market, working closely with NHS colleagues to ensure shared ambitions are achieved.

The social care workforce

The social care workforce ranges from social workers directly employed by Councils to care workers employed in the independent sector and family carers who provide care on a paid for or voluntary basis. A study by Skills for Care in 2016 showed that 78% of employed carers in North London worked in the independent sector. Employment terms and conditions can be challenging, with care workers being paid near the National Minimum Wage or London Living Wage (depending on the terms and conditions of the Council in North London) with variances in their contractual terms. Whilst many new starters (73%) in the independent care sector have previous experience of working in adult social care in North London (suggesting we retain our workforce well) , the average turnover rate in the region is 21% with some boroughs seeing as any new starters as those leaving the sector. The care sector in North London also employs a large number of non-British nationals (42%), with some boroughs seeing more non-British national employed vs British nationals. Uncertainty on the future of non-British workforce creates additional pressure and anxiety in the marketplace, which is a challenge shared in other public services including the NHS.

North London Councils will be working together with NHS colleagues under the STP workforce workstream to develop capacity and skills in the care workforce.

Prevention

Much of the burden of ill health, poor quality of life, and health inequalities in North London is preventable. Between 2012 and 2014, an estimated 20% (4,628) of deaths in our community were from preventable causes. By focusing on helping people to stay well we will improve health and wellbeing outcomes for our whole population, reduce health inequalities, and help manage demand for health and care services in both the immediate and longer term.

We will embed evidence-based prevention and early intervention across the whole health and care system. This will include council services, social care and the voluntary and community sector. We will build upon on the individual strengths that each part of the public sector in North London can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and other organisations such as the London Fire Brigade in preventing falls.

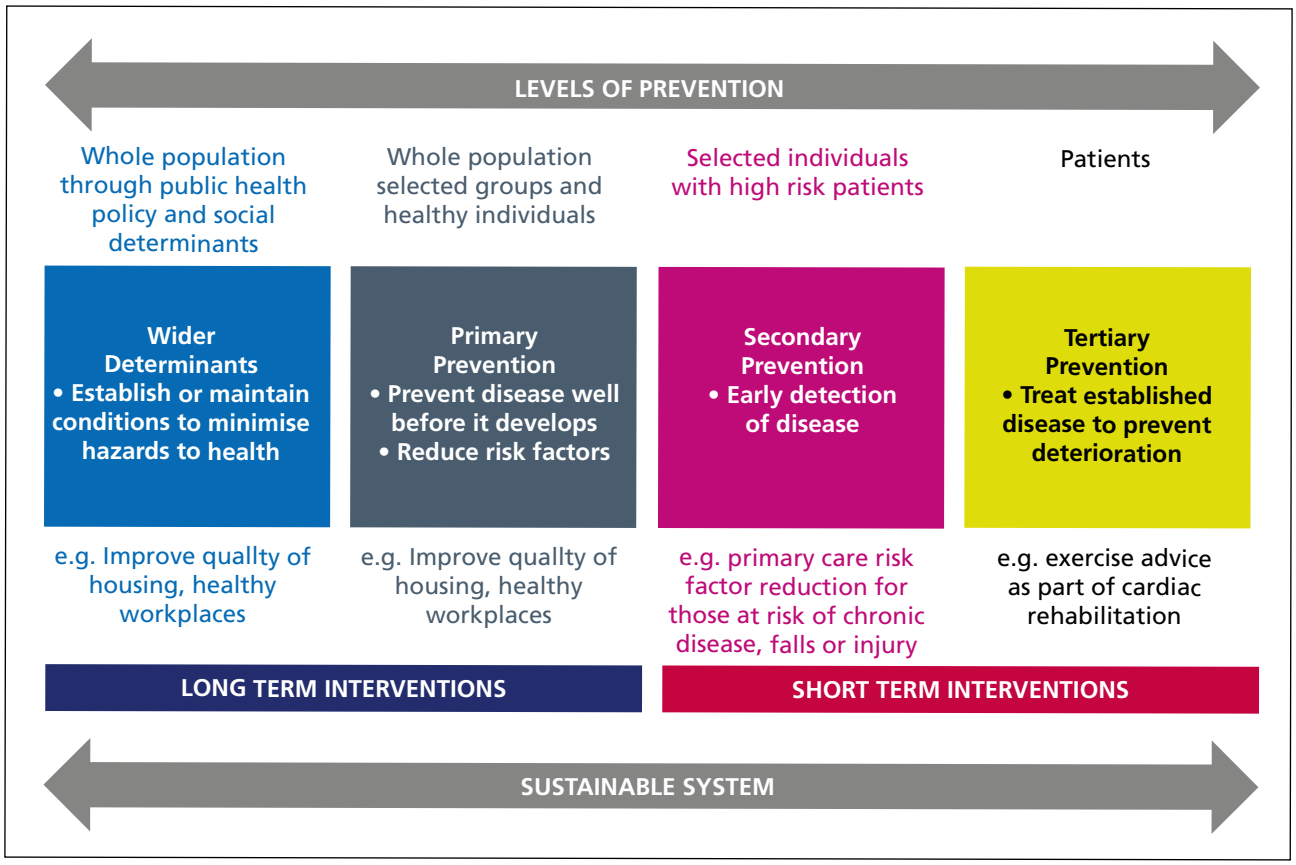
Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence alcohol assertive outreach worker and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures, which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his alcohol assertive outreach worker, which will include psychological help.

We also recognise the important contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill

health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

Our prevention plan focuses on interventions and system change across the whole spectrum of prevention (exhibit 3), where there is strong evidence of effectiveness. We have identified opportunities where we could quickly build upon successful local initiatives across North London to achieve economies of scale.

Exhibt 3: Approach to prevention



We will concentrate our efforts on three priority areas with different initiatives:

Workstream	Initiative	Description	Deliverable
Workforce for prevention	Making Every Contact Count (MECC)	Residents will be appropriately directed to services that might be of benefit to them, including lifestyle interventions and those addressing the social determinants of health e.g. debt, employment, housing. The 'brief advice' and signposting given as part of the MECC programmes will increase the numbers of referrals into preventative services. Residents with mental health issues, including dementia, will be identified more quickly and guided towards the right support service to address their needs.	Increase the number of staff across the health and care system and the wider public sector participating in online MECC training. Increase the number of frontline health and care staff participating in face-to-face MECC training.
	Mental Health First Aid (MHFA)		Increase the number of non-medical frontline staff (NHS and LA) trained in MHFA.
	Dementia awareness		Increase the number of NHS and social care staff trained in basic dementia awareness. Commence training for dementia friendly GP practices.
Healthy environments	Haringey devolution pilot	Pioneer new approaches to tackling problem gambling, alcohol misuse and smoking to secure the sustainability of the NHS, and reduce demand on social care by creating a supportive environment where it is easier to make healthy choices. Prevent people with mental health difficulties from becoming long-term unemployed and claiming ESA benefits by providing effective early help and job retention support.	Rapid application of learning across North London.
	Child Obesity	Reduce levels of childhood obesity, reduce the negative impacts on children's physical and mental health over the short and longer term through ensuring that the settings where children spend their time are recognised as healthy, and promote healthy eating and physical activity. Reduce the health and wellbeing gap by targeting settings in our most deprived communities and those with a high proportion of children from some BAME groups who are more likely to be overweight / obese.	Increase the number of early years' settings and schools in North London accredited as healthy schools or early years settings.
	Workplace Wellbeing	Build on existing momentum and commitment to promote a culture that improves health and wellbeing of employees, by working with the North London Health Education England lead, North London healthy workplace leads and Healthy London Partnerships to promote a culture that improves health and wellbeing of employees and leads to healthy and productive workplaces.	All North London NHS and local government organisations sign up to and attain at least achievement standard of the Healthy Workplace Charter.

Healthier choices	Obesity	Develop and up-scale the delivery of weight management programmes which include integrated physical and wellbeing activities. Specifically reduce the health and wellbeing gap by targeting those living with a mental illness and a physical condition and those from Black and South Asian minority ethnic groups living in the most deprived areas.	Increase the percentage of overweight/obese residents accessing support. Increase the number of overweight and obese residents losing ≥3% of their body weight
	Smoking	Radically up-scale the delivery of smoking cessation activities across North London, and in all parts of the system, as well as increasing the options available to residents who want to quit smoking. This includes: the use of digital (smartphone) apps being developed at a pan London level; increasing community support through the use of the voluntary and community sector; and providing more specialist addiction support for those with highly addictive behaviours. To reduce the detrimental health impacts on foetuses and young children, there will also be additional support for pregnant women to quit smoking, including the expansion of CO monitoring. To specifically close the health and wellbeing gap, we will target disadvantaged groups for intervention, including people with serious mental health problems, learning disabilities, specific BAME groups, and those from the most deprived communities.	Reduce smoking prevalence Increase the number of 4-week smoking quitters per year. Reduce smoking related hospital admissions
	Alcohol	Increase in the capacity and reach of alcohol liaison teams, alcohol outreach teams, as well as an increase in alcohol screening rates across North London, to identify and proactively manage via and intensive support programme a complex cohort of high risk and dependent drinkers so that their health needs are stabilised. This will reduce the number of people in crisis and help to avoid repeat hospital admissions and call-outs for blue light services. To reduce the health and wellbeing gap, interventions will be targeting high risk and dependent drinkers who are disproportionately from the most deprived communities.	Reduce alcohol-related hospital admissions Increase in alcohol screening rates
	Falls	Falls-related hospital admissions will be reduced through the use of a multifactorial intervention combining regular exercise (including strength and balance), modifications to people's homes and regular review of medications, delivered in collaboration across the local public sector organisations and with the voluntary and community sector. This will include collaboration with London Fire Brigade (in Camden and Islington initially) as part of their 'Safe and Well' initiative, as well as identifying people who have had minor falls for early intervention.	Reduce falls-related hospital admissions
	Sexual health - contraception	There will be an increase in the offer and uptake of long acting reversible contraceptives to achieve national average expenditure. Residents will have increased choice and convenience of access of contraceptive methods, including via primary care, maternity, abortion, and early pregnancy loss services. There will also be training and skills development for health professionals and awareness raising and outreach in the community.	Increase the offer and uptake of long acting reversible contraceptives to achieve national average expenditure. Reduce unwanted pregnancies
	Sexual health – late HIV diagnoses	There will be an increase in the offer and uptake of HIV testing to diagnose people with HIV earlier across the system. New regional on-line services will also help increase access to HIV testing, as will outreach and promotion with higher risk and more vulnerable groups.	Reduce late HIV diagnoses.

We will know we have been successful when:

- Every member of the public sector workforce in North London is a champion for prevention and taking proactive steps to close the health and wellbeing gap;
- Our residents, families and communities are supported to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing;
- There are fewer hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths;
- We close the health inequalities gap, through disproportionately greater improvements in health for people with mental health problems and learning disabilities, specific BAME groups, and those in the most deprived communities;
- We start to reverse the trend in childhood obesity, by proactively working across different settings to promote healthier eating and more physical activity among children and young people, as well as using our regulatory powers;
- Those working in North London become healthier, through increased levels of active travel, supporting positive mental health wellbeing, supporting employees to quit smoking and to eat more healthily, leading to reduced absences and increased productivity.

In 2017/18 we will:

- Ensure that a prevention focus is effectively embedded in all the other clinical workstreams in the plan.
- Seek to identify investment funding to take forward early implementation of the prevention priorities set out in the plan.

Health and care closer to home

Working closely with all system partners, including hospitals, GPs, Community and Social Care, as well as with Patients/Residents and the voluntary sector, we will deliver the right care at the right time to the whole population.

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. Social care and the voluntary sector will play a key role in the design, development and expansion of the future model.

Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special "stream" of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

North London has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making the care closer to home integrated network model the default approach to care and place based commissioning of services. We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for

some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed. The model will make sure services are focused on the care of people within neighbourhoods.

Achieving care closer to home will need to be underpinned by more resilient communities that are able to support residents live independently at home, where that support is needed. The support may be provided by families, carers, neighbours or from voluntary and community groups, all of whom have central roles to play.

Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks'** (CHINs[1]): These may be virtual or physical, and will potentially cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients;
- **Quality Improvement Support Teams** (QIST) will also operate from CHINs, to reduce unwarranted variation by providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients which will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes;
- **Extended Access:** Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Telephone triage, virtual consultations and online booking systems will be available for all patients;
- **Social Prescribing:** In line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by nine-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across North London; scaling up weight management programmes with integrated physical and wellbeing activities; reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception. The care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.

1 CHINS is a working title only – name to be co-designed with patients and residents

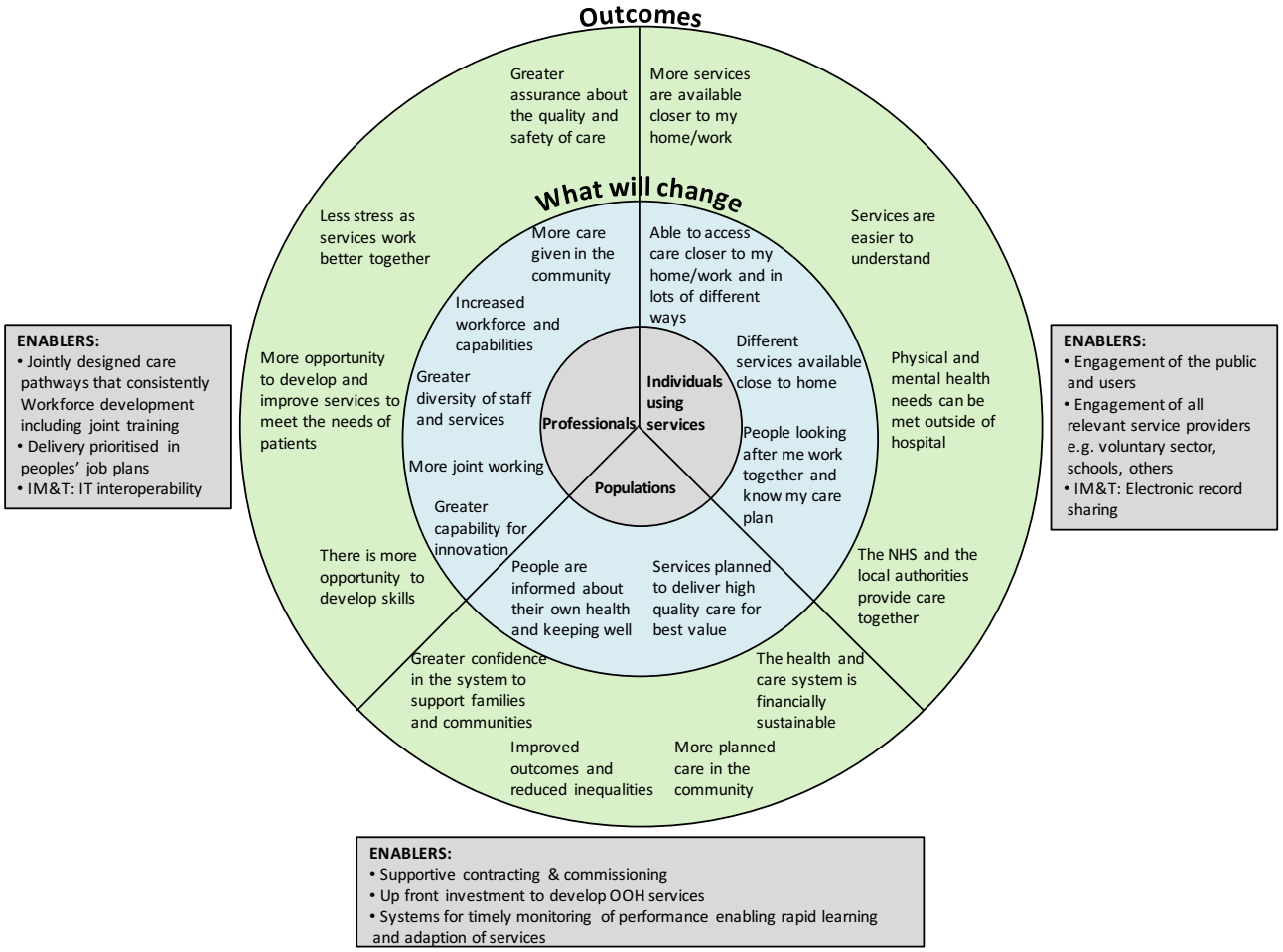
The impacts of three main strands of this workstream are detailed below:

Initiative	Description	Deliverable
Improved access	Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Patients will be able to access a GP through a variety of different methods such as telephone and e-consultations as well as book appointments and access their records online.	• Improved patient satisfaction with access to primary care • Reduced number of patients with a primary care appropriate problem seen in A&E or Urgent Care • A health and care system that is more resilient
Quality Improvement Support Teams	Improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes.	• Reduction in unwarranted clinical variation • Reduction in activity and cost of secondary care services • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Reduction in inequalities in health • Ensuring people have a positive experience of care
Care closer to Home Integrated Networks (CHINs)	CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focused on the strengths of residents, families and communities	• Reduction in clinical variation • Reduction in activity and cost of secondary care services • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Reduction in inequalities in health • Ensuring people have a positive experience of care

Improving outcomes will be the crucial measure of success of the care closer to home model. The benefits of our health and care closer to home model include:

- Improved patient satisfaction with access to primary care
- Reduced unwarranted clinical variation
- Prevention of people from dying prematurely
- Reduced inequalities in health
- Enhanced quality of life for people with long-term conditions
- More people have a positive experience of care and support to self-care
- Shared learning across CHINs and QISTs and ability to roll out best practice, new technology and new ways of working more quickly across North London

Exhibit 4: Delivery of the Better Health for London outcomes through the health and care closer to home model



We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) to establish a single LCS contract framework for the whole of North London. This LCS contract will have agreed outcomes which are shared with the Health and Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The Integrated Personal Commissioning site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions;
- realign service provision in light of new service developments related to IPC and Personal Health Budgets;
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.

In 2017/18 we will:

- Offer improved access to Primary Care across the whole of North London: Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- Implement the first wave of 'Care Closer to Home Integrated Networks' (CHINs) in each of the boroughs and invest in the corresponding Quality Improvement Support Teams. We aim to achieve comprehensive coverage of these networks during 2018/19

Urgent and emergency care[2]

We are all aware of the pressures faced in A&E departments throughout the country. Every year we hear about breaches of waiting times and ever-increasing the winter pressures. We know the system is overburdened and cannot meet expectations for performance and patient experience.

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations.

The Health and Social Care services within our five boroughs will be working collectively to solve problems that affect a person's care. We will explore new ways of delivering our services to provide the best quality services for the resources we have available. This will span from the moment somebody identifies that they have an urgent or emergency need through to when they return home.

The focus on urgent and emergency care services will reduce confusion about which service people should access, will reduce the number of unplanned admissions to hospital and will support people to return home from hospital as soon as possible. This will improve people's experience of the care they receive when unwell or in crisis and make sure that people have their care on a planned basis wherever possible.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In the future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the falls response part of the community based admission avoidance team. Mary will then be visited at home by the falls team on the same day, who will design a package of care to support Mary to stay at home. The falls team will be able to make a rapid appointment with her GP or a hospital specialist if they think that Mary would benefit from a medical opinion. Mary will then get the treatment and support that she needs, quickly, to help support her.

2 This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system

To do this we need to work with local people to understand the urgent and emergency care services that they need and would choose to access. We will work with local people in designing our services to better understand the way they want to use services for an urgent or emergency need.

Our top priorities are:

- To create a consistent and reliable Urgent and Emergency Care service by 2021 that is accessible to the public and easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes
- To review current Urgent and Emergency Care services and compare them against the defined national and London-wide standards
- To implement a high quality Integrated Urgent Care model which complies with IUC 'top 8' requirements set nationally
- To develop high quality, responsive 7 day community services, enabling more care to be provided closer to a person's home
- To develop an enhanced community based, admission avoidance model to support care being provided closer to a person's home and to reduce the number of avoidable hospital admissions
- To develop high quality ambulatory care services across North London, supporting people to receive acute care on an outpatient/ day case basis and thereby reducing the number of avoidable hospital admissions

The projects that we will be starting with first will focus on:

Workstream	Description	Initiatives	Impact
Enhanced Community Based Admission Avoidance & Ambulatory Emergency Care	Developing high quality, responsive community-based services that work 7 days a week, and support someone to have their care closer to home and therefore not requiring admission to hospital or the need to attend an emergency department.	This focuses on: • joining up of all community-based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access ; • developing services in acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment; and • developing admission avoidance models to support ambulatory / short stay community based care for paediatrics.	Key benefits to be achieved include reductions in admissions and readmissions and improved patient experience

Workstream	Description	Initiatives	Impact
Acute Frailty Pathway	Developing the care we provide for frail older people who become unwell to support them to be assessed and treated quickly, so they can remain in their home for as long as possible	This focuses on: 1. enabling rapid, early, risk-based assessments of elderly people by senior geriatricians and the provision of diagnostic support, therapy, mental heal teams, access to care in the community 7 days a week and access to rehabilitation teams through a single point of access; 2. enabling rapid treatment of frail older people by standardising services, processes and pathways across North London to ensure that only those requiring admission are admitted to hospital; 3. enabling rapid discharge of medically optimised frailty patients.	Key benefits to be achieved include reducing variation, improving patient outcomes and improving patient flow
Last Phase of Life	Improving the quality of peoples' care within the last phase of their life, to support them to die in their place of choice	This focuses on: 1. improving the care of care home patients in the last 12 months of life by embedding practice facilitators / case finders in the relevant local community palliative care service to identify, support and record care planning information for care and nursing home residents in their last year of life; 2. Specialist Palliative Care (SPC) services working together to reorganise services around two hubs (north and south) to provide SPC advice 7/7 a week, enable Single Points of Access and to reduce inequity of provision; 3. Telemedicine - remote Band 7 nurses will support 3-5 Band 5 nurses who visit patients and provide care in community and 'eSHIFT' technology will provide remote access to electronic patient records, enabling Band 5 nurses to communicate key clinical findings centrally, and be given expert advice on next steps.	Key benefits to be achieved include reducing A&E admissions and non-elective activity, improving end of life care, improving patient experience, and improving the knowledge and care of the social care workforce.

Workstream	Description	Initiatives	Impact
Integrated Urgent Care	Improving and standardising access to Urgent Care across North London to avoid the need to attend an emergency department	This focuses on implementing a high quality Integrated Urgent Care model which brings together current urgent care services such as 111, GP out of hours, Pharmacy, Urgent Care Centres and Minor Injury Units to create a single, unified approach to urgent care in line with the London UEC designation standards	Key benefits to be achieved include a reduction in A&E activity and an increase access to a locality GP/ Primary Care clinician
Simplified Discharge	Addressing the multiple different reasons that mean somebody's discharge from hospital back to their home is delayed	This involves: 1. establishing a Trusted Assessor Model wherein health and social care professionals complete a single assessment of patients' needs, which can be shared, reducing duplication; 2. developing 7 day community services to support discharge processes through the development of single access points, including a North London discharge referral form; 3. improving patient flow through the hospital, ensuring the right care can be delivered at the right place at the right time through the implementation of the 'SAFER' patient flow rules; 4. supporting shorter hospital stays by ensuring that, where appropriate, an assessment of on-going care and community support needs takes place in an environment familiar to an individual, either at home or using 'step down' beds; 5. stroke - transformation of service delivery to implement a consistent approach to the management and delivery of stroke pathways across North London.	Key expected benefits include reduction in delayed transfers of care, improved patient flow, reduction in readmissions, reduction in excess bed days and improved patient experience results.

In 2017/18 we will:

- Join up all community based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access
- Develop services in all acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment on a same day basis with no overnight stay
- Develop admission avoidance models to support ambulatory/ short stay/ community based care for Paediatrics

- Implement simplified discharge for stroke patients
- Begin design work to improve and standardise access to Urgent Care across North London to avoid the need to attend an emergency department

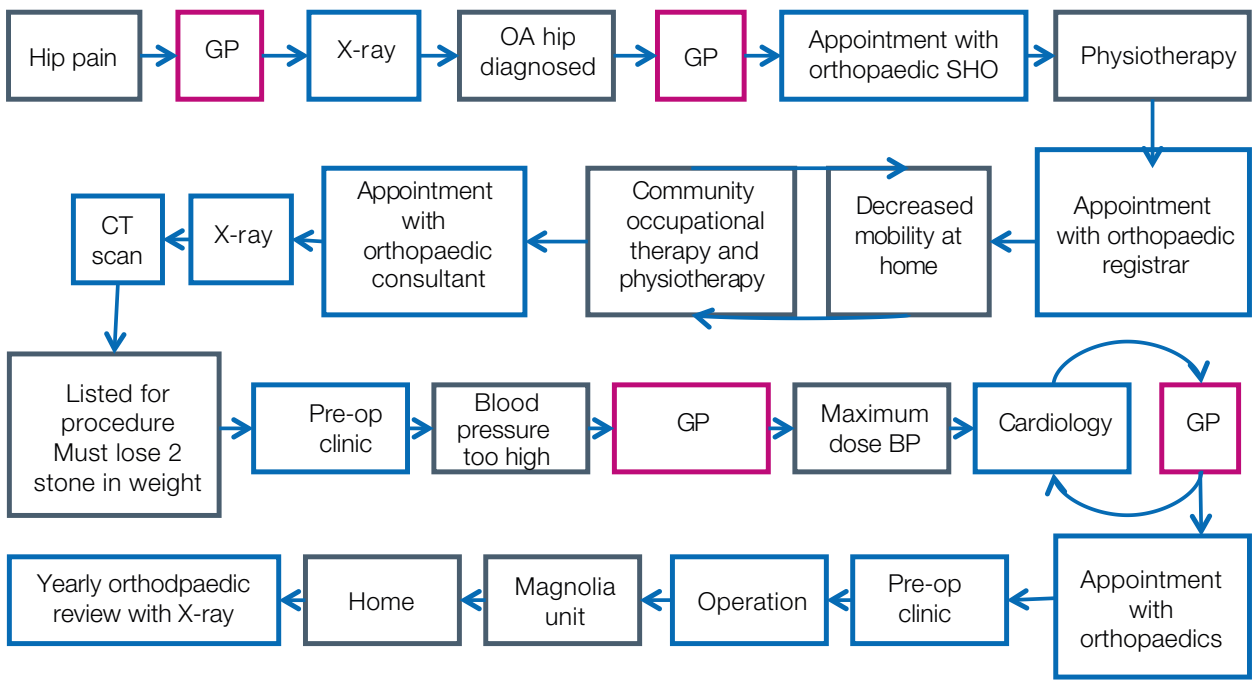
Planned care

Building on the opportunities identified through RightCare[3], we will deliver the best value planned care services across North London to reduce unwarranted variation in planned care across providers in North London. This will include;

- Reducing variation in the length of stay in hospital
- Reducing variation in the number of outpatient appointments received by patients with similar needs.
- Optimising pathways to ensure patient safety, quality and outcomes, and efficient care delivery.
- Standardising Procedures of Limited Clinical Effectiveness (PoLCE), consultant to consultant (C2C) referrals and referral threshold policy across North London to ensure parity of care regardless of patient's postcode.

Below is an example of a journey from a patient who was suffering from hip pain. Due to handoffs, inefficiencies and suboptimal advice and information transfers, this patient's pathway continued for more than three years.

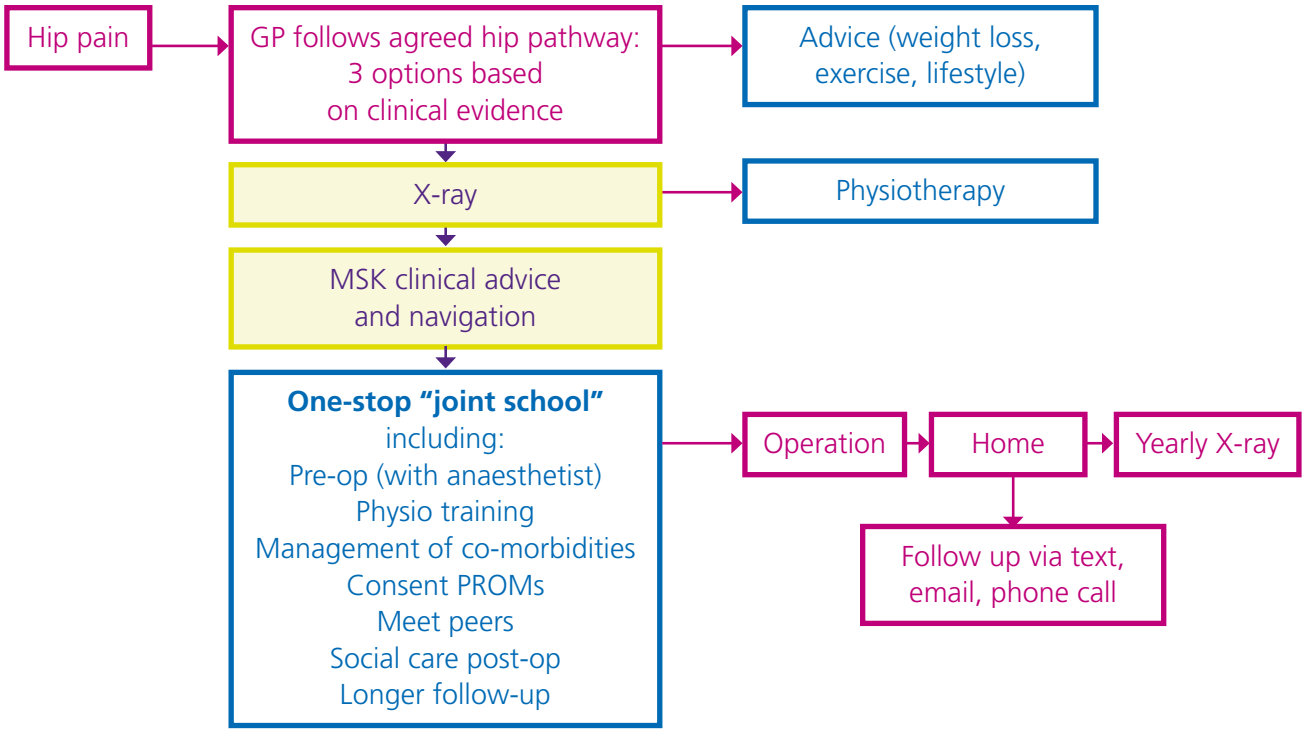
Exhibit 5: Example of previous patient journey



Moving forward the planned care workstream will seek to create a system where patient journeys are as efficient, safe and well managed as possible. As a result the new pathway will look more like the below and last a much shorter amount of time.

3 RightCare Atlas of Variation in Healthcare, September 2015

Exhibit 6: Example of revised patient journey



As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience. In order to deliver this the workstream will adopt the following principles:

- Standardised approach to pathway delivery across CCGs and hospitals
- Senior clinical triage and advice with access to multidisciplinary triage where appropriate
- Majority of outpatients managed within a community or primary care based service
- Community services supervised by senior clinicians
- Diagnostics ordered once and only when clinically necessary – reduce over ordering
- One stop service/co-location to improve patient experience
- Follow-up once, and only when necessary
- Patient centred, safe services
- Payment mechanism based on whole system management and clinical outcomes
- Quality of GP referrals and clinical thresholds improved – protocol driven
- Educational support for primary care through training and development led by senior clinicians
- Provision of health and advice telephone lines for clinicians
- Integrated IT/information portal
- Use of technology to deliver virtual services
- Standardised approach to Procedures of Limited Clinical Effectiveness (POLCEs)
- Standardised approach to consultant to consultant referrals

Drawing on local and global examples of best practice and building on the evidence, we will redesign pathways with local clinicians and patients, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics. A key enabler to the work will be the provision of enhanced advice, based on competency to make sure everyone within the system, including patients, have the right access in order to manage their conditions.

We will leverage the following opportunities for improvement to planned care pathways:

- clinical advice and navigation: ensuring competency based advice and navigation for patients so they are managed in the most optimal way for their condition
- standardised PoLCE and consultant to consultant policies: ensuring parity of care and reduction in

handoffs and unnecessary procedures

- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital

Below is an outline of the eight areas of focus and the resulting benefits for the system:

Workstream	Initiatives	Description	Impact
Group 1 'High volume'	MSK Dermatology	High volume referrer where extensive work is already being undertaken across North London	• Improved patient experience • Improved staff experience • Delivery of associated financial savings with the workstream • Reduction in the number of secondary care attendances • Improved utilisation of inpatient services
Group 2 'Integrated CAN'	Clinical Advice and Navigation	Single point of access for advice and navigation and referral management	• Improved patient experience • Improved staff experience • Delivery of associated financial savings with the workstream • Reduction in the number of secondary care attendances
Group 3 'Work in train'	Neurology Urology Ophthalmology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	• Improved patient experience • Improved staff experience • Delivery of associated financial savings with the workstream • Reduction in the number of secondary care attendances • Improved utilisation of inpatient services
Group 4 'Fastest First'	Gynaecology Gastroenterology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	• Improved patient experience • Improved staff experience • Delivery of associated financial savings with the workstream • Reduction in the number of secondary care attendances • Improved utilisation of inpatient services
	Colorectal Surgery	High volume service, identified as priority through stocktake and/or Right Care data	
Group 5 'Avoiding the postcode lottery'	PoLCE Consultant to consultant referral	Standardisation of thresholds and policy across North London to ensure parity of care provision.	• Improved patient experience • Improved staff experience
Group 6	Diagnostics	Standardisation of diagnostics thresholds and ordering across North London	• Improved patient experience • Improved staff experience • Improved utilisation of diagnostics

Workstream	Initiatives	Description	Impact
Group 7 'Phase 2'	Vascular Surgery	High volume service, identified as priority through stocktake and/or Right Care data	• Integrated pathways and services • Reduction in variation in length of stay • Standardisation of service and pathways across North London • New financial models based on whole system design • Improved patient experience
	Breast Surgery		
	Hepatobiliary & pancreatic surgery, Upper GI surgery		
	General Surgery		
	ENT	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	
Group 8 'Local schemes'	Local Schemes	Local CCG specific schemes that do display any initial benefit to North London level work	• New local models based on the need of borough or area specific population

To deliver on the above, a series of interventions will be put in place at each stage of the planned care pathway. These are illustrated and detailed below.

Exhibit 7: Interventions that support optimised planned care pathways

Pre-primary care	Primary care	Outpatient care	Inpatient pre-operative care	Surgery	Inpatient post-operative care	Follow-up post discharge
• Non-medical support and education	• Expert first point of contact • Only when ready • Structured referral template • Diagnostic protocols • Shared protocols • Monitoring and transparency	• One-stop outpatient clinics • MDT clinic	• Preoperative assessment • Re-check prior to surgery • Short-notice reserve list	• Consultant-level feedback • Ring-fenced elective beds • Theatre utilisation	• Enhanced recovery • Effective planning for discharge	• Nurse led or virtual follow up

Implementation of these high level interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the

first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicians at the initial appointment. Structured referral templates are currently used by some providers and commissioners in North London to good effect, but would be used more widely as part of the optimised planned care pathway.

- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue regarding the quality of referrals and continuously improve their own referral practices.
- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physiotherapists and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied:** patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced planned care beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for planned care patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

In 2017/18 we will:

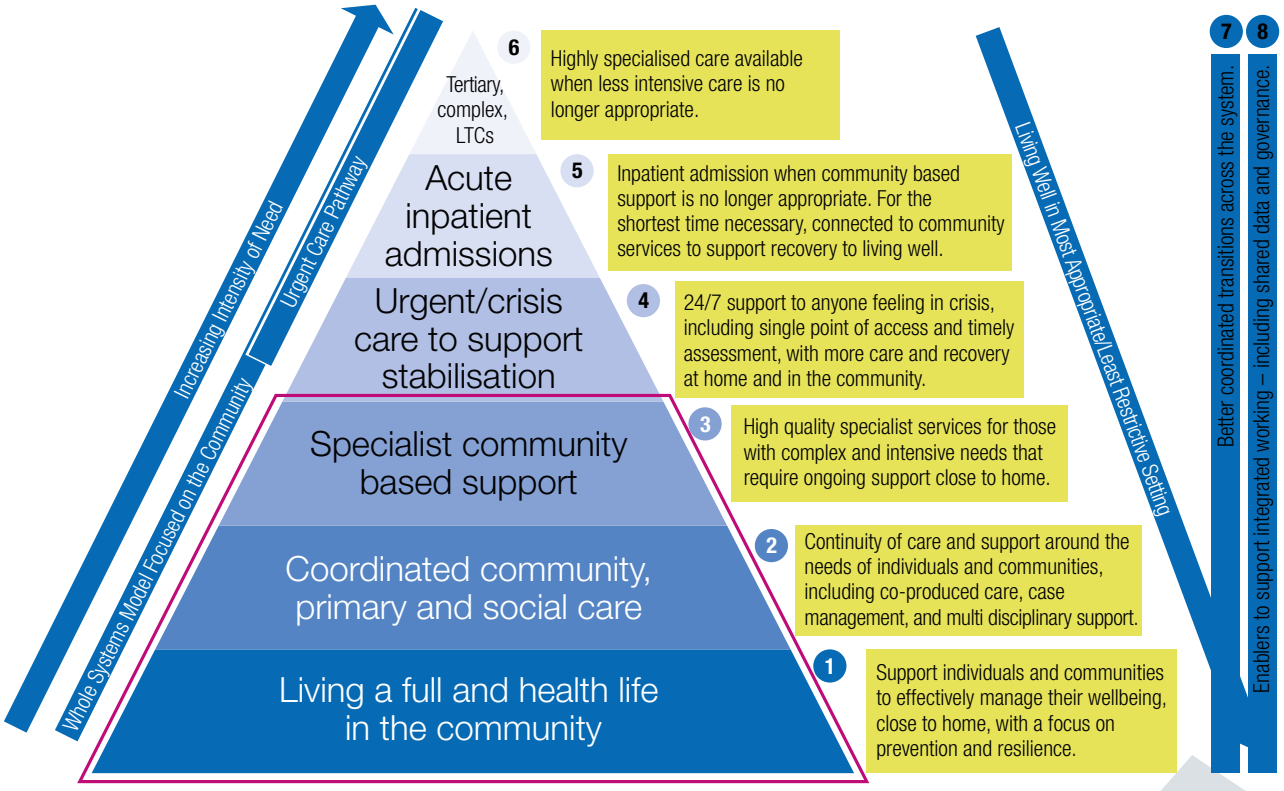
- Work with local clinicians and patients, responding to local needs and opportunities to redesign pathways in:
  > MSK and Dermatology
  > Urology, Neurology and Ophthalmology
  > Gynaecology, Gastroenterology and Colorectal Surgery
- Design a single point of access for advice and navigation and referral management
- Standardise thresholds and policy across North London to ensure parity of care provision through a review of Policies of Limited Clinical Effectiveness and Consultant to Consultant referrals
- Standardise diagnostics thresholds and ordering across North London

Mental health

Our ambition is that unless someone requires highly specialised care, they will be able to receive the care they need with North London, and not require an out of area placement. By investing in community based care, we aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds.

We will develop a 'stepped' model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.

Exhibit 8: The mental health 'stepped' model of care



We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce

inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will work towards achieving the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95% treated within 18 weeks.

Through this work we aim to bring all of North London up to the same level of care quality. No matter where in North London you live, you can expect to receive the same high quality care. This includes:

- increase mental health basic awareness, reduce stigma and increase mental health self-awareness
- support at risk population to stay well
- provide more accessible mental health support delivered at locality level
- increased alternatives to admission and support for discharge to enable more people to live well in the community, with better crisis support
- eliminate the need for out of area placement for female service users who require psychiatric intensive care via the female PICU initiative
- give more women access to specialist perinatal mental health services
- make sure more children have access to mental health support and unless highly specialised care is required, eliminate out of area placements for children requiring inpatient support
- more people in A&E and on physical health inpatient wards to have their mental health needs supported
- support more people to spend more time at home, rather than in hospital
- For North London to become more dementia friendly

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liaison psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Broadly the programme covers mental health support for all age groups and the current identified initiatives include:

- Community resilience
- Primary care mental health
- Acute pathway – including Health Based Place of Safety, S136, alternatives to admission
- Female psychiatric intensive care unit (PICU)
- Child and adolescent mental health services (CAMHS) and Perinatal mental health
- Mental health liaison
- Dementia

Over time other areas may be identified which have the potential to deliver savings. Currently out of scope are specialist commissioned mental health services (excluding Tier 4 CAMHS) although this may be reviewed over time.

In the development of this model of care we are committed to coproducing with those who have lived experience. We have established an 'experts by experience' group, the EbyE Board, with representation from across our 5 boroughs. The group formed in December 2016, and going forward will be involved in all of our areas of work, and support us in further engagement and coproduction across North London.

Initiatives will cover mental health support for all age groups and include:

Workstream	Description	Impact
Improving Community Resilience	Both for the general population, and those at risk of developing mental ill health or of becoming more severe. For the general population this includes a health promotion campaign aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at-risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support[4]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies[5].This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.	• 3% reduction sick days • 165 new jobs via IPS scheme • Reduction in suicide rate • Improved well-being for the general and at-risk population

4 Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within North London)

5 Five Year Forward View - Reduce suicide by 10%

Workstream	Description	Impact
Increasing access to primary care mental health services	Ensuring more accessible and extensive mental health support is delivered locally within primary care services. This will be developed as part of the Care and Health Integrated Networks ; enabling physical health and mental health needs to be treated and supported together[6]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[7], with more care to be offered through Care and Health Integrated Networks rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need[8] with a focus on supporting people with long term conditions. In 2017/18 the Primary Care Based Mental Health service is being rolled out to all Islington CCG practices. This service provides assessment and support within primary care, as well as training for GPs, so that more people can have their mental health supported in primary care rather than secondary care.	• 30% reduction in secondary care MH referrals • Delivery of national IAPT targets
Improving the acute mental health pathway	Building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to hospital admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to provide more effective discharge, enabling people to live well in the community. In the southern part of North London a plan is being developed to close the A&E HBPoSs, and move to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north section of North London there is the potential to develop a complex rehab ward.	• Improved patient experience • Improved stakeholder satisfaction • Reduced LoS • Avoidance of need for additional inpatient beds. • Bed occupancy maintained at 95% • HBPoS provision to meet North London needs
Developing a female Psychiatric Intensive Care Unit (PICU):	It is important to facilitate local provision of inpatient services to female patients requiring psychiatric intensive care. There is currently none available in North London. Patients will be able to remain close to their communities, with a more streamlined and effective pathway with the focus on recovery. A potential site within North London has been identified, and work is underway to develop the plan further.	• Eliminate out of area placements • Improved quality of provision and patient experience • Reduced LoS • Financial savings.

6 FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within North London)

7 Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within North London)

8 Five Year Forward View – increased IAPT to reach 25% of need by 2020/21

Workstream		Description	Impact
Investing in mental health liaison services		By scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments (EDs), we can ensure more people in Emergency Departments and on inpatient wards being treated for their physical health problems will also have their mental health needs assessed and supported.	• Improved patient experience • Improved A&E performance • Average of 1 day reduction in length of stay • Reduction in readmissions
Investing in a dementia friendly North London		Looking at prevention and early intervention, supporting people to remain at home longer and supporting carers. This will be delivered in line with national standards around dementia.	• A dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
Focusing on perinatal and child and adolescent mental health services (CAMHS)	Shared dataset	Develop shared dataset to enable comparison and shared learning across North London	• 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 • Reduction in LoS and admissions • Elimination of OOA placements • Investment in outreach offer
	Eating Disorders	Invest in eating disorders	
	Workforce	Planning for a workforce that meets the mental health and psychological well-being needs of children and young people in North London, including CYP IAPT workforce capability programme	
	Transforming Care	Supporting children and young people with challenging behaviour in the community, preventing the need for residential admission	
	Perinatal	Develop a specialist community perinatal mental health team so that more women have access to evidence based specialist perinatal mental health care	
	Child House Model	Following best practice to support abused children in North London	
	Crisis Pathway	Develop an North London crisis pathway that includes 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, and review of S136 provision	
	Youth Justice	Work with NHS England to develop co-commissioning model for youth justice	

Focusing on perinatal and child and adolescent mental health services (CAMHS):
We know 50% of all mental illness in adults begins before 14 years of age and 75% by 18[9]. There is significant financial cost associated with perinatal mental ill health along with negative social/ emotional impacts on a child's life, health and wellbeing[10], Focusing on children and young peoples' mental health and wellbeing and perinatal mental health as key priorities we can improve the long term mental health outcomes for our population. The eight priority areas identified above form

9 Cavendish Square Group
10 Centre for Mental Health and London School of Economics

the joint aspect of the North London Children and Young People (CYP) Transformation Plans. The principles of THRIVE[11] 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.

There are a number of interdependencies across the North London mental health workstream and the other elements of our programme of work. Other areas of work such as workforce are crucial in identifying the future workforce we need in order to deliver these initiatives, which includes new roles and developing new skills.

The Estates workstream is another important enabler of a number our initiatives. This includes the redevelopment of the Barnet, Enfield and Haringey Mental Health Trust, St Ann's site and the Camden and Islington Foundation Trust St Pancras site in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site.

The proposed developments of the St Ann's and St Pancras sites would:

- Transform the current inadequate acute mental health inpatient environments on both sites
- Provide more therapeutic and recovery focussed surroundings for patients and staff
- Improve clinical efficiency and greater integration of physical and mental health care
- Release estates across the trusts, to enable development of community-based integrated physical and mental health facilities
- Develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence
- Provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

The delivery of these initiatives, and the realisation of the proposed benefits, is critically dependent on increased investment. For 2017/18 to date we have identified investment of an additional £1.3m and have succeeded in accessing a further £2.5m from national transformation funding.

Priorities for mental health are being taken forward in line with available funding at this stage and with a focus on the ability to test new models of provision and strengthen the evidence base for effectiveness. The STP remains committed to expanding the pace of transformation in mental health care as resources, including national transformation funding become available.

In 2017/18 we will:

- Roll out primary care mental health services in Islington
- Establish integrated IAPT capacity in Haringey and Islington
- Map and design the acute care pathway
- Establish a specialist community perinatal mental health teamBid for local commissioning of Tier 4 CAMHS
- Develop core 24 hour mental health liaison services at UCLH and North Middlesex
- Plan the development of a local female PICU to be put in place in 2018/19
- Seek to identify further investment funding to take forward implementation of other priorities in line with the plan

11 THRIVE is a population approach to children and young people's mental health developed by the Tavistock and Portman Foundation Trust and Anna Freud Centre which aims to replace the traditional tiered model with one which tailors the response of services to the presenting needs and expressed preferences of young people.

Cancer

Working in partnership as the UCLH Cancer Collaborative, Commissioners and providers across north central and north east London and west Essex joined together in late 2015 to form the national Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, under the auspices of NHS England's new care models programme.

We aim to save lives and improve patient outcomes and experience for those with cancer in North London and beyond by driving changes in delivery of cancer care across a whole health system that will save hundreds of lives, reduce variation and improve quality of care.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our top priorities are to:

- **Improve survival:** through earlier diagnosis, implementation of best practice and improved access to novel diagnostics and therapeutics
- **Improve patient experience:** by reducing pathway delays (sustainable delivery of 62 day standard), supporting care closer to home and developing integrated patient pathways across primary and secondary care, physical and mental health, health and social care
- **Reduce cost:** using new models of care, reducing variation in pathways and closer integration between providers and across the commissioning landscape
- **Generate new income:** by capitalising on our position of natural competitive advantage in translational and clinical cancer research

Faster diagnosis will be delivered at pace and scale through a range of approaches including the use of decision support tools mobilising primary care in the early detection of cancer, driving the straight to test agenda and effective modelling to focus diagnostic capacity most efficiently on areas of need. Quality of care, variation in treatment and outcomes and improved cancer waits will be tackled through implementing agreed whole pathways of care through diagnosis and treatment to living with and beyond cancer and end of life care. Efficiencies can be further consolidated through innovative service delivery models and partnerships to deliver personalised cancer care from diagnosis to living with cancer and beyond.

Our cancer workstream builds on the platform established by the National Cancer Vanguard and encompasses a breadth of priorities, primarily the recommendations from the National Cancer Taskforce. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across North London, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models, implement interventions to increase screening uptake rates, lead innovation in cancer diagnostics and deliver a programme to improve awareness of cancer symptoms in primary care.
- **Pathway improvement:** across the region there is an on-going challenge to ensure that patient' rights under the NHS constitution concerning waiting times for cancer diagnostics and treatments are consistently realised. We are working together as a whole system to understand where the 'pinch points' are that cause delays in pathways, and to be able to 'flex' diagnostic capacity and workforce. We have already enabled reconfiguration of some small volume MDTs to improve diagnostic pathway and workforce efficiency and resilience.
- **Living with and beyond cancer:** working with patients, hospitals and GP practices to support long term self-management, increase care in community settings and improve both understanding and communication of patients' holistic needs between healthcare professionals and with patients.
- **End of life care:** evidence indicates a need for service improvement to ensure that patients are better supported to choose the location for their last days of life. There is also growing evidence indicating a need for better informed clinical and patient decision making concerning the value of therapeutic interventions in the last days of life.
- **New models of care:** we are developing the case for a single provider model for radiotherapy in North London, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and links the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality standard for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer took place in September 2016.
- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we are developing balanced scorecards which can made available to MDTs, providers and commissioners through a free to access web-based platform. A project on interventions in the last three months of life is about to launch in conjunction with PHE.
- **Cancer Academy:** a new Academy is being launched to provide infrastructure and expertise to develop programmes for patients, primary care, multidisciplinary teams, cancer professionals and staff working in cancer clinical research. The Academy is working closely with partners across London as well as with UCL to collaborate effectively in programme design and delivery.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

We are focused on achieving a step change in key patient outcomes including:
- Deliver Cancer Taskforce aspiration for proportion stage 1 & 2 diagnoses by 2020
- Reduce to the national average or below the proportion of patients diagnosed in an emergency setting
- Achieve and sustain delivery of the 62 day access standard from the 2nd quarter of 2017/18
- Improve patient experience to achieve or exceed national average performance
- Reduce variation in these outcomes across NCEL and close the gap with the best performing regions, aiming for no CCG to be in the lowest quartile for any of these outcomes by the end of 2018/19

- Aiming to improve overall one year survival rate and reduce the current large variation seen across North and East London

In 2017/18 we will:
- Achieve a shift in the stage at which patients receive a cancer diagnosis, through a range of access and awareness improvements.
- Agree new care models in chemotherapy and radiotherapy to reduce variation in quality, improve financial sustainability and support care closer to home
- Work to define and capture the outcomes that matter to patients along their pathway from diagnosis to living with and beyond cancer so that this information can be fed back to patients, clinicians, providers and commissioners
- Undertake analysis that will improve patient experience and informed decision on therapeutic interventions during the last days of life.
- Define and implement best practice cancer pathways and service delivery models.
- Reduce wastage and improve value for money from cancer drugs spend

Maternity

In 2014-15 there were approximately 20,000 babies born to North London residents and 24,000 births delivered by the local Trusts. In North London there are specialist maternity services centred on a single tertiary level neonatal unit, as well as obstetric, midwifery led-units and home births taking place. The population is diverse and growing and experiences significant fluctuations as people using health and care services move in and out of the city. North London has significant areas of deprivation as well as older women, more likely to be overweight or obese and likely to experience medical complications in pregnancy such as gestational diabetes, when compared with the national averages.

Across North London, fewer women access services in midwifery-led settings, within birth centres and at home than would be clinically indicated. While community midwifery antenatal care is offered by all providers, more care can be provided close to home or work. Women are not being offered choice of care setting or receiving continuity of antenatal or postnatal care. There is a lower than national average score for experience during the antenatal, intrapartum and postnatal periods and perinatal mental health support is varied.

In November 2016, North London was successful in a bid to become an early adopter of the National Maternity Transformation Programme. This programme sets out to achieve the ambitions of the Better Births report - the output from the National Maternity Review conducted earlier in 2016.

Based on the Better Births report, the primary objectives for their Maternity Programme are:
- To improve the experience of women accessing maternity services in North London
- To provide increased community-based choice across the pathway of care and greater access to midwifery-led care within birth centres and for home birth
- To improve continuity of maternity care, including continuity of carer
- To improve the safety of maternity care provided to women
- To improve the quality of information offered during pregnancy so that women can be supported to make choices that are most appropriate for their needs
- To develop a single point of access or centralised booking service

The key areas of transformation have been identified and summarised into three main categories:

Personalisation – We will redesign maternity provision so that women and their families will be able to choose maternity care in a variety of settings and by the most appropriate clinicians. This will be achieved through the development of innovative models of care, advice and education

which, where possible, will take place outside of the acute hospital setting. This will require staff development, process improvement and the development of appropriate early information around risk to choice and continuity. The gap between the actual and desired place of care will be reduced and births in midwifery-led settings (where appropriate) will be increased. Women will have an engaged professional advocate (usually their midwife) to provide unbiased support and advice. Maternity teams will work closely with the emerging perinatal mental health services to develop improved services for women affected by mental ill health.

Continuity - The majority of care will be provided in community hubs by midwives working in partnership with other agencies including:

- Social Services
- Health Visiting
- Family Nurse Partnership
- Housing
- Contraception
- Mental health
- Neonatal outreach with classes offered to all (antenatal, breastfeeding, parenting, pre-conceptual care for next pregnancies)

Autonomous teams of midwives will be supported by named obstetricians with the governance, training, protocols and processes to work in any facility within the North London system. There will be continuity from the initial booking visit through the availability of a centralised booking service offering appointments, information and advice. Maternity information will be shared across North London organisations through the implementation of electronic medical records. Continuity of postnatal care will be improved through revised models of care and care plans.

Safer Care – Governance and training will be centralised so the system becomes more responsive and learns from events. Duplication will be reduced with prompt response to abnormal results achieved through equal access to all systems partners (with a woman's permission). We will continue to reduce perinatal deaths through the Still Birth Care Bundle, investigating deaths using a standardised review process, increasing utero transfers to L3 units, reviewing capacity and escalating 'red' outcomes for peer review. Benchmarking and driving improvement plus ensuring the Maternity Services dataset is completed by all providers. Care will be delivered by a multi-profession workforce which is able to work across organisations to support new models of care and improve staff safety levels.

The programme will be delivered through four workstreams, which address different elements of the transformation plan. However, because of the interdependencies between the workstreams, the working groups will need to be cross cutting. For example, the work on improving community care through the establishment of community hubs is dependent on the work to establish systems for collaborative working. The establishment of a single point of access is dependent upon the work on choice.

Those elements of work on safer care, which don't fall specifically into one of the four workstreams, will be picked up within a Quality and Safety Subgroup of the Local Maternity Services Board.

Furthermore, given the considerable body of research suggesting that foetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, the Partnership will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy.

In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improving the diet of women of reproductive age has the potential to reduce the health needs of both women and children in the longer term.

Below is an outline of our plans in more detail:

Workstream	Initiative	Description/Deliverable	Impact
Ensuring equality of choice for all North London women regarding place and type of care	Identify current birth settings and which are chosen at present	Detailed mapping of current offer for birth, antenatal and postnatal care by each Trust has been completed. Engage service users to understand the factors that impact choice. Map key blockers to ensuring choice is offered and perceived as such by women. Map the current processes and how staff and women perceive them. Engage women to understand what choice means to them. Engage staff to understand how these systems could improve. Review information available and standardise. Consider a North London wide website for information. Produce standardised decision making tools, linking to single point of access work. Review guidelines, milestones and workforce to ensure able to implement new models of care.	• Improvement in patient satisfaction in relation to choice and information offered. • Increased score within CQC survey relating to choice questions. More women say they are offered choice of place of antenatal, birth and postnatal care. • Improved and streamlined systems for clinical staff.
	Determine factors impacting choice of birth setting		
	Identify current antenatal and postnatal settings and which are chosen		
	Determine factors impacting choice of antenatal and postnatal settings		
	Standardise the process for offering choice of care setting at referral		
	Ensure women have equal access to a range of antenatal, birth and postnatal settings whichever Trust they choose		

Workstream	Initiative	Description/Deliverable	Impact
Improving community services	Mapping of existing community services Identification of maternity activity at community sites Mapping of existing processes underpinning services Development of North London wide community model of care Development of North London wide antenatal pathway Development of North London wide postnatal pathway Implementation of community hubs Reconfiguration and training of North London workforce Communication of change	Detailed mapping of current service locations and activity has been completed. Further mapping to identify other co-located services to follow. Detailed mapping of antenatal and postnatal pathways including for out of area women and those from in area who birth outside to be completed. A new vision for community services, including models of care and pathways to be developed in conjunction with stakeholders. Develop a plan for the configuration of hubs and other locations, including staffing, IT etc. Develop policies, a training plan and materials.	• More care available closer to home or work for women outside an acute setting. • Clear pathways of care across geographical boundaries. • Improved continuity of carer for women. • Improved satisfaction for staff in being able to provide continuity. • Improved postnatal care, demonstrated through improved CQC survey scores and London continuity audits. • Reduced blood spot screening Sis.
Implementation of single point of access	Determine existing access models Determine preferred future model Ensure staff equipped to transition to new model Refine literature offered to women	Mapping to identify current booking patterns is complete. In-depth review of referral processes to be undertaken. Work with women and families to map factors, which shape choices made at booking. Develop vision for new model by examining what is available elsewhere and engaging with stakeholders to determine the most appropriate for North London. Review and refine current information in conjunction with choice and community work streams.	• Increased level of informed choice about type and location of care at beginning of pregnancy. • Increased rates of early booking to meet screening target at 10+0 weeks. • Reduced levels of DNAs, reduced levels of multiple appointments and bookings. • Streamlined systems within maternity services.

Workstream	Initiative	Description/Deliverable	Impact
Implementation of collaborative working approach	Implementation of shared processes and procedures Implementation of shared communication approach Implementation of a mobile workforce Enabling shared access to patient data / IT	Working closely with work stream 2 this work stream is about enabling the establishment of community hubs and the ability for staff to work across the system. Governance and indemnity systems and processes will be reviewed and changes required enabling staff to work across the system. Pathways and models of care into and out of acute care to the community will need to be mapped. Along with current training systems and materials so that a new models of education and training can be developed (As per work stream 2).	• A mobile workforce that can be flexed across the system. • Improved demand management at times of increased activity. • More efficient use of maternity services across North London. • Improved continuity of care for women with the greatest medical and social need.

In 2017/18 we will:

- Standardise the process for offering women a choice of care setting at referral in North London
- Ensure women have equal access to the different birth settings and antenatal care/postnatal care settings at whichever North London Trust they book with
- Improve Community Services through a review of current pathways and provision that will lead to the design of community hubs
- Work with relevant partners to design a single point of access for maternity services

Children and Young People

Children and young people are a significant proportion of the total population of North London (approximately 25% to 30%).The health and wellbeing of our children and young people today will determine the health and wellbeing of all future generations. Our service transformation therefore must include a specific focus on our younger population.

Our simple aim is to ensure children and young people are as happy, safe and healthy as possible and have access to opportunities that allow them to achieve their full potential.

We are committed to reducing health inequalities with a focus on prevention and early intervention. We believe that we need to work across health, education and social care in North London to do this, particularly maximising the potential of nurseries and schools to improve health and wellbeing of our children and young people.

We know that poverty, deprivation and inadequate housing are the greatest determinants of poor health and wellbeing outcomes in children and young people and we face significant demographic challenges. We also know that issues such as domestic violence can impact negatively on the mental

health and wellbeing of children. Our case for change demonstrated that 30% of local children grow up in child poverty, with 6% living in households where no one works. Four of our five boroughs are in the top 10% of areas in England for the number of homeless households with a priority need, and all five are in the top 10% or number of households in temporary accommodation.

In response to these challenges, we have established a North London-wide Children and Young People's Network which will champion children and young people's service development and drive up quality and efficiency. Our priority areas are:

Paediatric elective and emergency surgery - Children & Young people should have equal access to surgery based on clinical need. Surgery should be undertaken as close to home as possible by staff with the requisite training and skills. There is opportunity to commission and deliver surgery differently across the footprint to achieve high quality care whilst at the same time realising economic benefits.

School readiness by five - Supporting children to have the very best start in life is very important to their future health and life opportunities. However, we know a third of our children in North London do not reach a good level of development in preparation for school. We will explore how to work together to have the biggest impact on this area, in particular by improving oral health of children (tooth extraction is the biggest cause of hospital admission nationally in school aged children five to nine years of age) and by improving children and young people's speech, language and communication.

Long term conditions - Asthma is the most common long term condition in the UK and, on average, affects three pupils in every school classroom. We will draw on the London paediatric asthma standards to ensure children and young people are routinely followed up by their GP practice after an asthma related A&E attendance or admission; to ensure every registered asthmatic has a written asthma management plan and an annual health review, which will include correct inhaler technique and medication review; and to extend the Asthma Friendly Schools Initiative successfully piloted in Islington.

Reducing emergency attendances and admissions - The network will play a pivotal role in supporting the delivery of reduced paediatric A&E attendances and emergency hospital admissions by 20% by March 2021. This will mean new models of care will be tested and developed across the footprint.

In addition to the areas above, the network will promote an all age, life course approach across all other workstreams within this plan.

To tackle obesity and the number of children who are overweight, we will promote active travel, sport and play for children in schools, encouraging schools to deliver the Take 10, Active 15, Walk a daily mile initiatives that have been successfully adopted in other parts of the country. By 2020/21, our aim is that four out of five early years' settings and schools in North London will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Working with the Mental Health workstream of this plan, we will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families.

We will capitalise on the universal services of MIND, Place2Be and established voluntary sector initiatives like **Hope Tottenham** that are already working directly with families and young people.

Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will work collaboratively with the mental health workstream to deliver the Child and Adolescent Mental Health Services (CAMHS) and perinatal initiatives as detailed above. We will explore ways to develop the Partnership and link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy and to reduce the health needs of children in the longer term.

In 2017/18 we will:

- Engage with the other workstreams in the partnership to support the delivery of their plans to improve the lives of children
- Develop a more detailed delivery plan for work that falls outside of the remit of the other workstreams ready to implement in 2018/19

Specialised commissioning

The London Specialist Planning Board has set out the scope of its work, and established four workstreams on clinical pathways, in Renal, Cardiovascular, Cancer and Paediatrics. We are actively participating in the groups which held their first meetings at the end of January: it is too early to know how these workstreams will impact on North London which has already undertaken significant reconfiguration in three of these. We also understand that NHS England is driving a number of initiatives through commissioning, to control expenditure on high cost drugs and devices. We will incorporate information on these, together with further refinement of additional priorities and North London-driven activity in due course.

New commissioning and delivery models

As part of the development process of this plan, and in response to the changing healthcare landscape in North London, the five CCGs have agreed to establish new ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. The establishment of a more formalised degree of cooperation between the five CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Group model which aims to bring together a network of hospital providers
- increasing financial risk
- stretched capability and capacity

We have agreed to establish a joint committee across the five CCGs to enable joint governance of some key commissioning decisions; the development of a common commissioning strategy and financial strategy; and the establishment of some shared CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and

outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next two years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described above, to ensure that health commissioning in North London delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements were agreed by governing bodies in November 2016 and a single Accountable Officer is now in place. The remaining new post holders will start early in 2017/18.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Haringey & Islington Wellbeing Partnership, the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of organisations across the system to get their views on the different options for new delivery models, and the broad consensus includes moving over time towards:

- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles
- a move towards some sort of population based capitated budget for the new delivery vehicles
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value

We recognise that the health & care landscape in London is particularly complicated, so we do not expect to implement any significant changes in the short term but will keep our approach under review.

Consolidation of specialties

We will identify clinical areas that would benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we cannot shy away from making changes where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in North London. We have successfully done this across:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

We recognise that there are other service areas which are currently or may become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. We agree that improving quality should always be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes.

This work is at an early stage. No decisions have been made. Over the next year we will review whether these or any other services would benefit from consolidation or networking. Consideration of any requirements for consolidation of services will be undertaken within each of our clinical workstreams as they develop more detailed delivery plans. The Health and Care Cabinet will retain oversight of this work to maintain a whole system perspective.

Enablers

As well as making the changes outlined above in prevention and service transformation, we need to ensure the infrastructure and resources we have are redesigned and aligned to deliver these transformed services - these workstreams are known as enablers. To achieve this, we will work as a sector to share and transform the vehicles that underpin delivery.

Workforce

Our vision is to support North London health and social care organisations to be excellent employers, committed to supporting the wellbeing of staff whilst also preparing them to deliver the new care models in a range of settings. We will work with North London organisations across all health and care settings to support their collaborative efforts to achieve this whilst ensuring that everything we do contributes to the following aims:

1. Improve patient experience and outcomes through improved staff experience and engagement
2. Define and adopt new ways of working, including working across health and care settings
3. Maximise workforce efficiency and productivity
4. Create a reputation where North London is recognised as a great place to work aiding recruitment and retention
5. Promote and provide an excellent learning environment
6. Develop, implement and embed a systematic approach to leadership development.

To support these aims we are committed to co-creating, communicating and collaboratively delivering plans to address capacity, quality, cost and capability of our workforce. As leaders, we will encourage a culture of networking, collaborating and educational asset sharing, as we believe that strong relationships between our staff are the best way of achieving change. The 'Breaking Down the Barriers' programme (a collaboration between Health Education England, UCL Partners and a number of our Trusts that aims to improve mental and physical health through education and training) is a positive example of an initiative which will be taken forward through developing such a culture.

We will achieve efficiencies in employment by:

- connecting employment services and processes collectively across the footprint
- enabling North London organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages
- facilitating the implementation of new models of care, providing a framework for the deployment of staff to new settings and areas of greatest need

We will develop initiatives to equip the existing workforce with new skills and ways of working, ensuring that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will implement plans emerging from the workstreams to equip people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model.

Since the inception of the STP, we have commissioned 446 postgraduate career development programmes and rotations for our nurses to develop the skills required to fulfil our vision of an agile, highly skilled, North London workforce. This work will continue over the life of the plan through initiatives such as the Capital Nurse programme (for which we have already affirmed our commitment to deliver) and through a single implementation plan for the sector, boroughs and organisations.

We have five successful Community Education Provider Networks (CEPNs) in North London who are starting to focus their work to the following core themes:

- Retention
- Clinical skills
- Widening participation
- Carers and communities
- New ways of working and new roles
- Building a stronger interface with secondary care to enable skills transfer

Our CEPNs are an example of a network/asset sharing based approach to improvement. Delivering improvements to primary and community care through initiatives such as Care Closer to Home Integrated Networks (CHINs) is fundamental to achieving the service ambitions set out in our plan.

A note on mitigating the potential risks of Brexit: We do not currently know how the process of the UK leaving the EU will impact on health and care services but we do know North London is a cosmopolitan area with many people from the EU settled here as workers and residents. We know Brexit it is a real concern to staff, patients and residents – both in terms of who will provide their care, who will run their services and what it will mean for the livelihoods of friends and family. In the current political and economic climate, a safe supply of workers to meet the needs of our patients in North London. Our retention strategies are aimed at continuing to attract and retain the right people, thus reducing the reliance on overseas staff. Our HR community is working closely with the Mayor of London to ensure that overseas workers, who are vital to our health economy, remain part of our health economy.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population but are employed outside of the public sector, including home care workers and personal assistants. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness.

We will implement initiatives to equip existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and enhancing emotional resilience in themselves, their teams and their patients. We have developed a health coaching competency framework which has now been rolled out across each of our Trusts, with each Trust now leading a specific person-centred conversation initiative.

We will support the Prevention workstream in training all frontline NHS and social care staff in Making Every Contact Count (MECC). Similar work will be undertaken to ensure that all non-medical frontline staff receive training in Mental Health First Aid (MHFA) and basic dementia awareness. We have created a Dementia Awareness programme in North London, which we will continue to develop and ramp-up to focus on Tiers 1, 2 and 3. This programme, developed by Health Education England and UCL Partners, has been nationally acclaimed.

While most of the people who will be engaged in delivering the North London vision are already with us, working in roles which will need to adapt or change in some way, we will also help to establish a number of new roles such as physician associates, care navigators and advanced clinical practitioners. We will support strategic workforce planning and redesign and commission training for skill enhancement, role diversification and new role implementation. Much of this work has begun, but others will be contingent on the definition of new clinical models.

To enable transformation, we will deliver system-level organisational development, supporting leaders and teams through the transformation journey. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.

As part of our Delivery Plan we have brought together the health and social care workforce community under the strategic leadership of the LWAB (Local Workforce Action Board) and initiated a programme of work in the following areas that help deliver the six aims outlined earlier:

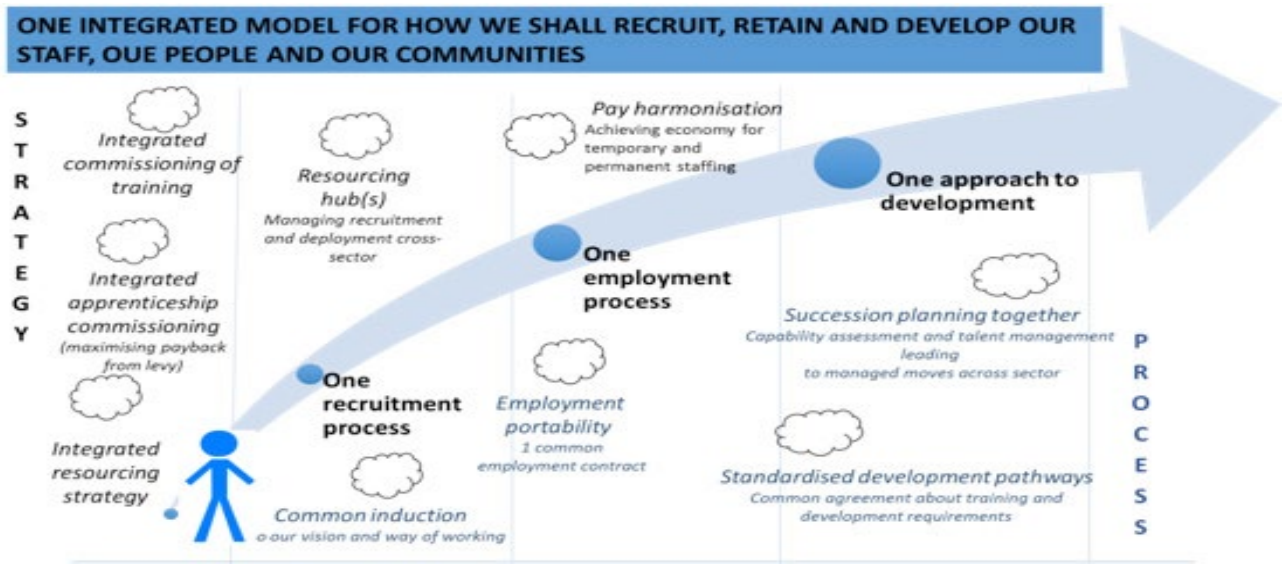
- Resourcing and integrated employment (aim 4)
- Learning and development (aim 5)
- Enabling new models of care (aim 2)
- Enabling productivity and back office rationalisation (aim 3)

We have launched collaborative work programmes to improve staff retention, manage temporary staff rates of pay, procure a shared bank and reduce levels of agency expenditure. We have already identified significant savings against these initiatives which we are committed to achieving. Building the brand of North London as a place of choice to train and work is a pivotal enabler to these ambitions; where permanent or temporary employment is deemed much more attractive than agency work; whilst remaining flexible.

We recognise the benefits of collaborating on learning and development and our delivery plan includes work on shared leadership, Organisational Development programmes and a review of Learning and Development capacity and delivery, as well as a joint approach to new arrangements for apprenticeships.

These initiatives, together with work on creating common employment policies and procedures, will improve employment portability and further the aim of achieving more integrated employment across North London.

Exhibit 9: Integrated model of employment



The Workforce workstream is a key enabler for the new models of care emerging from the workstreams. We will lead workshops and task and finish projects to facilitate agreed workforce plans. The NHS provider HR community is also collaborating on a review of back-office HR processes; shared HR systems and policies will facilitate this work.

For the next stage of the Workforce workstream, we will turn our focus to the clinical workstreams to accelerate the pace at which they develop new service models and define the workforce they require.

Engagement and the development of close working with the clinical workstreams has been a key element of our initial work and this now needs to progress into the delivery of workforce plans to transform services. We will support scenario modelling to assess the financial benefits of the new models and the impact of new roles and changing settings for providing care.

Below is an outline of the different areas we are working on:

Work package	Initiative	Description	Deliverable
New Models of Care (Workforce as an enabler)	Package of work for each of the clinical work streams	Support the new models of care leads in understanding changes to workforce resulting from the new models of care covering capacity changes, new roles, changed roles, skills, training, competencies, recruitment and professional and career development. Bring together professional expertise in pathway designers with HR expertise to ensure credible plans for implementation	• Workforce modelling and analysis • Workforce design • Education & Training design and delivery • Develop change management skills and capacity to support new models of care
Primary Care	Recruitment & Retention Training & Development New Roles	Review and re-alignment of GP Training across London/ North London. Implementation of new role programme. Implementation of retention schemes and training of existing workforce	• Workforce design to take place concurrently with CHIN development timelines • Delivery of workforce aspects of the GP Forward View
Resourcing	Recruitment & Retention Temporary Staffing Bank	To reduce turnover across North London and retain existing skills To consolidate temporary resourcing activity across North London and to provide attractive and comparable rates and reduce agency spend Single procurement for a shared bank platform/service	• Stage one qualitative "deep dive" assessment • Reward Assessment • Common Recruitment Policy and Processes • Pay data report to LWAB • Platform for one provider that enables Trusts to join the bank
Learning & Development	Statutory and Mandatory Shared provision Apprenticeships	Standardise and streamline and extend one approach to statutory and mandatory training Pooling resources across North London and developing shared capabilities for in house delivery of education, training and workforce development Collaborative approach to apprenticeships	• Standard common approach , content, topics and standards implemented to delivery models for statutory training • Initial phase provides an in depth review of learning centres, e-learning platforms, library services, simulation facilities and current provision • Shared policies including pay, terms and conditions • Co-ordinated approach to capabilities • Joint procurement of providers • Joint planning of shared cohorts

Work package	Initiative	Description	Deliverable
Integrated Employment Model	Branding Employment portability Career frameworks	To encourage employment flexibility across the health and social care system. To implement employment portability and career frameworks that supports the new models of care.	• Employment Concordat • Shared Vision • Programme of work
Productivity	HR Administration	Future HR operating models that consolidates HR transactional activity	• Standardisation and streamlining of policies and processes and procedures and an operating model for future delivery

Our Local Workforce Action Board has matured into a dynamic forum for improvement, bringing together the workforce community from across all our stakeholders as a key vehicle for developing, approving and assuring our plans. It will continue to provide oversight and challenge to current programmes, ensuring that benefits are realised while extending the reach of these programmes and bringing new ones on-stream.

Key challenges for 2017/18 will be to support the service in:

- Breaking down the boundaries that exist between hospitals and primary care, health and social care and between generalists and specialists
- Building the future workforce to tie in with the implementation of new service models, where there is a significant lead time in training new staff
- Investing, developing and deploying support staff to become a more flexible and cost-effective resource that reduces pressure on highly qualified staff
- Extending skills of registered professionals and training advanced practitioners to fill gaps in the medical workforce, provide rewarding clinical career options and mentoring for less experienced staff

In 2017/18 we will:

- Work with the Care Closer to Home workstream to ensure the required staffing mix is available
- Work with Primary Care colleagues to support the transformation of access to Primary Care seven days a week
- Work to reduce turnover across North London and retain existing skills to support delivery of the above
- Roll out a collaborative approach to learning and development and apprenticeships

Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population.

The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability and
- to enable the delivery of a portfolio of estates transformation projects that support the implementation of clinical change in the Partnership

There a number of barriers to achieving this including:

- in North London, there are a significant number of organisations and the differences in governance, objectives and incentives between each organisation, can result in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for non- foundation trusts to retain capital receipts, budget "annuality" and the difficulty of accessing capital investment for re-provision, especially in the constrained fiscal environment for the NHS
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government)
- the primary and community estate requires development to create 'care closer to home', improved access and to meet the needs of significant population growth. Capital funding to develop this estate is scarce and significant proportion of the community and primary estate is not owned by the partners in the Partnership

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative North London / national process (or devolved to sub-regional or London-level)
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation

It is anticipated that the London devolution agreement for health and care will be agreed in Spring 2017. In the currently agreed London timetable, North London expects to be able to use devolved powers in shadow form initially, moving to full use of devolved powers after 2017/18. We want to use devolution as an opportunity to accelerate the development of the estate needed for care closer to home, securing greater utilisation of community estate and capital for redevelopment from disposals of surplus estate. We also want to ensure that devolved powers enable us to address the need for better quality mental health in-patient facilities at greater pace.

A London Estates Board has been established to oversee the implementation of estates devolution in London. An early priority for North London in 2017/18 is to develop its legally constituted governance for devolved powers.

We anticipate the following benefits from the estates workstream and devolution:

- a whole system approach to estates development across North London, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across North London
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann's we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The three providers are working together on this strategic estates project which aligns estates priorities between all three trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the potential relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with outputs due mid-2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c. £400m with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that around £325m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progression on this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across North London to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- our modelling indicates that development of the estate required for care closer to home will need capital investment of circa £111m. North London has been successful in securing some investment from NHS England's Estates and Technology Transformation Fund and an allocation from the NHS Information Governance Fund. However, the funding secured, in common with other STP footprints, will not meet the full cost of development.

In 2017/18 we will:

- develop detailed business cases for the care closer to home estate to support the developing CHIN framework by working closely with the Care Closer to Home and the Planned Care workstreams
- use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate

Digital

We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the North London population.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. We will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of a North London Population Health Management System (exhibit 10) which supports prevention, service transformation and productivity, and would assist in meeting the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

Exhibit 10: North London Population Health System Management

Activate	**Digitally activated population** Personal Health Record; Self management; remote monitoring; digital transactions	**Information Governance**	**Data Quality and Validation**	**NCL Digital Delivery Model**
Analyse	**Insights driven health system** Health system benchmarking; cohort stratification; patient tracking; case management; whole pathway decision support; predictive modelling			
Share	**Integrated care** Shared health and care records; care plans			
Link	**Integration and messaging** Health Information Exchange; information and messaging standards; document, image and data exchange			
Digitise	**Applications** Electronic health records; clinical documentation; ePrescribing and closed loop medication management; orders and results; device integration; alerts and decision support	• CCGs • Primary care Social care • Acute, community, mental health and specialist providers • Care homes		
Enable	**Infrastructure** Network; wifi; unified comms; email; collaboration tools; end user technology; virtual care services			

The six elements that make up our digital strategy are:

- **Activate:** We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.

- **Analyse:** We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link:** We will enable information to be shared across the health and care systems seamlessly.
- **Share:** We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable:** We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21.

In 2017/18 we will:

- Develop and adopt a common Information Sharing Agreement
- Develop a connectivity strategy for North London
- Develop a system-wide approach for Integration and Data Platform
- Review the opportunities for the consolidation of the ICT services across providers
- Identify digital maturity investment objectives across providers
- Scope of Universal Capabilities reporting

Addressing the financial gap

Not only do we aspire to provide the best services that improve outcomes and reduce inequalities, we need to make the system financially sustainable.

The financial analysis that we have undertaken (exhibit 11) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in North London and the growth in funding that the NHS expects to receive over the five years of the STP.

Exhibit 11: The 'do nothing' financial gap for North London

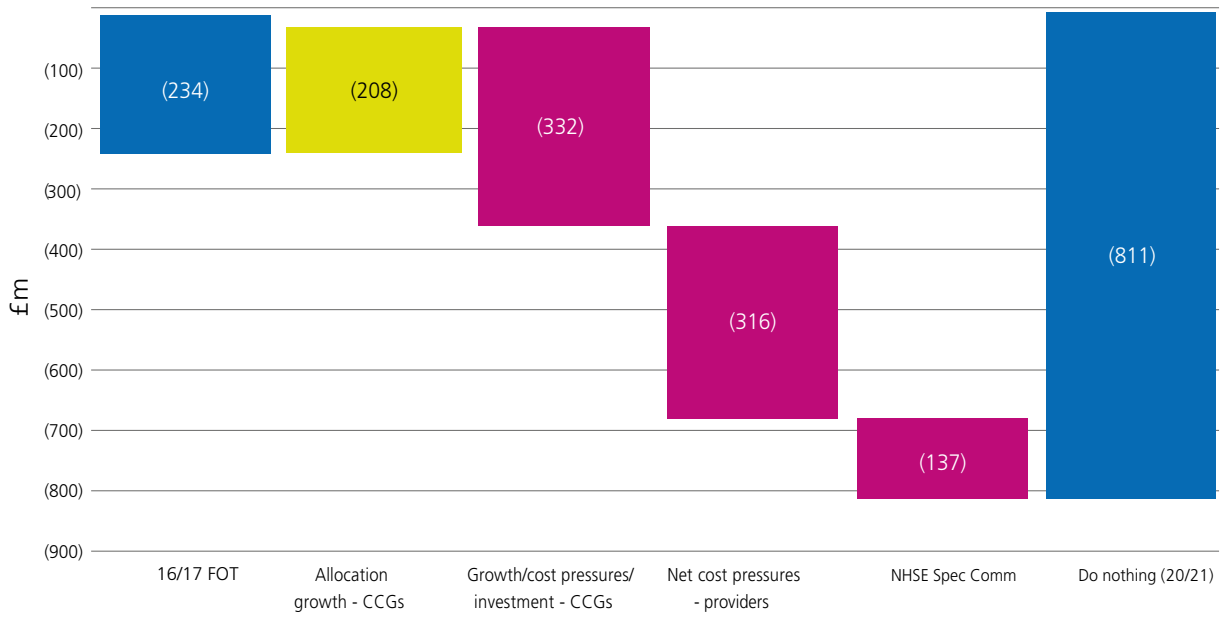
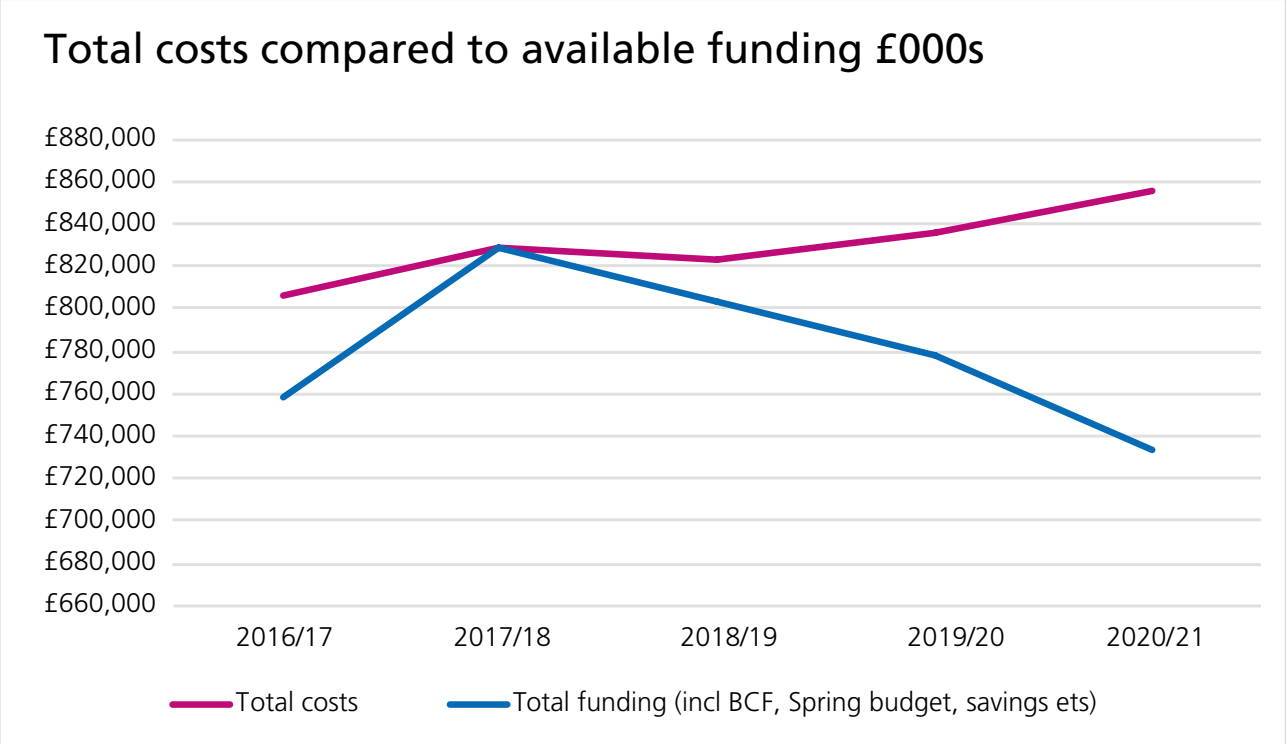


Exhibit 12 shows the financial pressure facing Councils in North London (for children's and adult social care and public health), which includes additional funding announced in the 2015 Spending Review, 2016 Autumn Statement and 2017 Spring Budget.

Exhibit 12 – North London Council pressure budget pressure 2016/17 – 2020/21



Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, we will have an estimated £811m deficit across the NHS in North London in 2020/2021. North London Councils will face a budget pressure of £247m for social care and public health by 2020/21, even when all additional funding announced by the Government has been taken into account. Local government finance legislation states that Councils must deliver a balanced budget each year, so North London Councils are using a variety of measures to offset this financial pressure, including increasing the pace on the delivery of transformation programmes, using savings from elsewhere in the organisation, and drawing from financial reserves accrued in previous years.

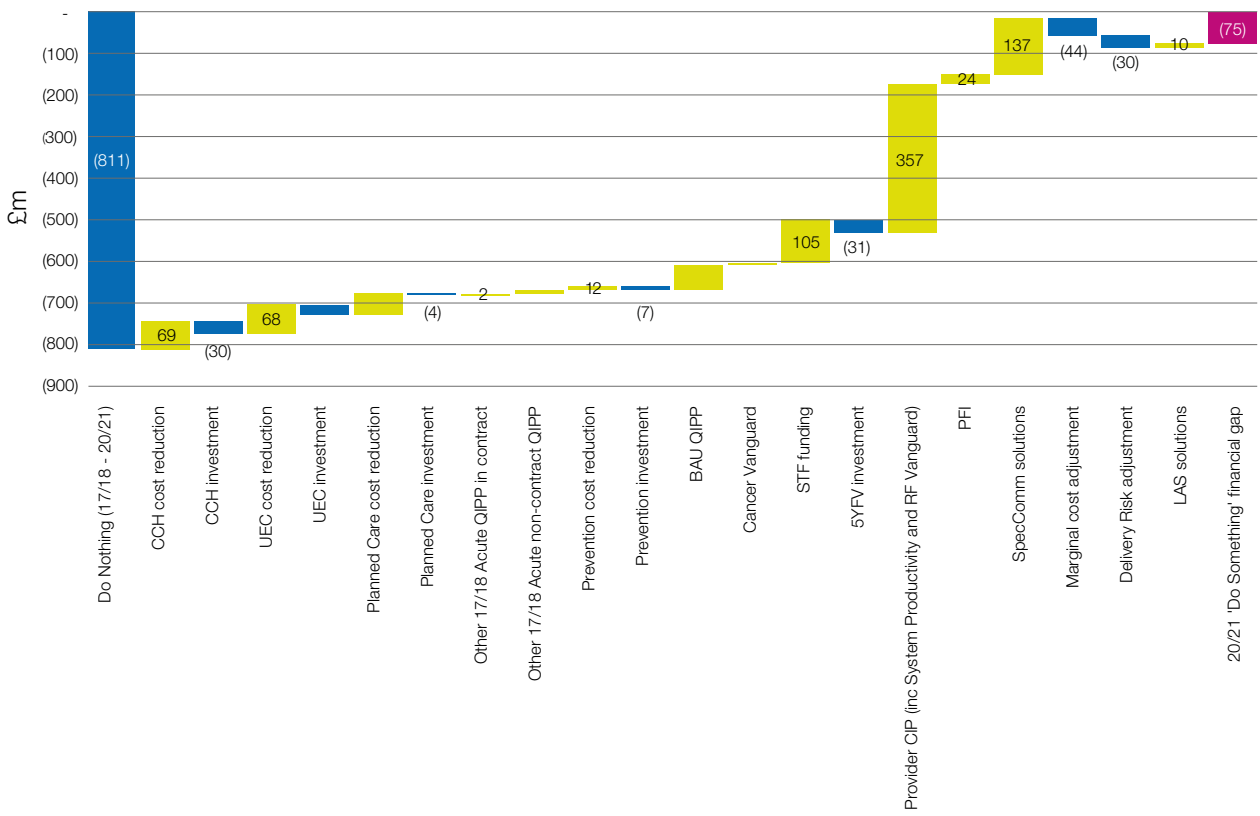
Further work is being undertaken to develop a full understanding of the financial pressures on North London Councils, particularly in adult social care, with a view to working closely together in 2017/18 to understand how we can jointly address the financial gap we face as a system. In particular, the NHS within North London is seeking to learn from local authority colleagues' best practice in relation to reducing cost whilst improving the experience of service users and the public.

As such, the rest of this section refers to plans to address the financial gap across the NHS in North London.

This 'do-nothing' financial gap has been calculated on a normalised recurrent basis (i.e. excluding one-off items) in accordance with NHS England and NHS Improvement guidance. The main drivers of the financial gap are the increased projected demands on the NHS as a result of the increasing population, and within this the demographic changes of an increasing elderly population in particular, as well as the increasing costs of providing healthcare, e.g. due to inflation. Although the NHS in North London is receiving additional resources, the combined impact of the projected increase in demand and cost increases are forecast to be greater than the increase in resources. This therefore results in the 'do-nothing' recurrent projected deficit in 2020/21 increasing to £811m, from the forecast 2016/17 outturn of £234m.

The STP in North London has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 13) whilst this addresses more than 90% of the financial gap, we recognise that further work is needed to close it entirely.

Exhibit 13: The 'Do something' financial gap to 2020/21



The key elements of the plan are set out in detail earlier in this document. Exhibit 13 shows how these contribute to the improvement in the annual financial position of the North London system over 5 years. The savings that will be delivered from the key areas of transformation are:

- **Care closer to home:** savings of £69m have been estimated from improving access to primary care and providing community-based care(with £30m of investment);
- **Urgent and Emergency care:** savings of £68m (with £20m of investment) to proactively identify early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; provide ambulatory-based care; and reducing delays to discharge.
- **Optimising the planned care pathway:** savings of £49m (with £4m of investment) through redesigning outpatient and planed care pathways.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £12m, with £7m investment.
- **UCLH Cancer Vanguard**, savings of £4m and Royal Free Hospital Chain Vanguard, included in the provider CIP section below.
- **Productivity** savings are planned to be achieved, including both 'business as usual' cost

improvements across providers, and wider system savings through working together of £357m in total. Business as usual QIPP schemes (non-acute) total £57m. Further details of the productivity savings projected are set out below.

BAU productivity

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity. Lord Carter's report on hospital productivity has shown that there is variation in how productive different NHS services are, and provides a "model hospital" website to help providers to understand where productivity improvements can be made. In addition to specific Carter initiatives within providers, each organisation will also have an intensive programme of cost improvement opportunities. The assumed levels of provider CIP in each year for 2017/18 and 2018/19 are based upon providers' detailed operating plans. Beyond this, a general assumption of 2% per year productivity improvement is made – this is a "net" figure as trusts usually experience additional external cost pressures each year (for example, PFI charges, rates increases and education funding losses) which must be offset with new savings first, before delivering an overall productivity improvement.

Analysis by NHS Improvement, provided by an independent firm, has indicated that a figure of around 2% per year is a reasonable maximum expectation in relation to annual productivity improvement for NHS providers. In an environment of reducing activity growth, for example as a result of the STP's work to provide patient care in more appropriate and less acute settings, it becomes more challenging to deliver a higher level productivity improvement.

System-wide productivity

Notwithstanding the above, we know from the Carter work that we have opportunities to improve productivity further without detriment to the service we provide our patients and service users. Much of this comes from working more closely across different organisations within the STP in addition to work within organisations. North London has already consolidated many services across organisations, both clinically (such as cardiac, cancer and neurosurgery) and non-clinically (such as payroll, pathology laboratory services and procurement) which means there are fewer opportunities remaining.

However, we have identified a number of additional opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together rather than in isolation) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from more efficient contracting between CCGs and trusts. As the STP has developed, it has become the norm for organisations to work together in realising savings, and these savings are incorporated within the CIP plans of each provider.

Specific initiatives to improve productivity are described in the sections below.

Workforce

The Delivery Plan for Workforce includes a range of initiatives that have the effect of sharing back office workforce activity. These include:

- Standardising and streamlining statutory and mandatory training to deliver a standard common approach
- Pooling training resources across North London and developing shared capabilities in the delivery of education, training and workforce development

- Developing a common approach to Apprenticeships including joint procurement of providers with the aim of maximising the benefit from the levy
- Reviewing and standardising rates of pay for temporary staff across North London with an initial focus on locum medical pay
- A integrated review on workforce supply and reward to inform a new North London specific pay and non-pay benefit strategy for our permanent workforce
- Developing a platform for one staff bank which enables trusts to join at a time of their choosing. UCLH is leading a collaborative procurement to appoint a new provider not just for UCLH but for all other provider organisations within the STP who wish to join. This will reduce administrative costs and increase the number of temporary staff that are paid through a "staff bank" rather than through more expensive agency arrangements

These initiatives will help improve the efficiency of our HR functions as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We also commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.

Digital and ICT Consolidation

There are two main themes in relation to the use of digital technology across the STP – firstly the transformational ICT initiatives that will help improve the way in which organisations communicate with each other and their patients (which is described elsewhere in this document), and secondly reducing the costs of providing existing technology such as PCs, telephony, networks and other IT infrastructure. This second area is being addressed through a new digital technology partnership with Atos, a large IT company, which has the potential to significantly reduce costs across STP organisations by consolidating expenditure whilst also improving the resilience and quality of services. UCLH have already signed a contract with Atos that will reduce costs by c. £30m over ten years, and this was procured in such a way that other STP organisations can readily join.

Other Workstreams for System-wide Productivity Improvement

- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management. This will be driven through the procurement shared service that already exists for 5 of our North London providers, with further collaborative work across the Shelford Group and the London Mental Health network augmenting this work.
- **Back office:** We have worked over the last 4 months to review opportunities for back office consolidation, centralisation and outsourcing, supported by external consultancy and internal project management. Although in many areas the external work suggested limited opportunities for further productivity improvement in the short term, we are actively seeking to reduce our overheads and improve service resilience across the footprint and are progressing with the following key workstreams in addition to those highlighted above:
  - Enhance and extend the existing shared procurement arrangements (which serve most NHS providers within North London) to reduce non-pay costs; maximise use of wider procurement networks for large teaching trusts and mental health trusts.
  - Review with HR Directors and our workforce workstream the opportunities and enthusiasm for HR transaction consolidation.
  - Review with Finance Directors opportunities for process alignment, resource sharing and cost reduction across organisations' finance directorates.
  - Progress further outsourcing of payroll functions and take opportunities to consolidate contracts where feasible to do so.

- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.
- **Operational and clinical variation:** all acute providers are actively progressing plans in relation to the Carter productivity work. Reducing variation is a key part of the Royal Free's Group model, and we will also be working collectively to reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the planned care workstream.

Commissioner business as usual efficiencies (QIPP)

We will continue to deliver significant "business as usual" efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention) comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services includes an assumption of increased efficiency equivalent supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care assumes increased efficiency supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing assumes increased efficiency including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.
- **Private Finance Initiatives (PFIs)** – whilst we recognise the role that PFI projects have had on modernising the NHS's buildings, we also believe that they don't represent value for money for individual NHS Trusts. We have modelled a conservative estimate of the saving (£24m per year) that could be made from terminating these contracts and bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, or alternatively to seek additional central funding for these schemes if terminating them is not possible, recognising that there are a number of constraints.
- **Other** - Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the North London proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. North London hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

These improvements cannot be achieved without investment. The plan is based on investment of £20m in urgent and emergency care, £7m in prevention, £30m in care closer to home, and £4m in planned care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the Health and Care Cabinet within North London we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £44m marginal cost (i.e. stranded costs) and £30m 'delivery risk adjustment' in the financial analysis.

Delivery through 2 year contracts in North London

Delivering the STP is a priority for health and care commissioners and providers in North London - and our commissioning intentions, operating plans and contracts reflect this. All NHS contracts within the STP incorporate the impact of the STP's planned initiatives, particularly those that seek to provide care to our patients in a more appropriate, less acute setting. This strategic alignment, working as a system, will help support delivery. Whilst we recognise that implementation will look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Having two year contracts based around our STP delivery plans will help these plans to be implemented quickly, as well as supporting a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for working more closely as a system between commissioners and providers in the future.

We have also ensured that organisations' operating plans are strategically consistent with the STP. In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money.

Recognising that we have still not achieved financial balance in the current plan to 2020/21, we will continue to look for further opportunities for further efficiencies, in line with the Five Year Forward View Next Steps document, published recently by NHS England.

2017/18 position

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Although there are plans in place to reduce the recurrent deficit in 2017/18, the targets set for 2017/18 are for an in-year surplus. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this. Recognising this, we are continuing to work on reducing the risks of delivering existing plans for 2017/18, as well as looking for further immediate opportunities for further efficiencies, beyond those set out above, including one-off non-recurrent measures that could improve the financial position in 2017/18, pending the full implementation of the transformational changes planned over the period to 2020/21.

To support our plan, NHS England and NHS Improvement have initiated a Capped Expenditure Process, to help the NHS produce a set of affordable plans for 2017/18. This aims to help us deliver the best possible clinical outcomes for local people within the funding available.

Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. North London also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of North London.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being "business as usual" these are included in the 'do nothing' scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- UCLH new clinical facilities: haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments;
- Royal Free - Chase Farm redevelopment (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan)

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- Estates redevelopment relating to our St Pancras/St Ann's/Moorfields proposals - £404m, assumed to be funded through disposals £326m), DH loans (£39m and Donations (£37m), of which £272m (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above;
- Primary Care for Care Closer to Home and Five Year Forward View investment (£111m – assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- IT investment (£159m with a further £21m in 2021/22) – all assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in North London to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to

assume that such investment is not required and won't deliver value simply because of the stage in development of these plans that North London is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help North London make best use of its current assets to support the delivery of our vision.

Communications and Engagement

Since November 2016, we have been working with the NCL Joint health oversight and scrutiny committee (JHOSC). We have presented at the JHOSC and shared with the committee and members of the public our draft plan and introduced some of the areas of work. In January, the committee presented a report which included a number of recommendations to the NCL STP. We have responded to these recommendations and will continue to attend the JHOSC meetings to share our progress and respond to questions and feedback with a commitment to transparency and collaboration. As part of our work with the JHOSC, we have agreed a number of principles to guide the NCL process:

- Put the needs of individual patients, carers, residents and communities truly at the centre;
- Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;
- Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;
- Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;
- Focus on building resilient patients, carers, residents and communities -and on where resources can have the biggest sustainable impact.

The full report responding to the JHOSC recommendations can be found at **http://democracy.camden.gov.uk/documents/s57037/response%20to%20JHOSC%20report%20January%202017%20-%20final.pdf**

We have come a long way since being asked to come together as 21 health and social care organisations with disparate views in December 2015. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the five boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the "Ladder of Citizen Participation"). We will undertake different types of engagement as set out on the ladder as appropriate:

1. 'inform' stakeholders
2. 'engage' with stakeholders in open discussions
3. 'co-design/ co-produce' services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

Our future plans

To help us meet our communication and engagement commitments we have formed a communications and engagement workstream. Membership of this group includes representatives from the 21 partner organisations, Healthwatch, voluntary sector representatives and lay people.

Working together as partners, we have established an evidence based engagement model and drawn of the expertise of communications leads from our CCG's, local authorities and provider organisations. We have identified key population groups and those members of your community that can at times be hard to reach. Working alongside Healthwatch and the voluntary sector we are now taking our proposals to the community for input and advice.

- In partnership with CCGs and Healthwatch we will participate in pan-NCL events on the overall plan and any specific issues that may arise at pan North London or individual borough level.
- Each workstream area has an engagement plan and will hosting meetings and events with patients, service users, carers and with the public on focussed topics such as urgent and emergency care, primary care, and mental health. This will help us to get more in-depth input from the community about their needs and how they expect services to be delivered.
- Our website will provide opportunities for online surveys and an online FAQ which will be kept current
- Our website will feature animations, infographics and relevant resources that will help people better understand the plan.
- We will link our website to social media and to promote our public engagement programmes and share information. We will also use these channels push residents and stakeholders to our website to test ideas and share progress on local priorities.

To do this, we will:

- Work alongside Healthwatch and the voluntary sector, to identify representative groups, resident associations and other interest groups, local authority engagement networks and the many other networks available to the 21 partner organisations to reach out to the public and share proposals.
- We work in partnership with the communications and engagement teams across North London health and care organisations and together access their community activities and channels to share information about our proposals and progress and invite feedback and participation when appropriate.
- We will use existing online engagement tools used by partners to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to submit our work to the Joint Health Overview and Scrutiny Committee (JHOSC) ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all FOI requests, public enquiries, media stories and providing an update to the Transformation Board and meeting with elected members.

The health and care workforce is a significant stakeholder in the STP process. We have been providing a weekly update from the convenor of news and important meeting dates.

To engage more fully with our health and care workforce we are developing a staff engagement strategy in partnership with the workforce workstream. This will include identifying and training workplace champions, well versed in the priority areas of work who can speak at staff forums and events on the STP programme and articulate the implications and benefits of a more sustainable health and care system.

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- face-to-face meetings with professional organisations (e.g. Royal College of Physicians) to seek advice on communicating and engaging with specific cohorts within the health and care workforce and the most relevant issues.
- participating in or hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This includes joint commissioners and working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- working with membership organisations to showcase the range of work which is happening across North London and share with staff the proposals and what the future health and care workforce will look like and how changes to how health and care is delivered may affect them.

We will continue to build our communications and engagement capabilities across the system. The Communications and engagement workstream meets monthly to develop and co-design the communications and engagement strategy. This forum is designed to build skills and expertise in engagement and brings together communication and engagement practitioners, clinical expertise, Healthwatch, voluntary sector and layperson representative in one room with a commitment to best practice in engagement.

There are many stakeholders in this programme of work. The most important is the residents of the five North London boroughs. Communicating with such a large and diverse audience is challenging. We will utilise the existing communications channels available through the 21 partner organisations and our network of voluntary sector organisations, Healthwatch and professional colleges and bodies.

The workstreams will identify specific key audiences appropriate to their proposals and engage with these groups of patients, service users, carers and other interested parties. It is through this work we can make sure that services meet the needs of people rather than the current system that is often disparate and disjointed for the person accessing.

Public consultation

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

Each of the partner organisations has conducted numerous engagement activities over past two years. This has included events, resident and staff surveys, forums, public meetings as well as input and feedback via organisational channels.

This data has helped us build a comprehensive picture of local views and concerns about health and care services. We know that people expect:

- People want more joined up health and care services

- People want health and care closer to where they live or work
- Services that are flexible, that adapt to people's differing needs
- People want to tell their story once
- Good signposting and information
- Access to services for a diverse population including interpreting services
- Simple, effective admin process which support patients to access the right service
- Compassionate healthcare professionals
- Access to a wide range of community support
- To not forget about carers and family

The launch of our North London Partners in health and care website (July 2017) will provide a single platform for information of the STP for residents, staff and other stakeholders.

On the website we will provide the most up to date information about our plan and the progress we are making to improve the health and wellbeing of the people of North London.

It is on our website where we will share stories of real local people and how the changes we are proposing make a difference to how they access care but also improving their health and care outcomes. It will also be our platform for inviting local people to participate in activities and events to help as co-design and co-produce services.

Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of our plans in relation to equality. We have carried out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

The analysis has considered the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate any unintended consequences for some groups. The analysis of the plans to date found that no groups will suffer a negative impact from the plan, rather the plans will have a broadly positive impact on health inequalities. Exhibit 11 summarises these impacts, indicating for each workstream, what is the expected impact on health inequalities for each protected characteristic. Detailed impact assessments for each workstream and each protected characteristic are available by emailing us at **nclstppmo@nhs.net**.

Exhibit 11: summary of impacts by workstream

Workstream \ Protected characteristic	Disability	Sex	Race	Age	Gender reassignment	Sexual orientation	Religion or belief	Pregnancy and maternity	Other groups
Care closer to home									
Urgent & Emergency Care									
Mental Health									
Cancer									
Planned Care									
Productivity									
Prevention									
Digital									
Estates									
Workforce									
Maternity									
Communications and Engagement									

No impact Positive impact

Disability

Most workstreams will have a positive impact on inequalities associated with disabilities, which include physical, visual, and sensory impairment, and mental health problems or learning difficulties.

Some workstreams specifically aim to reduce health inequalities experienced by residents with disabilities. For example, the **Prevention workstream** will develop smoking cessation services that specifically target people with learning disabilities, including a payment to incentivise providers to

target this population group.

Patients with disabilities and their carers frequently experience disjointed health and care provision that fails to consider their needs in the round, or put the patient at the centre. Multiple workstreams, such as **Urgent and Emergency Care, Planned Care**, and **Care Closer to Home**, will seek to develop better integrated care to enable people with complex needs to have their needs more proactively assessed and met and to experience more joined up care.

Physical access to facilities and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently as a concern. The work by the **Estates workstream** is particularly relevant for this, as the review, re-purposing and reinvestment in estate will be done in the context of ensuring access for residents and patients with disabilities, e.g. in terms of level access/ramps, and in terms of ensuring premises are located at places that are most accessible by public transport etc. The work of the **Communications and Engagement workstream** will also aim to ensure that all venues used for events are assessed for accessibility for people with disabilities. Additionally, the review of office space and flexible working arrangements planned by the **Productivity workstream** and enabled by the **Digital workstream** may result in encouraging more flexible working opportunities for staff with disabilities.

As an overarching programme, the **Mental Health workstream** will have a positive impact for people suffering from mental ill health. For example, building community resilience will increase mental health basic awareness, reduce stigma, and increase mental health self-awareness. The **Workforce workstream** will also contribute to reducing stigma by ensuring that staff recruitment, training and retention practices are fully compliant with best practice.

Some ways of delivery of these projects will further facilitate access to services for people with disabilities. For example, the new care model proposed by the **Cancer workstream** has a strong emphasis on care closer to home, which has the potential to improve access for patients with disabilities. The **Workforce workstream** will also contribute to facilitating access by promoting a workforce that is better able to deliver care in appropriate settings, closer to home.

The **Maternity workstream** expects to have a positive impact on inequalities related to disability. Specific work is being planned to engage service users and community organisations to help ensure the needs of residents with disabilities are firmly built into workstream plans and implementation.

Sex

Men and women do experience different health outcomes. However, these differences are difficult to isolate as being caused by gender alone, as gender interacts with other characteristics such as ethnicity and age, leading to considerable differences in the determinants of health for each population group.

However, some differences can be identified. For example, men are typically underserved by mental health services. The **Mental Health workstream** will target men in its community resilience, primary care mental health, and acute pathway projects, in order to address this inequality. Men may also be less likely to engage with preventive services delivered in 'traditional' healthcare services and settings, e.g. general practices. The **Prevention workstream** will use voluntary and community sector organisations to provide services to harder to reach groups, hopefully increasing the uptake of those services by men.

Some workstreams have identified other differences between men and women that will be addressed during the implementation phase. For example, men are generally more likely to die prematurely from

chronic diseases than women. In the **Care Closer to Home workstream**, the Care Closer to Home Integrated Networks (CHINs) will need to redesign services to make them more accessible to men and to find ways of engaging them earlier and to build resilience and self-care more effectively. Additionally, data from the recent Urgent and Emergency Care stocktake demonstrates that women use some services, such as walk-in centres, more than men. Resident engagement work by the **Urgent and Emergency Care workstream** will ensure that both genders are engaged in the design of Urgent and Emergency Care services across North London.

Men and women still carry significantly different burdens of work, caring, and other responsibilities. The **Workforce workstream w**ill seek to improve access to flexible employment arrangements, providing North London workers with a wider variety of work options.

The **Maternity workstream** also expects to have a positive impact on male partners as well as on women, although this needs to be further explored as these plans develop.

Race

Language and cultural factors can determine health inequalities in groups defined by race and ethnicity.

The focus on healthier environments and settings as part of the **Prevention workstream** is fundamental to the reduction of health inequalities. By promoting positive changes in the settings where people grow, live, and work, we will be positively impacting on equality of opportunities, helping to reduce the health inequalities experienced by groups with certain characteristics, such as race and ethnicity.

One important determinant of different health outcomes between ethnic groups is differences in health service use. Greater involvement of and working with voluntary and community sector services and organisations at a local level in the planning and delivery of care and support should help professionals to become more responsive to the diverse needs of the communities they serve. This should enable more people to access advice and services that they might otherwise not access or use. The focus on working with and engaging the community is an important focus of the work of the **Prevention**, **Care Closer to Home**, **Cancer**, **Planned Care**, and **Mental Health workstreams**.

The investment and strengthening of primary care, expected through the **Care Closer to Home workstream**, should impact positively on inequalities in health and in particular improve the health of people from ethnic minorities.

The **Urgent and Emergency Care workstream** aims to improve the monitoring of ethnicity data within Urgent and Emergency Care services and is working alongside Healthwatch to develop a co-production strategy to engage harder to reach communities. Ensuring services are accessible and reach key population groups, including recognising language as a key determinant of access, will be a key consideration for this workstream.

The population served by maternity services is diverse, with high immigrant populations and in particular those who do not have English as their first language. Services can be difficult to navigate, with greater choice available to those best able to work their way through the system. The **Maternity workstream** aims to improve information regarding women's choices and the services that are available, and will equip staff to better signpost and guide women and their families through their maternity journey.

The **Workforce workstream** will ensure the recruitment, retention and development of underrepresented groups in North London, thus improving equality of opportunities.

The **Communications and Engagement workstream** will ensure opportunities for engagement are accessible to people from different cultural or ethnic groups, and will ensure all communication are made available in easy read or key community language.

Age

Age is a major determinant of health and care needs, health outcomes, and service utilisation. The services provided by each workstream will seek to benefit different age groups and tackle age-related inequalities.

A major goal of the **Care Closer to Home workstream** is to provide better integrated care. This will enable frail older people to have their needs more proactively and holistically assessed and met, and to experience more joined up care.

There is a growing population of older people in North London. The **Urgent and Emergency Care workstream** has developed a frailty pathway project to address the specific needs of an ageing population. This will be considered in a range of areas, such as relationships with staff, accessibility of buildings, accessibility and cost of transport, and their overall experience of local healthcare. Additionally, future service design within this workstream will consider accessibility to specific facilities by target age group.

The **Prevention workstream** will maintain a focus on supporting children and young people to have healthy lives, ensuring that the settings in which they spend much of their time – early years' childcare and nurseries, and schools – give them the opportunity to be healthy. Additionally, it will make use of digital technologies and analytics to deliver interventions (e.g. apps), in order to promote access to services to young people. This workstream will also ensure that working age adults have the best chance to be healthy at work, by ensuring that the North London workforce (in its widest sense) is supported by organisational environments and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

The **Mental Health workstream** also includes projects that target specific population age groups, such as developments in children and adolescent mental health services, to better meet the needs of children and young people with mental health needs. This workstream will also invest in developing a dementia friendly North London, to better support older people living with dementia.

Experiences of maternity services can be very different according to maternal age. The **Maternity workstream** will link into existing services for young people under twenty. There are greater numbers of women over forty having babies in London than in other parts of the country. This workstream will examine the specific needs of this group and will create appropriate pathways of care for them.

The **Estates workstream** will ensure that the transformation of services and premises will be carried out in such a way as to consider the needs of the old and young, and target improvements in service provision. The **Workforce workstream** will guarantee that staff recruitment, training and retention practices would be fully compliant with best practice. The **Communications and Engagement workstream** will look to ensure that venues for engagement events are accessible for older people, who more frequently have mobility needs.

Transgender

People who experience their body to be different from their assigned gender at birth remain a vulnerable group that suffers from an array of health inequalities. Some people may choose not to access services because their assigned gender on clinical records does not match how they personally experience their gender, which could cause distress and anxiety for the individual having to explain this to staff.

The **Care Closer to Home workstream** will aim to provide this group with the same quality and accessibility of services as for the rest of the population: improved access to more proactive and integrated care and the services better tailored to the needs of diverse local communities.

Under the **Urgent and Emergency Care workstream**, each service will develop its own policy regarding transgender and transsexual service users to ensure there is no discrimination and they are treated considerately and with respect. Regional or national organisations that represent individuals who are / have undergone gender reassignment will be invited to share their perspective within the formal consultation process.

Although the potential impact is not fully known, greater personalisation of care and improved choice provided by the **Maternity workstream** should have a positive impact on this population group.

The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language and venues are welcoming and consider the needs of all, including bathroom facilities that are trans-friendly.

Sexual Orientation

There are clear differences in health outcomes between people of different sexual orientations. These differences will be addressed by the **Care Closer to Home** and **Urgent and Emergency Care workstreams** by improved access to more proactive and integrated care, by providing adequate training for all staff and by gathering further evidence and insight from local residents, organisations and groups to better understand their experiences of services and care. The **Workforce workstream** will further contribute by guaranteeing adequate staffing and skill mix, which should promote positive outcomes for all patients. Staff recruitment, training and retention practices will be fully compliant with best practice. The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language.

Furthermore, several workstreams plan to use voluntary and community sector organisations to deliver their interventions. This approach is intended to facilitate access to services by groups of people who are traditionally harder to reach.

Religion or belief

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure there is no discrimination of service users according to their religion or belief, by providing improved access to more proactive and integrated care, delivering services that are better tailored to the needs of diverse local communities, and giving consideration to physical, cultural or behavioural barriers in the design of new services. The **Communications and Engagement workstream** will consider days of worship and cultural holidays or festivities.

The use of voluntary and community sector organisations to deliver interventions by several workstreams will also further facilitate access to and engagement in services by groups of people who are typically harder to reach.

Pregnancy and Maternity

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure that, when designing new services, access and mobility issues will be considered for visitors and the ability for mothers to breastfeed and for parents to change babies as part of providers' consideration of service use.

The **Mental Health workstream**, through greater mental health support in primary care, will raise awareness of mental ill health in the perinatal period. Additionally, through the perinatal mental health programme, this workstream will support more women with their mental health in the perinatal period.

The **Productivity, Estates, Communications and Engagement, and Workforce workstreams** will all contribute to increasing opportunities for pregnant women and people with parental duties by reviewing flexible and remote working arrangements, encouraging more flexible working opportunities.

The **Prevention workstream** will develop projects with a specific focus on pregnant women. For example, smoking cessation services will specifically target pregnant women, including a payment to incentivise providers to target this particular population group. This will ensure that appropriate treatment is available to pregnant women, as traditionally not all services offer support for this group.

This is a particularly important group for the **Maternity workstream**, whose major impact is likely to be on pregnant women and parents. In terms of women and families using the services, increased access to care closer to home, improved choice and personalised care should improve access during pregnancy.

Other Groups

The eight protected characteristics defined by the 2010 Equality Act do not exhaust all determinants that can lead to health inequalities. One major determinant is socioeconomic circumstance – income, education, employment, occupation, among others, can have significant impacts on an individual's health. Several workstreams will have an impact on socioeconomic health inequalities.

The **Prevention workstream** aspires to follow a model of proportionate universalism, which seeks to offer a universal service that is accessible to all but also target communities and groups where additional needs exist. Accordingly, it is not anticipated that a specific group of residents would be discriminated against, and this active approach will likely lead to a decrease in health inequalities. Some actions that will be suggested to guarantee this include:

- Setting specific targets for communities that carry a disproportionate weight of ill-health, in order to guarantee that their increased need is met with adequate services;
- Working with a variety of organizations, such as public, voluntary, and community sector, will allow a wider reach, ensuring residents of many social groups have the opportunity to be involved;
- Working in a variety of formats, such as the better use digital technologies, will facilitate this wide reach of North London residents;
- Maintaining a focus on contextual determinants – such as opportunities to eat a balanced diet, to exercise, or to work in a health-promoting environment – as key to guaranteeing equality

of opportunities, absence of discrimination, and promotion of good relationships between communities.

The **Care Closer to Home workstream** also explicitly seeks to address inequalities. Each Care Closer to Home Integrated Network (CHIN) will be provided with public health information showing where there are inequalities in health in their population which need to be addressed and they will be monitored on how effectively they deliver this outcome. Investing in primary care services is shown to reduce inequalities in health, reduce costs, improve access to more appropriate services, reduce in-hospital mortality, and reduce hospital admission rates. This is particularly important in North London, as there are high levels of A&E attendances across North London compared to national and peer averages, and also very high levels of first outpatient attendances.

Homelessness is of particular interest to the **Urgent and Emergency Care workstream**, as homeless people attend A&E more often than the general population, are admitted more often, and once admitted tend to stay longer. These and other issues regarding other vulnerable groups will be taken into consideration and addressed through local engagement groups and the co-production of Urgent and Emergency services.

The prevalence of severe mental illness varies amongst the North London boroughs, but is high across all areas. North London lies in the bottom quartile nationally, with varying outcomes across the boroughs. The **Mental Health workstream** will aim to reduce inequalities across the five boroughs so that no matter where someone lives in North London they can expect to receive the same high quality of care.

The **Cancer** and **Maternity workstreams** will also support work to understand where inequalities to access exist and will look to build evidence based solutions to address these. For example, the Cancer Vanguard includes a project to review the relative effectiveness of different types of invite to participate in screening.

The **Productivity** and the **Workforce workstreams** will also to contribute to reducing health inequalities by encouraging more flexible working opportunities.

The **Communications and Engagement workstream** will seek to have a positive impact by ensuring that all communications and engagement activities use inclusive language.

Based on work previously done by the Islington CCG in building their personal health record, the **Digital workstream** will consult extensively with the public and patients to ensure that design, data presentation and access mechanisms are inclusive and support accessibility good practice.

We will continue to build on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions of the plan. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure our we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees' communication needs). Our aim is to enable different groups to be fully involved as the plans progress.

Conclusion and next steps

We have made significant progress in developing our specific ideas for how we will achieve this. We have worked hard over the last few months to further develop our thinking, building on the evidence and by involving hundreds of members of staff from each of the provider and commissioning organisations and local authorities within North London. We held public meetings in each of the boroughs in September 2016 as the starting point to an ongoing conversation with the local community. We recognise there is more work to be done to engage with the community in the months ahead.

We have also worked proactively with the Joint Health Overview & Scrutiny Committee in North London to ensure that our developing plans are scrutinised and the robustness of our plan is challenged.

The STP has been developed to deliver the vision we have set out, the vision that the public has told us they want. As a sector, we have committed to the development and implementation of the delivery plans within each of the areas outlined above that can achieve the much wanted and much needed change. At the same time, we are clear that we will not lose focus on the longer term transformation and prevention work that will support sustainability.

Our work to April 2018 will focus on:

- taking steps to stabilise our financial position
- implementing our priorities as set out in this document in to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly
- build on the early engagement with the public and staff

There remain issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

For further information or to contact us please email **nclstppmo@nhs.net**.

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	Health and Wellbeing Board **20th July 2017**
Title	**Better Care Fund plan for 2017/18**
Report of	Strategic Director for Adults, Communities and Health LB Barnet Chief Operating Officer Barnet CCG
Wards	All
Date added to Forward Plan	September 2015
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: Joint Position Statement on Integrated Care,
Officer Contact Details	Dawn Wakeling, Strategic Director for Adults, Communities and Health Dawn.Wakeling@barnet.gov.uk Kay Matthews, Chief Operating Officer, Barnet CCG Kay.Matthews@barnetccg.nhs.uk

Summary

The Barnet Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan has a total pooled budget of £ £24,899,540, for the financial year 2017-18. The core elements of the BCF plan are services for frail and older people and those with long term conditions (LTCs), such as: Barnet Integrated Locality Team (BILT), Rapid Response Team, deployment of a risk stratification for early identification of those in need, 7 day services including hospital social work, and provision of community equipment. The overarching aim of the plan is to provide integrated care and support that intervenes early, prevents crises, responds quickly and helps people stay independent for longer.

Usually, national BCF guidance is issued each December for the following financial year's BCF plans. The Barnet HWB then approves the Barnet BCF plan in the subsequent spring, for submission to NHS England, and the plan is then enacted for the new financial year. However, for 2017-19, the detailed national BCF guidance and timescales for submission were published on 4th July 2017. HWB. Therefore no HWB has approved BCF plans for 2017-19 at this point.

The published national guidance has set a date of 11th September for submission of the BCF plan to NHS England (NHSE). In addition, each HWB area is required to submit a high level plan for the reduction of delayed transfers of care from hospital on 21st July. This report sets out:

- The requirements for the next round of BCF plans, based on the published policy framework and guidance
- The planned use of the IBCF funding for Barnet
- Work underway to develop the Barnet plan

As the BCF submission date is before the next meeting of the HWB, the report asks the HWB to confirm its agreement to the chairman and vice-chairman approving the plan on behalf of the board, in order that the submission deadline can be met. The full plan will then be presented to the September HWB meeting.

The report also updates the HWB on the progress made since the HWB discussion earlier this year to develop a broader approach to integrated care, drawing together the Better Care Fund plan with the Care Closer to Home programme. The intention is that Care Closer to Home will form the centrepiece of the refreshed BCF plan, in line with the direction of travel set by the HWB. As part of this, the HWB is asked to endorse the summary position statement on integrated care developed jointly by officers from BCCG and LBB.

Recommendations

The Health and Wellbeing Board is asked to

1. **Note the BCF requirements 2017-19; including amended national conditions and financial requirements.**

2. **Note the progress made on implementing the integrated approach to BCF and Care closer to home.**

3. **Endorse the Barnet Council and Barnet Clinical Commissioning Group summary shared position on integrated care.**

4. **Consider and comment on the scope of the BCF plan (care strategy).**

5. **As the submission date for the BCF plan is before the next Health and Wellbeing Board meeting on 14th September, the HWB is asked to delegate its agreement to the BCF plan being approved for submission to NHSE by the chairman and vice-chairman on behalf of the full board.**

1. WHY THIS REPORT IS NEEDED

1.1 Whilst Better Care Fund Plans have been required since 2013, the forthcoming BCF round has revised requirements, which are set out in this report. The Barnet BCF plan also needs to respond to the wider policy context for health and care: for example, by ensuring that it is consistent with the North Central London sustainability and transformation plan (NCL STP), the direction set by the 'Next Steps on the Five Year Forward View' and the Care Act 2014. This report sets out these revised requirements and how the Barnet BCF plan will support local implementation of key STP and organisational initiatives.

1.2 The Better Care Fund 2017-19

1.2.2 The Policy Framework for the 2017-19 Integration and Better Care Fund, published in March 2017, covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. This is supplemented by the detailed planning guidance published on 4th July 2017. Local areas are asked to set out in their BCF plan how they will achieve further integration by 2020, in line with the policy requirement of the 2015 Comprehensive Spending Review. In effect, the requirement is to set out the local vision for integrated care, which allows local flexibility so each HWB can determine the best approach to integration for their residents and patients.

1.2.3 The Policy Framework encourages alignment with STPs but is not prescriptive in terms of what form this should take; it could refer to commissioning or provision in all or part of the STP footprint. In general terms, the national policy direction of the BCF remains the same: to deliver integrated care to people so it feels like they are receiving a single service. Key changes in the policy framework are the increased emphasis on reducing delayed transfers of care and the introduction of the 'Improved BCF' (IBCF), a direct grant to councils.

1.2.4 For 2017-19, there are four national conditions - a reduction from previous years. Condition number 4 is a new national condition. Condition number 2 has been updated.

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest a specific proportion of the fund in NHS commissioned out-of-hospital services; (or retain it as part of local risk-sharing)

- Managing Transfers of Care (to ensure people's care transfers smoothly between services and settings).

1.2.5 Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four performance metrics. The number of key BCF metrics has also been reduced.

- Delayed transfers of care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes; and
- Effectiveness of reablement

1.2.6 The Policy Framework sets out detailed definitions of the conditions and the metrics. The full Framework and planning guidance can be found in the background papers to this report.

1.2.7 The Framework states that although some conditions have been removed, local areas still need to continue to implement these and set out how this is being done in their narrative BCF plan. Removed conditions are: 7 day working; IT inter-operability; and joint approach to assessments and care planning.

1.2.8 The Policy Framework also sets out that: the most integrated areas will be able to graduate from the Better Care Fund, which is intended to reduce national reporting requirements; new integration performance metrics will be developed; & the Care Quality Commission will carry out reviews in a small number of areas, focussing on the "interface of health and social care".

1.2.9 The capital Disabled Facilities Grant (DFG) remains part of the BCF and local areas are encouraged to ensure that their plans capture how adaptations are being used to support the aims of the BCF.

1.2.10 The planning guidance sets out more detail on the requirements for reducing delayed transfers of care. All HWB areas are expected to implement the High Impact Change model for transfers of care. This model includes: early discharge planning; monitoring patient flow; discharge to assess; trusted assessors; multi-disciplinary discharge support; seven day services; choice for patients; and enhancing health in care homes. Plans should be agreed by all partners and at A&E Delivery Boards.

1.2.11 Areas are also asked to complete a plan for reductions in DTOCs, to achieve the NHSE mandate to NHS organisations that DTOCs are no more than 3.5% of occupied hospital bed days by September 2017. These plans – called trajectories in the guidance – have to be submitted by 21st July 2017. The

trajectory should include agreed targets for DTOC reduction for both the NHS and local authorities. These are expected to be consistent with the level of ambition required by the Department of Health. Performance against these targets will be reported quarterly to NHSE .

1.3 BCF financial aspects

1.3.1 The BCF is now made up of three elements: the CCG minimum contribution; the Disabled Facilities Grant; and the improved BCF (IBCF). The Barnet Better Care Fund CCG minimum contribution for 2017/8 and 2018/19 is as follows:

Funding	2017/18	2018/19
Total CCG (£000s)	22,736	23,168
Main Ring-Fenced Elements		
RNF (£000s)	6,870	7,000
Out of hospital commissioning (£000s)	6,461	6,584

1.3.2 These figures include an uplift of 1.79% for 2017/18 and 1.9% for 2018/19, as required in national policy. The table above shows the CCG minimum contribution to the BCF, and the two mandated sub-amounts required for out of hospital services and adult social care (referred to as RNF – relative needs formula).

1.3.3 The Disabled Facilities Grant (DFG) is given directly to Councils with housing duties, to be spent on home adaptations for disabled and elderly people. In 2016-17, the Council carried out 241 DFG adaptations, at a cost of £2.09m. In 17/18 the amount to Barnet for the DFG is £2,163,540; figures for 18-19 have not yet been released. The Authority also top this by up to 2m where we have a need for enhanced adaptions to ensure that an individual remains independent.

1.3.4 The planning guidance states that new burdens funding for the Care Act 2014 remains a ring-fenced part of the BCF and that CCG carers support funding also remains part of the BCF, from the core allocation.

1.3.5 Local BCF plans will need to evidence that they have followed the national policy requirements described above on the financial aspects of the BCF in order to be approved by NHSE. More detail on the financial requirements is set out in the policy framework and the planning guidance.

1.4 Improved Better Care Fund (IBCF)

1.4.1 In addition, the Government's Spending Review in 2015 announced additional money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. This is called the Improved Better Care Fund (IBCF). This is a direct grant to local authorities under section 31 of the Local Government Act 2003. The national guidance states that this additional funding for adult social care in 2017-19 should be pooled into the local BCF. It also states that this funding does not replace, and must not be offset against the CCG minimum BCF contribution to adult social care.

1.4.2 For Barnet, this represents funding as follows:

Grant Description	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)	Total (£m)
Improved Better Care Fund (iBCF) Spending Review 2015		2.7	5.9	8.6
Additional Funding (iBCF) Spring Budget 2017	5.4	4.1	2.0	11.5
Total Funding for Barnet	5.4	6.8	7.9	20.6

1.4.3 In terms of the additional IBCF, the published grant conditions set out the following requirements:

1.4.4 Grant paid to a local authority under this determination may be used only for: the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported. A recipient local authority must:

a) Pool the grant funding into the local Better Care Fund;

b) Work with the relevant clinical commissioning group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) Provide quarterly reports as required by the Secretary of State

1.4.5 The government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with clinical commissioning groups involved in agreeing the Better Care Fund plan.

1.4.6 Council and CCG officers have been working to develop plans for the use of this funding, which were agreed by the Council's Adults and Safeguarding Committee in June 2017. Development of the plans was led by the CCG and LBB adults Joint Commissioning Unit, and were reviewed a number of times by the Urgent Care Programme Board, chaired by Barnet CCG and Royal Free Foundation Trust colleagues. Full details can be found in the attached Adults and Safeguarding Committee report. The allocation of funding is being used to:

- Increase rates paid to social care providers for residential and nursing care home placements, following an independent price benchmarking review
- Inflationary uplifts to home care providers, again following a review
- Purchase more home care and enablement care
- Increase hospital social work and care brokerage capacity
- Increase capacity at the first point of contact for adult social care
- The funding is being directed at services for older people and will support the NHS to manage pressures in the system by securing more care and speeding up the service user's journey.

1.5 Barnet's Better Care Fund – progress to date and lessons for the future

1.5.1 The Barnet Better Care Fund plan has been based since its inception on a model with the main elements set out below. The model includes services not funded by the BCF core allocation but from other CCG and Council core funding and ring-fenced Public Health Grant. The full BCF plan for 2016-7 is attached at the end of this report.

1.5.2 Prevention services targeting older people and those with long term conditions: self-care; community dementia support; services for falls, stroke and end of life; equipment and adaptations; Ageing Well; carers support; Later Life planning and advice.

1.5.3 Proactive care for older people and those with long term conditions: multi-disciplinary case conferences; Barnet Integrated Locality Team (BILT); single point of access for community health; and use of the risk stratification tool.

1.5.4 Rapid Care and Seven Day working: Rapid Care service; 7 day hospital social work service; additional enablement services.

1.5.5 Enabling funding was also used for programme management, joint commissioning posts, IT development (shared care records) and the Quality in Care Homes Team.

1.5.6 In 2016-17, a review of all BCF services was undertaken by the Joint Commissioning Unit. The learning from this was that the service model followed the evidence base for integrated care and that services were mostly meeting their intended aims. However, there was a need for:

- Significantly increased usage and throughput of the proactive care services, especially BILT and risk stratification.
- Improved linkages and pathways between the prevention services and proactive and rapid care services., so that they support those most at risk of escalating care needs.
- Improved linkages and pathways between mainstream services including acute admission avoidance schemes funded outside the BCF, and BCF funded services.
- The need to improve alignment across BCF commissioned services and other commissioned services targeting the same or similar group of patients/service users, including the potential for de-commissioning or remodelling services that might duplicate in the areas of crisis de-escalation/admission prevention/early discharge.
- These learning points are being incorporated into the development of the BCF plan for 2017-19.

1.6 Care Closer to Home and local delivery of the NCL STP

1.6.1 The HWB has previously agreed that there should be a unified approach to the Better Care Fund and local implementation of the NCL STP. Following the HWB workshop discussion in March, officers have streamlined the programme governance and management for BCF and STP delivery. Separate groups have been merged into a revised joint commissioning executive group, which reports to the HWB and now acts as the programme board for BCF and Care Closer to Home, the principal STP initiative for local implementation. This group includes health and care providers, GP governing body members, and CCG and Council lead officers.

1.6.2 As agreed at the HWB workshop, the Care Closer to Home (CC2H) delivery plan and BCF plan will be a single plan, to be presented to the HWB for approval as the Barnet local care strategy. This will be presented at the September HWB meeting. The full implementation of CC2H will also need to include a focus on children and young people; and prevention and public health.

1.7 Joint position on integrated care

1.7.1 At its first meeting in its new format, the JCEG reviewed and agreed a joint position statement on integrated care, with the intention of reporting it to the HWB for endorsement. The full position statement is attached at appendix 1.

The HWB is asked to endorse this document, which was developed following the March HWB workshop and summarises the key agreements between the CCG and Council as health and care commissioners to develop CC2H and integrated care. These agreements will be used in developing the BCF plan and will shape the actions within it.

1.8 Direction of travel for the Barnet BCF plan

1.8.1 Officers are now working on developing the BCF plan, based on the BCF Policy Framework and planning guidance; and on the local shared position statement, Care Closer to Home plans and the work of the Urgent Care Recovery programme. The contents of the BCF submission will include:

- Refreshed vision statement. The Barnet BCF vision statement is still relevant but requires some updating to incorporate the NCL STP principles, the model of CC2H and the most recent updates from the HWB strategy and CCG and Council corporate plans.
- The delivery plan for CC2H, which will include the establishment of CHINs (networked GP practices offering enhanced and increased care, with multi-disciplinary elements), QISTs (quality support teams for primary care).
- Information and prevention services. The BCF and other plans have implemented a comprehensive set of information & advice, prevention and early intervention services for older people, carers and those with dementia and long-term conditions. The plan will set these out and how they link to CHINs and admission prevention services. This will include the further development of 'Ageing Well/altogether better' to cover the whole borough and include proactive prevention work for those at risk of escalating care needs. Information and advice services will also be included.
- The role and linkages of adult social care services to CHINS, acute care and prevention services. This will include the strengths based social care model.
- A self- assessment against the high impact change model and local plans to reduce delayed transfers of care. This will draw from the urgent care recovery plan.

1.9 The plans for the use of the IBCF and how they support the wider BCF aims.

1.9.1 The plan will need to describe how current BCF services such as BILT, rapid care and the community point of access need to evolve to align with CHINs and how this will be implemented. The plan will also need to set out how the various admission avoidance and discharge support services currently

commissioned across health and social care become more aligned and streamlined.

1.9.2 The plan will address the policy requirements and national conditions of the BCF, which are measured by key lines of enquiry (KLOE). The plan will give evidence setting out how each KLOE is met.

1.9.3 The submission will include a narrative plan, the detailed financial plan and the agreed performance targets for the national metrics.

2 REASONS FOR RECOMMENDATIONS

2.1 The development of the draft plan will be overseen by the joint commissioning executive group. As it will not be possible to present the final draft plan to a quorate HWB meeting before the submission deadline, the HWB is therefore asked to confirm its agreement to direction of travel for the BCF plan set out above and also its agreement to the chairman and vice-chairman approving the plan on behalf of the board, in order that the submission deadline can be met. The full plan will then be presented to the September HWB meeting.

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable, all areas are required to submit a BCF Plan based on greater integration of health and social care within the timescales set out by NHSE.

4 POST DECISION IMPLEMENTATION

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

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The BCF Plan aligns with the twin overarching aims of our Barnet Joint Health and Wellbeing Strategy 2015 to 2020; Keeping Well; and Promoting Independence. There are also clear links with the Barnet Council Corporate Plan, the Priorities and Spending Review, the outline aims of Council 5 year commissioning intentions for adult social care and Barnet CCG Operating Plan.

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

5.2.1 The BCF Plan details the financial LBB and CCG contributions which will likely comprise the pooled budget used to deliver integrated health and social care services to improved outcomes for patients and service users.

5.2.2 For 2017-2018 the overall Better Care Fund pot has increased by a £400,000 uplift to the core CCG allocation and £192,409 increase in Disabled Facilities Grants (DFG) funding. Therefore, the Better Care Fund Allocation for Barnet in 2017/18 is £24, 899,540. The DFG funding figures for 18/19 are not yet available and so the Better Care Fund Allocation for Barnet in 18/19 currently stands at £23,168,138.

5.3 Social Value

5.3.1 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.

5.3.2 Social Value will be considered during procurement and review activity detailed as part of the BCF plans for 2017/18. Our plans clearly recognise 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.

5.4 Legal and Constitutional References

5.4.1 The BCF is allocated to Local Areas and placed into pooled budgets under joint governance arrangements detailed in S75 Agreements for Integrated Care between CCGs and councils (Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets).

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

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

5.4.4 The DFG is included to incorporate the provision of adaptations into strategic considerations and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier local authorities in 2017/18. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG funding to their respective housing authorities (district councils in two-tier

areas) from the pooled budget so they can continue to meet their statutory duty to adapt the homes of disabled people, including for young people aged up to 17.

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

5.4.6 Under the Council's Constitution, Responsibility for Functions (Annex A) the Health and Wellbeing Board has the following responsibility within its Terms of Reference

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

(9); Specific responsibility for:

5.4.6.1 Overseeing public health

5.4.6.2 Developing further health and social care integration

5.5 Risk Management

5.5.1 JCEG have led the detailed work to review the performance of the BCF plan in 2016/17. At a CCG level this has involved assessing the financial performance, risks and the outputs of the associated Managing Crisis Better QIPP. At a council level the senior team have also reviewed the deliverables in line with the medium term financial savings plan.

5.5.2 As part of managing the resilience across the system, partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions.

5.5.3 These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked the over use of acute care. Evidenced by the engagement exercises around establishing the local commissioning intentions 1 within the CCG and the Council.

5.6 Equalities and Diversity

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

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

5.6.3 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.

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

5.7 Consultation and Engagement

5.7.1 The BCF Plan details the public engagement with patients and service users as well as with providers. The content of our Better Care Fund (BCF) has been discussed with providers, users, clinicians and carers as an integral part of our strategic planning processes. The starting point for all discussions has been our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board (HWBB). Through co-producing these documents, and basing our planning on evidence and feedback, we have worked hard to establish our engagement on the basis of partnership working over many months. In this context we have had many engagement events, including with GP leads and service providers.

5.8 Insight

5.8.1 Our plans for 2017-2018 are informed by the:

5.8.1.1 Refreshed Barnet Joint Strategic Needs Assessment (JSNA)
5.8.1.2 The review of BCF interventions against the evidence base, as detailed in the report

6. BACKGROUND PAPERS

6.1.1.1 2017-19 Integration and Better Care Fund Policy Framework Department of Health and Department for Communities and Local Government https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

6.1.1.2 Integration and Better Care Fund planning requirements for 2017-19 Department of Health and Department for Communities and Local Government https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625229/Integration_BCF_planning_requirements.pdf

6.1.1.3 LB Barnet Adults and Safeguarding committee June 2017 Market stability and the use of social care funding announced in Spring Budget 2017 http://barnet.moderngov.co.uk/documents/s40056/Market%20stability%20and%20the%20use%20of%20social%20care%20funding%20announced%20in%20Spring%20Budget%202017.pdf

6.1.1.4 LB Health and Wellbeing Board May 2016 Better Care Fund Plan 2016-2017 http://committeepapers.barnet.gov.uk/documents/s31770/BCF%2016%20-%2017%20HWBB%20May%202016.pdf

Appendix 1

Summary of LBB and BCCG shared position on integrated care: Better Care Fund, Care Closer to Home (CC2H), new delivery models

Report of Dawn Wakeling and Kay Matthews

1. Introduction

NHS Barnet CCG, Barnet council and NHS providers have been working together, on the Barnet footprint and as part of the NCL STP, to progress integration in the commissioning and the delivery of integrated care. This report sets out the current status of integration and the shared ambition and agreement regarding further development of integration. The substance of this report has been taken from CCG governing body discussions, Health and Wellbeing Board (HWB) discussions and additional meetings between chief executives of BCCG, LBB and NHS providers. (Note: the main focus of the report is on adult services.)

2. Current status of integration

General

- A range of integrated services is in place, jointly commissioned by the CCG and LBB. These are governed through JCEG and managed through S75 agreements. Progress on these is regularly reviewed at JCEG (a full list of S75s is available from Zoe Garbett). The value of these services across adults and children's, excluding BCF, is circa £11M per annum. JCEG is accountable to the HWB.
- Two joint commissioning teams are in place between LBB and BCCG, one for adult services and one for children's services. These teams lead on commissioning community services, mental health, voluntary sector, therapies, & social care provision. The JCEG has within its terms of reference the responsibility for signing off the work programmes for both teams. These are then reported through to the HWB.
- Both BCCG and LBB are responsible for the work programme of the HWB and the Health and Wellbeing strategy. The HWB is chaired by a Cllr from LBB, with the chair of the CCG as vice-chair.

Better Care Fund

- LBB and BCCG have a Better Care Fund plan with a total BCF pooled budget of c. £24M per annum. The core elements of the BCF plan are services for the frail elderly and those with long term conditions (LTCs), such as: Barnet Integrated Locality Team (BILT), Rapid Response Team, risk stratification, 7 day hospital social work, and community equipment. This plan will be updated over the next 3 months, in line with national requirements from DH/DCLG and NHSE.
- **It has been agreed by the HWB, LBB and BCCG that the BCF plan for 2017-19 should be more ambitious and should include the delivery of STP-driven initiatives (such as CC2H) and other local plans, so there is one plan for integrated care and commissioning (particularly for adults). The working title for this is the local care strategy**

3. STP local initiatives

Care Closer to Home (CC2H)

- The NCL STP gives local areas responsibility for the delivery of the care closer to home (CC2H) workstream, with the establishment of CHINs (CC2H integrated networks) and QISTs (quality improvement support teams) a core deliverable for 2017/18.
- The JCEG's refreshed terms of reference and membership gives it the programme board role for CC2H and reflects the triumvirate leadership of the NCL STP.
- **It has been agreed by BCCG, LBB and the HWB that the CC2H work programme will be jointly led by BCCG and LBB.**
- **The agreed plan currently is to develop CHINs and QISTs across Barnet, with the intention that the first three come on stream in 17/18.**

New delivery models/accountable care

- The NCL STP has already considered the potential for new delivery models (accountable care approaches) across NCL and within NCL. No model or firm plan has been agreed by the NCL STP but this work will be picked up again with a view to acceleration in 2017/18. It is expected that all STPs will consider the potential for new delivery models, in line with the Five Year Forward View (FYFV). To ensure an appropriate approach and model for Barnet as this work is taken forward at the STP level, the CEOs of LBB, BCCG, Royal Free, CLCH, BEH, the GP Federation and the BCCG chair, have already met to discuss their shared aspirations for new delivery models on the Barnet footprint.
- The partner organisations have identified that there are potential patient/service user benefits from new delivery models and that the challenges in the health and care system necessitate partnership working and whole system solutions.
- The group of CEOs/the chair of the CCG have identified the Primary Care Home (PCH) model as a preferred model of accountable care for Barnet because of its alignment with the CC2H model and the overall benefits associated with it.
- **The CEOs have collectively confirmed their support for exploring the potential of new delivery models and have tasked directors from each organisation to take this work forward. The agreement is to trial, on a small scale, a Primary Care Home pilot, as part of the roll out of CHINs. This will take into account the necessary design of funding, risk-sharing and accountability arrangements. Timescales are to be confirmed and are subject to design and agreement of the trial. Plans for a pilot will be developed during 2017/18. Further work will be dependent on the learning from the trial. A report back to the CEO group will take place in May 2017.**

Other

- The JCEG will also oversee the delivery of other STP-driven initiatives that require local delivery. This work will be developed over time and is likely to include prevention, children and young people, mental health, elective care.

4. The Better Care Fund 2017-19

This year Barnet will have to submit a 2-year BCF plan. The national conditions of the BCF are:

1. Plans to be jointly agreed, approved by the Health and Wellbeing Board.
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned Out of Hospital services, which may include 7 day services and adult social care
4. Managing transfers of care (MTOC): implement the high impact change model for MTOC to support system wide improvements in transfers of care

Plans will also need to set out the area's vision for integrating health and social care by 2020.

A key change to the new BCF policy framework is the increased emphasis on reducing delayed transfers of care (DTOC) from acute hospital. This links the BCF plan with the Barnet A&E delivery board and the recovery programme for the A&E 4 hour target, led by Neil Snee. The A&E Delivery Board will have lead responsibility for action to reduce DTOCs, through the recovery programme. The A&E recovery programme will be governed through the A&E delivery board. Work to reduce DTOCs will not be duplicated by the JCEG. However, the actions to improve DTOCs within the A&E recovery programme will be set out in the BCF plan submission to demonstrate how BCF national condition 4 is being met. Dependencies between the two plans will be logged in both sets of project documentation.

5. The scope of local care strategy

(Note – this covers the adult health and care perspective; content on children and young people and public health to be added)

CC2H

- Delivery of CHINs and QISTs; and CHIN – primary care home pilot
- Realignment and remodelling of BILT and other current BCF and community health initiatives, developing an enhanced and expanded model of multi-disciplinary working across Barnet for older people and those with LTCs.
- CHINs will need to have, as the centre of a network, links and pathways to all the following:

Strength based adult social care

- Continued expansion of the new model of social work in community hubs; alignment and linkage with CHINs.

Early intervention

- Introduction of Local Area Co-ordination model (the progression of Ageing Well) to deliver more early intervention and build community capacity.
- Prevention and early intervention services commissioning: older people.
- Alignment of prevention services and community participation activity with integrated care model: information, advice, signposting, use of VCS database, volunteer matching, links to and the role of community groups.
- Self-care and social prescribing: linking to public health and leisure services.

Support for specific conditions

- Living with and beyond cancer.
- Stroke, dementia, end of life care.
- Mental health: better links between employment support, wellbeing hub, the Network.

Redesign of partnerships

- Increasing the scale of pooled budget and commissioning across BCCG and LBB.
- Joint approach to co-production, engagement/comms and patient/user participation between LBB and BCCG.
- Integrated commissioning of CHC and ASC care placements and packages; joint approach to care market sustainability and development.
- Integrated care provider quality improvement function across LBB and BCCG.
- Integration of CHC and ASC functionality

6. Summary

- The HWB has agreed to develop a local care strategy. This will be a single strategic plan that will develop and deliver improved integrated care in Barnet. The plan will sit underneath the Joint Health and Wellbeing Strategy and support the delivery of published commissioning intentions. The strategy will include the establishment of CHINs in Barnet and developing accountable care. It will include local implementation of STP initiatives and reference existing integration. It will set out the links with the local A&E recovery programme and reference actions on DTOCs. The intention is that this strategy is submitted as the Barnet Better Care Fund plan for 2017-19.
- Further consideration of the elements of the strategy covering children's health and public health is required.
- The working groups and project/programme boards for previously separate integrated care projects therefore been brought together into the refreshed JCEG, to lead the creation and delivery of the new strategy.
- Two core tasks for the new JCEG are to oversee the development and implementation of the CHIN model through effective programme management and to explore and develop the work on the primary care home pilot in 17/18.

7. Next steps

- Officers from BCCG, LBB and the Federation will develop a joint resourcing and programme delivery plan to support the development of CHINs and QISTs across Barnet and, subject to further design, proposals for the primary care home pilot within the CC2H programme.
- Officers from LBB and BCCG will progress the development of the care strategy.
- The intention is to present a draft care strategy to the HWB in June 2017.

AGENDA ITEM 9

	Health and Wellbeing Board **20th July 2017**
Title	**Tackling health inequalities in Barnet including suicide prevention**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1 - Inequalities in life expectancy Appendix 2 - Suicide prevention report Appendix 3 – Thrive London briefing
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Summary

This paper provides an analysis of life expectancy inequalities in the borough. It suggests that there has been no significant change in life expectancy inequalities.. The drivers of these inequalities are examined.

There is evidence nationally that areas with high levels of deprivation have higher rates of suicide, which is not observable locally.

The 2017 suicide prevention report and action plan has been completed. Local preventative actions in 2016 are reviewed and an action plan for 2017 presented.

Recommendations

1. **That the Health and Wellbeing Board notes the analysis of life expectancy inequality (at Appendix 1).**

2. **That the Board approve the 2017 suicide prevention report and action plan (at Appendix 2).**

3. **That the board notes the launch of the Thrive London mental health programme.**

1. WHY THIS REPORT IS NEEDED

1.1 This report has been produced in response to a query raised in November 2016 about an apparent increase in life expectancy inequality reflected in the 2016 borough health profile produced by Public Health England.

1.2 It also shares with the Board the 2017 suicide prevention report and action plan and a briefing on the Mayor of London's Thrive programme which identifies suicide prevention as one of the priority areas for action on mental health in the capital along with understanding of mental health, community resilience, targeted prevention for children and young people and employment support.

2. REASONS FOR RECOMMENDATIONS

2.1 The analysis of life expectancy inequalities has been provided in response to a health and wellbeing board request.

2.2 The 2017 suicide prevention report and action plan is shared to allow the board oversight of suicide rates in the borough and preventative actions.

2.3 The Thrive programme sets out ambitious aspirations for mental health and aims to galvanise city wide action. Barnet has innovative examples of good practice that have helped to inform these aspirations and we aim to share these and to learn from good practice elsewhere.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

4.1 The suicide prevention report and action plan is reviewed annually with partners updating on actions undertaken and planned and future intentions shared and reviewed.

4.2

4.3 Members of the public health team also engage with suicide prevention planning at the Barnet, Enfield and Haringey and London levels.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Council's Corporate Plan (2015-2020) identifies a commitment to increasing health and well-being and reducing health inequalities as a central theme in all activities across the council by 2020.

5.1.2 The Joint Health and Wellbeing Strategy (2015-2020) includes a commitment to monitor life expectancy inequalities and recognises the annual prevention report and action plan produced by public health.

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

5.2.1 Public health staff facilitate the production of the suicide prevention report. The actions included are the commitments of the respective partners that choose to contribute.

5.2.2 Actions owned by public health are expected to be delivered within existing staffing resources.

5.2.3 Public health has provided £9k from the public health grant in 2016/17 to support bereavement support of residents affected by suicide.

5.3 **Social Value**

5.3.1 Not applicable.

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:

-To directly address health inequalities through its strategies.

-To promote partnership and, as appropriate, integration, across all necessary areas.

5.5 **Risk Management**

5.5.1 Suicide prevention is shared responsibility of a wide range of agencies and the borough action plan is the product of those partners' commitments. Delivery of those actions is the responsibility of the partners individually. A six monthly progress review meeting is held with partners in order to identify any delivery issues.

5.5.2 Communication regarding suicides is inherently sensitive because of the potential for suicide contagion. Samaritans have produced media guidelines and these have been shared with communications and with local press.

5.6 **Equalities and Diversity**

5.6.1 The life expectancy inequality report describes the scale of variation in life expectancy across the borough based on deciles of deprivation as well as some of the drivers of those inequalities.

5.6.2 Variation in suicide rates locally are not statistically significant, although given the small numbers involved only very large differences would be observable.

5.7 **Consultation and Engagement**

5.7.1 The suicide prevention report is produced through the work of a workgroup that involves a wide variety of statutory and voluntary/community sector organisations and service users.

5.8 **Insight**

5.8.1 Data has been drawn from a wide variety of national and local data sources as referenced in the respective reports.

6. BACKGROUND PAPERS

6.1 Health and Wellbeing Board, 10th November 2016, agenda item 6, Joint Health and Wellbeing Strategy Implementation plan annual report. https://barnet.moderngov.co.uk/mgAi.aspx?ID=19442

Inequalities in life expectancy in Barnet.

Introduction

In November 2016, members of the Health and Wellbeing Board noted an apparent increase in life expectancy inequality when reviewing a borough health profile produced by Public Health England. This paper provides a more detailed analysis and suggests that there has been no significant change. The drivers of health inequalities and actions to address them are also considered.

Nationally

Whilst there have been significant improvements in life expectancy, health inequalities between the most affluent and disadvantaged communities are longstanding, deep-seated and have proved difficult to change (National Audit Office, 2010).

Office of National Statistics (2015) analysis indicates that there has been little change in the level of inequality in England between the most and least deprived for both life expectancy and disability free life expectancy over the past two decades.

Locally

The 2016 Barnet Health Profile indicated that there is a life expectancies gap between deciles of the population defined by deprivation indices of 7.6 years for males and 5.6 years for females. These figures, based on a calculation of difference between deciles with the highest and lowest life expectancies, are subject to considerable random variation. A more robust analysis is provided by a 'slope index' calculation, as in figure 1 below, which provides a calculation of the range in years of life expectancy across the social gradient, eliminating the random variation around estimates for individual deciles.

Figure 1: Slope index of inequality in life expectancy at birth in Barnet (Male)

Period	Value	Lower CI	Upper CI
2010 - 12	8.0	6.6	9.4
2011 - 13	7.3	5.9	8.7
2012 - 14	7.3	6.0	8.7
2013 - 15	7.3	6.0	8.6

Source: http://fingertips.phe.org.uk/profile/health-profiles/data#page/4/gid/1938132974/pat/6/par/E12000007/ati/102/are/E09000003/iid/92901/age/1/sex/1

Figures calculated by Public Health England using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation 2015 (IMD 2015) scores from the Department for Communities and Local Government.

Figure 2: Slope index of inequality in life expectancy at birth in Barnet (Female)

Period	Value	Lower CI	Upper CI
2010 - 12	5.3	4.1	6.6
2011 - 13	5.4	4.2	6.7
2012 - 14	5.0	3.7	6.2
2013 - 15	5.0	3.7	6.2

Source: http://fingertips.phe.org.uk/profile/health-profiles/data#page/4/gid/1938132974/pat/6/par/E12000007/ati/102/are/E09000003/iid/92901/age/1/sex/2

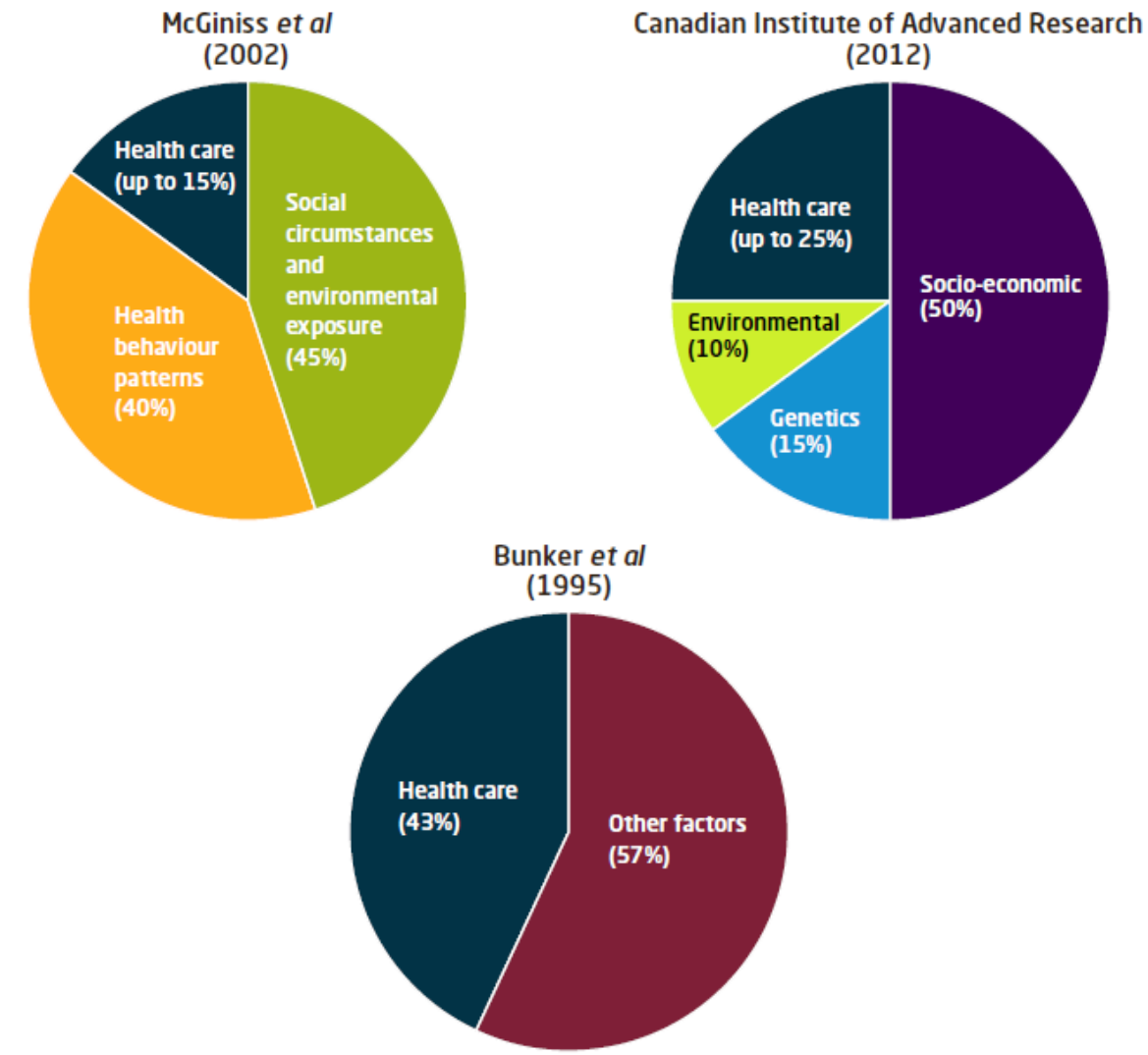
Figures calculated by Public Health England using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation 2015 (IMD 2015) scores from the Department for Communities and Local Government.

The figures indicate that the life expectancy gap is consistently higher for males than females. The figures do not show any clear trend given the degree of random variation described by the lower and upper confidence intervals. On this basis we would conclude that there is no clear evidence that life expectancy inequality is worsening in Barnet but consistent with the picture nationally, those inequalities are marked and persistent.

Causes of health inequalities

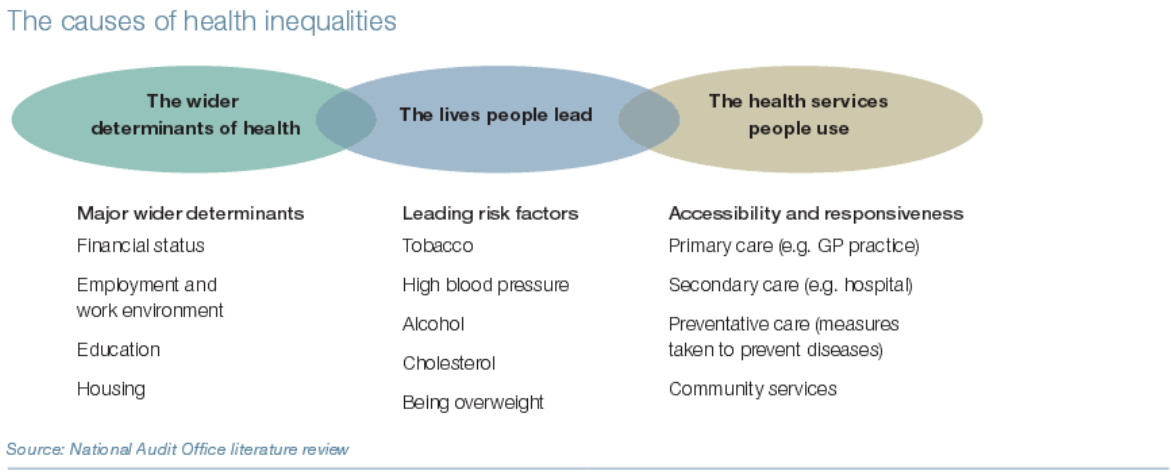
In order to understand health inequalities and the opportunities to address them further it is necessary to look at the factors that drive them. Estimates are summarised in figure 3 below.

Figure 3: Estimates of the relative contribution of different factors to our health



Source: The King's Fund 2013

There is no clear consensus as to the relative impact of different factors on health status but a wide variety of social, economic and cultural factors have been identified as summarised in figure 4 below.



Given this diversity of influences, a wide variety of data is relevant in assessing the potential drivers of inequality in Barnet.

Causes of death

The segment tool (Public Health England, 2016) describes the life expectancy gap by cause of death. It summarises which conditions drive disparities in age specific mortality.

Figures 5 and 6 below shows a breakdown of the life expectancy gap between Barnet's most deprived and most affluent quintiles by cause of death for males and females.

Figure 5: Scarf chart of the life expectancy gap between Barnet's most and least deprived quintile by broad cause of death 2012-14 (males).

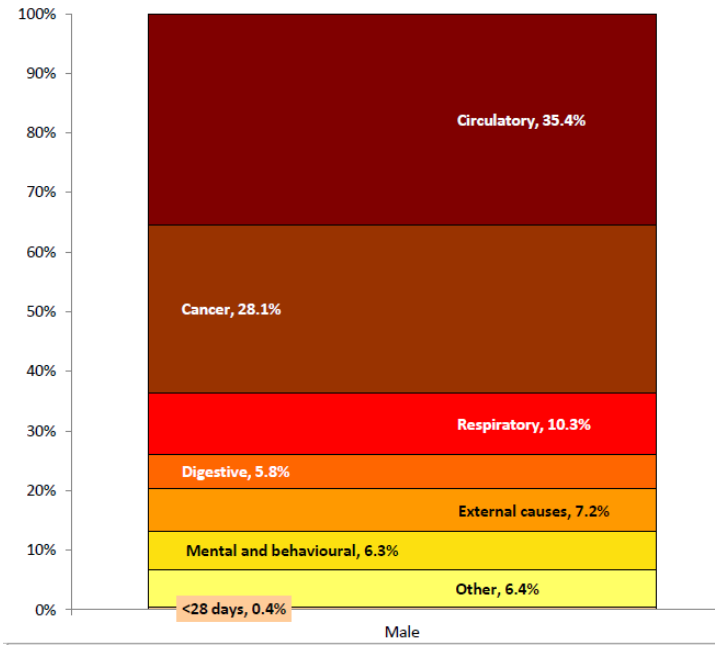
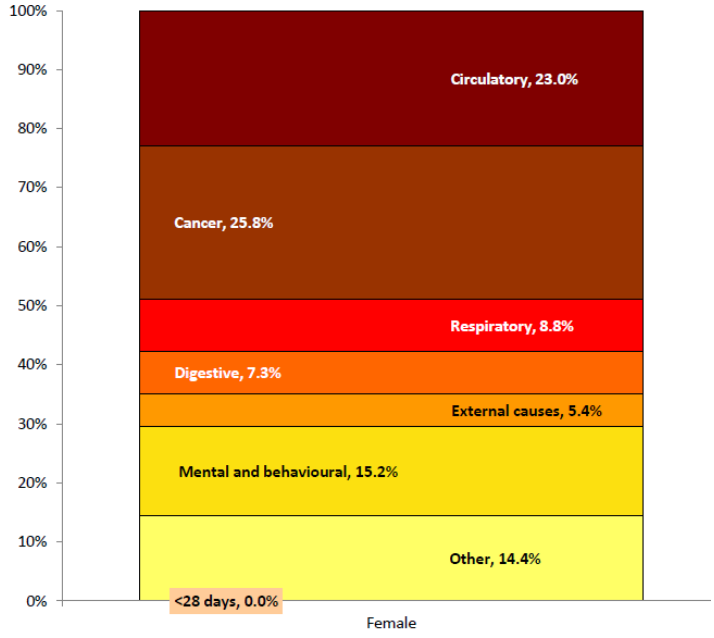


Figure 6: Scarf chart of the life expectancy gap between Barnet's most and least deprived quintile by broad cause of death 2012-14 (females).

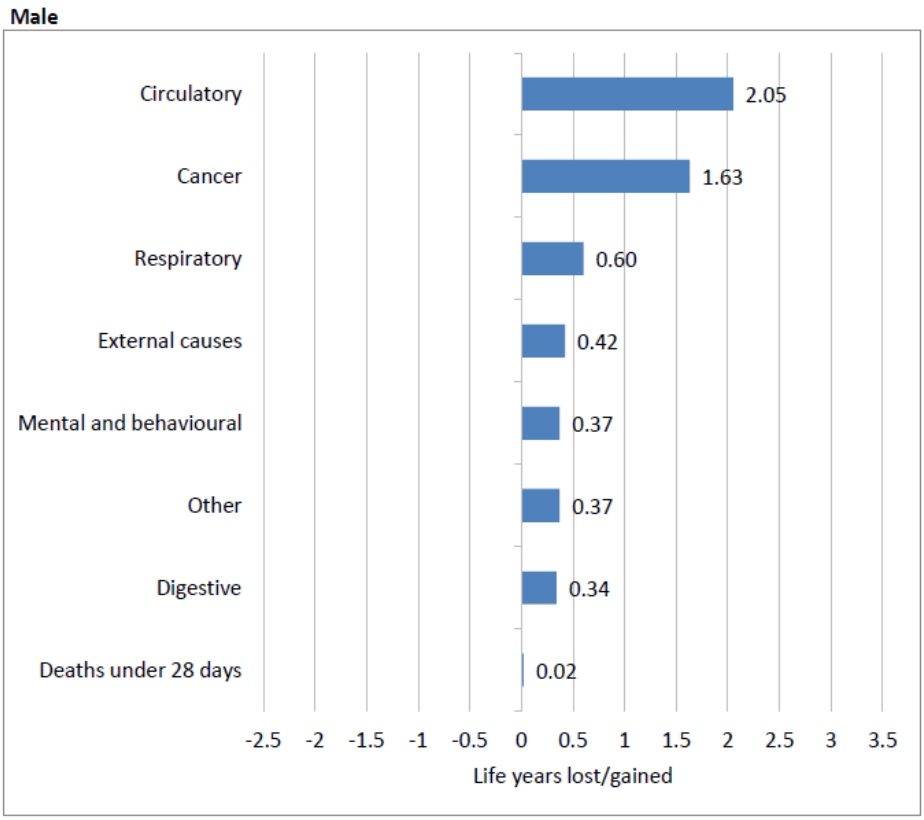


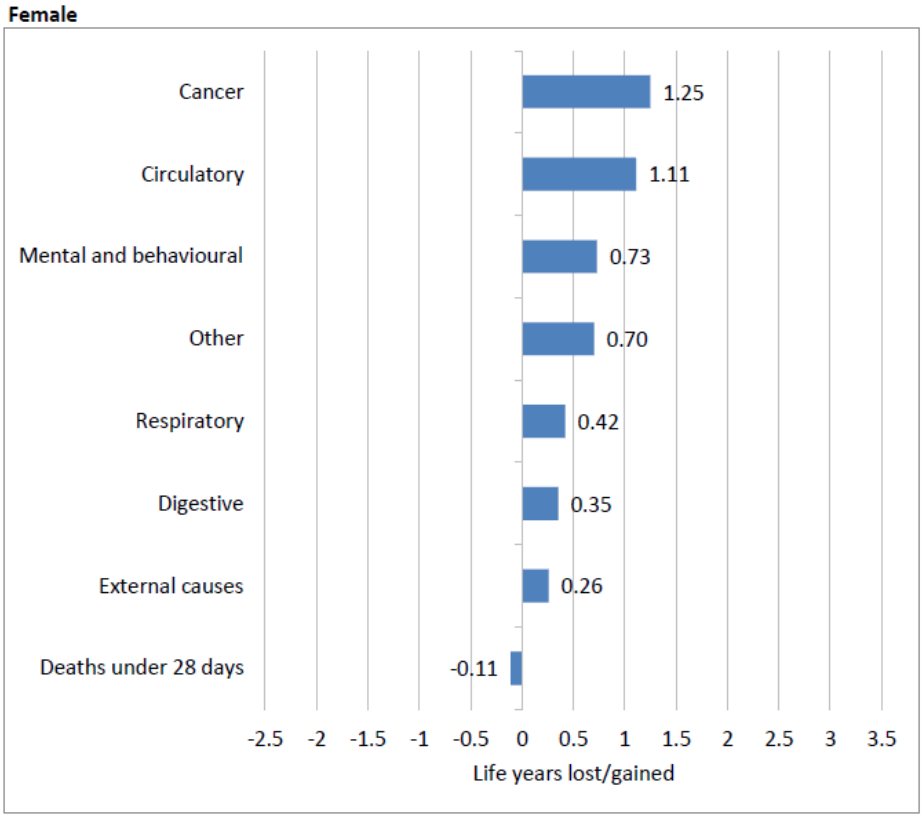
For both males and females, circulatory disease and cancer are the two biggest causes of death that contribute to the gap in life expectancy although for males the

circulatory causes account for a much larger percentage. Mental and behavioural causes account for a higher percentage of the life expectancy gap amongst women.

The figure below show the potential narrowing of the life expectancy gap that could be achieved by tackling this variation in cause of death by condition.

Figures 7: Bar charts showing life expectancy years gained or lost if Barnet's most deprived quintile had the same mortality rates as Barnet's most affluent quintile, by broad cause of death, 2012-2014





Prevention

The Department of Health (2007) estimated that around 15 to 20 per cent of inequalities in mortality rates can be directly influenced by health interventions which prevent or reduce the risk of ill health, representing thousands of people dying earlier than might otherwise be the case. It identified three key interventions (prescribing of blood pressure and cholesterol medication and smoking cessation) that provide cost-effective means of reducing the gap in life expectancy. Despite this, these remain areas where there is marked variation in practice.

Significant opportunities are available through tackling variation in primary care. Quality Improvement Support Teams (QISTs) are currently being developed and have the potential to deliver significant improvements.

The figure below provides an example of variation in a measure of hypertension management between Barnet practices.

Figure 8: Percentage of patients with hypertension whose last blood pressure reading (measured in the preceding 12 months) is not 150/90 mmHg or less by GP practice

Source: PHE (2016) Primary Care Intelligence Packs – CVD.

Whilst the individual practice detail is not clear at this scale, the figure does show a marked difference in the percentage of patients with managed hypertension between practices that is likely to be beyond anything that might be explained by different patient characteristics.

Lifestyle factors

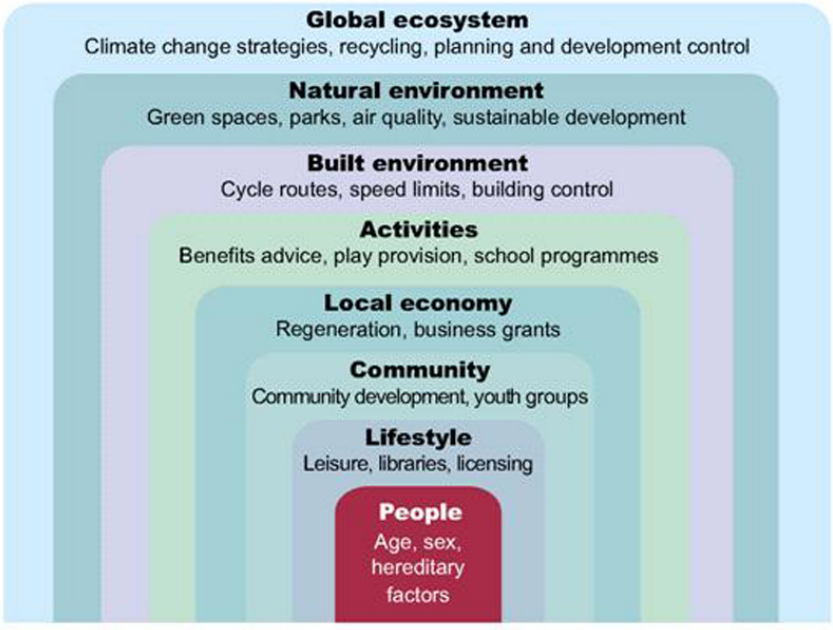
Kings fund analysis (2012) of the clustering of unhealthy behaviours over time found that the overall proportion of the population that engaged in three or four unhealthy behaviours declined significantly, from around 33 per cent of the population in 2003 to around 25 per cent by 2008. However, these reductions were seen mainly among those in higher socio-economic and educational groups. People with no

qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours in 2008, compared with only three times as likely in 2003. These worsening disparities in health behaviours can only exacerbate health inequalities.

Those from a socioeconomically deprived background are more likely to be impacted by harmful drinking and alcohol dependence, and are also more likely to smoke and to be obese, all of which lead to associated negative health impacts. PHE (2013 and 2016) analysis has indicated that alcohol related deaths for the most deprived decile are 53% higher than amongst the most affluent decile of the population. 33% of women with no qualifications are obese, compared to 18% of women with a degree or equivalent level qualification. Action on Smoking and Health (2016) analysis found that 23% of those with an annual income of less than £10,000 are smokers, compared to 11% of those with an income of £40,000 or more

Wider determinants

A very wide range of social, economic and environmental factors impact on health outcomes and health inequalities as the following figure summarises.



PHE (2017) provides borough level analysis of a wide range of indicators. It shows that Barnet fairs very well when compared to both regional and national data with only a few exceptions. These include:

- Unemployment (8.4% as compared to 6.1% for London and 5.1% for England).
- Statutory homelessness: households in temporary accommodation (19.9/1000 and compared to 14.9/1000 for London and 3.1/1000 for England).
- Overcrowded households (10.2% as compared to 4.8% for England but 11.6% for London)
- Young people (aged 16-24) providing 20+ hours/week of unpaid care (1.4% compared 1.3% for England but 1.5% for London).

Public health is currently working with colleagues across the council and beyond on housing/homelessness, employment and carer support and particular attention will be given to ensure that the relationship between these issues and health inequalities are recognised along with opportunities for mitigation.

The Centre for Wellbeing (2016) analysis of inequality across the country indicates that Barnet is amongst the most equal areas, ranking 10th in the country, along with neighbouring boroughs – Enfield (1st) and Harrow (3rd).

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Office for National Statistics (2015) Inequality in Health and Life Expectancies within Upper Tier Local Authorities: 2009 to 2013. Available at:

http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/inequalityinhealthandlifeexpectancieswithinuppertierlocalauthorities/2009to2013 (last accessed 2nd June 2017)

Public Health England (2013) Social and Economic Inequalities in Diet and Physical Activity. Available at: http://www.noo.org.uk/uploads/doc/vid_19253_Social_and_economic_inequalities_in_diet_and_physical_activity_04.11.13.pdf (last accessed 2nd June 2017)

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Public Health England (2016) Wider determinants profiles. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/596516/Wider_Determinants_of_Health_March_2017_statistical_commentary.pdf (last accessed 2nd June 2017)

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Appendix 2

London Borough of Barnet Suicide Prevention Report 2017/2018

Authored by:

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Date:

June 2017

Introduction

The 2017/2018 suicide prevention report and action plan provides an update on progress made in 2016/2017 on the agreed actions to support suicide prevention in Barnet, and presents the actions agreed by partners for 2017/2018.

Following a recommendation from the Barnet Enfield and Haringey Mental Health Trust Tri-borough workshop in 2016 an audit of the coroner's data has been conducted. The results of this are also presented.

National Data

Statistics for death by suicide

The most recent ONS data are from 2015 and reflect the deaths that were registered in that year rather than the deaths that actually took place in 2015. The data show a slight increase in the rate of suicides in the UK in those aged 10 and over from 10.8 deaths per 100,000 (95% CI 10.5-11.1) population in 2014 to 10.9 per 100,000 (95% CI 10.6-11.1) in 2015[1], although this was not statistically significant. The change was driven by a rise in the female suicide rate, from 5.2 per 100,000 to 5.4 deaths per 100,000, while the rate in males fell from 16.8 deaths per 100,000 to 16.6 deaths per 100,000. The female rate was at its highest since 2005, however men are still three times more likely to die by suicide than females[1].

Among males the highest rates of suicide are in the 45-59 and 30-44 year age groups at 22.3 and 21.0 deaths per 100,000 population respectively. Both have been falling since 2013[1]. In comparison, under-30s had the lowest rate at 10.6, but this has shown a steady increase over the last few years[1].

As in males, the suicide rates in females were highest among those aged 45-59 and 30-44 at 7.6 and 6.0 per 100,000 population respectively[1]. However the 30-44 year old age group is the only one to show a decrease since last year. The lowest rates were in 10-29 year olds.

In female older people (60-74 year olds and 75 and over), the rate of suicides has increased since 2014; this is slightly more in 60-74 year olds (5.4 per 100,000) compared with those aged 75 and over (4.8 per 100,000 people)[1].

In 2015 hanging remained the most common method of suicide in both men and women. There was an increase in the proportion of deaths by hanging to 58% in men (55% in 2014) and 43% in women (42% in 2014)[1,2]. The second most common method of suicide was poisoning although this has fallen in both males (19% to 18%) and females (37% to 35%)[2].

[1]Suicide in the United Kingdom: 2015 registrations (2015) Office for National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations [1][accessed online 25/1/17]

[2] Suicide in the United Kingdom: 2014 registrations (2014) Office for National Statistics http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations [accessed online 25/1/17]

The proportion of people dying by other methods of suicide, including drowning and falling, has remained fairly constant over the last 10 years.

Local statistics

Data have been collected from the following sources to provide a comprehensive picture of suicides and other deaths resulting from self-harm in Barnet: ONS, British Transport Police (BTP) and Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT). In addition an audit of the North London coroner's data was carried out, providing more in depth information about factors that may be associated with suicides and other deaths resulting from self-harm in Barnet. Data on emergency admissions to hospital for self-harm have also been included.

It is important to note that interpretation of death as a suicide varies between organisations meaning that deaths initially investigated as potential suicides may not be classified as such by the coroner following an inquest.

Suicide rates in Barnet

Public Health England (PHE) has calculated age-standardised suicide rates based on the aggregate of deaths over a three year period using ONS data. Averages over three years provide a more accurate reflection of long-term trends as, due to the small numbers involved, annual changes may be a consequence of natural fluctuations[3]. Where the total number of deaths was less than 25, the rate has not been calculated as it would be unreliable[4].

Rates have also been calculated according to age categories, using data aggregated across five years to reduce the impact of random variation[5].

When interpreting trends it is important to note that ONS data reflect the number of deaths registered in a year; the coroner's data reflect the number of deaths that took place in the calendar year.

[3] Local suicide prevention planning: a practice resource (2016) Public Health England http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf [accessed online 25/1/17]

[4] Suicide Prevention Profile. Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000007/ati/102/are/E09000002 [accessed online 25/1/17]

[5] Suicide Prevention Profile. Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/6/gid/1938132828/pat/6/par/E12000007/ati/102/are/E09000002/iid/91390/age/294/sex/1 [accessed online 25/4/17]

Age-standardised suicide rates

Suicide Rate (age standardised per 100,000) 2013-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
All	9.3 (7.3-11.5)	8.6 (8.2-9.0)	10.1 (10.0-10.3)
Male	14.2 (10.7-18.5)	13.4 (12.6-14.1)	15.8 (15.5-16.1)
Female	Calculation of the rate would be unreliable due to the low numbers involved[4]	4.1 (3.7-4.6)	4.7 (4.6-4.9)

Table 1. The age-standardised suicide rates per 100,000 population in Barnet, London and England (2013-2015)[4].

The data from 2013 to 2015 show an overall age-standardised suicide rate in Barnet of 9.3 per 100,000 population[4], compared with a rate of 6.8 per 100,000 population (95% CI 5.2-8.7) from 2012 to 2014.[6] The male rate from 2013 to 2015 was 14.2 per 100,000 population[4], compared with 9.0 per 100,000 (95% CI 6.5-12.3) from 2012 to 2014[6]. The rates in Barnet are not statistically significantly different from those in London and England either overall or for males.

The data suggest that there may have been a rise in suicide rates both overall and in males although it is important to recognise that none of these increases are statistically significant and may be due to random variation. Given the low number of female suicides, an overall increase may be driven by an increase in the male rate which is in contrast to the national decline observed in 2015.

[6] London Borough of Barnet Suicide Prevention Report (2016). Barnet Public Health Team.

Suicide rates in males

Suicide Rate (per 100,000) 2011-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
10-34 years	6.8 (4.3-10.3)	8.0 (7.4-8.6)	10.5 (10.2-10.8)
35-64 years	14.2 (10.5-18.9)	16.8 (15.9-17.7)	20.8 (20.4-21.2)
65+ years	16.4 (9.7-25.9)	13.1 (11.6-14.7)	12.6 (12.1-13.1)

Table 2. Male suicide rates per 100,000 population according to age categories in Barnet, London and England (2011-2015)[4].

The data show that the suicide rate per 100,000 population is significantly lower in the 35-64 year age group compared with the rate in England[4]. The other groups do not appear to differ significantly from the rates in London and England. The rates equate to 22, 48 and 18 deaths in each of the categories respectively indicating that although the highest rate of suicides was in the 65+ age group, the age category with the highest number of deaths was the 35-64 year olds[4].

Suicide rate in females

The local authority crude mortality rates for females could not be calculated due to the small numbers involved[4].

Suicide Rate (per 100,000) 2011-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
10-34 years	Calculation of the rate would be unreliable due to the low numbers involved[4]	2.7 (2.3-3.1)	2.9 (2.8-3.1)
35-64 years	Calculation of the rate would be unreliable due to the low numbers involved[4]	5.0 (4.5-5.5)	6.0 (5.8-6.2)
65+ years	Calculation of the rate would be unreliable due to the low numbers involved[4]	5.2 (4.4-6.1)	4.4 (4.2-4.7)

Table 3. Female suicide rates per 100,000 population according to age categories in Barnet, London and England (2011-2015)[4].

Suicide rate in Barnet, Enfield and Haringey

Comparing Barnet with Enfield and Haringey, with whom the borough shares mental health services, the overall age-standardised suicide rate is not statistically significantly different[4]. This pattern is also evident in men.

Suicide Rate (age standardised per 100,000) 2013-2015	Barnet (95% CI)	Enfield (95% CI)	Haringey (95% CI)
All	9.3 (7.3-11.5)	6.9 (5.1-9.0)	10.8 (8.2-13.9)
Male	14.2 (10.7-18.5)	11.0 (7.9-14.9)	18.2 (12.9-24.6)
Female	Calculation of the rate would be unreliable due to the low numbers involved[4]	Calculation of the rate would be unreliable due to the low numbers involved4	Calculation of the rate would be unreliable due to the low numbers involved[4]

Table 4. The age-standardised suicide rates per 100,000 population in Barnet, Enfield and Haringey[4].

Emergency admissions for self-harm in Barnet

PHE has collated data on intentional self-harm serious enough to result in an emergency hospital admission for 2014/2015. The definition of self-harm is intentional self-injury or poisoning, regardless of the motivation or intention to end their life[7]. A history of self-harm, regardless of intent, is the strongest predictor for a person to subsequently take their own life, particularly in those who have multiple hospital presentations following an episode of self-harm[3,8]. A person who self-harms is 50-100 times more likely to die from suicide in the

[7] Public Health Profiles. Emergency hospital admissions for intentional self-Harm. Public Health England. https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/21001/age/1/sex/4 [accessed online 24/4/17]

[8] Assessment of suicide risk in people with clinical depression: A clinical guide (n.d.). Centre for suicide research, Department of Psychiatry, University of Oxford. http://cebmh.warne.ox.ac.uk/csr/clinicalguide/riskfactors.html [accessed online 24/4/17]

12 months following the episode of self-harm[9]. Half of those who die from suicide have previously self-harmed, often shortly prior to their death[3].

Table 5 below shows that the rate per 100,000 people in Barnet is just over half the rate in England overall and is not significantly different from that in London[10].

	England (95% CI)	**London (95% CI)**	**Barnet (95% CI)**
Emergency hospital admissions for intentional self-harm: directly age-sex standardised rate per 100,000 **(2014/15)**	191.4 (190.3-192.6)	97.3 (95.1-99.4)	99.0 (89.1-109.6)

Table 5. Age and sex-standardised rates of emergency hospital admissions due to intentional self-harm in Barnet per 100,000 population[10].

Barnet Enfield and Haringey Mental Health Trust Data

Data on serious incidents (SI) were requested from BEH MHT. These include suicides and suspected suicides of patients under the care of the trust or within six months of discharge. Suspected suicides are subject to a Coroner's inquest therefore the number of confirmed suicides is likely to be lower.

	2015 to 2016 (1st April – 31st March	**2016 to 2017 (1st April to 13th February)**
Serious incidents (including suicides and suspected suicides)	65	59
Suspected suicides (as reported on Datix)	20	20

[9] Self-Harm. NICE Guidance (2013) National Institute for Health and Care Excellence https://www.nice.org.uk/guidance/qs34/chapter/Introduction-and-overview [accessed online 24/4/17]

[10] Public Health Profiles. Emergency hospital admissions for intentional self-Harm https://fingertips.phe.org.uk/search/self%20harm#pat/6/ati/102/par/E12000007 [accessed online 24/4/17]

Table 11. Table showing trust-wide numbers of serious incidents and suspected suicides of current or recently discharged BEH MHT patients.

There are clear processes in place at BEH MHT to investigate all SI; these were documented in the 2016/2017 Barnet Suicide Prevention Report[6].

North London coroner's data

Audit

Methodology

The public health team conducted an audit of the North London coroner's data from 2011 to 2015 with the aim of trying to identify local patterns or drivers that could signal areas for targeted intervention. This was the first time such an audit had been carried out. Permission to conduct the audit and access to the data was sought via the coroner's clerk. The audit was carried out by one member of the public health team between November 2016 and March 2017.

Where it is suspected that a person may have taken their own life the death must be referred to the coroner[11]. An inquest will be held to establish the circumstances of the death. This will include understanding how, when and why the person died[12]. The inquest findings are recorded on the coroner's electronic database along with demographic details, post mortem results, medical letters and toxicology results. Data were collected for deaths that received the following conclusions:

- Suicide
- Open verdict
- All other verdicts - where death resulted from self-harm
- Accidental deaths*
- Alcohol/drug related deaths and road traffic accidents*

*Accidental, alcohol/drug related deaths, and road traffic accidents were included only where there was insufficient information available to the auditor to exclude intent. The interpretation was based on the information provided based on narrative provided by the coroner and is quite a subjective process.

The following groups were included in the audit:

- Those who died in Barnet (but may have been resident elsewhere)

[11] When death occurs: which deaths must be reported to the coroner? Manchester City Council http://www.manchester.gov.uk/info/626/coroners/5532/when_death_occurs/2 [accessed online 4/4/17]

[12] Inquest. NHS Choices http://www.nhs.uk/conditions/Inquest/Pages/Introduction.aspx [accessed online 4/4/17]

- Those who attempted to end their life in Barnet (but may have died elsewhere)
- Those who were resident in Barnet (but may have died elsewhere)

The decision was made to include all of these groups because of their relevance to suicide prevention interventions in the borough. Deaths and attempts in the borough can be affected by preventative interventions in public places such as rail and tube stations; and local care pathways and infrastructure will impact on those who are resident in Barnet. No restriction was placed on age.

The audit framework was provided by the Haringey public health team and used with their permission. Key areas of analysis included:

- Age
- Method
- History of mental health problems
- Self harm
- Substance misuse
- Contact with health services
- Place of birth
- Employment

The results of the audit have been shared with the members of the suicide prevention group. Understanding the history of mental ill health and self-harm, potential risk factors (e.g. unemployment, social isolation, debt), and previous contact with services (such as mental health, primary care and drug & alcohol) of people who take their own lives may identify opportunities to learn and improve practice at a local service level. However the numbers are too small to provide a strong enough evidence base for population-level interventions as they cannot provide statistical assurance of trends or associations. Due to the overall small numbers of suicides, annual collection of data is unlikely to be of use. Data could be collected on a three to five-year basis as this would provide stronger evidence of trends. Data collection across Barnet, Enfield and Haringey, or at a London-wide level will provide a stronger basis to inform future interventions. The analysis has raised issues which are being raised with colleagues regionally. Data collection across Barnet, Enfield and Haringey is being explored as is the possibility of future London-wide data collection through the Thrive London programme which is working towards improving mental health across London.

The coroner has agreed to inform the public health team about emerging areas of concern such as suicide clusters associated with a particular method or location. This is an area where the coroner's data would be of value and would support population-level approaches

such as raising awareness of and providing information about suicide and help-seeking behaviour in the community[13].

Barnet suicide prevention meeting of key partners

This year's suicide prevention meeting was held in March 2017 and was attended by partners from Barnet Council, Barnet Clinical Commissioning Group, BEH MHT, Barnet Adult Substance Misuse Service, primary care and North London Samaritans.

The suicide prevention group meets on a twice-yearly basis. Its remit is to:

- Share relevant local data and intelligence to support the understanding of suicides and deaths of undetermined intent in Barnet;
- Develop and implement Barnet's suicide prevention action plan;
- Identify gaps in and opportunities for the suicide prevention work;
- Raise concerns and queries;
- and suggest additional membership as appropriate

The meeting provided an opportunity to present and discuss some of the audit data, review the 2016/2017 suicide prevention action plan and develop new actions for 2017/2018. Discussions resulted in a number of actions being closed, while others were carried over to 2017/2018 plan where partners felt that further work was required. Where an action has been closed but partners would benefit from updates on that area of work, these will be provided at subsequent meetings. The minutes from the meeting have been included in appendix 1 of this report, incorporating areas that require further exploration. An update meeting will be held in September 2017 and these areas will be reviewed to determine whether additional actions should be added to the plan.

[13] Identifying and responding to suicide clusters and contagion: a practical resource (2015). Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf [accessed online 1/6/17]

Appendix 2

Actions have been categorised into a number of strategic themes:

- Communications
- Accessibility
- Pathways
- Stigmatisation
- Data
- Workforce

These were devised by partners during the 2016 suicide prevention meeting with the aim of providing a clear framework for the action plan.

Update on the 2016/2017 Action Plan

Strategic theme/s	Agreed action	Lead partner/s	Progress/Timescale	Outcome
Communications	**To clarify the processes around BTP referrals to the local authority of individuals considered to have needs under the Care Act.**	BTP	Clarified that referrals for people with needs under the Care Act are now working as they should; they are appropriately being sent through Social Care Direct. Referrals are of those who have been detained under a Section 136 by BTP or have received a BTP suicide prevention plan.	Action closed but work to be done by public health (PH) to understand concerns that inappropriate referrals are being made to Social Care Direct and BEH MHT by the Metropolitan Police.
Accessibility	**For the Joint Commissioning Unit (JCU) to review bereavement services.**	Paula Arnell/PH	The PH team has worked with the JCU to develop specific support by Barnet Bereavement Services for those	Action closed but updates will be provided to the group as the new

			bereaved by suicide.	service develops.
Pathways, Stigmatisation	**Barnet Voice to be put in touch with the council representative who deals with freedom passes to understand problems around the renewal of freedom passes for people with mental health problems, including why evidence from GPs is not being accepted; and determine how to address this.**	PH	Freedom Pass Renewals Improvement Group set up to review the process of issuing Freedom Passes. Identified that people with mental health problems were previously assessed in their own category which was not in line with the Department for Transport guidance. Now assessed under the category 'refused a licence, other than on grounds of persistent misuse of drugs or alcohol'. Recognised that this will exclude some people who had previously been eligible. Pass holders will be contacted three months before passes expire and will have the opportunity to appeal. GP evidence can be accepted for this category.	Action closed.
Communications	**Online safety work to be discussed with the Safer Communities Team.**	PH	An article on cyber-bullying, self-harm and suicide with tips for teachers was included in the school circular on 8th of February as part of Safer Internet Day and Children's	Action ongoing and carried over to 17/18 plan.

			Mental Health Week. The PH team is working with the communications department to circulate an article on cyberbullying, self-harm and suicide for parents. An online safety subgroup of the Barnet Safeguarding Children Board has been set up to strategically develop online safety work in Barnet. Work is taking place on an online safety award for primary schools.	
Communications	**For Barnet Voice and PH to revisit the production of resources on Barnet Voice's support services.**	PH/Barnet Voice representative	To be included in the Barnet community directory	Action closed
Pathways	**BTP and drug & alcohol services to communicate regarding alcohol and drug-related incidents on the railways, to identify entry into care pathways.**	Bridget O'Dwyer and BTP	Drug & alcohol services have followed up with BTP. There is an intention for joint working going forward, with BTP being able to signpost to drug and alcohol services.	Action closed but updates on the work between BTP and the drug & alcohol services to be provided at subsequent meetings.
Pathways	**The CCG to discuss the development of a framework for practices to analyse suicides and ensure sharing**	CCG	PH has carried out an audit of the coroner's data from 2011-2015. Access to certain information (e.g. last contact with primary care) was	Action carried over to the 17/18 plan and will involve the development of a template

	of good practice		limited which reduces the ability to draw reliable conclusions. The Coroner has agreed to update PH on relevant emerging areas of concern (e.g. new methods of suicide).	to collect data following SI involving patients under the care of General Practice. The national significant event audit guidance can be used to support this.
Accessibility, Pathways	**The CCG to discuss progress on auditing crisis and community services for patients readmitted to crisis services**	CCG	Action has been discussed with the CCG and plans are in place for commissioners in Barnet, Enfield and Haringey to complete a service review/service development plan of the Crisis Resolution and Home Treatment Team services by January 2018.	Action carried over to the 17/18 plan.
Pathways	**To look into the quality of accommodation that patients are discharged into.**	Housing Strategy Group	A weekly discussion takes place between the Trust/CCG and senior social care managers across Barnet, Enfield and Haringey regarding patients ready for discharge. For Barnet patients who receive a package funded by social care, a Brokerage Team will assist the allocated worker to find suitable accommodation, meeting eligible	Action closed.

			needs under the Care Act 2014. A joint housing and social care group considers referrals for housing through Barnet Homes where support is also required. If there is a continuing health care need the CCG will assess for a CHC funded placement or package of care.	
Workforce	**Adult Social Care to consider options for suicide prevention training for staff.**	PH	Adult Social Care staff undertook the self-harm and suicide prevention training commissioned by PH. Family Services are commissioning suicide prevention for their staff as part of the 'Child A' action plan.	Action closed but updates will be provided at future meetings.
Workforce	**PH to liaise with BEH MHT to create a resource for GPs and other healthcare professionals to support them to manage people with self-harm and suicidal ideation.**	BEH MHT	BEH MHT has agreed to develop a resource to support healthcare professionals.	Action ongoing and carried over to the 17/18 plan.

Appendix 2

2017/2018 Suicide Prevention Action Plan

The actions for the 2017/2018 plan have been developed based on local priorities, findings from the audit and the national suicide prevention strategy[19].

Strategic theme/s	Agreed action	Lead partner/s	Timescale
Communications	**To develop e-safety work in Barnet through the Barnet Children Safeguarding Board (BCSB) e-safety subgroup, ensuring strategic engagement with schools and parents.**	PH/BCSB e-safety subgroup.	Ongoing with a further meeting in July 2017
Data	**To develop a template to enable data collection following significant events, including suspected suicides and suicide attempts, involving patients under the care of General Practice.**	PH/Charlotte Benjamin	September 2017
Accessibility, Pathways	**Barnet, Enfield and Haringey commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.**	Enfield CCG	January 2018
Workforce	**BEH MHT to create a resource for GPs and other**	BEH MHT	September 2017

	healthcare professionals to support them to manage people with self-harm and suicidal ideation.		
Workforce	**BEH MHT to work with Primary Care to develop and deliver suicide prevention training for GPs.**	Charlotte Benjamin/BEH MHT	September 2017
Workforce	**To liaise with the DWP for BEH MHT to review their 'six point plans' and provide training to DWP staff to support the implementation of the plans.**	PH/BEH MHT/DWP	To revisit with DWP by November 2017
Communications	**To raise concerns about irresponsible reporting of deaths resulting from self-harm with Samaritans as these occur; and engage with the local media where appropriate to ensure that deaths are reported in line with the Samaritans media guidelines.**	PH	Ongoing
Pathways	**To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts.**	PH	September 2017

Pathways	**To understand the care pathway for people who present to the London Ambulance Service with self-harm, suicidal ideation or suicide attempts.**	PH	September 2017
Workforce	**To liaise with relevant partner organisations (e.g. Barnet Homes, older people's services) to ascertain training needs around identifying suicide risk.**	PH	March 2018
Workforce	**To work with relevant partners to understand schools' needs around suicide prevention; and to develop a suicide prevention pathway for schools and partners, linking with the Resilience and Healthy Schools programmes.**	PH	March 2018
Data	**PH to raise the possibility of collecting data at a BEH and London-level to explore suicide rates in migrant populations and according to occupation status with relevant colleagues.**	PH	September 2017

Appendix 2

Correlation with the national strategy

Barnet has already implemented, and plans to implement a number of actions that support the national strategy. These are summarised below.

National priority area(s)[19]	Barnet action(s)
Providing better information and support to those bereaved or affected by suicide	The PH team has worked with commissioners to develop specific bereavement support for those bereaved by suicide.
Tailoring approaches to improve mental health in specific groups: • **Children and young people** • **Users of drug and alcohol services** • **Perinatal mental health** • **People in receipt of employment benefits** • **Lesbian, gay, bisexual and transgender; black and minority ethnic; people with long-term conditions and people with untreated depression**	PH commissioned self-harm and suicide prevention training for staff working with children and young people. Family services are to commission suicide prevention training for social workers. An Online Counselling and Support Service for 11-25 yr olds has been commisioned and is currently being promoted across Barnet Schools A Resilient Schools Programme led by Public Health has been launched in the first 6 Barnet schools and a coordinator has been appointed. A new Emotional Wellbeing Team has been established in Barnet Council funded by Health Education England to support low/moderate anxiety/depression in young people who do not meet the CAMHS threshold of need. M.A.C UK/Reach is a new project in the process of setting up with the council to go live working with gang members and hard to reach individuals with mental health and high risk behaviours Barnet's Adult Substance Misuse Service and BTP are to work jointly to facilitate signposting of people involved in drug and/or alcohol-related events on the railways into drug and alcohol services. To engage strategically with schools and parents around e-safety through the BCSB e-safety subgroup. To work with relevant partners to understand schools' needs around suicide prevention; and to

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	develop a suicide prevention pathway for schools and partners, linking with the Resilience and Healthy Schools programmes. The PH team is to liaise with the Department of Work and Pensions regarding training from BEH MHT to support staff to implement six point plans. To liaise with relevant partner organisations (e.g. Barnet Homes, older people's services) to ascertain training needs around identifying suicide risk.
Supporting research, data collection and monitoring	The PH team has audited the North London Coroner's data from 2011-2015 to identify areas for potential intervention. PH and primary care are to work together to develop a template to enable data collection following significant events, including suspected suicides and suicide attempts, involving patients under the care of General Practice.
Reducing the risk of self-harm as a key indicator of suicide risk **Reducing the risk of suicide in high risk groups**	BEH MHT are to develop a resource for GPs and other healthcare professionals to support them to manage people with self-harm and suicidal ideation. BEH MHT is to work with Primary Care to develop and deliver suicide prevention training for GPs. To understand the care pathway for people who present to the London Ambulance Service with self-harm, suicidal ideation or suicide attempts. To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts. Barnet, Enfield and Haringey commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.
Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour	To review local news stories reporting on deaths from self-harm and raise any concerns with Samaritans to ensure that deaths are being reported responsibly.

Conclusion

The 2017/2018 report and action plan, which will be presented to the Health and Wellbeing Board in July 2017, shows clear areas of progress since 2016/2017 (e.g. development of a targeted approach to supporting people bereaved by suicide, an audit of the coroner's data).

Consideration must be given to how the coroner's data should be used going forward. The small number of deaths at a borough-level does not provide sufficient statistical assurance on which to base population-level interventions. Where it may be of particular value however is through the support of learning and improvement in local services; and in the identification of suicide clusters and contagion. Going forward there should be exploration of data collection at the level of Barnet, Enfield and Haringey, or across London which would provide a stronger evidence base for population-level interventions.

It is important that partners take responsibility for their actions, and any difficulties achieving what is required should be brought to September's suicide prevention update meeting for discussion with the group. Where the group or responsible partner feels that an action that was previously agreed can no longer be achieved, a decision must be made as to whether to remove that action from the plan.

Proposals are being put forward for a BEH MHT suicide prevention strategy or plan; the Barnet Public Health team will be participating in the development of this work. This will support staff and carers following a suicide, and implement the recommendations for secondary care from the National Confidential Inquiry into Suicide and Homicide which will support local suicide prevention efforts.

Appendix 1

Methodology for coding deaths by suicide

To get an understanding of the coding process a discussion was held with a Senior Research Officer at the Office for National Statistics (ONS). The ONS defines suicide as all deaths from intentional self-harm for persons aged 10 and over, and deaths of undetermined intent in those aged 15 and over. Further detail on the coding of deaths by the ONS is included in appendix 1.

Deaths of undetermined intent are those that result from self-harm (e.g. poisoning) but where there is insufficient evidence to suggest that the person intended to end their life. The ONS codes suicide deaths under the following ICD-10 (International Classification of Diseases) categories:

- Intentional self-harm
- Injury/poisoning of undetermined intent

Coding is based on the information obtained from the Coroner's office. This information includes not only the Coroner's conclusion but the circumstances surrounding the death. Deaths are included or excluded in the ONS statistics as follows:

Coroner's conclusion	**Inclusion in the ONS data**
Suicide	Yes
Open	Yes
Accident/misadventure	No, but some drug deaths fall into the category of misadventure and would be included if there was insufficient evidence to exclude intent.
Alcohol/drug related	Possibly, if there was insufficient evidence to exclude intent.
Road traffic accidents	No
All other verdicts	Yes, where death resulted from self-harm.

Appendix 2 delete

The table below shows the breakdown of individuals who died in and were residents of Barnet by country of birth, and the suicide rate in each group.

Country of birth	No. of people in the audit population who died in Barnet and were resident in Barnet (2011-2015)	Percentage of the audit population (2011-2015)	No. of Barnet residents according to country of birth (2011)	Suicide rate per 100,000 (95% CI) 2011-2015
UK (England, Northern Ireland)	65	48.9%	212,496	6.1 (3.3-10.5)
Western Europe (Republic of Ireland, Spain, Germany, France)	8	6.0%	11,252	14.2 (1.0-57.0)

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Healthy London Partnership

Thrive LDN:
A citywide movement to improve the mental health and wellbeing of all Londoners

London Health & Wellbeing Board Chairs Network

15th June 2017

Supported by and delivering for:

Public Health England

NHS

SUPPORTED BY MAYOR OF LONDON

LONDON COUNCILS

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

What is Thrive LDN?

Thrive LDN is supported by The Mayor of London, Sadiq Khan, and is led by the London Health Board, along with many public, private and charitable organisations. It has been developed with the support of Londoners, including people with lived experience of mental health.

Thrive LDN has **five thematic areas** these include:

- Improving people's understanding of mental health
- Thriving Communities
- Children and young people
- Employment
- Suicide prevention

What is Thrive LDN?

Thrive LDN
towards happier, healthier lives

Collective identity	▪ Thrive LDN is a collective identity for mental wellbeing in the capital. ▪ This identity aims to resonate with both the diversity of the system and diversity of London's communities. ▪ It will offer people the opportunity to join around and localise a collective purpose for mental wellbeing in London.
Citywide movement	▪ Thrive LDN is a citywide movement to improve the mental wellbeing of all Londoners. ▪ It aims to energise and mobilise Londoners to think, talk and act more about mental wellbeing. ▪ Through this intention, it will offer people the opportunity to coproduce thriving communities with London's public, private and charitable sectors.
System partnership	▪ Thrive LDN is a systems partnership of London's public, private, charitable and community sectors to identify and deliver actions once for the whole of London. ▪ It aims to bring a broad range of competing initiatives together to look at what is best done at a citywide level. ▪ It is an opportunity to galvanise leaders from different parts of the system around areas of mutual interest and action.

Journey of Thrive LDN

Thrive LDN
towards happier, healthier lives

The development of Thrive LDN began in April 2016 and has involved many conversations with a range of people and organisations.

A range of activities were held to establish the scope of Thrive LDN, engaging with over 200 people from a variety of different backgrounds.

The Mayor of London formally launched his intention for Thrive LDN in December 2016.

The five thematic areas consisted of task and finish groups working with professionals and those with lived experience; these groups recommended outputs for each area.

The complexities of a citywide approach

There is a recognition that many activities that influence health and wellbeing happen locally, with both public sector and charitable organisations often operating at a borough level.

There are, however, times when working at a London level is an advantage to help ensure consistency, and guarantee good work is recognised and shared.

The complexity of partnership working cannot be underestimated. A city wide approach leverages both political support and status to our work and **increases the impact to galvanise the system and Londoners to step up.**

Within London there is a strong history of collaboration in recent years. For example:

- The London Health Board (LHB) and other partners have developed ten ambitions for London to help **our capital become the world's healthiest city**
- Local Government and the NHS are working at borough level to better integrate care and support for local people
- We are also seeing sub regional and regional integration. Devolution principles of subsidiarity and additionality align to Thrive LDN's principles

Tangible Outputs from Thematic Areas

Task and Finish Groups were set up for each of the thematic areas, the following provides the key tangible outputs from them.

Improving Understanding of Mental Health	▪ Whole community campaigns, school based interventions, individual training programmes and websites with information. ▪ Mental health first aid training as part of individual training programmes. ▪ School based Interventions linked with Mind's initiative Time To Change (TTC) children and young people (CYP) work.
Community Resilience	▪ Social prescribing has potential to reduce the gap: supporting work opportunities and 49% of CCGs supporting social prescribing. ▪ 20% of patients presenting to a GP have a social problem, lack of job or other. Identify how Thrive LDN can support social prescribing and other enabling mechanisms to connect the world of formal health and care services with local communities. ▪ A healthy good job is a sustainable health outcome.
Children and Young People	▪ School based mental health literacy campaigns linked with TTC CYP work. ▪ Reduction in the arrest and charge rates of looked after children.

Tangible Outputs from Thematic Areas

Employment	▪ Work with SMEs and extend the Individual Placement and Support (IPS) as part of the devolution work. ▪ Work with the DWP work and health programme for those with a long-term condition and long-term unemployed. ▪ TTC Employers pledge can feed into the broader Mayors Healthy Workplace Charter, perhaps with it being a component of it. The proposed pledge to be considered with the TTC pledge in mind so as not to duplicate. ▪ Thrive LDN will use the launch in July to help promote the TTC Hub application process, and will have discussions with areas they know which may have a strong case for a hub, potentially using STP footprint areas as well as/rather than borough level
Suicide Prevention	▪ Links with local suicide prevention plans to reduce number of suicides. ▪ Child Death Overview Panel (CDOP) work across London to link in with 0-18 aged avoidable deaths. ▪ Suicide prevention through reducing access to medication as a means working with Primary Care, taking an approach similar to the HLP Asthma Campaign.

Opportunities for Thrive to add value

Prevention Opportunities (in alignment to STPs and Devolution)

Working at a London level to **galvanise public health to spread and scale primary interventions** which could add value and help prevent mental illness.

Plus having a **targeted approach** towards populations at high risk of mental ill health or those who experience higher levels of stigma could help **reduce the level of prevalence of mental illness** within these cohorts.

Moreover by supporting the Time to Change campaign we can help **reduce the level of mental health related stigma across London**

Establishing links with local suicide prevention plans to **reduce number of suicides in London**

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Opportunities for Thrive to add value

Social prescribing:

The Thrive LDN movement can help support social prescribing and other enabling mechanisms to **connect the world of formal health and care services with local communities.**

One of the Health Inequality Strategy's key objectives is to **mainstream social prescribing across London**, by supporting the community and voluntary sector, thereby increasing volunteering opportunities, improving health literacy, and communities' ability to engage in social action.

Opportunities for Thrive to add value

Suicide and Thrive LDN:

London will commit to and **promote a 'zero suicide aspiration'** whilst supporting the system to deliver against the 10% reduction of suicide rates as required by the MHFYFV.

System-wide action to improve data gathering so we can better understand why people complete/attempt suicide which will help inform and improve prevention and interventions.

Working with coroners to develop a 'true picture of London' to explore how we can better inform Londoners about where to go for support and how this can be improved.

The overall aspiration is to ensure that London is provided with education-based resources that can be deployed across sectors **to deliver age appropriate and culturally sensitive suicide and prevention awareness and education sessions.**

Mayor's manifesto promises

The London Health Board committed to explore the potential for a 'mental health roadmap' for London in December 2015 which has through a process of stakeholder engagement become Thrive LDN.

Mental health and wellbeing is prominent in the Mayor's manifesto:

- A commitment to greater support for mental health
- Leadership of a campaign to break down the stigma of mental illness
- Improvements in the availability of information and support
- Encouraging better joint working between boroughs, health services, police, transport and voluntary sectors when dealing with people with mental health issues

Mental Health is a priority of the Health Inequalities Strategy (HIS) which is due to go out to consultation in July 2017.

Community engagement through the launch of Thrive LDN (4 July) will allow public, private and voluntary sectors to work more collaboratively.

Plans Going Forward - Thrive LDN launch

Thrive LDN will only succeed by **working with people across London and continuously developing plans based on their feedback.**

Therefore, how we communicate about Thrive LDN and **how we include people and communities in its development is a key component** of Thrive LDN's purpose

The official launch for Thrive LDN is the 4th July. The Mayor (alongside LHB partners) will launch Thrive LDN's first publication, detailing the work of the Task and Finish Groups and setting out our plans for next year.

Over the summer period **Thrive LDN aims to reach 2 million Londoners**, and have approximately 100,000 interactions across the city.

These interactions include a TfL poster campaign, Problem Solving Booths across London, and utilising the Talk London platform.

A "Collaboration with Londoners" will be launched to build the movement throughout the summer and encourage all Londoners to take action to improve their mental wellbeing and support local initiatives that improve others' mental wellbeing.

London Borough Engagement

Thrive LDN
towards happier, healthier lives

We want to work with London Boroughs and have a tailored approach for local areas depending upon the needs of the community

- Between September-October we will hold sub-regional events with at least one representative from each political group.
- We have previously engaged with Cllr Mental Health Champions, therefore this engagement will look to build on this, with the aim to involve as many Councillors as possible.
- The dates of the sub-regional events will be circulated once the details have been confirmed.

Keys Points to Consider

- ***What is your vision for the future of mental health in London?***
- ***How can HWB Chairs do to help engagement?***
- ***Are Thrive LDN's ambitions aligned to those in your local area?***
- ***How can Thrive LDN add value to existing mental health initiatives?***
- ***What are the barriers/critical success factors?***

Healthy London Partnership

For further information about Thrive LDN:

Twitter - @ThriveLDN
Email - thrive@london.gov.uk

Supported by and delivering for:

Public Health England

NHS

SUPPORTED BY MAYOR OF LONDON

LONDON COUNCILS

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

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AGENDA ITEM 10

	Health and Wellbeing Board **20 July 2017**
Title	**Joint Health and Wellbeing Strategy (2015 – 2020) progress update including Care Closer to Home**
Report of	Strategic Director of Adults, Communities and Health, LBB Strategic Director of 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 – Joint Health and Wellbeing Strategy Progress Overview
Officer Contact Details	Kirstie Haines, Adults Wellbeing Strategic Lead Kirstie.haines@barnet.gov.uk Emma Coles, Safeguarding Adults Board Business Manager Emma.coles@barnet.gov.uk

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 including an update on Care Closer to Home.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on progress to deliver the Joint Health and Wellbeing Strategy (2015-2020) including Care Closer to Home.**

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 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

[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

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 people to gain and	Assure promotion and uptake	Work to integrate health and

		retain employment and promote healthy workplaces	of all screening including cancer screening and the early identification of disease	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 receive progress reports at every other 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 March 2017, against the priority areas in table 1, progress is reported as:

- Green – 45% (5 areas)
- Green / amber – 9% (1 area)
- Amber – 36% (4 areas)
- Red – 9% (1 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 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 however, using the existing resources of the participating organisations.

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

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Appendix 1: Joint Health and Wellbeing Strategy progress report, March 2017 - June 2017

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

<table>
<tr><td>Theme</td><td colspan="2">Preparing for a healthy life</td></tr>
<tr><td>Objectives</td><td colspan="2">Improving outcomes for babies, young children and their families</td></tr>
<tr><td>Area of focus (1)</td><td>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.</td><td>AMBER

Date of substantive report to HWBB:

TBC</td></tr>
<tr><td>Progress since March 2017</td><td colspan="2">Health and wellbeing of looked after children (LAC)
Two young people, placed out of borough, have not had their IHAs completed so a consultant from Barnet is going to visit the young people in June 2017 to complete the IHAs.
Of the 12 children and young people who required an IHA in March, almost all (11 out of 12, 92%) were seen within the timescale. The remaining review is out of borough, the team continue to chase that this is completed as soon as possible.
Of the 6 children and young people requiring an IHA in April, 100% were completed within the timescales.
From data received at the end of May there had been nine entries into care; 1 IHA completed, 1 DNA and rebooked, 5 IHA booked, 1 remand (requested), 1 no longer LAC.
Significant improvements have been seen regarding IHA performance (being within statutory timeframes). Performance has improved from 50% in January and 19% in February to 92% for March and 100% for April which can be attributed to:
Considerable work with the GPs and stakeholders to improve the pathway
The nursing team increasing the number of reminders that young people and foster carers receive</td></tr>
</table>

	prior to the appointment which includes calls and emails the day before the appointment • Improved communication and working between CLCH and social care (including placements) • Previously key workers were reporting that no-one was able to attend appointments with the young people, this issue has now been resolved • Independent Reviewing Officers are now involved in any key issues, this has been particularly helpful for out of borough placements. **Review health assessments (RHAs)** In quarter 4 of 2016/17, 74 RHAs were completed 98% within the timescales. Five young people did not attend appointments in January and were seen in February, March and one in April. A thematic analysis of the review health assessments completed in this period found that: • There was one case with child sexual exploitation concerns and was known to MASE • Three had recognised learning disabilities • Four were referred to CAMHs • Two were referred to a GP regarding concerns about their weight. **Locally based placements** On Thursday 25 May the Corporate Parenting Advisory Panel reviewed performance information for a range of indicators relating to the provision of service and outcomes for LAC and care leavers[1]. In the data reported, external residential placements had risen from 9.4% the previous month to 10.4% which is above the target tolerance monitor of 9.6% due to an increase in the numbers of children exhibiting challenging behaviour and those with complex needs e.g. children with concerns linked to Child Sexual Exploitation. Also, LBB foster placements (including kinships) had reduced from 46.5% to 43.1% due to fostering not being the preferred choice and children with challenging behaviour or complex needs needing additional support / preparation work in specialist residential provision.
Planned activity	• The IHA process has improved significantly, however, there are still delays in the LAC Health Team receiving the IHA report from health professionals. The Team is working with health professionals to improve this.

[1] Corporate Parenting Advisory Panel - https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=208&MId=8790&Ver=4

	• Review and redesign the process for IHAs • Designated Medical Officer to continue to quality assure reviews and support quality improvements • Continue to monitor the completion of IHAs including looking at IHAs for specific cohorts such as children with Special educational needs and disabilities (SEND) • LAC IHA Stakeholder meeting continues to meet but quarterly • To track, monitor and reduce numbers of external residential placements • Action for LBB foster placements: to increase numbers of therapeutically trained foster carers to undertake specialist placements.	
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:** September 2017
Progress since March 2017	All children centres in Barnet have now achieved the Healthy Early Years standard. Public health has been working closely with NHSE and PHE and has developed a project plan to increase MMR uptake using targeted approach. Public Health arranged two childhood immunisation trainings for children centre staff which have been delivered by PHE. The purpose of the training was to increase take-up of childhood immunisation and ensure coverage across the demographic groups in Barnet Barnet supported the European immunisation campaign by using WHO resources and promoting the week through a variety of social media platforms. Children centres were also provided with campaign resources and were encouraged to support the campaign. Public Health has informed GPs about the current uptake rates in Barnet. GPs have been encouraged to increase uptake and aim to reach the London average rate.	
Planned activity	Public health will work with NHSE and PHE to identify barriers to uptake in Barnet.	

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** October 2017
Progress since March 2017	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. The decision has been made to pilot the new way of working in the East-Central Locality area – starting from September 2017 – and a lead partner for the area has volunteered to lead the partnership work. The pilot will include early years, family support, youth services, children's health and voluntary early intervention services. The pilot model has been shaped using feedback from young people and from partners. If successful, the model will be rolled out across the borough over the next 18 months.	
Planned activity	East-Central Hub Development Group will continue to meet over the next three months to develop the detail of the model. Pilot to go live in September 2017. Decision on future delivery of children's health services (Health Visitors, Family Nurse Partnership and School Nursing) also due September 2017. Evaluation of model in February/March 2018.	
Theme	Wellbeing in the community	
Objectives	Creating circumstances that enable people to have greater life opportunities	

Theme **Objectives**	Wellbeing in the community Creating circumstances that enable people to have greater life opportunities	**GREEN** **Date of substantive report to HWBB:** September 2017
Area of focus (4a)	**Mental health** remains a priority, as reflected in the NCL STP and local plans such as CYPP and H&WBB strategy 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 re commission CAMHS at the HWBB in September 2016 • Public health are supporting the redesign of Children's Mental Health & Wellbeing services; 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: September 2017	
Progress since March 2017	**Child and Adolescent Mental Health Services (CAMHS)** • The CAMHS procurement is proceeding with a number of key milestones already achieved including o CYP Emotional Health and Wellbeing consultation was undertaken in conjunction with the councils Voice of	

	the Child team with 400 young people including pupils of 25 schools (inc primary, secondary, special, faith based and a PRU), Youthorium 2017 youth convention at the Allianz Park and a further 7000+ online (concluded April 2017) o PIN was issued On 12th April 2017 o Procurement Soft Market Launch event at the Allianz Park Stadium in May attended by a substantial number of providers including several from the VCS o Outline service model has been developed and presented to potential providers o Face to face Soft Market Testing (competitive dialogue) sessions have taken place throughout May and June with a range of provider organisations interested in bidding for the new services contract o As a result of feedback from these session the procurement timeline has been extended to 1st April 2018 o CAMHS Procurement Implementation Group has been established and meet on a weekly basis o CYP Emotional Wellbeing and Mental Health Operational Group has been established to ensure cross programme awareness and support delivery **Expansion and Development of Children's Mental Health & Wellbeing services** • Following consultation with Barnet's Children and Young People, we have commissioned an Online Counselling and Support Service for 11-25 yr olds called Kooth which is currently being promoted across Barnet Schools • We have established a Resilient Schools Programme led by Public Health which has been launched in the first 6 Barnet schools (2 secondary, 2 primary and 2 specialist schools). • A Resilience Schools coordinator (Jayne Abbott) has been recruited • A new Emotional Wellbeing Team (4 trainees and manager) has been established in Barnet Council-funded by Health Education England in the first year- to support low/moderate anxiety/depression in young people who do not meet the CAMHS threshold of need. The team is being embedded into the councils service structures • M.A.C UK/Reach is a new project in the process of setting up with the council to go live working with gang members and hard to reach individuals with mental health and high risk behaviours
Planned activity	Undertake a series of procurement workshops in preparation of going to market to design light touch regime offer based upon feedback from the SMT competitive dialogue sessions Creation of a suite of documents to form part of the information supplied as a legal requirement of procurement process Offer to be formally published in Official Journal of the European Union in August/Sept 2017

	CYP IAPT capacity building opportunities to be investigated with support offered throughout Barnet Council, VCS organisations and NHS trusts meeting due in July with a view to bidding for funds later the year Extension of crisis care offer to be negotiated with current providers with a view to a service being offered at weekends Decision due in July 2017 Opportunities for VCS capacity building programmes to be explored with umbrella organisations such as Young Barnet Foundation and Community Barnet meeting to take place in July 2017 Mental Health First Aiders in Schools programme to be co-produced with Hendon School and Public Health and Rolled out throughout Barnet in next academic year 2017/18 Continue to support the UNICEF Child Friendly Communities programme implementation. Next meeting due in July 2017	
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 March 2017	**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 Primary Care link working and Wellbeing Hub: - 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. - Since the last report referrals to secondary care from primary care have been minimised. There are around 40% fewer referrals and there are fewer inappropriate referrals, 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 Coverage rolled out across all Barnet localities in January 2017 and referrals have been received from all 62 practices – each practice now has a named, dedicated Linkworker o GP Practitioners promote the direct benefits of the Linkworker and integrated service to their colleagues. Dr Holz attends Team meetings monthly to support solution-focused approaches. Linkworkers are attending Practice meetings to meet with all GPs and promote the service. o There has been some turnover in the team recently, due to promotion, and new Linkworkers are being recruited. o Patient feedback is positive – “it was the best assessment I have ever had in many years of using services!” GPs continue to praise the service for supporting them with advice on referral pathways to community services and assessments for patients with complex needs. o Direct links with the wider collaborative are key to the success of the service with the following organisations attending team meetings: MARAC, Employment and Benefit Support Agencies, Bright Futures, Westminster Drug Project, Eating Disorder service, Future Paths, SOLACE, and Twining Employment. The Wellbeing Hub had its official launch at the Reimagining Mental Health meeting on 9th February 2017. The

	Wellbeing Hub continues to grow and provide a single gateway for mental health earlier intervention services. The new service model and resulting pathways have been designed to support the customers experience and apply strengths based practice. More people with mental health issues will receive support focused on helping with their whole life, for example, getting a job and a home of their own. The new model maintains partnership working with health whilst increasing focus on holistic support and access to the community. Joint pathways with partner organisations are established and there is a shared commitment to support individuals and work collaboratively. Staff have undergone joint training with Linkworkers, the Network staff and community based staff and are delivering Emotional Health Checks in the community A task group has been set up to continue building relationships with community organisations. The Network has developed stronger links with the Wellbeing Hub and has established a weekly joint referral meeting and a drop in session for the Wellbeing centre at the Network building. The Network, the Wellbeing Hub and a Hub Link Worker lead meet weekly to discuss cases which are open to more than one service. Most significant and measurable results: 1. Primary Care Linkworkers achieved an overall 40% reduction in referrals to secondary care from South Barnet since commencement of linkworker service. A total of 2,103 referred patients have received the service since August 2016. 2. Did not attend rate below 10% target (May 2017 – 5.45%) 3. Average of 94% of a total 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	Evaluation of the Primary Care Linkworker and Wellbeing Hub models – Dr Mike Scanlan has recommended a number of measures to embed the services. These are being considered and follow up to be determined. Work continues to ensure the IT systems are effective and the aforementioned task group will continue to build on community links and provide a critical eye to the service as it continues under the new model.

	Commissioners are working with the Wellbeing Hub and Mind Matters (IAPT) to offer a wide range of psychological therapies to reach more people in the community. Work is continuing to join up services with IPS and MAPs. Other step down pathways are being considered to deliver better outcomes from acutes and to continue to prevent admissions. Services are commencing phase 3 redesign of integrated Wellbeing Services through integrating IAPT, Wellbeing Hub and services and Talking Therapies. Further planning is expected to focus on greater integration within the Care Closer to Home agenda and continue to support local mental health developments for the NCL STP.	
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 March 2017	**April 2016 – March 2017** **Employment and healthy workplaces (good progress)** • Individual Placement and Support (IPS): The service has engaged 78 residents and secured 46 jobs during the year. The performance compares favourably against national benchmarking. We have enter into a Social Impact Bond co-commissioning arrangements which has brought in additional funding in 17/18 and the CCG are considering giving consideration to the future of the service as part of its wider review of mental health services. • Motivational and Psychological Support (MAPS): The service received 432 referrals, engaged 216 residents and	

	helped 64 residents to move into jobs during the year. • The council's community based Jobs Team in Burnt Oak has supported over 800 people since March 2015 and supported 300 people into work. In early 2017 the model was replicated in the south of the borough around Childs Hill and Golders Green. • Barnet's employment support services have received attention regionally and nationally with several visits from the Department of Work and Pensions. They have been recognised as models of good practice and have helped inform the ambitions outlined in the London Thrive programme. **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: o Specialist employment support for ASC learning disabilities clients (IQ under 70) o Supporting mental health clients to retain employment o 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.	
		Date of substantive report to HWBB: TBC

Theme	How we live	
Objectives	**Encouraging healthier lifestyles**	
Area of focus (6)	**Reduce excess weight in children (10 – 11 years old) (overweight and obese)** Year / Target / Reported 2016/17 / 32% / Current (2016/17 quarter 2) – 32.58% 2017/18 / 32.6% 2019/20 / 32.6%	**GREEN**
	Reduce excess weight in adults (overweight and obese) 56.8% 2016/17 Year / Target / Reported 2016/17 / 56.8% / Current (2016/17 quarter 2) – 56.75% 2017/18 / 57.8% /	**GREEN / AMBER**

	2019/20	57.8%		**Date of substantive report to HWBB:** September 2017 (as part of Public Health's performance report)
Progress since March 2017 and planned activity	**Children's Weight management** • Public Health team participated on Pan London conversation on childhood obesity – Great Weight Debate. Report produced and uploaded to Council website. • Support to the development of the Healthy Weight Strategy to define objectives for the strategy. • Tier 2 targeted service still continues to offer weight management services to children who are over-weight and obese (between > 91st centile to > 98th centile). The service has been evaluated and evaluation report with recommendations will be shared with stakeholders in Sept 17. • Planned activity includes reviewing of KPI's, scoping the possibility of teenage offer as part of the healthy weight pathway and implementing recommendations from evaluation. • A working group will meet to develop a strategic action plan based on HW Strategy objectives. • Planned re-procurement of T2 services to begin in August 2017. Adult Weight Management The development of the Healthy Weight Strategy has been informed by a stakeholder event, and the draft is in progress. This has been delayed by staffing issues and will be back on track shortly. There has been a range of work which relates this this area however and an intention to incorporate healthy weight objectives			

	on a systems wide approach. These include: A focus on the built environment and how we can maximise the built environments role in encouraging healthy lifestyles for all residents. We are working with planners and planning commissioners to integrate health outcomes into planning decisions, regeneration and growth (on-going) and are part of a national pilot with the Town and Country Planning Association to engage planners in public health outcomes. The healthier catering commitment has continued with substantial support and an awards ceremony took place in Sept with another planned for Sep 2017	
Area of focus (7)	**Increase screening uptake** • Target: increase screening uptake	**RED** **Date of substantive report to HWBB:** TBC
Progress since March 2017	It is intended that the NHS screening assurance group (which draws together a range of statutory and voluntary/community sector partners with an interest in screening) supports NHSE with the production of performance reports and suggesting possible actions to promote uptake in localities. NHSE have been approached to propose a schedule of work. Locally there will be a campaign in June focused on promoting uptake of cervical screening. Jo's trust, a national charity, will be holding 2 days of events in the borough. The communities together network have also been approached to explore potential ways in which community partners might be able to support promotion efforts.	
Planned activity	To support NHSE in reviewing reporting once they are able to engage. Summer cervical cancer campaign.	

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**	**AMBER** **Date of substantive report to HWBB:** July 2017
Progress since November	Care Closer to Home Programme - progress update on Governance, project activity and links with Adult Social care New Operating Model Governance: • Membership of the Joint Commissioning Executive Group has been expanded to include providers (CLCH NHS Trust; Royal Free London NHS Foundation Trust; Barnet, Enfield & Haringey Mental Health Trust; Barnet GP Federation and LB Barnet Adults & Communities Delivery Unit) and the group has been rescheduled as the Joint Commissioning Executive, Care Closer to Home (CC2H) Programme Board. • The JCE CC2H Programme Board has approved the development of a Care Strategy and held a workshop style discussion on the vision and aspirations for Care Closer to Home, which will be written up into a report and presented to the HWB at a later date. • The CEOs of LBB, BCCG, Royal Free, CLCH, BEH, the GP Federation and the BCCG chair, have met to discuss their shared aspirations for new delivery models on the Barnet footprint and have collectively confirmed their support for exploring the potential of new delivery models as part of the CC2H Programme. Project Highlights: • Expressions of Interest received from 5 CHIN groups in Barnet – 3 CHINS approved, the first CHIN in Burnt Oak, covering 5 GP practices and a population of 51,000 will go live from 1 October 2017. • The CHIN will work under the governance arrangements of the Barnet Federated GPs Ltd who will also oversee the development of QIST (Quality Improvement Service Teams) that will be integral to the development of the CHIN and its quality improvement programme. • QiPP savings for this year have been identified and mapped to CHIN delivery at an HRG level.	

	• Practice level data has been produced to inform CHIN objectives, but requires refinement. • CHIN and QIST development is being overseen by the NCL Care Closer to Home Board and the Joint Consultative Executive Group (JCEG) which is jointly chaired by the Local Authority and CCG. • It has also been agreed that CHINs will need to have links and pathways to strength based social care operating model and early intervention Adult Social Care New Operating Model: Strength Based Practice and 'Care Space' Hubs: • The council has implemented strengths-based social care, a delivery approach which encompasses social work and occupational staff working in a strengths-based way with service users and carers. • Staff are working in the community, in specially developed Care Spaces (Assessment Hubs) or co-located with the voluntary and community sector; and increased signposting, prevention and early intervention. • Strengths-based social care aims to promote resilience for service users and carers, improve quality of practice, and reduce the reliance on funded packages of care. • A strengths-based practice training programme was co-developed through a successful pilot in Quarter 1 last year and rolled out across the A&C operational teams in Quarters 2 and 3; the programme was shortlisted for the Creative and Innovative Social Work Practice award at the Social Worker of the Year awards. • CareSpaces were rolled out across the borough, enabling operational teams to make stronger links with local communities and service users to have better access to community resources, with two hubs (the Independent Living Centre and Anne Owens) co-located with local voluntary and community sector (VCS) organisations.
Planned activity	Governance/Project Activity : • Officers from BCCG, LBB and the Federation will develop a joint resourcing and programme delivery plan to support the development of CHINs and QISTs across Barnet. • In July the JCE CC2H Programme Board will consider a report on the Local Area Co-ordination work and prevention services in Barnet. • The Board will also oversee the delivery of other STP-driven initiatives that require local delivery. This work will be developed over time and is likely to include prevention, children and young people, mental health and elective care. • Engage and identify practices interested in taking part in the CHIN to ensure population coverage • Identify the support requirements needed by the CHIN including clinical and managerial leads

	• Agree and approve CHIN governance arrangements • Develop the leadership and partnership from across health and social care and establish CHIN management board • Work with partners from public health and Business Intelligence to understand the specific needs of the CHIN population. • Identify the outcomes the CHIN(s) aspires to improve • Set out proposed model for achievement of outcomes for approval by CCG/JCEG • Prepare Business Case for approval of CHIN outcomes including financial budget to support changes • Identify the CHINs approach to engaging with local people and support required from partners • Mobilise changes identified to key pathways to deliver agreed outcomes Strengths Based Practice: • Further work will take place during 2017/18 to embed and enhance the strengths-based model. Five priority themes for on-going change and improvement have been identified: Evolving Practice, Embedding and improving services, effectively working together, Empowering and engaging others. • Examples of the improvement initiatives include a dedicated resource for strength based coaching; enhanced links between quality board, panel and customer feedback; developing prevention and local area coordination, continued front door transformation, increased targeted use of new services provisions (e.g. shared lives and telecare) • Continuing to explore options for Care Space hubs	
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)	**GREEN**

		Date of substantive report to HWBB: TBC
Progress since March 2017	Good progress has been made on the Carers and Young Carers Strategy Action Plan for year one and the year two action plan has been drafted. The new contract for integrated support services for carers and young carers continues to be delivered and is performing well. The support offered through this contract includes:- • Carrying out statutory carers assessments • Delivery of the Carers Emergency Card Scheme •Hospital support service for carers and young carers – service • Better digital resources- on-going • Improved employment support for carers • Better engagement with schools regarding identification and supporting young carers • Activities and peer support for carers and young carers • Mentoring for young carers • Better engagement with schools regarding support for young carers • Activities for carers and young carers The Lead Provider continues to engage with carers and young carers regarding the quality of services and in considering gaps in service provision and is engaging with carers and young carers whilst developing new carers support groups and activities and developing new services. • LBB continues to be a member of 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 The Council are in year two of delivering a Specialist Dementia Support Service for adults with dementia and their carers focused on helping to improve their health and wellbeing, maximize their independence and help sustain carers in their caring role. Support offered through the service includes assessments, support planning and providing training and information and advice to carers of adults with dementia and information and advice and activities focused on reminiscence to adults with dementia. • The Council will again be promoting and supporting carers week 2017 with the Lead Provider 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. . Family Services have commissioned specialist training for their staff on supporting young carers they come into contact with and this training is being offered to practitioners in Family Services and Adults and Communities. The Provider for carers and young carers support services is also offering training to young carers. Extensive engagement has also been carried out in various forums promoting supporting carers and young carers and applying a whole family approach to support offered including the Family Service Practitioners Forum, Adults and Communities staff and the A&C Voluntary Community Sector Forum
Planned activity	• To continue to carry out extensive engagement to promote supporting and helping to identify carers and young carers to stakeholders with a particular focus on health settings. • To continue to deliver the carers and young carers strategy action plan for year two • To continue to expand the carers support offer within Barnet • To continue to promote the employers for carers scheme with local SME's in Barnet • To continue to deliver regular training to staff within Adults and Communities and Family Services regarding identification of carers and young carers, support available and applying a whole family approach to support offered

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AGENDA ITEM 11

	Health and Wellbeing Board **20 July 2017**
Title	**Adults Engagement Strategy Update**
Report of	Adults and Communities Director
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 – Working groups update summary Appendix 2 – Guide to good engagement Appendix 3 – Information working group report
Officer Contact Details	Ella Goschalk, Engagement Lead, Adults and Communities Email: ella.goschalk@barnet.gov.uk Tel: 020 8359 4712

Summary

The new Adults and Communities Engagement Strategy and structure has been in place since the summer of 2016.

This report brings an update on progress to date including:

- The work of the Involvement Board
- Outcomes of completed working groups
- Working groups currently in progress and expected outcomes
- People Bank update and wider engagement
- Other concerns raised by Resident Representatives
- Plans for the annual Engagement Summit

The link between Health and Wellbeing Board, the Involvement Board and engagement activity is important and will continue to be crucial to the success of engagement activity.

This report was written collaboratively by officers and Resident Representatives from the Involvement Board.

Recommendations

1. **That the Health and Wellbeing Board note the progress made to date as part of the Adults and Communities Engagement Strategy.**
2. **That the Health and Wellbeing Board continue to support and champion engagement activity in social care and health.**
3. **That the Health and Wellbeing Board note and comment on the completed Guide to Good Engagement and support with its dissemination and use.**

1. WHY THIS REPORT IS NEEDED

1.1 In January 2016 a report was brought to the Health and Wellbeing Board outlining draft proposals of the review of the engagement structure.

1.2 The Board agreed that there would be a reporting line between it and the new Engagement Structure, with an update every 6 months.

1.3 A report was brought to the Board in November 2016, and this report brings a further update on progress since that date.

2. REASONS FOR RECOMMENDATIONS

2.1 The Involvement Board work plan has been progressing well, and is outlined in more detail in Appendix 1.

2.2 Five working groups have now completed their projects:

- Guide to good engagement
- Information: Web re-design
- Dementia information
- Community equipment and telecare
- Crisis intervention and early intervention: Crash Pad service design

2.3 Each of these working groups has co-produced a product or plan which will have a clear impact.

2.4 The **Guide to good engagement** working group focused on designing a guide for Council and CCG staff, as well as other professionals and organisations who engage with older people and people with disabilities.

2.5 This was a piece of true co-production, and gives clear and straightforward guidance to professionals about what to consider when doing a piece of engagement work.

2.6 Working group members commented that this was a really good piece of work that all contributed to.

2.7 The **Information and advice group** focused on re-designing the carers' web pages of the Council website, which can be seen at

https://www.barnet.gov.uk/citizen-home/adult-social-care/welcome-to-carers.html

2.8 Working groups made up of People Bank members were combined with testing in the community, involving people at Mencap, Age UK and Carers Centre events.

2.9 The approach has been a success, with new pages that look and feel different to the rest of the website. Residents taking part gave lots of positive feedback such as:

'Today I feel that I have made an impact, it's great to see that you are interested in improving the service for the people that use it.'

2.10 This piece of work has highlighted the importance of involving residents throughout, and we are continuing to use this methodology for the rest of the adult social care pages of the website.

2.11 The more detailed report is included as Appendix 3, which is also an example of the type of reports being produced for each working group.

2.12 The **dementia information** working group met in January and February 2017, focusing on the availability and quality of information about dementia in the borough.

2.13 The group found that while there is good information available, this is not always easily accessible or known to the public, especially before diagnosis. They also made recommendations to improve information to faith/minority groups.

2.14 The group put together an action plan for improving access to information that will be implemented through the Barnet Dementia Manifesto Project Group with others working in this area.

2.15 Members of the group and the Involvement Board felt that there are so many different pieces of work on dementia, and that this can be confusing and complex for users.

2.16 The **community equipment and telecare** working group met throughout April, May and June. With the new care technology provider, Argenti, the group helped to design the communications approach, highlight areas of concern and review promotional materials.

2.17 Argenti found it very valuable to have service user input so early on in implementing the service, and will look at ways to involve users on an ongoing basis as they have done in other contracts.

2.18 The Crisis intervention and early intervention: **Crash Pad service design** working group involved sessions with the Mencap 'Have your say' group as well as a working group from the People Bank.

2.19 The group helped to design this new crisis intervention service for people with learning disabilities / autism. The group members made a series of suggestions and recommendations about how the new service will work, including:

- Considerations for when the service takes place in someone's family home or supported living home
- How the professionals should treat the client and their family – and what they should know
- Impact on other services the person receives
- How the service is funded and what happens next

2.20 The majority of recommendations have been built into the service, with some remaining issues being finalised in July.

2.21 The group also reviewed the 'pen picture' form and the referral form – and their feedback has been put into the final documents.

2.22 The commissioners and providers have said how useful it was to get input from residents – especially in bringing up issues that they hadn't thought of before.

2.23 The remaining working groups are currently in progress:

Working group	**When?**	**Aims**
Employment	June - July 2017	Two groups to look at: • Day opportunities strategy • Employment and mental health
End of life care	June - September 2017	• Led by the CCG • To be scoped in more detail in first meeting • There has been some concern from Involvement Board members about the pace of setting this group up
Hospital discharge	Starting July 2017	• Led by the CCG • To be scoped in more detail in first meeting • Complex topic with lots of interest
Making services accessible to everyone	May – July 2017	• Working with Procurement to build in more consideration of disabilities and support needs when buying and managing services
Autism	July – August 2017	• Being scoped with Joint Commissioning Unit – building on Autism self assessment

2.24 The **Involvement Board** now has a full complement of resident representatives, including two resident representatives for Learning Disability who started in March. They are being supported by Carole Dukes from Barnet Mencap.

2.25 We are continuing to work with the Board to make sure that meetings are collaborative and that resident representatives are able to raise issues between meetings.

2.26 Involvement Board members and People Bank members received training to support them in their roles which was run by Healthwatch Barnet. The training was received positively.

2.26 Resident Representatives have raised a number of issues that are of concern to them and the community. These are:

Finchley Memorial Hospital

- There is concern about the use of space in the hospital and more generally the lack of community involvement. Neil Hales, CCG Associate Director gave an update to the Involvement Board and has given assurance the Board will be updated and involved.
- There were some concerns raised about the audiology services – the relevant resident representative has met with Neil Hales and Concordia to progress this.

Mental Health

- There were concerns raised that the working groups don't have enough focus on mental health.
- It was discussed at the Board that there has been ongoing engagement as part of Reimagining Mental Health and other programmes, and that the Adults and Communities engagement strategy needed strengthening. However, many of the working groups will have an impact on mental health services and there will be new opportunities next year when new priorities are decided.

2.27 The **People Bank** is our database of people who are involved in adult social care and health which started in 2014.

2.28 From September 2016 we undertook a refresh of the database, to ensure that the information was up to date and in compliance with data protection legislation, and people were still interested in being involved.

2.29 We also asked people if they were happy to share their information with the CCG for opportunities to engage jointly.

2.30 The database now has 155 active members, and there is a plan in place to expand the numbers and diversity of people getting involved, through attendance at events, working with social care staff and via community groups.

2.31 Since the refresh closed in February, 44 new people have joined the People Bank. We will continue to grow the People Bank and aim to double the numbers within 1 year.

2.32 The **Annual Engagement Summit** will be held on 6 July 2017. It will be a great opportunity to celebrate the work achieved in the past year and to decide on priorities for next year. A report from the Annual Summit will be included in the next Health and Wellbeing Board update.

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable

4 POST DECISION IMPLEMENTATION

4.1 Continued implementation of the Adults and Communities Engagement Strategy.

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Corporate Plan 2015-2020 states that "greater community participation, engagement and involvement will be an essential part of the change the council will achieve over the next five years."

5.1.2 Engagement work in adult social care and health plays a key part in this, while also supporting with the aim of "services [that] are of good quality, represent value for money and achieve the outcomes residents want".

5.1.3 The Joint Health and Wellbeing Strategy 2015-2020 sets out that it "aims to support residents and communities to become equal partners, with public services, to improve health and wellbeing."

5.1.4 The engagement strategy and work supports these aims through the provision of opportunities to shape health and social care services.

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

5.2.1 All of the proposals documented within this report will be delivered in line with the current budget set out by Adults and Communities for the purpose of engagement.

5.2.2 A strong engagement strategy will mean that services are delivered more effectively and provide great value for money due to being more closely aligned with the needs and experiences of residents.

5.3 Social Value

5.3.1 Not applicable

5.4 Legal and Constitutional References

5.4.1 The Best Value Statutory Guidance (Department for Communities and Local Government, 2012) states that **"**before deciding how to fulfil their Best Value Duty – authorities are under a duty to consult representatives of a wide range of local persons; this is not optional. Authorities must consult representatives of council tax payers, those who use or are likely to use services provided by the authority, and those appearing to the authority to have an interest in any area within which the authority carries out functions. Authorities should include local voluntary and community organisations and small businesses in such consultation. This should apply at all stages of the commissioning cycle, including when considering the decommissioning of services."

5.4.2 The Care and Support Statutory Guidance that is issued under the Care Act 2014 states in section 4.50 that "Local authorities should pursue the principle that market shaping and commissioning should be shared endeavours, with commissioners working alongside people with care and support needs, carers, family members, care providers, representatives of care workers, relevant voluntary, user and other support organisations and the public to find shared and agreed solutions."

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

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

5.5 Risk Management

5.5.1 There is a risk that people involved in engagement become frustrated and disengaged from the process if engagement is too broad, outcomes are unclear or change is slow to happen. This will be mitigated through:

- The working group structure, which involves focused activities and working towards a clear outcome.
- Honest communication with residents about what can or cannot be changed, and how long this will take.

5.5.2 There is a risk that the diversity of the borough is not represented in engagement activity and therefore changes are not in line with people's needs. This will be mitigated through:

- Ensuring that engagement activity is accessible to people with a variety

of needs.

- Expanding the number and diversity of people signed up to the People Bank
- Looking at ways to engage with groups that can feed into the working group structure; we have already started doing this with the Mencap 'have your say' group, made up of people with Learning Disabilities.

5.6 Equalities and Diversity

5.6.1 The engagement work will support equalities and diversity in terms of ensuring that a wider range of people will be able to influence the work of social care and health

5.6.2 We are working towards ensuring that people with different accessibility needs can engage, whether in meetings or using alternative formats. The Guide to Good Engagement is extremely helpful in this.

5.6.3 The People Bank database can be broken down into people's different interests and characteristics, so we can communicate with relevant groups as appropriate.

5.6.4 People Bank members have also filled in equalities monitoring forms, so we can monitor diversity over time.

5.7 Consultation and Engagement

5.7.1 Consultation and engagement is a key part of this work. The Involvement Board is made up of 12 elected resident representatives who oversee the workplan.

5.8 **Insight**

5.8.1 We will use insight and data in the working groups where appropriate, for example making sure to focus on groups more impacted by certain services, or using data to give evidence and context for people attending working groups.

6 BACKGROUND PAPERS

6.1 This paper follows on from the decisions of the Health and Wellbeing Board in January 2016 and the update in November 2016. The minutes can be found in the following two links:

- https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8389&Ver=4
- https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8715&Ver=4

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Adults and Communities
Involvement Board: Working Groups update
June 2017

Theme	Subject	Discussion from Annual Summit 2016 – what could improve?	Summary of working groups • ***What was the focus?*** • ***What recommendations were made?*** • ***What changes took place?*** • ***How will it be sustained?***	Status
Guide to good engagement	Co-producing a guide for professionals to developing good engagement	• Getting **information** before meetings, in the correct, accessible format • **Networking** opportunities • **Involving** the right people • **Avoiding jargon** or using a glossary • Getting **feedback** on what has been done	• Working group met between Oct 2016 and Jan 2017 • **Co-produced a guide for use throughout Barnet on how to deliver good engagement on health and social care services** • Included the recommendations from the Annual Summit • Shared with community groups and Council colleagues • We will continue to use and promote	**Complete**
Information	Adult Social Care website pages refresh	• Communication between different services • Information for people to look up services for themselves • An **online directory** of preferred services • 'Condition Champions' – staff who are experts in certain areas • When using **online everything should be in one place** so information can be easily pulled or	• Focus was on the information available online • Working groups and user testing from Oct 2016 to Feb 2017 • **Carers' web pages designed collaboratively**, with pages continuously updated from user feedback and recommendations • Approach was very successful and Council looking to use it as part of wider web development. Ongoing	**Complete**

		printed off.	opportunities to be involved in website design.	

Dementia services	Improving dementia information and engagement in Barnet	• Bringing together providers to **improve knowledge and information** about dementia
		• Better support for families and carers after diagnosis
		• **Earlier education** and information to identify symptoms
		• Opportunities for financing dementia services
			• Working group met in January and February 2017, looking at
			  ○ Information needed by residents
			  ○ When this information is needed
			  ○ Where the information can be best accessed
			  ○ The format in which information is needed
			• **The group put together an action plan** that will be implemented through the Barnet Dementia Manifesto Project Group to improve dementia information in the borough.
			• Follow up meeting scheduled for May 2017 to look at wider issues.
				Complete

Crisis Intervention and early intervention	Designing the new Crash Pad service for people with learning disabilities / autism	• Information about what to do in a crisis, including clear point of contact
		• There should be **better facilities** in a crisis, for example a crash pad.
		• There should be **better communication** between crisis intervention service and other services
		• Crisis plans should become **more personalised**
			• Group focus was on the Crash Pad service for Learning Disabilities / Autism
			• Series of recommendations for how the service should run, including:
			  ○ Suggesting a new name for the service
			  ○ Suggestions for how it should work alongside other services (e.g. carers emergency plan, day centres and transport)
			  ○ Feedback on the proposed model for the service, including different approaches within family homes or supported living
				Complete

			○ Feedback on Pen Picture templates • Has been fed into service design meetings with the new providers and the **majority of recommendations** taken on • A few issues are still to be decided – further feedback in July *Follow up session in 3 months*	
Community equipment and telecare	Designing improvements for telecare services	• There should be a **better up take** of telecare • There should be **better information** or access to information about community equipment and telecare • There should be more conversation surrounding community equipment and telecare; we should be '**spreading the word**'	Sessions complete between April – June with new care technology provider, Argenti. The group worked on: • How the service should be **promoted**, what staff should know**, what information a user would need**. This will be part of the promotional materials and plan. • **Barriers** to people accessing technology and giving guidance on how this can be overcome • Reviewing **leaflets and materials** – which will be built into the design • Ideas on how users can be involved in designing and testing new technology	**Complete**
Employment	Improving employment of people who use health and social care services	• Employers are not employing enough residents with Mental Health, Learning Difficulties or Sensory Impairment needs. • How we get feedback from employers who are receiving	Two strands to this group: • One focusing on barriers for people with Learning Disabilities to get employment. It will look at how providers can influence employers on the main issues	**In progress**

		residents from employment support services	• One focusing on barriers for people with Mental Health problems to get employment	
Making services accessible to everyone	Ensuring new services have accessibility embedded	• Understanding budget implications for services requiring accessibility adaptations • There needs to be a clear way that residents can make recommendations to change processes.	2 out of 3 sessions complete. Work currently in progress: • Putting together a **set of guidelines** for providers who want to provide health/social care services for Barnet residents • **Reviewing the questions** that are used during the Procurement process to make sure accessibility is being fully considered • Looking at ways to **report poor accessibility**	**In progress**
End of life care	Improving End of Life care for carers and those who are cared for	• **Better information** on this topic, tailored to different groups • **Better training** for staff in care homes • Keeping the **end of life care registers** up to date • Better use of **personal health budgets**	• First two sessions set for Friday 30 June and Friday 21 July • To be scoped in more detail during the first session with working group members	**In progress**
Hospital discharge	Improving the experience of hospital discharge	• Better **communication** during the process, for example people with English as a second language and/or hearing impairments • Early identification of **carers** and young carers. Regular feedback about carers experience	• To be scoped in more detail during the first session • First session will be mid July – Council working with CCG and Royal Free Trust	**In progress**

		• Better liaison between different trusts • Better use of current resources e.g. **voluntary groups**, including for communication support • Opportunities to share **good experiences** with CCG		
Autism	Reviewing the autism strategy and action plan	• Look at **diagnostic pathway** for autism • Opportunity to set up **groups** that develop confidence and social skills. • Opportunity to set up **peer support**	• To start in late July/August – awaiting findings from Autism Self-Assessment Framework • To be scoped in more detail during first session, based on those findings	**In progress**

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A Guide to Good Engagement with Residents

Co-produced by the Guide to Good Engagement Working Group, part of Adults and Communities People Bank

BARNET
LONDON BOROUGH

NHS
Barnet Clinical Commissioning Group

About Us

The Guide to Good Engagement Working Group came together as part of the Adults and Communities engagement structure.

Members have volunteered to be part of the group due to their experience and expertise with engagement.

Members experience includes engagement with:

- voluntary sector groups e.g. Barnet Elderly Asians Group
- local authorities e.g. Barnet Council
- Barnet Clinical Commissioning Group
- NHS
- special interest groups e.g. Residents' Associations.

The section on accessibility for people with learning disabilities was written with members of Barnet Mencap. All the members have a learning disability.

Contents

Part 1 - Key skills in engagement

Part 2 - Making engagement accessible for everyone

Part 1: Key skills in engagement

Why engage with residents?

Delivering good engagement can often be a time consuming and resource intensive process.
This can stop organisations and individuals wanting to work with residents.

When engagement is delivered effectively it can have a number of benefits which can easily outweigh the inputs that are required.

The key benefits of good engagement are:

Improving outcomes:

- services are developed in a way that works for the people using them
- services have a better understanding of public expectations
- changes and decisions are evidenced using resident experience
- strong partnerships are built with residents.

Building partnerships:

- residents are happier with changes they are able to shape
- residents are more connected to the communities they live and work in
- residents become positive ambassadors for engaging communities
- relationships with residents who have previously made complaints can improve
- resident satisfaction can improve
- complaints can reduce.

Evidence for decision making

- residents provide evidence on why certain decisions are made
- residents can give insight into the impact of decisions that are made
- residents' input will provide more weight to reports and committee papers
- residents' input will provide evidence in cases of legal challenge.

Cost effectiveness

- designing services that meet the needs of those who use them provides good value for money
- engaging with residents early means key issues are identified at the start
- ensuring services do not need to be regularly changed, as they are appropriate for communities from the start
- engaging appropriately should reduce the risk of costly legal challenge in the future.

What does good engagement look like?

In order to develop positive experiences of engagement it is essential to understand what good engagement is. Poor engagement can be as damaging to the organisation's reputation as not undertaking any engagement at all.

Ensuring successful engagement relies on working closely with residents. This will build trust, ensure people feel valued and build confidence in the work we do.

In order to support this, good engagement should be:

Representative – The people you work with should reflect the diversity of the population affected by the decisions you make.

Honest – The areas of change need to be made clear. Areas that cannot be changed need to be clearly communicated and explained. Restrictions, for example budget constraints, need to be communicated from the start.

Meaningful – There needs to be a real opportunity in the project to make changes and influence an outcome. The people you engage with should be able to see the impact of the work they do when the project is complete.

Timely – Engagement should be planned into a project at the key milestones so that the work is relevant to the development of the project. Enough time should be given to ensure residents are able to fully understand the information and be able to respond effectively.

Accessible – Engagement opportunities should be set up to enable everyone with an interest to be involved in ways they choose.

Complete – Engagement needs to be completed by identifying and reporting back to those involved, the effects and changes their engagement has had. Without this, people can feel frustrated that their comments and time have not been used effectively.

The 4 steps to engaging

1. Design

During the planning of any project, engagement should be considered before any work on the project takes place.

To decide what you are engaging on, think about:

- what you want to know from the engagement
- what can be changed after the engagement
- what cannot be changed after the engagement.

To decide who are you engaging with, think about:

- who must you work with
- who will be affected by this
- who may be interested in this.

To decide the methods used in engagement, think about:

- the level of impact the subject will have
- the level of influence people will have
- the role and experience of the people with whom you engage
- any additional needs that people may have
- the pace of the work should be dictated by the residents and not the project; this can often take longer than is expected.

2. Plan

It is essential that you plan the details of your engagement activities. This is to ensure that you are able to keep track of the work you are doing.

Key dates:

- which dates cannot be changed?
- map out the dates that are not able to be moved first and plan the rest of your engagement work around this.

Communications:

- how will you let people know about the engagement activities you want to run?
- what are the best ways of reaching the different people who are identified in your design stage?
- how much will your communications cost?
- is additional time needed for large scale communications such as printing and posting?

Facilitators:

- With any face-to-face engagement, you need to identify who will be best placed to facilitate the work
- Often two people are best:
  - one person with skills in working with people and facilitation
  - one person with knowledge of the subject matter.

Practical issues:

- do you need to book a venue and if so is the venue large enough?
- does the venue have suitable toilets and access for disabled people?
- do you need to arrange refreshments?
- are you going to offer a financial incentive for people to engage?
- what do you need to be able to make the method of engagement successful? e.g. if sending out a survey, do you need pre-paid return envelopes?

What is needed to engage?

- appropriate and concise information to enable full understanding
- information written in plain English
- information about where events are being held and who to contact
- what is expected of people during engagement.

3. Deliver

If you have followed through with the design and planning, delivery of your intended engagement activities should be a clear process.

Some key points to remember during delivery are:

- remind people close to the time of the engagement activities, what is happening and of any deadlines that are coming up
- send out anything people will need to read in advance of meetings and bring copies to the event
- ensure that for face-to-face sessions, you have everything you need in advance of the session
- if engagement activities are taking place over a long period of time, get feedback at each stage and make amendments to the plan as necessary
- ensure all information is captured from the different engagement methods you are using.

4. Report

The engagement process is only complete when a report is made for those involved. The function of the report is to show three things:

- residents' input was valued
- residents' input was used effectively
- the work done was based on residents' input.

Key areas to consider when reporting are:

- show how input was used, e.g. in reports to committees
- thank people immediately after the engagement activity, for their participation and advise what the next steps will be
- provide updates when any key pieces of work happen, e.g. committee reports or key decision making
- be transparent with participants and feedback on all aspects of engagement, even if these are not being taken further
- advise people on how to engage further with the organisation if they wish to.

Part 2: How to make engagement accessible

General accessibility guidelines

Before engaging with residents, it is important to make sure the work you do is accessible to as many people as possible.

To make **written engagement** successful, you need to consider:

Language:

- keeping documents jargon free
- keeping documents free from subject specific terms
- providing a glossary of terms for difficult or unusual words
- writing acronyms out in full
- keeping information concise.

Font:

- Barnet Council style guide recommends using Arial 12 for all corporate documents
- Royal National Institute for the Blind (RNIB) recommends that large print should be 16 or 18 point and that anything over this is described as giant print
- this document is written in Century Gothic 14, which is the preferred size for people with learning disabilities.

General:

- providing contact details so residents can request written information in different formats
- allowing the appropriate amount of time for documents to be printed, posted and received
- sending documents at least 1 week in advance of an event to ensure they are read
- allowing the appropriate amount of time for people to read, understand and write a response
- allowing enough time for responses to be received back
- including a summary or contents page if documents are more than 4 pages long

To make **face-to-face** engagement successful you need to consider:

Acoustics:

- can speakers be heard clearly?
- do you need to use audio equipment so everyone in the room can hear clearly?
- minimising background noise wherever possible.

Lighting:

- it is bright enough that text can be easily read?
- if using a projector, that screens are positioned where any changes in light will not affect them.

Vision:

- that nobody is sitting where their vision of any presenters or presentations is affected
- People's positions around tables in relation to speakers
- if there is room for people to turn when presentations are taking place.

Temperature:

- whether the temperature is adjustable.

Furniture:

- whether furniture can easily be moved to provide the most suitable room setup
- whether there is space to move around safely and with ease
- whether there is somewhere to put coats and bags to avoid tripping.

Food:

- whether you need or want to provide refreshments or food
- asking for people's dietary needs
- clear labelling of food.

Agenda:

- if people need to move around the room is there enough room to do this safely?
- Will people be able to move easily if using communication support?
- does the set up of the day allow everyone access to all parts of the agenda?

General

- can people enter and leave the room easily?
- are the toilets accessible?
- are all areas well signposted?
- allowing time for breaks, but also be honest about how long things take.

Visual Accessibility

This section addresses how to support a person who may have a loss of vision. Every individual will have different abilities and need different adjustments to help them to be independent.

The best way to ensure engagement is accessible, is to ask the person what will help them most.

To make **written engagement** successful you need to consider:

Printing

- asking the person what size font will be best for them
- asking the person if they would prefer printing on A4 or A3
- providing contact details where people can request braille or audio translations
- ensuring that there is a clear contrast between the background colour and the colour of text
- that some people may request a dark background with light writing
- keeping writing well spaced to help people to read.

General

- hyperlinks in documents need to be descriptive of what they link to. People using technology to read documents are then able to identify the correct link
- providing copies of documents in advance so people have time to read them
- providing copies of any slides being used in advance, as people may not be able to see them on the day.

To make **face-to-face engagement** successful you need to consider:

Support:

- whether people need to be met and guided
- introducing yourself; ask how the person would like to be guided and determine what level of physical contact is needed
- explaining approaching obstacles that may not be seen.

Animal assistants:

- that animal assistants cannot be separated from their owner
- that if the animal is wearing an identity harness, they should not be petted
- that water may need to be provided for the animal.

General:

- some people with visual impairment don't look directly at people
- asking the person if they will be bringing any equipment and will they need to be seated nearer a plug point.

Hearing Accessibility

The best way to ensure engagement is accessible to anyone with hearing loss, is to ask the person what will help them most.

Each person with hearing loss has a right to define themselves how they wish, however there are broad categories of definitions:

- **Deaf**: note the capital D. It denotes those who are culturally deaf, who use sign language as their first or preferred language
- **deaf**: note the lower-case d. It denotes most other types of hearing loss, from profound to mild loss. deaf people will usually have developed speech and may prefer to speak and to read lips
- **hard-of-hearing**: usually a hearing loss due to age, but can be from any age. Usually describes a mild to moderate loss
- **deafened**: usually someone who has developed speech, but has acquired a severe to profound hearing loss as an adult.

To make **written engagement** successful you need to consider :

Language

- British Sign Language (BSL) is not the same as spoken English. Someone who knows BSL will not necessarily know English
- whenever writing to someone when BSL is their first language, keep sentences simple.

To make **face-to-face engagement** successful you need to consider :

Environment

- if there is good lighting
- keeping background to a minimum
- speakers standing where their faces can be seen clearly. This is particularly important for lipreading.

Translation

- Speech to Text Reporters (STTRs), who translate the spoken word into text using technology
- British Sign Language interpreters, who translate the spoken word into signs
- that public events without the need to book, will need to provide both types of translation
- If there are enough interpreters ensure they do not need to interpret for longer than 60-90 minutes
- whether hearing loops are provided or needed. Many modern hearing aids are not compatible with them and hearing loops are being superseded by other types of technology.

Communication

- the 4 steps to communicating well with someone with a hearing loss:
  - get the person's attention first
  - repeat what you have said only once
  - rephrase what you have said
  - write down what you want to say
- your body language and facial expressions when communicating and keep your face relaxed and neutral.
- slowing down speech and don't talk too fast
- don't cover your mouth or eat when talking.

Animal assistants:

- that animal assistants cannot be separated from their owner
- that if the animal is wearing an identity harness, they should not be petted
- that water may need to be provided for the animal.

Physical accessibility

This covers permanent and temporary difficulties which people may face including, mobility , speech and neurological conditions.

The best way to ensure engagement is accessible to anyone with physical needs is to ask the person what will help them most.

To make **face-to-face engagement** successful you need to consider:

Environment:

- hidden disabilities that may impact on people's physical abilities, e.g. a heart condition that may restrict the amount someone can walk.
- whether people are able to transfer from wheelchairs into alternative seating if this is required
- ensuring there is somewhere safe to store mobility aids that is near the person but will not cause an obstruction to others
- ensuring there is enough space to accommodate wheelchairs around the table
- ensuring the toilets are accessible to everyone who may need them.

Support:

- providing note takers for discussions to enable people to concentrate on participation
- providing communication cards to enable people to be involved
- asking people if they would like to bring someone to support them.

Agenda:

- whether there is enough time for people using communication aids to be able to say what they wish to
- if anyone needs specialist equipment
- planning meetings outside peak travel time allows ease of travel.

Accessibility for people with a learning disability

People with a learning disability do not always see themselves as having a disability but an impairment. People with learning disabilities want to be as independent as possible.

To make **written engagement** successful you may need to consider**:**

Using an Easy Read format document:

- Easy Read is a specialist type of document that uses simple sentences and pictures to aid understanding
- there are lots of guides on how to write easy read documents
- there are companies that can translate complex documents into Easy Read for you.

Using an easier to read font:

- people with a learning disability in Barnet have told us they like Century Gothic in 14 point
- people with learning disabilities in Barnet do not like the question mark in this font. Question marks can be changed to the Calibri Light font.
- only send information that is relevant to what you are asking people to do
- people with learning disabilities may need more time than usual to be able to understand information and be able to respond
- using pictures to aid understanding wherever possible.

To make **face-to-face engagement** successful you may need to consider:

- making support available for people to help them understand what is being said and ensure their voice is being heard
- having smaller groups so people feel more confident in speaking up
- ensuring your agenda is not rushed as people may need more time to be able to process information
- ensuring at least two people with learning disabilities are sat together at tables so that they are able to support each other
- using slides for a presentation with fewer words and more pictures to help people understand
- allowing plenty of time when changing slides so people have time to read them
- providing note takers and/or facilitators so people do not have to make notes as well
- using communication cards on the tables so that people are able to show when they want to speak and to say if they don't understand
- when using communication cards it is important that everyone uses the cards, whether they have a learning disability or not, to be as inclusive as possible
- asking everyone to wear name badges
- having regular breaks and don't make meetings too long
- telling people what impact they have made in a format that is easy for them to understand.

Resources

The following websites provide more information on the subject areas within this guide

JDA - is dedicated to supporting everyone who is deaf or hard of hearing, people of all faiths and none, at all stages of life.

Action on Hearing Loss - are working towards a world where hearing loss doesn't limit or label people and where tinnitus is silenced.

Royal National Institute for the Blind - raise awareness of sight problems, how to prevent sight loss, and they campaign for better services and a more inclusive society.

Thomas Pocklington Trust - are committed to increasing awareness and understanding of the needs of people with sight loss, as well as developing and implementing services which meet their needs and improves lives.

Mencap - is the leading voice of learning disability. They support people with a learning disability and their families and carers.

Barnet Mencap - provides advice, information and support for people with learning disabilities,autism or Asperger's and their family carers.

Radar - A radar key is a large, conspicuous, silver-coloured key that opens more than 9,000 accessible toilets in the UK.

Changing Places - standard accessible toilets do not meet the needs of all people with a disability.
People with profound and multiple learning disabilities, as well people with other physical disabilities such as spinal injuries, muscular dystrophy and multiple sclerosis often need extra equipment and space to allow them to use the toilets safely and comfortably. These needs are met by Changing Places toilets.

Scope - is a charity that works towards making the UK a place where disabled people have the same opportunities as everyone else.

The Disabilities Trust - is a leading national charity, providing innovative care, rehabilitation and support solutions for people with profound physical impairments, acquired brain injury and learning disabilities.

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Information and advice: Adult Social Care web pages

1. What was the aim of the group?

The aim of the group was for residents to improve and change the Barnet website. To start this work we focused on web pages specifically for Carers.

- Barnet Council asked Orange Bus (an external company) to lead User Experience (UX) workshops. These workshops were to gather feedback from people who use social care services on their thoughts about the current website and what they would like to change.

- The project worked in a flexible way. We were able to gain feedback on what people wanted, build it and then test it in a very short amount of time. This method of working allows for quick changes and adaptations to easily reach the desired result of a website that works for users.

2. How many times did the group meet and how many members?

The group met 3 times:

- Thursday 17 November – Barnet Independent Living Centre session 1
- Thursday 1 December – Barnet Independent Living Centre session 2
- Thursday 23 February – Barnet Independent Living Centre session 3

Testing was also done in the wider community:

- Monday 21 November – Age UK coffee morning
- Thursday 24 November – Carers Centre coffee morning
- Tuesday 6 December – Mencap coffee morning

The first group had 5 attendees. Orange Bus asked residents what they expect from a website, what they want from a website and what a website should do.

The second group had 6 attendees. Orange Bus showed residents a prototype of the carers' pages, which had been created based on the comments from the previous workshop. The attendees were individually asked to complete two tasks. One of the tasks was '*Imagine you're a carer and you need a break. Where, on the website, would you go to look?'*

The third group had 6 attendees. Orange Bus showed residents the live carers' page. The attendees were given print outs of the pages to look at in closer detail. Although this was the final workshop, Orange Bus continued to ask the residents what they thought, what we could improve or what they thought has been missed.

3. What were the overall outcomes of the group and how will they feed into the service? What plans are there for sustainability?

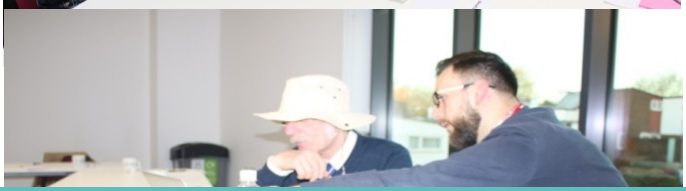
New pages for carers have been co-produced with residents and council officers. The overall outcome showed an excellent example of co-produced work which has been appreciated by the people who took part in the workshops, Orange Bus and by the Council. Some of the feedback was:

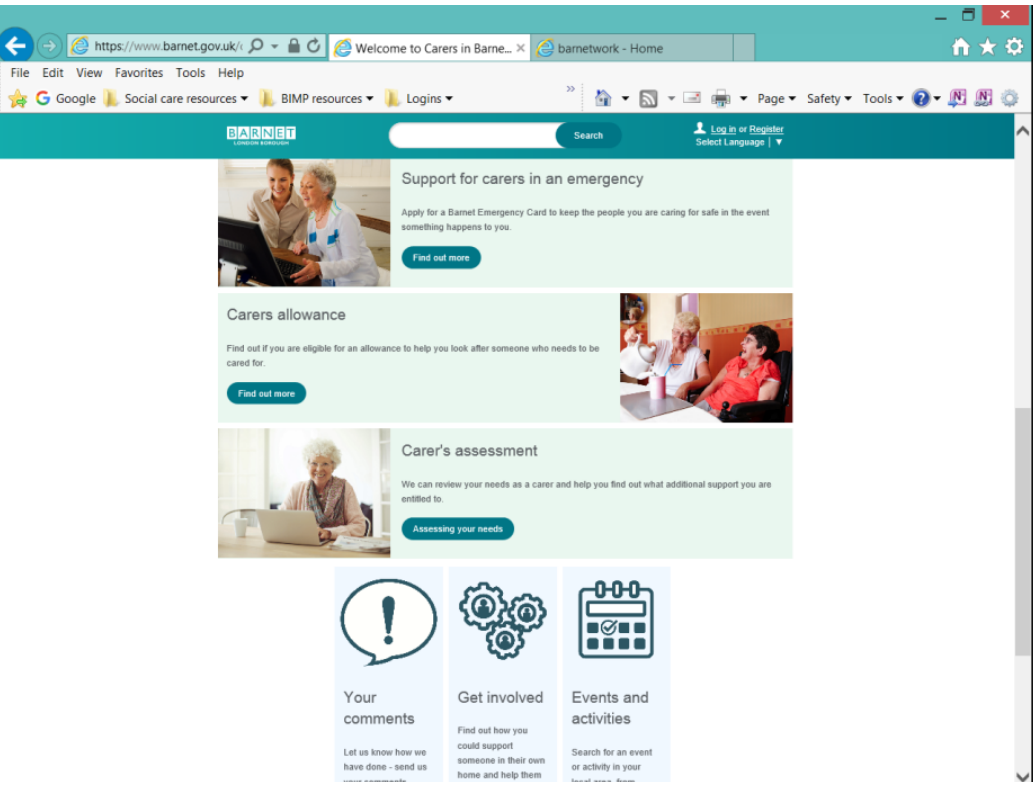
'Today I feel that I have made an impact, I found the day really rewarding, it's great to see that you are interested in improving the service for the people that use it.'

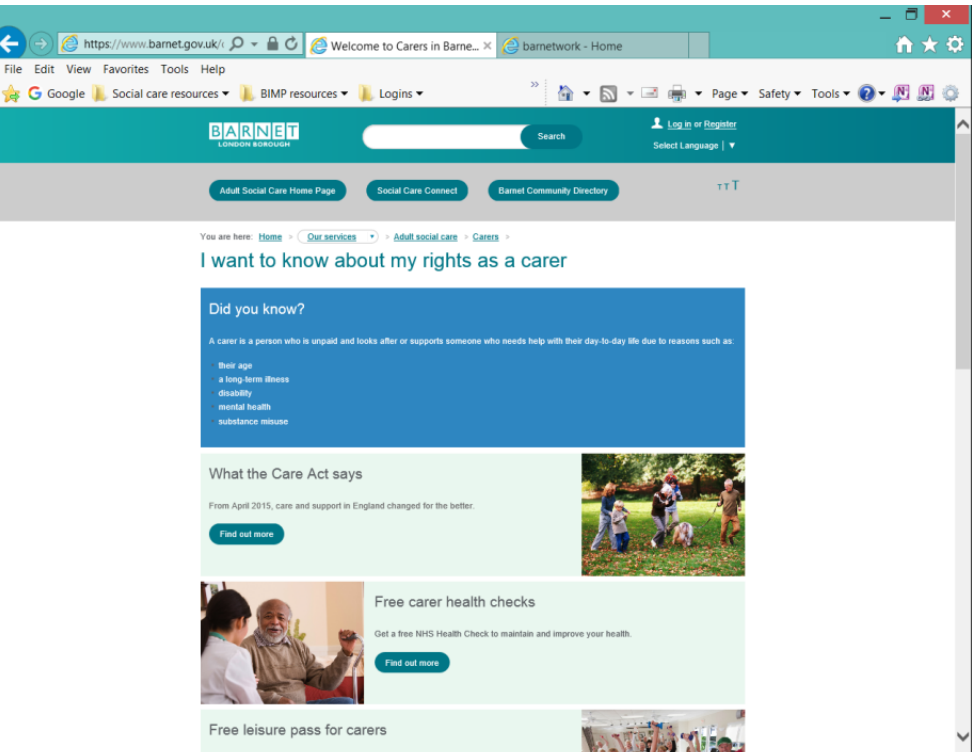
'I can see alterations have been made as a result of us sharing our own past experiences and learned knowledge'

The long term plan is for the rest of the adult social care pages to follow the same format as the carers pages. We will continue to do user testing in this way to make sure we reach the best result.

The website will be a fantastic example of co-produced work and we would like to thank everyone who has contributed so far, together we are on the road to something great.




https://www.barnet.gov.uk/
Welcome to Carers in Barne...
barnetwork - Home
File Edit View Favorites Tools Help
Google Social care resources BIMP resources Logins
Page Safety Tools
BARNET
LONDON BOROUGH
Search
Log in or Register
Select Language
Support for carers in an emergency
Apply for a Barnet Emergency Card to keep the people you are caring for safe in the event something happens to you.
Find out more
Carers allowance
Find out if you are eligible for an allowance to help you look after someone who needs to be cared for.
Find out more
Carer's assessment
We can review your needs as a carer and help you find out what additional support you are entitled to.
Assessing your needs
Your comments
Let us know how we have done - send us
Get involved
Find out how you could support someone in their own home and help them
Events and activities
Search for an event or activity in your


https://www.barnet.gov.uk/
Welcome to Carers in Barne...
barnetwork - Home
File Edit View Favorites Tools Help
Google Social care resources BIMP resources Logins
Page Safety Tools
BARNET
LONDON BOROUGH
Search
Log in or Register
Select Language
Adult Social Care Home Page
Social Care Connect
Barnet Community Directory
You are here: Home Our services Adult social care Carers
I want to know about my rights as a carer
Did you know?
A carer is a person who is unpaid and looks after or supports someone who needs help with their day-to-day life due to reasons such as:
their age
a long-term illness
disability
mental health
substance misuse
What the Care Act says
From April 2015, care and support in England changed for the better.
Find out more
Free carer health checks
Get a free NHS Health Check to maintain and improve your health.
Find out more
Free leisure pass for carers

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AGENDA ITEM 12

	Health and Wellbeing Board **20th July 2017**
Title	**The Growing Issue Of Shisha Smoking In Barnet**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: Evaluation of the Shisha campaign in Barnet
Officer Contact Details	Natalia Clifford, Consultant in Public Health Medicine Email: Natalia.clifford@harrow.gov.uk , Tel: 020 8420 9538

Summary

The purpose of the report is to inform the Health and Wellbeing Board of the campaign that was undertaken by the Shisha Task and Finish group in order to tackle the growing issue of shisha smoking in Barnet. The report draws on the evaluation of the campaign and highlights the successes in terms of outputs of the group.

The evaluation report made recommendations based on the combination of coordinated enforcement delivery and health education and promotion activities. The overall conclusion of the report is that the campaign was well received by Barnet residents and was executed well due to the coordinated action from the Task and Finish group.

Included in the success of the shisha campaign was the strong communications work undertaken by the council's communication team, in partnership with Public Health. Also, engagement work undertaken with Barnet's young residents in schools and youth centres and the development of a short video - all of which resulted in strong media coverage both online and in print.

Recommendations from the report supports a more strategic approach aimed at protecting the health and wellbeing of residents through a wider commissioning strategy on smoking.

Recommendations

1. **The Health and Wellbeing Board notes the successes of joined up activities to highlight the health risks associated with smoking shisha to the target audience.**

2. **The Health and Wellbeing Board acknowledges the findings of the shisha evaluation report and supports the implementation of key recommendations.**

3. **The Health and Wellbeing Board notes that further work on shisha will be taken forward bySmoking Prevention Working group for Barnet.**

1. WHY THIS REPORT IS NEEDED

1.1.1 The Health and Wellbeing Board agreed to receive a detailed report on the growing problem of Shisha in Barnet following a motion to full Council in December 2015 submitted by Councillor Hart which was referred to the Health and Wellbeing Board on 21st January 2016.

1.1.2 This report highlights how Public Health in collaboration with other council departments and key partners has addressed shisha smoking in Barnet.

1.1.3 In addition to this, this report summarises some of the key outputs of a comprehensive health education campaign aimed at educating Barnet residents on the health risks associated with smoking shisha.

1.2 SUMMARY OF SHISHA CAMPAIGN

1.2.1 Following a motion at Full Council in December 2015, Public Health led the health education campaign between October 2016 –March 2017.

1.2.2 The aims of the campaign was to:

- Raise awareness of the negative health impacts of shisha usage amongst all communities with a particular emphasis on young people; and

- Undertake an educational campaign, in partnership with regulatory officers, aimed at local shisha businesses to improve compliance within existing legislation and to consider the health impacts of these businesses.

1.2.3 To fulfil the aims of the campaign a Task and Finish group was established with representation from the council's Corporate Communications Team, Environmental Health, Trading Standards, Planning, Community Safety and Public Health. The group was chaired by the Consultant in Public Health with strategic support from the Community Safety Manager.

1.2.4 The campaign was undertaken in three phases:

- Phase 1: Formation of task and finish group, facilitation of focus group and development of imagery and regulatory activity
- Phase 2: Engagement with health care professionals and delivery of Cut Films workshops to schools and youth groups
- Phase 3: Communication campaign and activity from Environmental Health.

1.3 PHASE ONE

1.3.1 Phase one of the campaign undertook the setting up the Task and Finish group, development of the imagery by testing image effectiveness and authenticity, as highlighted in previous Health and Wellbeing Board papers (September 2016). This paper also described the methodology which included feedback from three separate focus groups:

1. Adults aged 18-70
2. Young People aged 14 – 17 and
3. Black and Minority Ethnic Groups (BAME) all of whom were residents of Barnet.

1.3.2 In addition to this, Regulatory Services conducted joint action within the hot spot areas and Environmental Health conducted advisory visits to shisha bars concentrating on the N3 and N12 area where businesses were given advice and guidance on Smoke Free compliance and the risk from shisha smoke.

1.2 PHASE 2

1.2.1 The second phase of the campaign aimed to engage with primary health care professionals and young people. The primary aims of the second phase were to:

- Increase the awareness of shisha among health care professionals in Barnet.
- Raise awareness of the health impacts of shisha among the young residents of Barnet.

1.2.2 Cut Films (Roy Castle Lung Cancer Foundation) undertook all engagement work with children and young people, however, some interaction from Public Health with Middlesex University in partnership with the council's Corporate Communication team was undertaken to raise awareness of the harms of shisha smoking amongst university students.

1.3 PHASE 3

1.3.1 The third phase entailed educating and informing local residents through a robust communications campaign. The Communications team implemented a communications strategy which included, a multi-media approach such as an online presence, interactive polls, information on the Council's webpage of key health education messages informing on the risks associated with smoking shisha. In addition to this, Environmental Health engaged with Barnet's shisha bars and undertook an exercise of observation within a

neighbouring borough (London Borough of Islington) on successful methods of discouraging nuisance and harm caused by unregulated shisha smoking and encouraging good practice when serving shisha.

1.4 EVALUATION

1.4.1 The evaluation report details seven key recommendations based on the outputs of the project. Key points are aimed at improving knowledge of shisha for health care professionals; ensuring consumer research is a key part of future health and wellbeing communications campaigns and working with other Local Authorities to enable economies of scale.

2 REASONS FOR RECOMMENDATIONS

2.1.1 Local intelligence demonstrated that there are still relatively high numbers of shisha businesses trading in Barnet. In May 2017, Barnet had 21 active premises operating shisha.

2.1.2 The recommendations within the evaluation report have been designed to be undertaken as part of a wider system as part of the Smoking Working Group. It is envisaged that activity will be -maintenance of health education..

3 SUMMARY OF SHISHA CAMPAIGN EVALUATION FINDINGS

3.1.1 The campaign was communicated to Barnet residents via high street posters and bus shelters within the borough. Also leaflets and posters were sent to GP surgeries and pharmacies. In addition, the council led an online digital campaign that made use of Twitter, Facebook, Instagram and the council's own website.

3.1.2 A telephone survey of 500 Barnet residents conducted in November 2016 found that 23% of those surveyed reported that they had seen the shisha campaign in November 2016. This measure was recorded at a point in time before the majority of the communications campaign was undertaken.

3.1.3 A more recent survey (May 2017) showed an increase in residents knowledge and recall and awareness of the shisha campaign.

3.1.4 Feedback from the local authority's website indicated that the web page on shisha was the most viewed page of the Public Health section of the website during January and February 2017. 41% of all users (n=3,987) who accessed the web page did so in order to view information about shisha.

3.1.5 Phase 2 included a separate online survey, which was completed by 119 residents, whilst this was not representative (over-representation of young people), it was found that 45% of respondents had seen the campaign either as a poster on a bus or at a bus shelter, or on the high street.

3.1.6 The survey indicated that respondents found the campaign engaging and informative. Responses included:

- 35% of respondents reported that they had stopped smoking shisha as a result of seeing the campaign.
- 71% reported that they had learnt something new from the campaign
- 43% that they had discussed shisha with a family member, friend or colleague since seeing the campaign
- 50% that they wanted to find out more about shisha.
- When asked about actions they felt local government might take to tackle shisha, the majority of respondents felt that greater actions should be taken by local authorities.
- 77% agreed that shisha businesses should be banned from trading if they were found to be selling shisha to anyone under the age of 18 years.

3.1.7 Feedback from a short survey of 19 primary care health professionals, most of whom provided advice to people about smoking, found that respondents reported less confidence in their knowledge and understanding about shisha than they did about cigarettes and cigars, indicating a need for targeted training on this subject for health professionals who advise on smoking cessation.

3.1.8 Phase 3 included a comprehensive communications roll out of the three key messages approved by the Board in September 2016 using different methodologies i.e. print media, online and e-communications and press releases. The key following messages were used in all communications:

- *"Smoking shisha could double your risk of cancer".*
- *"Shisha contains tobacco and can give you cancer".*
- *"Shisha contains as much addictive nicotine as cigarettes"*.

3.1.9 Inputs included (but not exclusive to) an advert for *Barnet First*, social media and twitter polls, a series of video blogs with a GP registrar, digital advertising which were geo-targeted Barnet residents and a series of press releases. This resulted in 90 votes as part of the twitter poll, 600 people exposed to the geo-digital advertising and 5,691 residents reached via Facebook with 9 likes.

3.1.10 The communications campaign has been nominated for two industry awards, one of which is a national award celebrating best practice in public sector communications. Results of this will be published in July 2017.

3.1.11 In addition to this, Cut Films engaged with 4264 students through 47 workshops. Workshops included a truth and myth game and young people were given the opportunity to express their opinions, misconceptions and ask questions that they may have about shisha, cigarettes and even e-cigarettes (vaping).

3.1.12 From the workshops, 84% of participants said they enjoyed the workshop and project, 87% of participants stated that they were more aware of the harms

associated with smoking shisha and 79% of participants stated that the workshop had made them consider not smoking shisha in the future.

3.1.13 Furthermore, it was important that the campaign received input from young people. Cut Films led engagement with students by recruiting young people from Barnet to design and share a short video on the health harms of smoking shisha. This film was well received by young people and as a result, the video has been nominated for the National Cut Film awards. Results will be published in July 2017.

3.1.14 In addition to earlier engagement with shisha premises by regulatory services (Phase 1), Environmental Health undertook a programme of comparison visits in Barnet and in Islington with Trading Standards colleagues. The purpose of this, was to understand how shisha premises are being regulated and gain insight into methods of encouraging compliance with Smoke Free Legislation.

3.1.15 Feedback from these visits noted that a dedicated officer was given the task to encourage compliance on all shisha regulated activities e.g. tobacco labelling, smoke free compliance and health and safety. It was noted that this was effective in reducing numbers non-compliance but required un-realistic high demand on Council resources.

4. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

4.3 The alternative to not including shisha as part of the borough Smoking and Prevention working group would entail loss of valuable resources. Campaign materials, which are evidence based and validated can re-used at opportune times within the year, for example, during Stoptober.

4.4 Furthermore, by drawing on all resources from partners, the Council can demonstrate to businesses that non-compliant premises are not tolerated and that the health and wellbeing of users is a priority.

5. POST DECISION IMPLEMENTATION

5.3 The Task and Finish group has no further need to meet. However, the focus on shisha will be part of the overall scope of the Smoking & Prevention working group led by Public Health.

5.4 Regulatory services will continue to work on issues relating to shisha smoking. In particularly, the sale of illegal tobacco products and unregulated packaging, checks under the Smoke Free Act will continue and joint working where there are hot spots of nuisance.

5.5 It is possible that a further 'top-up' mini campaign, depending on resources, will be undertaken using all the resources that have been developed. This will be delivered by the communications team and involve social media/digital campaign messaging, poster imagery within the council's magazine, Barnet First and compliance booklet to shisha premises.

6. IMPLICATIONS OF DECISION

6.3 Corporate Priorities and Performance

6.3.1 The Councils Corporate Strategy (2015-2020) highlights that Barnet's vision is that public sector services (including London Borough of Barnet) will be more integrated, intuitive and efficient.

6.3.2 The shisha campaign draws upon the fact that Public Health is a priority theme that cuts across all Council services. The partnership proposal to tackle shisha in Barnet fits into the Council vision of being integrated, intuitive and efficient service.

6.3.3 The Joint Health and Wellbeing Strategy (2015-2020) makes a commitment to reducing premature mortality due to cardiovascular disease and cancers. Smoking tobacco is a known contributory factor to these conditions. Also, tackling the growing use of shisha through health educational campaigns supports residents to adopt a healthy lifestyle which is one of the overarching aims of the strategy.

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

6.4.1 The partnership provided a coordinated approach. The campaign was run within budget.

6.5 Social Value

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

6.6 Legal and Constitutional References

6.1.1 The possibility of developing local legislation (a byelaw) on shisha control has been considered and is assessed as unlikely. In order to develop a byelaw, consideration must be given to whether the issues (i.e. the nuisance) are already covered by other legislation.

6.1.2 To create a byelaw, reliance on an enabling power under statute is required but if there is general legislation on subject then a byelaw would not be appropriate. Byelaws also usually have to be approved by the Secretary of State. Whilst there is not specific legislation on shisha smoking, there is legislation that covers the issue i.e. that which controls (cigarette) smoking

generally, as well as other legislation referred to in the report that can be used to control its environment.

6.1.3 The legislation Acts listed below can be used to control shisha.

- **Health Act 2006** - The primary legislation is the Health Act 2006, which states "that 'smoking' refers to smoking tobacco and anything which contains tobacco, or smoking any other substance.

- **Smoke free legislation** (the "smoking ban") prohibits smoking in enclosed public places and workplaces relates to any smoking product, whether it contains tobacco or not.

- **Consumer Protection Act 1987 (CPA)** - Primary legislation that states Tobacco containing shisha must comply with all the requirements of the tobacco products regulations.

- **Children & Young Persons (Protection from Tobacco) Act 1991** – It is illegal to supply tobacco to anyone under 18 years.

- **Anti-Social Behaviour, Crime and Policing Act 2014** - Puts victims at the heart of the response to Antisocial Behaviour (ASB).

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

- 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.

6.1.5 Specific responsibilities for:

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

6.2 Risk Management

6.2.1 The health risks associated with smoking shisha will remain a public health concern as part of the wider group.

6.3 Equalities and Diversity

6.3.1 The project does not exclude, prevent or discriminate against any of the

protected equality groups. Shisha smoking is traditionally more prevalent in certain (Middle Eastern) ethnic groups. However in London, it is becoming more popular amongst all ethnic groups, particularly young people. The campaign targeted all shisha users and was not be culturally specific.

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

6.4 Consultation and Engagement

5.7.1 The campaign materials were developed in consultation with Barnet residents and the short video aimed at young people was co-produced with young Barnet residents.

6.8 Insight

6.8.1 The evaluation report has provided insight into the outputs of the shisha campaign. Findings have shown that the campaign was well received and had good coverage within the borough.

6.8.2 Awareness of shisha and its harm was increased amongst Barnet residents, health professionals and young people in schools and youth centres.

6. BACKGROUND PAPERS

6.1 Health and Wellbeing Board, Thursday 21st January 2016. Motion from full Council, Tackling the Growing Problem of Shisha. https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8389&Ver=4

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Appendix 1

Shisha Public Education Awareness Campaign 2016-17 Evaluation Report

London Borough of Barnet

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Executive summary

This report describes the evaluation of LB Barnet's shisha public education campaign, conducted between October 2016 and February 2017. The campaign was developed in response to a motion at full Council in December 2015 and a report to the Health and Wellbeing Board that described a growing problem of shisha smoking in Barnet. This detailed the increasing number of businesses selling shisha in Barnet, together with the health harms caused by shisha and widespread misunderstandings about the risks associated with smoking shisha among young people. Barnet Public Health team led the development and implementation of a sustainable health promotion and education campaign. This had the following aims:

- Raising awareness of the negative health impacts of shisha usage amongst communities who use shisha with a particular emphasis on young people.
- Undertaking an educational campaign, in partnership with regulatory officers aimed at local shisha businesses to improve compliance within existing legislation and to consider the health impacts of these businesses.

A Task and Finish group was established, with representation from Environmental Health, Trading Standards, Planning, Community Safety and Public Health to coordinate and focus all activities on tackling the growing use of shisha in Barnet.

Environmental Health Actions and Outcomes

The Environmental Health department (EHD) undertook a programme of compliance visits to (all operating at the time) shisha bars and in Barnet.

The experience of EHD officers working to enforce compliance in LB Barnet was that the current powers and resources available were inadequate to bring about any meaningful disruption of the trade in the sale of shisha from bars and cafes. However, as part of the LB Barnet campaign, lessons on how to effectively eradicate the problem of shisha bars that operate beyond the law, were sought from other London local authorities.

Public Health education campaign

Research was conducted among three groups to inform the development of a marketing campaign, which aimed to inform residents of the harms of smoking shisha. Prototypes developed by the local authority were tested among research participants. The research found that:

- There was strong organisational support for LB Barnet to undertake a public education campaign on this subject, because there was a widespread awareness that:
  - shisha use had become increasingly diffuse in the borough
  - it was primarily young people who were likely to use shisha
  - that the health risks associated with smoking shisha were poorly understood, even by those who smoked shisha
- There was a desire for the campaign to include evidence based facts about shisha and to focus on the serious health conditions – cancers, heart disease, including deaths attributable to shisha – rather than what were considered to be relatively trivial conditions such as oral herpes.

- The public education campaign on shisha should make an explicit link to smoking cigarettes and the general harms caused by tobacco.
- The campaign should ensure that there are no 'unintended consequences' that might lead to viewers mistaking the campaign as a marketing campaign on behalf of shisha or shisha bars.

The campaign was communicated to LB Barnet residents via posters at bus shelters in the borough and billboards on high streets, and via leaflets and poster in GPs surgeries and pharmacies in the borough. In addition, the Council led an online digital campaign that made use of Twitter, Facebook and the Council's own website.

Feedback from the local authority's website analysis indicated that the web page on shisha was the most viewed page of the Public Health section of the website during January and February 2017.

A telephone survey of 500 LB Barnet residents conducted in November 2016 found that 23% of residents reported that they had seen the shisha campaign in November 2016. This measure was recorded at a point in time before the bulk of the expenditure on the campaign was committed. It can be expected therefore that the proportion of residents who were aware of the campaign in January and February was significantly higher.

A separate online survey completed by 119 respondents, which was not representative of all residents of the borough, found that 45% had seen the campaign, and that most of these had seen a poster on a bus or at a bus shelter, or on the high street. This survey over-represented young people and people who had smoked shisha. The fact the campaign was positively received by this group was indicative of the fact that it was well received by the key target audiences.

Overall, the survey indicated that respondents found the campaign engaging and informative.

- 71% reported that they had learnt something new from the campaign
- 43% that they had discussed shisha with a family member, friend or colleague since seeing the campaign
- 50% that they wanted to find out more about shisha.

Asked about actions they felt local government might take to tackle shisha, the majority of respondents felt that greater actions should be taken by local authorities.

- 81% thought that a licence should be required to sell shisha (it currently is not) in the same way as selling alcohol is licenced.
- 68% felt that bars or cafes that sold illegal tobacco in their shisha should be banned from trading.
- 77% agreed that shisha businesses should be banned from trading if they were found to be selling shisha to anyone under the age of 18 years.

Feedback from a short survey of 19 primary care health professionals, most of whom provided advice to people about smoking, found that respondents reported less confidence in their knowledge and understanding about shisha than they did about cigarettes and cigars, indicating a need for targeted training on this subject for health professionals who advise on smoking cessation.

Appendix 1

	Phase 1	Phase 2	Phase 3
Aims	To gain resident's insight on campaign resources, imagery and routes of prmotion To develop campaign imagery and resources	To increase understanding and awareness of harms associated with smoking shisha among Health Professionals To increase understanding and awareness of key messages among school students and (Middlesex) university students of the harms associated with smoking shisha.	To increase understanding and awareness of harms associated with smoking shisha among residents of Barnet. To raise awareness of shisha bar/café managers and owners of the need to comply with smoke-free legislation
Target population		Health care professionals including GPs and Pharmacies Children and young people	Shisha bars and cafes
Partners involved	Barnet Design team Word of Mouth Research Barnet Health Watch	Cut Films Barnet council communication team Middlesex University Communication Team	Barnet Environmental Health (RE) Barnet Communication Team

Table 1 table demonstrating campaign summary

Recommendations

1. **Provide training to primary care health professionals on shisha as well as other forms of smoked tobacco** - Ensure that primary care health professionals who currently provide advice to smokers about stopping/giving up/cutting down, are trained to advise clients about the harms of shisha and the importance of stopping (in the same way as other forms of smoked tobacco).
2. **Include providing advice on stopping shisha smoking as a specific item in the specification of commissioning documents for a Stop Smoking Service**- Plans to commission a Stop Smoking Service for the LB Barnet should include specific requirements on the providers about shisha. The commissioning documentation should include specifications that require staff that provide the service to be fully trained in advising on shisha smoking as part of their general interaction with clients about smoking tobacco products.
3. **Increase powers and funding to disrupt the trade in the sale of shisha from bars and cafes-** The experience of LB Barnet and LB Islington in tackling the sale of shisha from bars and cafes over the past few years was instructive. Learning from LB Islington indicates that in order to effectively reduce the number of shisha bars operating, local authorities need to work closely with trading standards team.
4. **Design, development and management of the campaign**- The public education campaign was designed and managed effectively, with input from all relevant departments in the Council. The aims, objectives and approach were clearly identified and external expertise was obtained, where it did not exist within the Council.

   For the Communications department, this was only the second campaign it had mounted (after Keep Barnet Tidy), and the campaign served to develop experience and confidence.

5. **Ensure consumer research is 'built in' to the development communications campaigns-** A recommendation for future communications is to ensure that consumer research to test the form and content (messaging, visual design and appeal, and channels) is 'designed in' as part of the requirements of the campaign. It is a common failing of public bodies to overlook this important step, on the assumption that the commissioning body or department believes it knows what needs to be communicated, how and to whom, and what will be effective. However, without independent consultation with intended audiences, there is a real risk of campaigns failing to communicate what was intended, and to sometimes communicate inappropriate messages – as would have happened in this campaign, had consumer research not been conducted. In this instance, the decision to conduct consumer research occurred as a result of the recommendation of the research agency commissioned to evaluate the campaign. It should however, be made 'part and parcel' of all communications campaigns, and managed by a department other than the communications department, in order to ensure independence and transparency.

6. **Pool resources with other local authorities to achieve economies of scale on health promotion**- Local authorities acquired responsibility for public health, including health promotion and education, as a result of the Health and Social Care Act 2012. The scale and costs of running local public education campaigns is frequently prohibitive, because of the costs involved in designing and developing interventions, and the limited purchasing power of any single local authority. However, when a number of local authorities are able to collaborate to develop joint campaigns, the purchasing power increases and the design and development costs are dispersed. Consideration should be given to more joint working on themes such as shisha and tobacco control more generally, as similar public issues are priorities across many London local authorities.

7. **Pool resources in order to undertake good quality summative evaluation research**- Understanding whether a campaign leads to changes in knowledge, attitudes or behaviours is vital for accountability. However, in order to answer these vital questions, commissioners must consider the resourcing of research. There is an established hierarchy of research designs to determine the effectiveness of interventions that seek to promote behaviour change. Pooling of resources between departments and possibly between local authorities working on similar issues, is one way of ensuring that sufficient funds are made available to fund evaluation research.

1. Introduction

This report describes the evaluation of LB Barnet's shisha public education campaign, conducted between October 2016 and February 2017.

Background to the campaign

In January 2016, the Health and Wellbeing Board of the LB Barnet received a detailed report on the growing problem of shisha smoking in Barnet, following a motion to full Council in December 2015 by Councillor Hart. The report detailed the increasing number of businesses selling shisha in Barnet. At the time of the report the Council's Environmental Health department had identified 23 shisha bars or cafes trading in the borough. The report stated that such establishments were often accompanied by non-compliant practices such as health and safety breaches, non-tax duty paid tobacco products and poor compliance with smoke-free legislation.

Health harms of smoking shisha

The report also identified the health harms associated with smoking shisha. It reported well-established evidence showing that shisha smoking was at least as harmful as smoking cigarettes.

Shisha has been found to be associated with several cancers, coronary artery disease, and deterioration of lung function. An association between second hand smoke and smoking in family settings or amongst young children has been linked to the development of childhood respiratory conditions. Women who smoke shisha during pregnancy have been found to have babies with low birth weights.

Shisha tobacco contains tobacco. This means it contains the same harmful substances that cigarettes contain, including nicotine, tar, carbon monoxide and heavy metals, such as arsenic and lead. As a result, shisha smokers are at risk of the same kinds of diseases as cigarette smokers, such as heart disease, cancer, respiratory disease and problems during pregnancy.

It is unclear exactly how much smoke or toxic substances shisha smokers are exposed to in a typical shisha session. Typically, people smoke shisha for much longer periods of time than they smoke a cigarette, and in one puff of shisha they may inhale the same amount of smoke as they get from a smoking a whole cigarette.

The average shisha-smoking session lasts an hour and research has shown that in this time the volume of smoke inhaled can be the same as from more than 100 cigarettes.

Some people mistakenly think that shisha smoking is not addictive because the water used in the pipe can absorb nicotine. However, because only some of the nicotine is absorbed by the water, shisha smokers are still exposed to enough nicotine to cause an addiction.

According to the NHS website,

> 'Smoking increases your risk of cancer, heart disease and respiratory problems. This is true whether you smoke cigarettes, bidi (thin cigarettes of tobacco wrapped in brown tendu leaf) or shisha (also known as a water pipe or hookah).
>
> A World Health Organization study has suggested that during one session on a water pipe (around 20 to 80 minutes) a person can inhale the same amount of smoke as a cigarette smoker consuming 100 or more cigarettes.

Like cigarette smoke, water pipe smoke contains cancer-causing chemicals and toxic gases such as carbon monoxide.'

Misunderstandings about the risks associated with smoking shisha

A number of studies have pointed to widespread misunderstandings about the risks associated with smoking shisha.

In general, surveys have suggested that there are common misbeliefs, including the following:

- That shisha is not as harmful as smoking cigarettes
- That shisha is not addictive (or not as addictive as smoking cigarettes)

Prevalence of shisha smoking

There is very limited evidence of the size of the problem of shisha smoking in the UK. A survey was conducted to assess the prevalence of shisha smoking in Great Britain in 2011/12. This reported that overall prevalence of shisha smoking was very low[1]. Just 11.6% of the adult population reported having *ever* used a water-pipe and only 1% reported using it once or twice a month.)

However, there is concern that the prevalence of shisha smoking is likely to be considerably higher, and may be increasing, among discrete social groups and some localities[2]. The key groups of concerns are young people aged 16-24, some minority ethnic groups and some localities where there is a sizeable minority ethnic population of people from North African or Middle Eastern origin, where shisha smoking is more culturally normalised.

An indicator of the increasing size of the problem is the number of shisha bars and cafes that have been established in parts of London, including the London Borough of Barnet, and the number of outlets that sell water-pipes for domestic and personal use.

Factors associated with the increase in shisha smoking in Barnet

The report to the Health and Wellbeing Board attributed the growing epidemic of shisha in Barnet to several factors.

- The introduction of flavoured shisha tobacco with it's reduced harshness and perceived pleasant flavour and aroma;
- The misperception that it is less damaging than cigarette smoke;

[1] Nicotine Tob Res. 2014 Jul;16(7):931-8. doi: 10.1093/ntr/ntu015. Epub 2014 Feb 18.
Prevalence of waterpipe (Shisha, Narghille, Hookah) use among adults in Great Britain and factors associated with waterpipe use: data from cross-sectional Online Surveys in 2012 and 2013.
Grant A1, Morrison R2, Dockrell MJ3.

[2] Waterpipe tobacco and electronic cigarette use in a southeast London adult sample: a cross-sectional analysis Mohammed Jawad Gerald Power J Public Health (Oxf) (2016) 38 (2): e114-e121.

- Social acceptance and being an essential part of family, peer and public gatherings and cafes and restaurant culture;
- Internet mass and social media;
- Low cost;
- Lack of shisha specific policy and regulation towards its use.

Identified groups at risk

The report further identified those groups thought to be most at risk of the harms caused by smoking shisha. It indicated that young people, including university students and school children were vulnerable to exposure to shisha.

Enforcement and regulation

The report found that the powers of enforcement which directly apply to shisha were limited and that a more effective route to address the issues, would be to address the overall compliance of businesses, utilising a wide partnership approach that can enforce all available legislative powers. Other London boroughs had used similar approaches successfully.

Health promotion campaign

Formation

In order to address the public's lack of knowledge and widespread misunderstandings about the risks posed by shisha, the report proposed a sustainable health promotion and education campaign to 'highlight the health risks associated with smoking shisha to current and potential smokers (of which a high proportion are young people) and also to highlight to premises the negative health impacts of smoking shisha to staff and neighbouring residents.'

Public Health led the development and implementation of a sustainable health promotion and education campaign, with the following aims:

- Raising awareness of the negative health impacts of shisha usage amongst communities who use shisha with a particular emphasis on young people;
- Undertaking an educational campaign, in partnership with regulatory officers aimed at local shisha businesses to improve compliance within existing legislation and to consider the health impacts of these businesses.

The approach included:

- Poster campaign utilising bus shelters, community centers, libraries and health premises;
- Digital campaign utilising social media to dispel myths and provide accurate information.
- Sign posting to existing resources including Barnet Stop Smoking Services;
- Training stop smoking advisors to include information on shisha smoking
- Targeted engagement with the voluntary sector to raise awareness within community groups where shisha use is prevalent
- Engagement and health promotion advice to shisha establishments

Implementation

A Task and Finish group was established, with representation from Environmental Health, Trading Standards, Planning, Community Safety and Public Health to coordinate and focus all activities on tackling the growing use of shisha in Barnet.

The Group facilitated and oversaw the delivery of a partnership approach to non-compliant premises to actively and fairly apply all relevant legislative powers available to the Council. This aimed to include proactively dealing with illegal structures related to shisha, coordinating joint visits with partners including HMRC where necessary and continuing to share intelligence with other regulatory services such as Planning.

2. London Borough of Barnet's shisha awareness campaign

Aims and Target Groups

In 2016 LB Barnet's Public Health department launched a public education campaign that had as a central aim, to raise awareness of the harms caused by smoking shisha.

The campaign had a number of target groups, including **residents of LB Barnet**, and within this, **young people**, **schools** and **university students** and **minority ethnic groups**. In addition, the campaign sought to provide information to the owners and managers of bars and cafes that sell shisha, to alert them to the requirements of existing legislation to protect public health. The campaign also sought to raise awareness of the concerns about smoking shisha among primary care health professionals.

The campaign aims where:

- To increase understanding and awareness of harms associated with smoking shisha among **residents** of Barnet.
- To engage Barnet's **public** in a debate about what actions the local authority should take to control/regulate shisha smoking (including bars/cafes)
- To increase understanding and awareness of key messages among identified target groups – **school students, university students, young people, BAME groups** - of the harms associated with smoking shisha.
- To increase understanding and awareness of harms associated with smoking shisha among **Health Professionals**
- To raise awareness of **shisha bar/café managers and owners** of the need to comply with smoke-free legislation

Appendix 1

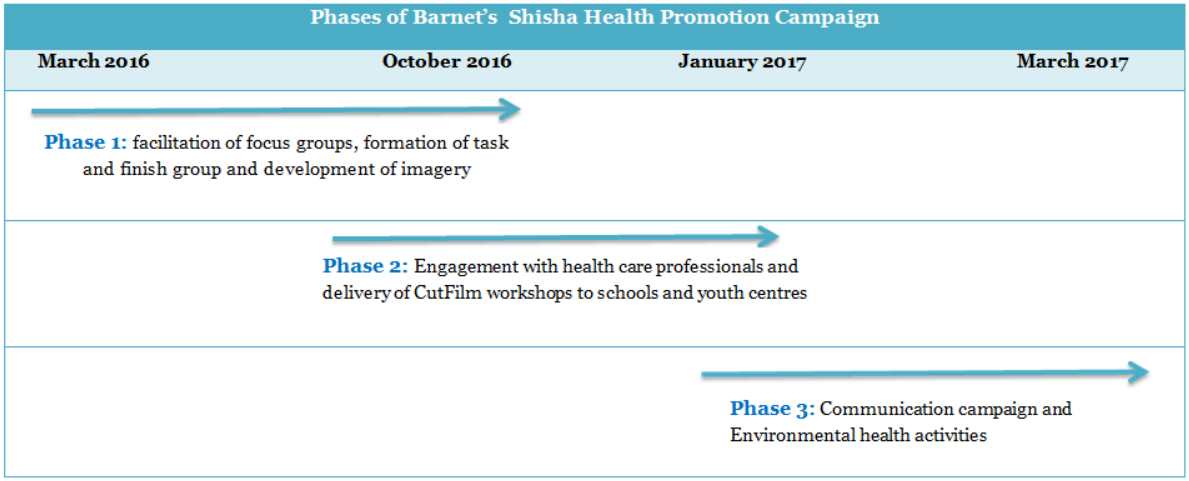


Figure 1 Different phases of the campaign

Partners involved:

Internal partners:

- Elected members- involvement is making the decision to develop an information campaign
- Barnet Public Team – provided strategic guidance and coordination and also involved in development and implementation of the campaign
- Environmental Health (RE)- were responsible for inspection and regulation of premises that sell shisha
- Barnet Council's Communications Team- developed imagery and messaging for the campaign and also implemented the project communications plan

External Partners:

- Cut Films- As a smoking prevention charity they were commissioned to promote the campaign among schools and youth centres in the borough.
- Word of Mouth Research- As a public health and social marketing consultancy they were commissioned to provide guidance and also to facilitate the focus groups for the development of imagery, to develop survey for residents and healthcare professionals and also to undertake the evaluation.
- Middlesex University Communications – They worked closely with Barnet Council's communication team to communicate the campaign to their students.

3. Evaluation

3.1 Phase one

Phase one was of the campaign was undertaken to inform the development of a proposed health promotion campaign and aimed to inform residents of the harms of smoking shisha. The fieldwork was conducted in late June and early July 2016.

Methods

The research involved three separate focus group discussions with

a) adults aged 18-70

b) young people aged 14-17

c) black and minority ethnic (BME) groups, all of whom were residents of LB Barnet.

The groups ran for between 70 – 90 minutes. The format of the research groups involved showing participants the proposed poster treatments. Participants were also shown a short video that may be used as part of the online campaign. The groups were moderated by Adam Crosier of Word of Mouth Research Ltd. Observers from LB Barnet attended all three groups. All discussions were audio recorded.

Key findings

The following findings emerged from the research about the various posters shown to the groups. These provided important information about what would motivate the public of Barnet to take notice of a public education campaign on shisha.

1. **The issue of shisha was considered to be important**, and there was organisational support for LB Barnet to undertake a public education campaign on this subject. The reason for this was because there was a widespread awareness that shisha use had become increasingly diffuse in the borough it was primarily young people who were likely to use shisha, that the health risks associated with smoking shisha were poorly understood, even by those who smoked shisha, and also there was agreement that improved knowledge would enable those considering to use (or currently using) shisha to make a more informed decision about their behaviour, and would provide friends and family of smokers with information to engage in discussion about the harms and risks. The idea of a public education campaign that provided new information and new knowledge was therefore widely regarded as appealing.

2. **There was a desire for the campaign to include evidence based facts about shisha,** including the harms to health caused by smoking shisha. The focus should be on the serious health conditions – cancers, heart disease, including deaths attributable to shisha – rather than what were considered to be relatively trivial conditions such as oral herpes. Information about the harms of shisha that lacked a clear evidence base was generally dismissed as 'propaganda' and the claims were considered to be 'exaggerated'.

3. **Participants in all three suggested that public education campaign on shisha should make an explicit link to smoking cigarettes and the general harms caused by tobacco.** The key failing in the posters that were tested, was the lack of this connection. Because smoking tobacco was so clearly established as harmful, the shisha awareness campaign would gain from this association, if the link was established.

4. **The participants suggested that the shisha campaign should ensure that there are no 'unintended consequences' that might lead to viewers mistaking the campaign as a marketing campaign on behalf of shisha or shisha bars.** Several participants felt that the tested materials (both posters and video) were open to a miss-reading that they glamourised the smoking of shisha. They identified clear means of avoiding this pitfall, namely by ensuring that the imagery used to describe any shisha paraphernalia is clearly portrayed as 'ugly' and 'disgusting', and definitely not open to a reading as 'cool' or 'hip'.

Responses to 'The Truth behind the Smoke' posters

The overall response from all three focus groups to the proposed 'Truth Behind the Smoke' (Image 1) was underwhelming. There was a general lack of a 'wow' factor among all groups, together with some confusion.

Respondents felt that the posters failed to provide information, and failed too to produce an emotional impact. Several participants felt that the imagery should be more shocking and emotive. They referenced anti-smoking adverts with pictures of real people affected by smoking, and suggested that this device was more powerful.

Respondents commented on the 'myth' statement, saying that information about sharing mouthpieces was not very alarming, and that the focus of the message should be on how bad the smoke is for health.

Only one participant in the young people's group commented spontaneously that the poster was 'scary', and even this was qualified by a statement that it would be better to have used more graphic imagery, along the lines of that used on cigarette packaging.

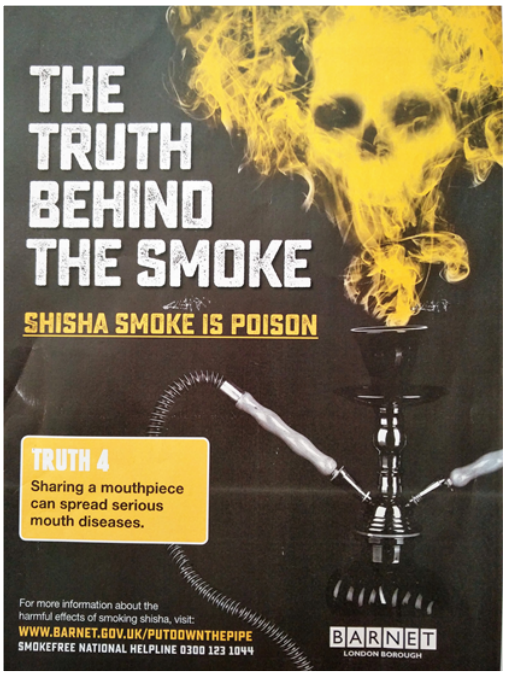


Figure 2 The Truth behind Smoke initial poster

The principal concern for the residents group and the BME group was that participants felt that the poster failed to answer the proposition within the headline, 'The Truth Behind the Smoke'. There was an expectation that the image and the text would work together, that the image would explain the written proposition, but it failed to do so.

On the positive side, most participants across all groups liked the colour scheme, felt that the black and mustard were powerful and appropriate colours that conveyed 'hazard/danger' and the fact that the imagery of the pipe and the skull/poison/lungs were clear and easily understood, if not regarded as especially powerful images in their own right.

However, most participants felt that the messages that the posters sought to convey were unclear and confusing. Having seen one version, several commented that they would ignore other treatments, because it had failed to engage them.

Imagery

The image of the shisha pipe attracted unprompted comments. The BME group, where all participants were shisha users found the image of the pipe clear and recognisable. However, the image was considered to be visually unclear to some participants in the residents group and the young people's group, particularly to those who were not familiar with shisha paraphernalia. There were several comments that the image should be re-worked to make the shisha pipe more distinct, as it was difficult to see it against the black background. The fact that the LB Barnet logo covered the bottom of the pipe was considered to be unhelpful, and simply obscured the image of the pipe. The role of the logo will be discussed below.

> *"The shisha pipe isn't clear – there is no water. It's not realistic. It's not clear what it is."* – Residents

> *"The lines blend in to the black. I can't tell what it is. I thought it was a hosepipe."* -Residents

While the intention behind the use of the skull image was understood, it was generally felt not to be effective in communicating fear. Rather it was considered to be an over-used image that was used to invoke fear in popular culture, and that through over use had lost impact.

> *"The skull thing. You know. You could see that as a cool thing. Skulls aren't necessarily bad."* -Young People

Participants in all three groups commented spontaneously that the imagery was tame, and made contrasts with the imagery used on cigarette packaging, that was more grotesque and graphic.

> *"I smoke Shisha once in a while. That wouldn't have any effect on me."* -Residents

> *"I think it would be better use similar images to what they use of cigarette packs, because that's been shown to work."* -Residents

Of the three treatments, the skull was preferred, however. The word 'poison' was liked by a minority of participants, who felt that this worked with the 'Shisha is Poison' slogan. The 'lungs' were generally disliked; with several participants commenting that they looked healthy, which was felt to be unmotivating.

> *"The lungs look healthy – that's not going to work on a poster about smoking."* -Young People

The risk of producing advertising that is misunderstood as promoting shisha smoking

Participants in the young people's group were more critical of the imagery of the shisha pipe, stating that its 'clean' and 'shiny' look, made shisha smoking appear 'cool' and appealing. The group felt that this poster could easily be confused for an advert to promote a shisha bar or café.

> *"The black – I've never been attracted to smoking shisha – but it kind of looks cool. I'm not going to lie. It looks nice. It attracts me to smoke shisha. All of it looks nice."*-Young People

> *"It's something that you easily see at the front of a shisha bar to show how cool it is, it's 'flirting with danger' kind of thing."* -Young People

The group made an important observation that it was vital that the poster should communicate that shisha should be seen as unappealing and unattractive, and that this should be done through the use of imagery that invoked a feeling of disgust.

> "*I think if it was ugly and dirty, you wouldn't want to smoke that, but., Yeah, that's true, it's clean, it looks polished. I think if I was trying to advertise a shisha bar, that colour scheme would work perfectly." -Yo*ung People

This observation was supported by the BME group, who agreed that the poster risked being seen as promotional of shisha.

A need for evidence based statements

Participants in all groups commented that they would expect a poster that proclaims the truth, to be supported with credible evidence. They also questioned the wording of the myths/truth statements. They found the messages to be not motivating, relatively trivial and missing the key point, that smoking shisha is equivalent – or worse than – smoking cigarettes, and that this represents new knowledge to most people, including those who may smoke shisha. This new knowledge was considered to be important, engaging and motivating. Young people were critical of the 'truth' statement about sharing mouthpieces, and felt that the seriousness of the harms caused by shisha were trivialised by focusing on this issue.

> *"If I saw that, the first thing I'd think of would be, 'so what? I share a cup of water with a friend. Sharing the water's not unhealthy; maybe sharing the cup is – but so what?" - Young People*

Failure to link shisha to cigarette smoking

There was consensus that the key message of the campaign should be to make explicit the link between smoking shisha and smoking cigarettes.

> *"The imagery is no good. What they should have done is piggyback on something else – like show a cigarette and says 'that equals this' – they didn't ask the fundamental question 'what do you want the poster to do?"- Residents*

Participants felt strongly that poster lacked a clear and impactful message. One person who had experience of using shisha described the kind of information that he found motivating, namely that smoking shisha is as harmful – if not more so – as smoking cigarettes.

> *"I think the myth [used on the poster] is the least helpful myth you could think of. No one is really aware that it uses tobacco. A myth I know of and I personally own a shisha pipe, is that smoking a shisha pipe for 30 minutes is equivalent to smoking a hundred cigarettes. I think that that is much clearer message and you're drawing a parallel with something that people know is dangerous (Others in group agree – 'brilliant')." -Residents*

> *"Everybody knows how bad cigarettes can be, so if you can show that shisha can be worse than cigarettes, then it will get the message across."- Young People*

Logo, helpline and website

There was a general feeling that the information relating to further information was too small, indicating that it was unimportant. One participant in the young people's group suggested that the helpline and website details should be as large as the main text if the goal was to encourage people to contact these services. As it stands, it was considered unlikely that anyone would take the time to follow up an enquiry by entering the details and there was a question about why a smoking helpline would be used for shisha. Furthermore, there were questions about why the helpline was not a freephone number. The LB Barnet logo was considered to be unproblematic if not especially relevant to many participants, especially as the website address indicates the sponsor of the campaign. The placement of the logo on the shisha pipe was not seen as helpful or interesting.

While the LB Barnet logo was not considered to be especially valuable, there was an expectation that there should be a sponsor, and to that extent, there were no criticisms of its inclusion.

Asked whether an alternative sponsor or alternative wording might provide additional legitimacy to the campaign, some participants mentioned the NHS and some felt that the inclusion of the words 'public health' might add credibility.

> *"I don't think it makes any different who sponsors it. I think the important thing is the facts."- Young People*

> *"I think if it was the NHS or the British Heart Foundation, people might take it slightly more important."- Young People*

Responses to the London Borough of Ealing image

The imagery used London Borough of Ealing's Shisha campaign was shown to the participants to provide feedback. The overall feedback was in-line with their previous comments and showing including cigarettes in the poster imagery was favoured.

> *"Because it shows the 200 cigarettes you make the comparison, I find that quite powerful." -Young People*

> *"It makes the shisha pipe look more disgusting." -Young People*

Following discussion of the merits of the LB Barnet posters participants were shown the LB Ealing poster, as a point of comparison. In all three groups, there was a palpable acknowledgement that this poster succeeded in achieving the communication objectives of a public education campaign on shisha. They considered it to be clear, persuasive and visually impactful. Participants liked the fact that the image and the text were simple, clear and informative. The image was also felt to be clear and made explicit the link between shisha and cigarettes. The used cigarette butts in a rusty shisha pipe communicated the dirty and disgusting sense. Indeed, all the ideas that participants had expressed as lacking in the LB Barnet posters, together with their suggestions, were felt to be contained within the LB Ealing poster.

Locations where the posters should and should not be placed

There was agreement that bus shelters would be an effective setting for the posters. However, several participants felt that the backs of buses would not be appropriate as there would be a

risk of any advertising that included messages about smoke, to be mistaken as being related to environmental pollution. Others suggested that the sides of buses would be appropriate and would catch the eye.

The young people's group suggested putting the posters up near shisha cafes and bars. They also suggested shopping centres. Young people considered local newspapers were appropriate for adults. Both the BME and the young people's group felt that the poster spaces in tube stations, both across the rails and alongside the escalators, would be ideal. Beyond this, participants identified GPs surgeries and pharmacies, supermarkets' boards and universities and colleges, including sixth form colleges. Youth clubs were also identified. Participants suggested including a QR code on the poster that would link to the website.

There was support for the use of an online campaign. Several commented that they doubted how effective Facebook would be, although they acknowledged that this was a means of targeting information to a defined population. Twitter was widely felt to be a good method of engaging people and there was strong support for the suggestion that residents be invited – as part of the campaign – to 'have their say' on what should be done to tackle shisha use. Some suggested Instagram would be appropriate, particularly for young people. A link to a survey/vote was felt to be a good idea.

2.4 Recommendations for phase one

1. The existing creative treatments 'The Truth Behind the Smoke' (skull, lungs and poison) failed in audience research. However, the image of the shisha pot, full of cigarette butts (LB Ealing) was successful. A new advertising brief should be developed based on the following recommendations, to make explicit the link between shisha and cigarette smoking – something that is missing from the 'Truth Behind the Smoke' posters.

2. The proposition should focus on the fact that shisha smoking is equivalent to or more harmful than smoking cigarettes, causes the same harms as smoking cigarettes, and that this is new knowledge that most people are unaware of.

3. There should be an explicit visual or textual link to known stop smoking campaigns. The image and headline must work together immediately, without the need for a sub-headline, as viewers will not read more than a single headline before dismissing it.

4. Where facts are included, they should always lead with the seriousness of health consequences of smoking shisha, and not on the less injurious concerns such as oral herpes.

5. The value of the advertising will be in informing those considering smoking shisha who currently believe it to be safe. It will also be valuable to those friends and family of young people who are confused about the risks of smoking shisha, in discouraging them from smoking shisha.

6. Shisha bars and cafes are widely considered to be cool and trendy, especially by young people (teenagers and early 20s). The shisha experience is based on an aesthetic of middle east/Persian culture, that involves a relaxed atmosphere, mixed with the thrill of nightclubs and nightlife. As part of the campaign, there could be an element that seeks to deglamorise shisha and shisha bars as a way of reducing its appeal to young people.

7. All advertising imagery should convey clearly the idea that shisha is uncool and unappealing. A valuable way of doing this is to invoke a feeling of disgust that is attached to smoking shisha in the viewer. No imagery should be used that simply presents the paraphernalia of shisha or of shisha smoking, as this is likely to be misinterpreted by viewers among the target audience as cool and appealing.

3.2 Phase 2

The second phase of the campaign was developed to engage with primary health care professionals and also young people.

The primary aims of the second phase were:

- **In increase the awareness of shisha among health care professionals in Barnet**
- **Increase the awareness of the harms of shisha among the young residents of Barnet**

Engagement with primary care professionals

To engage with health care professionals, "The Truth behind the Smoke" poster was sent to all GPs and Pharmacies in Barnet. GPs and Pharmacies in Barnet were encouraged to display the poster in the premises.

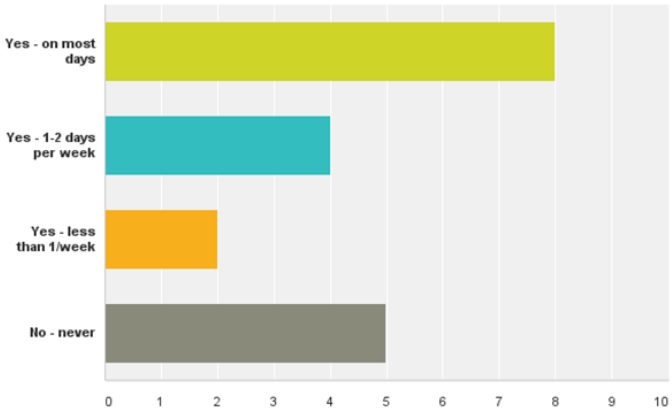
In addition, a short survey was sent via email to 56 GP surgeries and 54 pharmacies in LB Barnet. A total of 19 responses were received. The survey was conducted between December 2016 and February 2017. As with the feedback from the public survey, the findings from this survey are not generalizable to the whole population of primary care health professionals in GPs surgeries and pharmacies in LB Barnet.

Profile of respondents

All respondents confirmed that they either worked in LB Barnet (n=7), lived in LB Barnet (n=2) or lived and worked in LB Barnet (n=10)

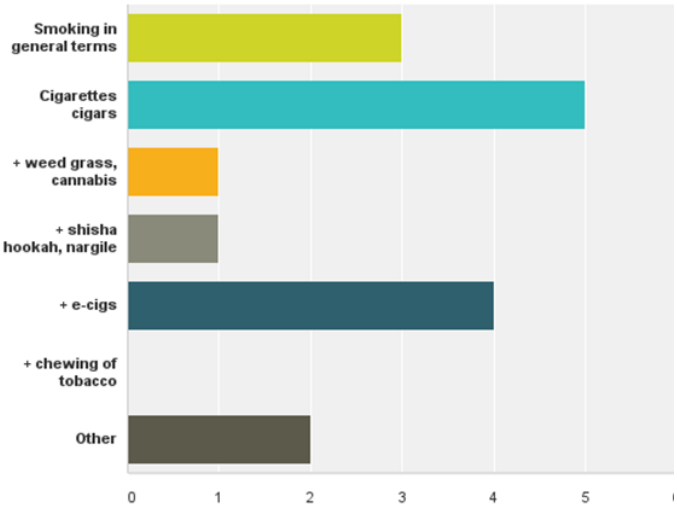
Frequency of provision of advice to patients about smoking

The respondents were asked if they provide advice about smoking behaviour to patients. 14 of the 19 respondents reported that as part of their professional role they advised patients/clients about their smoking behaviour. The majority did so 'on most days'.



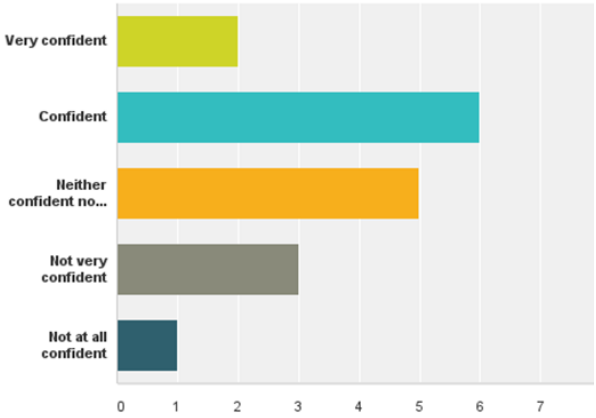
Substances that health professionals discuss when advising about smoking

Respondents were asked which substances they discussed as 'usual practice' when advising patients/clients about smoking. The majority reported that they discussed 'smoking in general terms' or focused on 'cigarettes and cigars'. Only one reported that they discussed shisha as part of their usual practice.

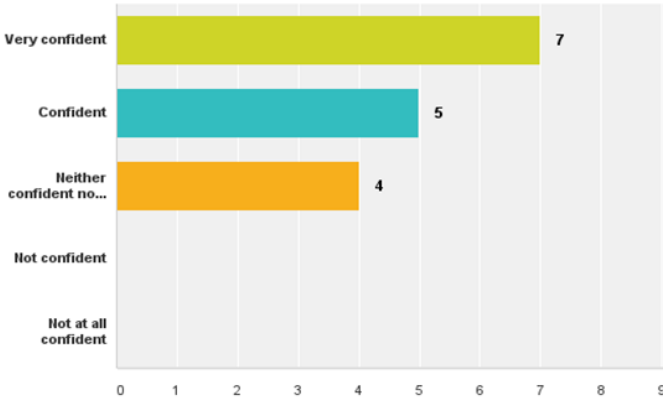


Confidence of health professionals in their knowledge of cigarettes/cigars

Respondents were asked to assess their confidence in their professional knowledge and understanding of cigarettes and cigars when advising patients/clients about smoking. The same question was then asked in relation to shisha. The feedback indicates that there may be a need for professional development of primary care staff to support their knowledge and understanding of shisha, in order to enable them to advise their patients and clients effectively.



Health care professionals' confidence in providing advice on cigars and cigarettes



Health care professionals' confidence in providing advice on shisha

Health care professional's awareness of the LB Barnet campaign

A briefing about shisha for health professionals was sent to all primary care staff by email in December 2016. All 5 respondents who responded to the survey after this date reported that they had received it. 9 respondents reported having seen the public campaign and 10 that they had not.

Engagement with Barnet's young residents

Barnet public health team commissioned Cut Films to engage with young people.

Health education workshops

Between 4th November 2016- 26th January 2017, Cut Films delivered health education workshop to raise awareness of harms of shisha smoking to 4264 students through 47 workshops. The workshops included a truth and myth game, where each individual student has a truth/myth card that they can hold up to agree or disagree with a statement. This provided a time for students to express their opinions, misconceptions and ask questions that they may have about shisha, cigarettes and even e-cigarettes (vaping). The workshops then move onto a media round, generating a discussion about shisha and advertising. The workshops were designed to be age appropriate, engaging and informative. Many young people as well as teachers expressed their astonishment at some of the facts.

The initial evaluation suggested that 84% of young people have said they enjoyed the workshop, **90%** have said they learned something new, 88% are more aware of the harms associated with shisha.

Short video development

Cut films also worked with a small group of young people and developed a short advert to inform other young people about the dangers of smoking in an informative and interesting way.

3.3 Phase 3

The third phase of the campaign was developed to educate and inform local residents and businesses about the risks of smoking shisha by dispelling the myths that surrounds its use, presenting the health facts and highlighting true health implications; and also to engage with the borough's shisha bars to raise awareness of the nuisance and harm caused by unregulated shisha smoking and encourage good practice when serving shisha.

Communications

The third phase of the Truth Behind the Smoke campaign ran from 3 January – 10 February 2017. This phase was developed by Barnet Public Health and Communications team and was implemented by the communications team. The evaluation of the communication routes used to communicate the campaign with the residents is summarised in the table below:

INPUTS	OUTPUTS (distribution, exposure, reach)	OUTTAKES (Awareness, Understanding, Engagement)	ORGANISATIONAL IMPACT (Reputation, revenue, costs reduction)
• Bus Shelter Panels and Six Sheet High Street Posters • Shisha campaign webpage • Copy for Barnet First • Advert for Barnet First • Questionnaire incentive • Video blogs with a GP registrar • Social Media Posts • Twitter Polls • Middlesex University Intranet • Press releases • School Circular • Digital Advertising • Article in the council staff e-newsletter, First Team. • News item in the Barnet Council intranet.	• The six sheet posters in the borough's high streets had over 17 million opportunities to see over the course of the campaign. • The bus shelter panel posters received over 10 million opportunities to see. • The shisha campaign website was viewed 1,799 times for an average of 3 minutes and 28 seconds. • Six video blogs were issued across our social media channels (Facebook, Twitter, Instagram and YouTube). • The video blogs were seen across the world • One press release was issued as part of the campaign. • The press release was picked up by both local newspapers (online and print) which reached 206,440 residents. • Information on Middlesex University's Intranet page was seen by 100,000 students. • 300 school teachers saw the shisha campaign article in the School Circular.	• In total, the video blogs were viewed 981 times. • The Twitter Poll launched at the beginning of the campaign received 90 votes, the most of any other Twitter Poll run by the council. • The paid-for Facebook post promoting the public engagement questionnaire reached 5,691 residents and received 9 likes and 89 clicks on to the questionnaire link. • 119 residents took part in the shisha public health engagement questionnaire, with 20 taking part in the incentive. • 80 per cent of young people aged 13 – 25 were exposed to digital advertising on websites such as YouTube and 600 people clicked on and interacted with the digital advertisement link. • The shisha article in First Team was viewed 1,700 times, with the link to the shisha campaign webpage being opened 41 times. • The news article on the Barnet Council Intranet page was viewed 65 times.	• Through the campaign we have raised the reputation of Barnet as a council which cares about the health and wellbeing of its residents; in March 2017 we were contacted by BBC London who had heard about the campaign and wanted to do a piece on how the council were raising awareness of the health effects.

Table 2 Summary of the communications campaign evaluation - Source: The Evaluation of Shisha campaign conducted by the LBB communication team

LB Barnet's Survey of Residents

The Council collects regular feedback on residents' awareness of its campaigns and other activities via a regular tracker survey. The Barnet Council Resident Perception survey involves around 500 respondents aged 18 and over, and is conducted by an independent market research agency on behalf of the Council. The survey is conducted by telephone. The following chart shows that during November 2016 the 'dangers of smoking Shisha' campaign was reported to have been seen by 23% of respondents. This survey was conducted prior to the commitment of most of the media spend budget, and it is therefore reasonable to assume that

the proportion of people who would have seen it in January and February 2017 would be greater.

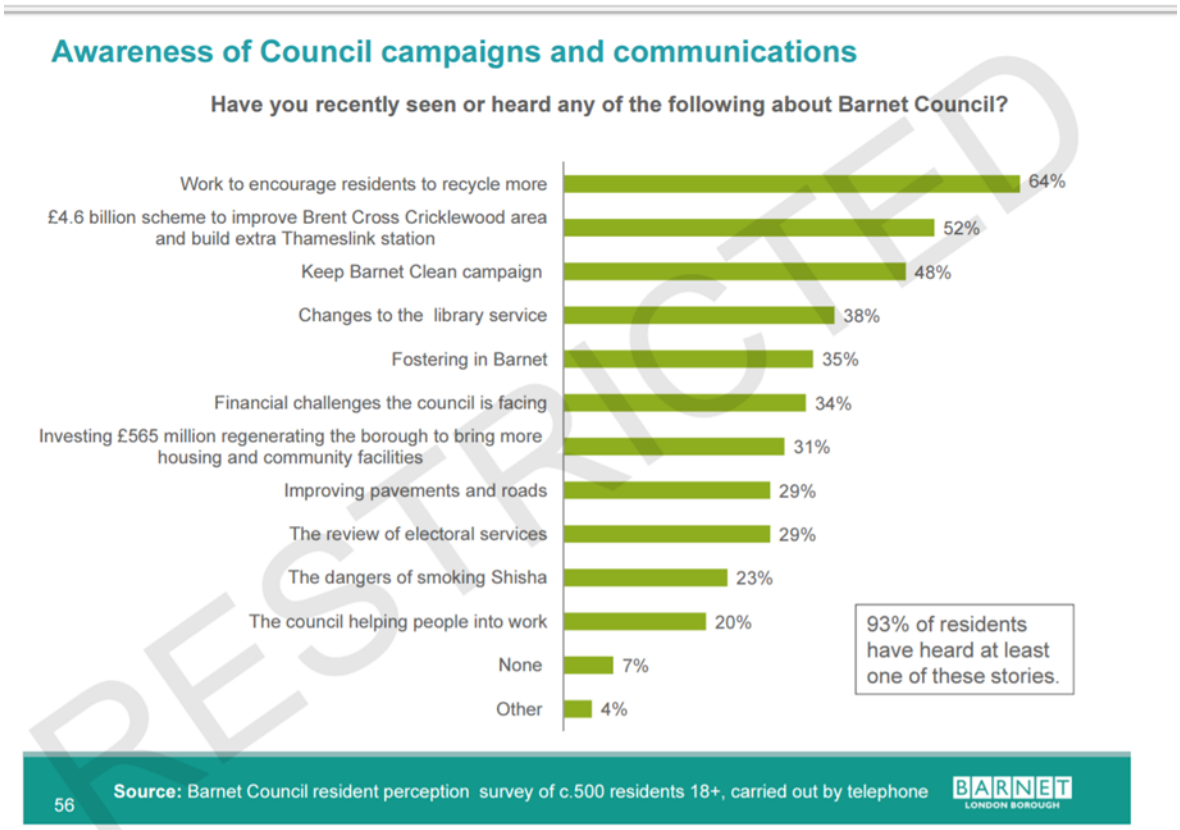


Figure 3 Barnet's resident's awareness of different campaigns ran by the council

Appendix 1

Analysis of public health issues on LB Barnet's website

Analysis of LB Barnet's website pages indicates that during January and February 2017, the web page for the Shisha campaign was the most visited page within the public health section of the website. During the period 23 January to 26 February, 41% of all users (n=3,987) who accessed the public health section, did so in order to view information about shisha.

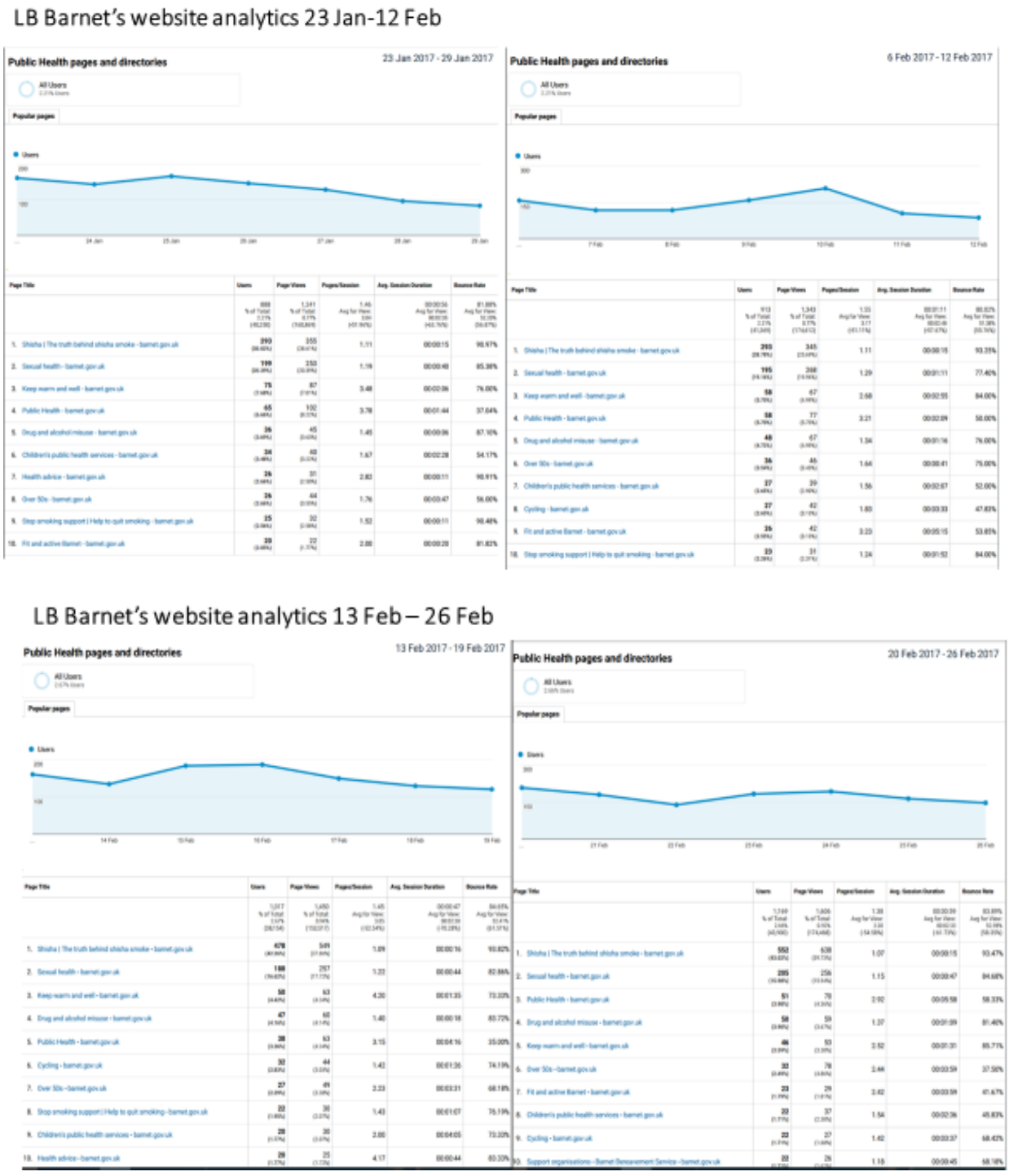


Figure 4- London borough of Barnet's shisha website analytics during the Shisha campaign - between 23rd January 2017 and 26th February 2017

3.4 Findings from an online survey of members of the public

How the online survey was promoted

The LB Shisha public education campaign was launched in October 2016 and ended in February 2017. The campaign used a range of channels, including paid for media space in key locations in Barnet, on bus shelters, bill boards, tube stations as well as GP surgeries and chemists/pharmacies. The campaign also included the use of social media, involving Twitter and Facebook.

A link was promoted on all imagery, inviting viewers to log into the Council's website to obtain further information and to give their feedback on the campaign. A series of questions about responses to the campaign, were asked in the form of an online survey, and members of the public were invited to respond. The online survey was made available via the LB Barnet website, and directions to the link were displayed on the static images of the campaign, as well as via social media (Twitter and Facebook) promotions undertaken by the Council's communications department.

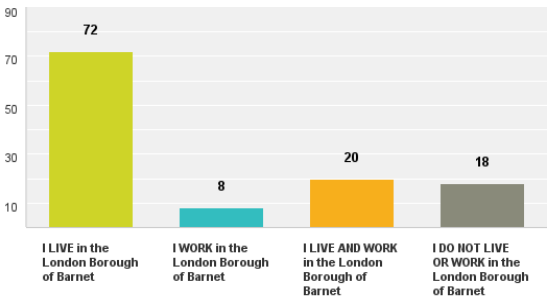
Survey responses

A total of 119 people responded to the survey, although not everyone who responded answered every question. As there were insufficient numbers of respondents to make a 'before' and 'after' campaign analysis meaningful, the percentages are presented here for information, against which to measure possible future health promotion efforts

Profile of respondents

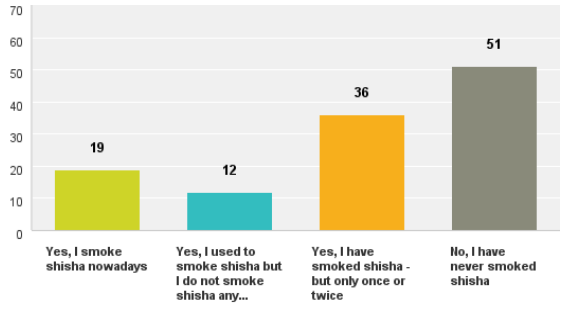
This was not a representative survey of the population of LB Barnet. Unsurprisingly, given the topic and the method of response, the profile of respondents was much younger than that of the borough overall, and the proportion of respondents who reported having ever used/tried smoking shisha was much higher than would be expected.

58% of respondents were female and 42% male.



Do you live or work in LB Barnet?

Overall, 85% of respondents were residents of LB Barnet and/or worked in the borough.



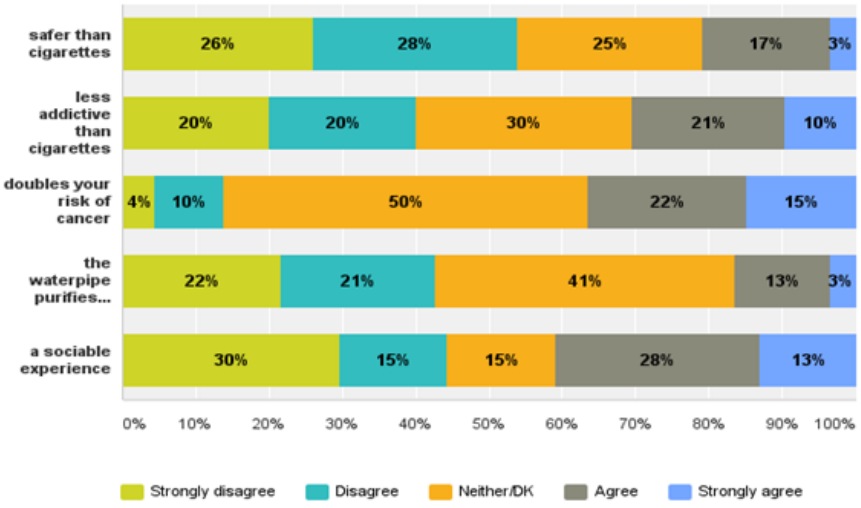
Have you smoked shisha?

67 respondents (57%) reported that they had smoked shisha on at least one occasion.

Attitudes to key campaign messages

A series of statements about smoking shisha were included in the survey, and respondents were invited to state whether they agreed or disagreed with each statement. The statements were

developed to reflect the key knowledge messages that the information campaign sought to address. In summary, these related to perceptions about the health harms caused by shisha, the risks of shisha smoking relative to cigarettes and the sociability of smoking shisha.



The responses to these statements indicated that while the largest proportion of respondents tended to agree with the factually accurate statement in all cases, there was a sizeable group who answered 'don't know/neither', indicating a need for further information giving.

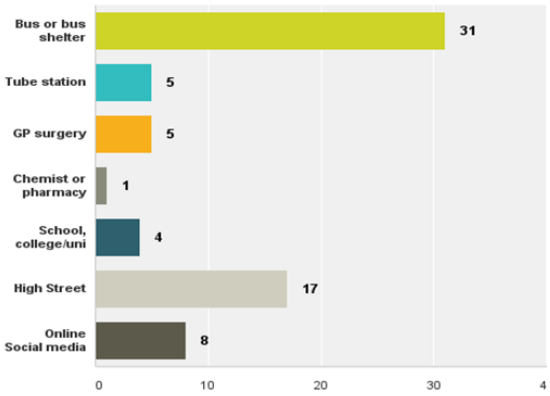
- 54% of respondents disagreed with the statement 'smoking shisha is safer than smoking cigarettes.'
- 40% disagreed that 'smoking shisha is less addictive than smoking cigarettes.'
- 37% agreed that 'smoking shisha doubles your risk of cancer'. However, 50% of respondents reported 'don't know/neither' to this item.
- 41% disagreed that 'the water-pipe involved in smoking shisha purifies the harmful substances that are inhaled.'
- 45% disagreed that 'smoking shisha is a sociable experience for people like me.'

Awareness of the campaign

45% of the residents reported that they had seen the campaign - The survey asked respondents whether they had seen the LB Barnet shisha public education campaign. An image of the poster was included to prompt recall. Of the 110 respondents to this question, 50 people (45%) reported that they had seen the campaign.

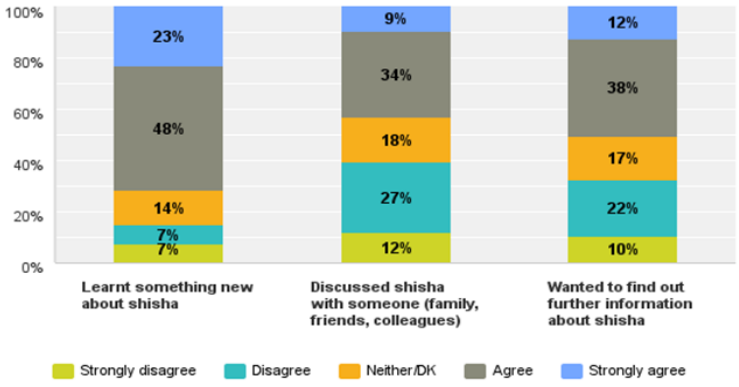
Where campaign was seen

The majority reported having seen it on a bus shelter or on the high street. - The respondents were asked about where they had seen the campaign. Of those respondents who reported having seen the campaign (n=49), the majority reported having seen it either in a bus or bus shelter or on the high street.



Impacts as a result of the campaign

The majority of the respondents reported that they had learnt something new from the campaign and over half of the respondents wanted to gain further information as the result of the campaign. Respondents were asked to agree or disagree with a series of statements that related to actions they may have taken as a result of having seen the campaign.

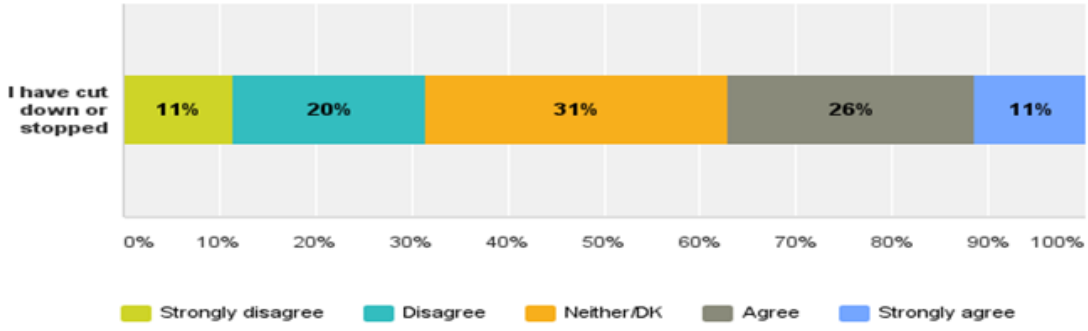


- 71% of respondents reported that they had learnt something new as a result of the campaign
- 43% agreed that they had discussed shisha with someone (a family member, a friend or a colleague).
- 51% reported that they wanted to find out further information about shisha as a

Reported behaviour changes among shisha smokers

The shisha smoker respondents were asked if they have cut down smoking shisha since seeing the campaign. 13 (37%) of the 35 respondents who reported having smoked shisha agreed with the statement that they had either cut down or stopped smoking shisha, since seeing the campaign.

Attitudes to potential actions by local government to tackle shisha



Respondents were asked whether they agreed or disagreed with a series of proposed actions that the local authority could take to tackle the issue of shisha smoking.

They were asked, 'do you think local authorities should have the power to..' followed by a series of statements. The findings indicate a clear desire for greater regulation of businesses selling shisha.

Allow the sale of shisha in cafes and bars without restriction	• 71% of respondents disagreed with this statement
Ban the sale of shisha in cafes and bars	• Responses were divided fairly evenly. 43% agreed and 39% disagreed and 18% did not know
Require owners of bars and cafes that sell shisha to apply for a licence, as with alcohol	• 81% of respondents agreed this statement
Allow the sale of shisha in cafes and bars, but only with greater controls than apply currently	• 58% of respondent agreed with this statement
Remove the right to trade from owners of shisha bars and cafes that sell illegal tobacco (e.g. non duty-paid or counterfeit tobacco)	• 68% of respondents agreed with this statement
Remove the right to trade from owners of shisha bars and cafes that sell shisha to people under the age of 18	• 77% of respondents agreed with this statement

Table 3 The respondents answer to the question do you think local authorities should have the power to..

Environmental Health engagement with shisha cafes /bars

Appendix 1

The Environmental Health department (EHD) undertook a programme of compliance visits to shisha bars and cafes in the 'hot spot' area of Finchley Road, where a cluster of bars and cafes existed. The EHD had monitored these premises for several years, prior to the Council's motion on shisha, as part of its continuing efforts relating to the enforcement of smoke-free legislation and of the sale of illegal tobacco and of sales to minors. The sector is marked by rapid turnover of ownership, frequent closure and re-opening of premises in the area, often by individuals who are related, by connections to anti-social activity and criminal activity and by difficulties for official bodies to maintain track of owners and managers, and as a result to enforce existing powers.

The experience of EHD officers working to enforce compliance in LB Barnet was that the current powers and resources available were inadequate to bring about any meaningful disruption of the trade in the sale of shisha from bars and cafes. However, as part of the LB Barnet campaign, lessons on how to effectively eradicate the problem of shisha bars that operate beyond the law, were sought from other London local authorities.

Conclusion

Overall London borough of Barnet's shisha campaign was successful in meeting its aims and objectives. The campaign was successfully reached out to the target population and was able to raise awareness of the health harms of shisha amongst the residents, raise awareness of the concept of shisha among health care professionals and also increase compliance of the shisha bars/ cafes in the borough. It also developed re-usable resources which could ease the implementation of any future campaigns. The campaign worked closely with a number of internal and external partners and also managed to better the reputation of the council.

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	Health and Wellbeing Board **20th July 2017**
Title	**Revised Terms of Reference and Minutes of the Joint Commissioning Executive Care Closer to Home Programme Board**
Report of	Strategic Director of Adults, Communities and Health
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1 – Joint Commissioning Executive, Care Closer to Home Programme Board Revised Terms of Reference. Appendix 2 - Minutes of the Joint Commissioning Executive Group 20 February 2017. Appendix 3 - Minutes of the Joint Commissioning Executive Group 25 April 2017. Appendix 4 - Minutes of the Joint Commissioning Executive Group and Care Closer to Home Programme Board 27 April 2017. Appendix 5 – Minutes of the Joint Commissioning Executive Group and Care Closer to Home Programme Board 18 May 2017.
Officer Contact Details	Courtney Davis Head of Adults Transformation courtney.davis@barnet.gov.uk

Summary

This report provides:

- Revised Terms of Reference for the Joint Commissioning Executive Care Closer to Home Programme Board (formerly known as the Joint Commissioning Executive Group) (Appendix 1).
- Minutes of the Joint Commissioning Executive Group meetings (Appendix 2 and 3).
- Minutes of the Joint Commissioning Executive Care Closer to Home Programme Board (Appendix 4 and 5).
- An update on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan.

Recommendations

1. **That the Health and Wellbeing Board comments on and approves the Joint Commissioning Executive Care Closer to Home Programme Board Terms of Reference (appendix 1).**
2. **That the Health and Wellbeing Board comments on and approves the minutes of the Joint Commissioning Executive Group meetings of 20 February 2017 (appendix 2) and 25 April 2017 (appendix 3).**
3. **That the Health and Wellbeing Board comments on and approves the minutes of the Joint Commissioning Executive Care Closer to Home Programme Board of 27 April 2017 (appendix 4) and 18 May 2017 (appendix 5).**

1. WHY THIS REPORT IS NEEDED

Purpose and Terms of Reference

1.1 On 26 May 2011 the Barnet Health and Wellbeing Board agreed to establish a Financial Planning group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The Financial Planning Group developed into the Joint Commissioning Executive Group (JCEG) in January 2016 with the key responsibility of overseeing the Better Care Fund, Section 75 agreements, the development of a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy through its respective membership. JCEG is required to report back to the Health and Wellbeing Board (HWBB).

1.2 On 9 March 2017 the Health and Wellbeing Board (HWB) held a workshop session to discuss the development of a local health and care delivery strategy. In light of the development of the Sustainability and Transformation Plan (STP)[1], it is important that the Barnet HWB can set out its collective priorities for the health and care system for 2017-18 and beyond.

[1] Barnet Council STP website: https://www.barnet.gov.uk/citizen-home/adult-social-care/north-central-london-sustainability-transformation-plan.html
Barnet CCG STP website: http://www.barnetccg.nhs.uk/about-us/sustainability-and-transformation-plan.htm

1.3 Key highlights impacting health and social care in 2017:

- NCL STP entering delivery phase from April 2017.
- Changes to NCL CCGs' management arrangements.
- Changes to health commissioning (functions delegated to a committee of 5 NCL CCGs).
- Two year BCF (2017 – 2019).
- NCL STP does not achieve financial balance for the sector.
- Activity in the urgent and emergency care pathway is increasing, with record levels attending A&E, high levels of delayed transfers of care, etc. This has a corresponding impact on planned care activity and earlier intervention by social and primary care.

1.4 The workshop agreed to develop a Health and Care Delivery Strategy which will provide a clear joined-up position setting out how the leaders of the Barnet health and care system anticipate the STP requirements being translated into local delivery. This supports and does not suspend other decision making or current strategies / commissioning intentions. It is also important to consider and appropriately manage communication and engagement with residents throughout the delivery strategy.

1.5 The workshop also agreed the current Joint Commissioning Executive Group (JCEG) would take on the role of overseeing and supporting local implementation of STP plans in Barnet, ensuring alignment with the goals and ambitions of the HWB and the Joint HWBS. This Group will shape local delivery of STP initiatives to ensure that each initiative meets local need and works for Barnet as a local system, as well as delivering STP requirements. A critical work stream identified to be led by this group is the Care Closer to Home work stream, as this encapsulates the existing BCF services, elements of urgent and emergency care, which are both led jointly at the moment; primary care improvement, led by the CCG; and public health, voluntary sector, volunteering and community capacity building, currently led by the Council. Therefore, JCEG membership has been expanded to include providers and rescheduled as the Joint Commissioning Executive, Care Closer to Home (CC2H) Programme Board. The Terms of Reference can be found at appendix 1.

1.6 It should be noted that, in taking on this role, the JCE / CC2H Programme Board does not supersede existing individual organisation decision-making routes but ensures strategic alignment and effective implementation across the CCG, Council, NHS and social care providers. The minutes of the JCE / CC2H will continue to be formally adopted and agreed through its reporting to the Health and Wellbeing Board.

1.7 Guidance on the Better Care Fund allocations for 2017/18 has not yet been published by NHS England.

Minutes and meetings

1.8 Minutes of the JCEG meeting held on 20 February 2017 are presented in appendix 2. In February the Group:

- Discussed the content of the North Central London Sustainability and Transformation plan; ensuring that this is appropriate from a Barnet

perspective particularly focusing on developments of Care Closer to Home; and planned for a HWBB workshop.
- Agreed action to improve the Community Equipment services particularly around the process of collections and monitoring.
- Agreed the Joint Health and Wellbeing Strategy Implementation Plan update and agreed to ensure action plans were in place to improve red RAG items.
- Considered plans to improve the maternal mental health pathway asking for strong baseline data and links with adults mental health developments to be included in the developments.
- Agreed the BCF Quarter 3 submission for NHS England.
- Scrutinised the BCF dashboard and further shaped the review of the BCF programme to be presented to the Group in April.

1.9 Minutes of the JCEG meeting held on 25 April 2017 are presented in appendix 3. In April the Group:

- Considered the BCF 2016/17 review and further advised on the scope, detail and dependencies of the review which will inform plans for 2017 – 2019.
- Reviewed S75 agreement performance and monitoring, ensuring appropriate mitigations and controls are in place.
- Agreed the updated schedules for Voluntary Sector Prevention Commissioning (2017 – 2022) and Community Equipment (2017 – 2021) to be signed and sealed by both parties in May 2017.
- Reviewed and noted the new process designed for children's continuing care which has been developed through the CCG working with Local Authority colleagues in Social Care and Education.
- Commented on progress to procure children's integrated therapies by April 2018.
- Commented on the progress to procure a new children and young people's emotional wellbeing and mental health services by January 2018.
- Agreed the updated TOR for the JCE CC2H Board.

1.10 Minutes of the meeting of the JCE CC2H Board held on 27 April 2017 are presented in appendix 4. In April the Board:

- Established and refined the purpose and focus of the Board.
- Agreed TOR to be presented to the HWB for agreement.
- Approved the development of a Care Strategy for presentation at the HWB.
- Considered progress to develop Care Closer to Home Integrated Networks (CHINs), agreeing further action.
- Agreed the Barnet Care Closer to Home project initiation document; agreeing actions to accelerate developments.
- Considered timescales and progress to develop BCF 2017/19.

1.11 Minutes of the meeting of the JCE CC2H held on 18 May 2017 are presented in appendix 5. In May the Board:

- Received a verbal update from BCCG on progress towards the development of the delivery plan and financial plan for CHINs.

- Considered the priorities for the business cases that will be developed by the CHINs.
- Reviewed notes from the January meeting of local NHS and Local Authority Chief Officers and agreed an outline agenda for the group's next meeting on 25 May.
- Held a workshop style discussion on the vision and aspirations for Care Closer to Home, which will be written up into a report and considered at a future meeting, prior to presentation at the HWB.

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 Care Closer to Home Programme Board) 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 / Joint Commissioning Executive Care Closer to Home Programme Board, 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, Care Closer to Home Programme Board to take forward its programme of work, the group will progress its work as scheduled in the areas of the Sustainability and Transformation Plan, Better Care Fund and Section 75 agreements.

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 The Joint Commissioning Executive Care Closer to Home Programme Board is responsible for the delivery of key health and social care national policy including the Sustainability and Transformation Plan and Better Care Fund.

5.1.2 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.

5.1.3 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, Care Closer to Home Programme Board acts as the senior joint commissioning group for integrated health and social care in Barnet.

5.3 **Social Value**

5.3.1 Social value will be considered and maximised in all policies and commissioning activity overseen by the Board.

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, Care Closer to Home Programme Board will factor in engagement with users and stakeholders to shape its

decision-making.

5.7.2 The Joint Commissioning Executive, Care Closer to Home Programme Board 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.

Appendix 1

Joint Commissioning Executive
Care Closer to Home Programme Board
Terms of Reference

The Joint Commissioning Executive Group (JCEG) will monitor existing joint arrangements between NHS Barnet Clinical Commissioning Group (CCG) and the London Borough of Barnet (LBB) and make recommendations to the relevant decision making bodies or officers for future joint arrangements.

The North Central London (NCL) Sustainability and Transformation Plan (STP) sets out wide ranging delivery plans covering the full range of health care. Whilst many of the STP aspirations are in alignment with the ambition set out in Barnet plans, it is important that as a local system there is a clear view of what is needed for the implementation of these plans in Barnet. JCEG will be a space for CCG, LBB and selected partners to discuss local priorities for commissioning and delivery across health and care in Barnet within the context of the STP.

JCEG will operate within existing schemes of delegation and reservation, constitutions and standing orders of each organisation.

Purpose

To operate as the executive delivery arm of the Health and Wellbeing Board.

To oversee the development and implementation of plans for an improved and integrated health and social care system including:

- the local delivery of the STP including being the programme board for Care Closer to Home
- the borough's Better Care Fund.
- the delivery of Section 75 agreements between NHS Barnet CCG and London Borough of Barnet.

Functions

1. To provide the overarching governance mechanism for the health and social care system transformation programme (STP), ensuring that the transformation programme is driven by the Barnet vision and that programme leads are adequately supported in their work and held to account for the delivery of their responsibilities. Key areas from the STP include:

   a) **Care Closer to Home**:
      - Develop and deliver the Care Closer to Home vision

- Consider, commission, prioritise and approve proposed new programmes and projects, approving programme briefs and business cases
- Identify programmes and projects that should be discontinued or re-prioritised due to changes in the environment
- Ensure consistency, compatibility and co-ordination between programmes and projects
- Manage high-level interdependencies and risks associated with all transformation programmes and the wider portfolio of change.
- Ensure programmes deliver against their outcomes, KPI's, budgets, timescales, quality measures and business benefits, as identified in their business cases
- Strategically identify, prioritise and allocate resources to programmes and projects, re-aligning where necessary including recommending financial allocations and changes to respective organisations
- Monitor the impact of transformation programme as a whole, including unintended consequences/dis-benefits, and agree appropriate strategic response
- Ensure that an overarching effective Communications and Engagement Strategy exists, including key messages for circulation to the partner organisation as the result of each meeting
- Ensure appropriate public and patient engagement is undertake across the programme.

b) Prevention
c) Children and young people
d) Urgent and emergency care pathways
e) Planned care
f) Mental health.

2. To oversee the delivery of the **Better Care Fund** including:

a) Overseeing the Integrated Care Model by holding the Joint Commissioning Unit and partners to account for its delivery
b) The Group is responsible for making recommendations on the governance and legal functions required to develop and implement the Better Care Fund Pooled budget and manage risk
c) Monitoring expenditure for budgets for the Better Care Fund and for wider work to integrate care services
d) Monitor progress in delivering Better Care Fund services and tracking benefits realisation against these budgets
e) Overseeing the financial risk of the Better Care Fund and, where necessary, making recommendations on recovery plans.

3. To oversee all **Section 75 agreements** held between the London Borough of Barnet and NHS Barnet CCG to ensure that they are operating effectively including:

a) Monitor performance reports at least quarterly, receiving an annual report which with onwards reporting to the Health and Wellbeing Board
b) Monitor expenditure and management of the pooled funds

c) Review risks to ensure that appropriate actions are in place
d) Oversee the extension and renewal process for Section 75 agreements.

Section 75 agreements are:

Adults	Community Equipment;
	Prevention / Voluntary Sector
	Learning Disability
	Campus Re-provision
	Health and Social Care Integration
	Mental Health (between the council and Barnet, Enfield and Haringey Mental Health Trust).
Children	Speech and Language Therapy
	Looked After Children
	Occupational Therapy
	Children and Young People Mental Health Services (from January 2018)

4. Performance and finances

a) 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
b) To ensure appropriate governance arrangements and management of additional budgets delegated to the Health and Wellbeing Board
c) To develop and review the work programme for the Health and Wellbeing Board and make recommendations for amendments or additions
d) To review reports being considered by the Health and Wellbeing Board which have financial or resource implications
e) To approve the work programmes of the Joint Commissioning Units (adults and children)
f) To agree business cases arising from the Joint Commissioning Units for adults and children requiring alignment of social care expenditure and activities
g) To support the refresh of the Joint Strategic Needs Assessment and oversee the refresh and implementation of the Joint Health and Wellbeing Strategy
h) 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.

5. Each organisation should ensure that the **risks** relating to BCF and section 75 agreements are clearly reflected on each organisation's respective Risk Registers and that these risks are reviewed regularly at each meetings and escalated to the Health and Wellbeing Board and the FPQ Committee as required.

Membership

Organisation	Post
Commissioning	
London Borough of Barnet (LBB)	Commissioning Director for Adults and Health
	Commissioning Director for Children and Young People
	Director of Public Health
	Director of Resources
NHS Barnet Clinical Commissioning Group (CCG)	Accountable Officer
	Director of Commissioning
	Director of Strategic Development
	CCG Board representatives (3)
	Chief Finance Officer
Providers	
London Borough of Barnet	Director of Adults and Communities
Central London Community Healthcare NHS Trust	Director of Divisional Operations
	Strategy Manager
Royal Free London NHS Foundation Trust	Hospital Director
	Director of Partnerships and Transactions
Barnet Enfield Haringey Mental Health Trust	Clinical Director
Barnet GP Federation	GP (2)
	MBI Health Group (working with the GP Federation)
Partners	
Community Education Providers Network	TBC
Healthwatch	Head of Healthwatch

Members are able to appoint a substitute to attend in their place if they are unavailable to attend a meeting.

Administration and Secretariat Support

The Council and CCG will provide support to the Board which will include taking and circulating minutes, organising meetings (dates; rooms), circulating papers and supporting agenda setting and developing a work programme. The following roles will support the Board:

- Associate Director of Governance & Corporate Affairs (CCG)
- Head of Adults Transformation (LBB)
- JCU Commissioning Lead (LBB)

Declaration of Interests

The Chair will ask at the beginning of each meeting whether any member has an interest about any item on the meeting agenda. If a member has a direct or indirect conflict with an issue on the agenda which may impact on their ability to objective, it should be declared at the meeting and recorded in the minutes. On the basis of the

interest declared, the Group will make a decision as to whether it is appropriate or not for this member to remain involved in considering the agenda item in question. The agenda for meetings will stipulate where items are for commissioners only and will be managed, as appropriate, by the Chair (e.g. through moving to part 2).

Quoracy

For the Group to be quorate, two representatives from each organisation (CCG and LBB) need to be present.

Chairmanship

There will be alternate chairing arrangements, shared between the Commissioning Director for Adults and Health (LBB) and the Director of Commissioning (CCG).

Reporting and Referrals

The minutes of all the JCEG meetings (including an attendance record) shall be formally recorded and submitted to the Health & Wellbeing Board for noting and comment, and to NHS Barnet CCG's Finance, Performance and QIPP Committee for noting.

The JCEG will refer matters for decision to the Health & Wellbeing Board and/or relevant NHS Barnet CCG and/or London Borough of Barnet officers or committees where appropriate (within the appropriate level of delegated authority to take decisions).

Frequency and Notice of Meetings

Meetings shall be held at least monthly, unless otherwise agreed.

Items of business to be transacted for inclusion on the agenda of the meeting should be approved via the work programme and agreed with the chair at least 15 working days before the meeting takes place (chairs are able to add items to the agenda as they arise). Any supporting papers should be sent to the members at least 5 working days before the meeting.

The Chair reserves the right to call for an urgent or extraordinary meeting of the Group through a virtual distribution of paper(s) with clear specific instructions to the members.

Review

These terms of reference will be reviewed on an annual basis and the work of this group is subject to both organisation's internal audit work plan and programme to review its effectiveness.

Minutes from the Health and Wellbeing Board – JCEG
Monday 20 February 2017
North London Business Park, Boardroom
15.30 – 17.00

Present:
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB
(MA) Muyi Adekoya, Joint Commissioning Manager Integration, LBB/BCCG
(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)

(NC) Natalia Clifford, Consultant in Public Health, Barnet and Harrow Public Health Team (item 5)

Apologies:
(AD) Anisa Darr, Resources Director, LBB
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(CMc) Collette McCarthy, Head of CYP Joint Commissioning, LBB/BCCG
(RH) Roger Hammond, Interim Chief Finance Officer, BCCG

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair, DW welcomed the attendees to the meeting. Apologies were noted as above.	
Policy and strategy		
2.	**NCL Sustainability and Transformation Plan (STP)** DW updated the group and explained that there had been a number of NCL meetings in January. DW went on to state that exploration of accountable care in Barnet had started. DW stressed the importance of taking a Barnet view of the STP developments. DW explained that there would be a workshop session for the Health and Wellbeing Board on the 9 March 2017. In light of the development of the STP, the purpose of the workshop session is for Health and Wellbeing Board members to discuss their local priorities for commissioning and delivery across health and care in Barnet. The aim is to develop strategic local plans which build on our joint strategies and programmes such as the Joint Health and Wellbeing Strategy and Better Care Fund. The workshop session which also explore governance for Care Closer to Home and the implications this has for the role of JCEG. DW tasked the Adults Joint Commissioning Unit (JCU) with improving the engagement with primary care. DW stated that JCEG needed to become a strategic, management group with representation across health and social care including clinical. The Group discussed the possibility of GP representation on JCEG and agreed for this to be raised at the workshop session. DW added that a pilot exploring a move towards some sort of population based capitated budget for the new delivery vehicles has started.	
3.	**Community Equipment 2017/18** At its last meeting, JCEG had asked for an update on the steps being taken to improve the delivery of the Community Equipment service.	

	NH presented an overview of the current service: • Projected overspend for 2016/17 of £198,000 • Orders for care homes rose by 25% in 2016/17 • Collections of existing equipment have increased from 2015/16 to 2016/17 due to the Delivery Unit chasing Care Homes when patients are deceased / 24 hour collection facility • Most common ordered equipment is pressure equipment such as mattresses, beds and riser recliners • Biggest increase in ordering is from the CLCH District Nursing team. NH went on to describe the proposed actions to improve delivery and manage the service within existing budgets: • CCG/LBB to clarify policy on equipment provision to Care Homes including compassion to like policies elsewhere • Hold review meetings with all high spending teams to understand any changes in ordering behaviour and to reinforce collections policy • Mailshot to all users regarding collections policy, which will also focus on collection of high value Community Equipment. Required ongoing and specifically as part of current Medequip contract ending The group discussed the proposal for a full time Scrutiny Officer (OT) across three boroughs (currently undertaken but only 8 hours a week). DW questioned if this would significantly increase the activity in Barnet and asked for **more information regarding the current use of this time and activity of the role to decide of the appropriate action.** NS asked how the CCG was improving the management of the provider (prescribers) and **asked for a paper, within the week, detailing the actions undertaken and planned.**	**NH** **MA / NH**
4.	**JHWB Strategy Implementation Plan** ZG gave an overview of the implementation plan which focuses on nine priorities agreed by the HWBB in November 2016. The paper will be presented to the HWBB on the 9 March 2017. **ZG to ask CMc to update LAC text to include all progress since November.** Care Closer to Home, a priority within the Strategy, will be considered by the HWBB in a workshop session as well as being considered at the HWBB on the 9 March 2017 as a substantive item.	**ZG**
5.	**Perinatal Mental Health Service** *NC attended for this item.* NC outlined that NCL, led by Islington, had been successful in winning a bid to improve perinatal mental health services. NC went on to describe some of the improvements required including services for mild and moderate mental health condition and developing a more comprehensive pathway. NS welcomed the update and stressed the importance of good baseline data and links with IAPT. NC said that there is good baseline data and she is working with Dr Charlotte Benjamin to see how Emotional Health Checks could be used in this pathway. NC went on to explain that the ambition is to support people as early as possible, building in screening at 10 weeks. The voluntary sector, such as Homestart, are engaged with the developments. NC stated that this pathway would lead the way national. The detail of the developments will be considered by the Children's Mental Health group (of which NS is a member), NC will return to JCEG in the summer with an update. The work will also be reported to the HWBB via the JHWB Strategy	

	implementation plan update.	
Performance and finance review		
6.	**BCF performance dashboard** The Group discussed performance concerns regarding delayed transfers of care and enablement and asked for a **report clearly stating:** • **Action taken to date** • **What we need to strategically focus on** • **Clear action plan going forward** • **Clear governance (which Board is responsible and responding)** The Group welcomed the level of detail provide in the dashboard but requires more narrative to ensure that the data is being used effectively. **The Group asked for an in-depth exploration of the BCF including an in-depth analysis of BILT and rapid care** DW stated that the BCF guidance was still not published and is of the understanding that the new guidance will be for a two year programme and is an opportunity for real change. **Finance** The Group noted that the BCF finances are on track according to the plan. **Q3 report** MA highlighted that progress was good compared to plans last year and also highlighted aspects that have impacted delivery such as the ASC IT system delays. The Group reviewed and agreed the report ahead of submission to NHS England on the 3 March.	**MA** **MA**
Business		
7.	**Minutes of previous meeting – 4 January and action log** The action plan was updated. A number of actions were covered in the agenda, in addition: • DW, NH and CMc met to discuss the strategic vision for health and social care in Barnet and how this would be discussed with the HWBB in a workshop session in March 2017. • The CCG is holding a public event on the 28 February 2017 to discuss the vision for healthcare in Barnet.	
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: 25 April 15.00 – 16.30 • Childrens integrated therapies procurements • BCF review including an in-depth analysis of BILT and rapid care • JCU workplans • JCEG TOR	

Minutes from the Health and Wellbeing Board – JCEG
Tuesday 25 April 2017
North London Business Park, Chapman Room
15.30 – 16.30

Present:
(AC) Andrew Colledge, Deputy Finance Officer, BCCG
(CMc) Collette McCarthy, Head of CYP Joint Commissioning, LBB/BCCG
(JL) Jeff Lake, Consultant in Public Health, LBB
(MA) Muyi Adekoya, Joint Commissioning Manager Integration, LBB/BCCG
(NS) Neil Snee, Director of Integrated Commissioning, BCCG (Chair)
(PP) Patricia Phillipson, Head of Finance, LBB
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB

Apologies:
(AD) Anisa Darr, Resources Director, LBB
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB
(LG) Leigh Griffin, Director of Strategic Development, BCCG
(NH) Neil Hales, Assistant Director Commissioning Development, BCCG
(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.	
2.	**Minutes of previous meeting – 20 February 2017 and action log** The minutes were agreed as an accurate record. Actions were noted and additional actions agreed: • Management of the community equipment provider, **ZG to check with NH that this was actioned** if not **MA to provide a paper by 10 May** • Update on BCF dashboard to be discussed at the next meeting to include measures of the prevention work (self-management, self-care, early support) • Progress on pooled budgets to go to CCG Executive 8 May, **PP and AC to review pooled budget and share learning with CMc for CAMHS**	**ZG / NH / MA** **PP/AC**
Performance and finance review		
3.	**BCF performance dashboard** MA explained that some of the metrics are based on NHS England data and/or provided on an annual basis which makes updating the dashboard difficult. MA provided an overview of performance: Non-Elective Admissions (NEL): The schemes within the plan are mainly focused	

	on targeting the older age group aged over 65. Non-Elective Admissions (NEL) for the over 65s has seen a reduction of 6% compared to 2015/16 for the first half of the year. Delayed transfers of care: The BCF measures a reduction in delayed transfers of care expressed as the number of delayed days in total from hospital and the data is expressed per 100,000 population. Barnet has significantly increased compared to last year. In response to questions from the Group MA outlined: • System wide issues which are monitored on a service level • MA had attended a BCF measuring and monitoring workshop • BCF schemes target people over the age of 65 therefore they will not have an impact on whole indicator • We do not have access to full system data • We have the opportunity to improve monitoring through the updated plans for BCF for 2017/19. **NS asked MA for further analysis and an expanded report on current KPIs, monitoring and services to go to CCG Executive 8 May.** JL offered to support this piece of work. The paper will also pick up the following action from the last meeting including looking at the impact of BCF programmes on the following: • Pace and Treat • 7 day social care • Extended hours hubs • Discharge to assess • Trusted assessor. **NS, NH, MA and DW to meet to review. Substantive paper to be taken to JCE on 18 May 2017. MA to invite CSU to the meeting.** **BCF Finance** The Group reviewed the BCF Finance and agreed the break even position. **BCF review** MA informed the Group that the policy framework for BCF had been received but the guidance has still not been published. MA explained that if this was not received by 28 April 2017 it will be delayed by the pre-election period. MA did state that jointly agreed elements of the fund can be spent. NS asked the group to provide comments to MA by the end of the week. MA stated BCF meetings had been set up for every two weeks and the review will be discussed.	**MA/JL** **MA**
4.	**Section 75 performance – including Voluntary Sector Transition Plan report and updates to VCS and Equipment** ZG updated on the performance report for S75s highlighting the following risks and	

	issues: • LAC health assessments are not meeting statutory timescales • Campus: concerns around the markets ability to respond to need • Risk of overspend in Community Equipment • Childrens S75s have been updated to reflect the planned procurement. Mitigations are in place. ZG went on to describe the new schedules which have been developed: • Community Equipment has been updated in line with the new contract with an end date of 30 June 2021 and an estimated annual pooled fund of £2,698,619 which will become a schedule of the overarching agreement • Voluntary Services Prevention Commissioning has been updated to reflect outcomes of the review completed last year where provision is no longer jointly commissioned with an end date of 31 March 2022 and a total pooled fund of £3,244,948 which will become a schedule of the overarching agreement. JCEG agreed the updated schedules. S75 for Community Equipment and Voluntary Prevention will be considered by the CCG FPQ 27 April. Following approval from FPQ the agreements will be signed and sealed.	
Policy and strategy		
5.	**Children's continuing care** CMc presented the paper, asking the Group to note the recent activity regarding children's continuing care which had taken place in light of recent legislation. A new process has been designed for children's continuing care which has been developed through the CCG working with Local Authority colleagues in Social Care and Education. A new pathway has been implemented and the funding methodology has been revised. A tripartite funding approach has now been agreed for complex children's care which allows for early intervention and improved working with the community. The financial pressure for each organisation is £1.1m which is a recurrent annual cost. This will be monitored and an update will be bought back to this group in quarter 2 to have oversight of the finances so that this group can oversee the approach and manage disputes. **NS asked CMc to compare our approach and finances to other areas.**	**CMc**
6.	**Children's Integrated Therapies Procurements** CMc gave an overview of the procurement activity bringing together occupational therapy, speech and language therapy, physiotherapy and orthotic services. Integrating this provision will improve outcomes and ensure the best use of resources. CMc stated that a consultancy has been engaged to support the remodelling. There has already been a lot of stakeholder engagement and the consultancy will be reporting at the end of April with their findings. Following this the new specification	

	and key outcome indicators will be developed. The new service will be in place from April 2018. CMc raised the financial implications for this work; commissioners are in discussions with colleagues in special educational needs and disabilities to increase their contribution to this pot and there may be implications for the CCG too. A further update will be presented to the Group in July 2017.	
7.	**CAMHS** CMc presented the paper on children and young people's emotional wellbeing and mental health services and the Group noted the key decisions made regarding this programme of work: • CCG and LBB will pool budgets though a section 75 agreement • Remodel community CAMHS with a move from to a prevention focused model • Agreed to go out to the market for new provision to be in place January 2018. CMc mentioned the real term increase in CAMHS funding and that soft market testing was taking place in May.	
Business		
8.	**TOR and Workplan** ZG informed the Group of the Groups merger with the Care Closer to Home and Primary Care Home Working groups. A TOR has been developed and will be further considered at the first meeting on 27 April. The Group noted the detailed forward work programme. CMc added: • LAC – June • Children's Integrated Therapies Procurement - July • Public Health nursing – September • Children's continuing care (tripartite funding) – October	
9.	**AOB** The Group noted that ZG will be moving on to a role in children's joint commissioning. NS, on behalf of the group, thanked ZG for her work on the HWBB and JCE.	
	Next meeting (JCE CC2H): JCE CC2H: • Thursday 27 April, 3 – 4pm • 18 May 9 – 10.30 (G6, NLBP)	

Joint Commissioning Executive
Care Closer to Home Programme Board

Thursday 27 April 2017
North London Business Park, Boardroom
15.00 – 16.00

Present:

(AC) Andrew Colledge, Deputy Finance Officer, BCCG
(AF) Amher Farooqi, BCCG Governing Body
(AP) Anuj Patel, Barnet GP Federation
(CD) Courtney Davis, Head of Adults Transformation, LBB
(CW) Cathy Walker, Director of Divisional Operations, Central London Community Healthcare NHS Trust
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB
(FJ) Fiona Jackson, Hospital Director, Royal Free London NHS Foundation Trust
(JH) Joanne Humphreys, Project Manager, LBB
(JL) Jeff Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(LG) Leigh Griffin, Director of Transition, BCCG
(MA) Muyi Adekoya, Joint Commissioning Manager, LBB/BCCG
(MK) Mathew Kendal, Director of Adults and Communities, LBB
(NH) Neil Hales, Assistant Director Commissioning Development, BCCG
(NS) Neil Snee, Director of Integrated Commissioning, BCCG
(PD) Peter Dutton, Clinical Director, Barnet Enfield Haringey Mental Health Trust
(SA) Sanjiv Ahluwalia, Barnet GP Federation
(TH) Tal Helbitz, BCCG Governing Body
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies:
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(CM) Chris Munday, Commissioning Director Children and Young People, LBB

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair, DW welcomed the attendees to the meeting. Apologies were noted as above.	
2.	**Purpose and TOR** DW introduced the paper and summarised recent activity which had led to the creation of the Board from discussions at the HWBB public meeting, HWBB workshop and the CCG Governing Body. The Board expands the membership of the LBB and CCG officer Joint Commissioning Executive Group and brings together relevant streams of work as well as partners. The Board will oversee the development and implementation of plans for an improved and integrated health and social care system including: • the local delivery of the STP including being the programme board for Care Closer to Home • the borough's Better Care Fund. • the delivery of Section 75 agreements between NHS Barnet CCG and London Borough of Barnet.	

	LG added that the Board has been developed to provide a space to jointly develop and deliver plans recognising the need to balance transformational change at pace and ensuring we are doing what is appropriate for Barnet. LG stated that this Board is where executive decision will be made at a local level and reported up to the Sustainability and Transformation Plan (STP). AF added that NCL were leading acute commissioning and CC2H was being developed at a local level. The Board considered the TOR. **CEPN and Healthwatch to be added as members.** The Board agreed the TOR, noting that they could be revisited for review at any time and that the TOR would be reported to the HWBB and CCG Executive in July with the minutes.	**ZG**
Strategy and Planning		
3.	**NCL Sustainability and Transformation Plan (STP): local delivery** DW introduced the paper as an opportunity for the Board to discuss and agree what it would like to know about, initiate and lead. JL provided an overview of the Public Health aspects of the paper: • Strategic integration is welcomed • No additional funding through Sustainability and Transformation Fund for prevention, the Board will need to consider how prevention will be delivered • Need to further review and consider CC2H and BCF to decide what can be taken forward and how this can be further aligned with Public Health • Building on the council's wellbeing duty (Care Act, 2014) • Developing targeted prevention around particular needs. **The Board agreed to ensure that activities were not duplicated and to ensure that all partners are aware of available provision.** SA stressed the importance of engaging providers in developments. FJ welcomed further support to develop providers noting the need for initiatives such as Making Every Contact Count (MECC). Maternal mental health was cited as an area of need. PD informed the group of an NCL perinatal mental health pathway which is being developed and stated the need to make sure that the service is available for Barnet mums. TH added the opportunity that the integrated care record brings to improve integration and closer working between local authority services and primary care. DW stressed that the key responsibilities of this Board are BCF and work streams from the STP (Care Closer to Home Integrated networks, CHINs and Quality Improvement Support Teams QISTs locally). Altogether Better will evolve and as it is funded through BCF and Public Health so will be reported to this group. The Board recognised the learning that can be taken from the Reimagining Mental Health approach which has resulted in the Wellbeing Hub.	**JL**

	To understand the Boards responsibility in relation to other Boards and programmes the group asked for **an overview of key related boards and their work programmes to establish interdependencies (links to stakeholder mapping).**	**CD**
4.	**CC2H – work programme** A joint report from DW and LG was presented. DW stated that the paper focused on adults and that the children and Public Health elements will be strengthened. The aim of the paper and the work of the Board is to develop a joint delivery plan for CC2H. The NCL STP gives local areas responsibility for the delivery of the care closer to home (CC2H) work stream, with the establishment of CHINs (CC2H integrated networks) and QISTs (quality improvement support teams) a core deliverable for 2017/18. The JCEG's refreshed terms of reference and membership gives it the programme board role for CC2H and reflects the triumvirate leadership of the NCL STP. It has been agreed by BCCG, LBB and the HWB that the CC2H work programme will be jointly led by BCCG and LBB. LG explained the CCGs activities to improve primary care. Access has been improved the availability of more appointments via the Federation. CHINs and QISTs are a new way of integrated working which will develop services. The aim is to get three CHINs established this year. CHINs follow a similar geography to QISTs. LG added the need to invest more in Locally Enhanced Services and review the equitable access to PMS contracts (currently run by 26 out of 61 practices). The Federation is working with vulnerable practices. DW added the potential for alignment of CHINs and QISTs with adult social care. DW stated that the councils volunteering and voluntary sector infrastructure could also compliment the developments. AP stated the need for practices to engage in the process and that having appropriate detail was key. The Board noted that developing too much in a short period of time risks overloading practices. Next steps were agreed as: • Officers from BCCG, LBB and the Federation will develop a joint resourcing and programme delivery plan to support the development of CHINs and QISTs across Barnet and, subject to further design, proposals for the primary care home pilot within the CC2H programme. **LG to bring initial draft to the next meeting on this Board.** • **Officers from LBB and BCCG will progress the development of the care strategy which will be owned by this Board** • **The intention is to present a draft care strategy to the HWB in July 2017.**	**LD** **DW/LG** **DW/LG**
5.	**PID for Primary Care Home / Capitated Budget Pilot (part of CC2H)** DW introduced the Capitated Budget Pilot PID. DW explained that this pilot is in its early stages with quality, risk, clinical governance and commercial aspects still needing to be worked out.	

	SA, who has been involved in the national developments, advised that this pilot should be in line with CHINs in a way that is sustainable. SA added that the health care system is not used to new ways of working and working in partnership; this needs to change rapidly. SA advised starting with data sharing and not risk. SA stated that the principles are correct and have worked well in other areas and that locally pace is needed to take this forward. AF stressed the importance of focusing on outcomes and not just on funding arrangements. DW stated that the plan involved starting small and developing and growing the model over time. DW added that it was important to have the right activities and flow of money taken at a system level and not cost shunting between partners. A formal group will be established to take this work forward. **Members to contact ZG if they would like to be involved by close of play Tuesday 2 May.** LG added that there was a workshop meeting with the Chief Executives in January and then next meeting of this group is on 25 May which allows for planning at the next meeting of this Board (18 May). **LG and DW to programme plan.**	**All** **LG/DW**
6.	**Timescale for BCF submission 2017** MA explained that the Policy Framework for BCF was made available on the 31 March. Two year plans are to be developed and the national conditions have reduced from eight to four. Technical guidance has not been received yet, when this is announced we will have six weeks to develop and submit our plan. MA explained that a review of the 2016/17 plan is currently underway. Small group has been set up to start the process of developing the two year plan. **Board members to send any reviews of the BCF to MA**.	**All**
Business		
7.	**Work programme of JCE / CC2H** The Board noted the JCE / CC2H work programme, comments are to be provided to ZG.	
8.	**Health and Wellbeing – HWBB work programme** The Board noted the HWBB Work Programme, comments are to be provided to ZG.	
9.	**AOB** None.	
	Next meeting: • 18 May 9 – 10.30 (G6, NLBP) Future meeting dates: • 9 – 10.30: 15 June • 2 – 4: 20 July • 2 – 4: 17 August • 2 – 4: 21 September • 2 – 4: 19 October • 2 – 4: 16 November • 2 – 4: 14 December	

Appendix 5

Joint Commissioning Executive
Care Closer to Home Programme Board
Meeting minutes Thursday 18 May 2017
North London Business Park, Room G6

9.00 – 10.30am

Present:
(AF) Ahmer Farooqi, BCCG Governing Body
(AiP) Anita Patel, Deputy Chair, Community Education Provider Network (CEPN)
(AuP) Anuj Patel, Barnet GP Federation
(CD) Courtney Davis, Head of Adults Transformation, LBB
(CW) Cathy Walker, Director of Divisional Ops, Central London Community Healthcare NHS Trust
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB (Co-chair)
(JH) Joanne Humphreys, Project Manager, LBB
(JL) Jeff Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(LG) Leigh Griffin, Director of Strategic Development, BCCG (Co- chair)
(MK) Mathew Kendall, Director of Adults and Communities, LBB
(NH) Neil Hales, Assistant Director Commissioning Development, BCCG
(NS) Nazia Scott, Adults Transformation Co-Ordinator, LBB (minutes)
(RA) Ron Agble, Director of Partnerships & Transactions, Royal Free London NHS Foundation Trust
(TH) Tal Helbitz, BCCG Governing Body

Apologies:
(NS) Neil Snee, Director of Integrated Commissioning, BCCG
(PD) Peter Dutton, Clinical Director, Barnet Enfield Haringey Mental Health Trust
(SR) Selina Rodrigues, Healthwatch Barnet

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair, LG welcomed the attendees to the meeting. Apologies were noted. LG advised that the meeting would cover items 4 (CHIN delivery and financial plan) and 5 (Chief Executive/Chair meeting) briefly and then focus upon item 3 (CC2H workshop discussion). AF declared a potential conflict of interest as a member of one of the GP practices that make up the first tranche of CHINs. A general conflict of interest was noted for all GPs and provider organisations (NHS and social care) present at the meeting.	
2.	**Minutes of Previous Meeting and Matters Arising** LG stated that this Board is where executive decisions will be made at a local (Barnet) level. Decisions will be reported up to the Health and Wellbeing Board, individual organisation governance and the North Central London Sustainability and Transformation Plan (NCL STP) board as appropriate. In terms of governance, this Board is established under the Health & Wellbeing Board (HWB) and will oversee the development and implementation of plans for an improved and integrated health and social care system in Barnet. Minutes had been circulated from the 25 April JCEG meeting and the 27 April JCE/CC2H Programme Board meeting. LG noted that from this meeting onwards, previous JCEG meetings were incorporated into these JCE/CC2H Programme	

	ITEM	ACTION
	Board meetings. LG asked those who had been present at the meeting to confirm the accuracy of the 25 April JCEG meeting minutes. Outstanding actions from the meeting were reviewed. **Action: Produce and circulate a separate action log for these meetings.** JL advised that the minutes were accurate. JL updated that he and MA had taken an action to produce a paper on NEAs and DTOCs. Due to the CCG's cyber security issues this paper has not been reviewed by MA and therefore not circulated to Board Members ahead of today's meeting **Action: Circulate NEAs/DTOCs paper to this Board** LG asked Board members to confirm the accuracy of the minutes from the JCE/CC2H Programme Board on 27 April. • AF advised that under Item 5 (p4) PID for Primary Care Home / Capitated Budget Pilot (part of CC2H) where it reads *"AF stressed the importance of focusing on outcomes and not funding arrangements"* this should read "focusing on outcomes and not **just** funding arrangements." • CD advised that work to produce a matrix of related boards and their work programmes, required to establish interdependencies (links to stakeholder mapping) remains in progress. This should be ready for the next meeting. It was agreed that this work should include LB and BCCG boards and work programmes, as well as the Acute sector boards and work packages (to help ensure there is no duplication of work). • LG suggested that the PMO in the CCG is included. • DW added for information that the urgent care recovery programme is separately governed. • LG advised that a joint resourcing and programme delivery plan to support the development of CHINs and QISTs across Barnet is still in progress and will be brought to the next meeting. LG needs to review this with DW before circulation. **Action: Amend minutes as advised by AF.** **Action: Bring matrix of related boards and work programmes to the June JCE/CC2H Programme Board meeting. To be included as a meeting agenda item.** **Action: Bring CHIN/PCH resourcing and delivery plan to the June JCE/CC2H Programme Board meeting.** DW reminded everyone that the minutes from this meeting are published and available in the public domain. LG added that Board members are responsible for checking the draft minutes and ensuring that actions are completed on time. DW noted that the Better Care Fund guidance had been unofficially published last week. It is likely that guidance will be published after the election, with first drafts of BCF plans to be produced around 6 weeks of the guidance being published. **Action: Circulate unofficial BCF guidance to Board members.**	**CD** **JL/MA** **CD** **CD** **LG** **CD**

	ITEM	ACTION
Strategy and Planning		
4.	**CHIN delivery and financial plan: review** LG informed the group that two significant meetings had taken place last week: 1. BCCG had met with GPs to discuss investment in locally commissioned services and how primary care provision can be incentivised in a way that is accessible to all practices. Detailed principles and options will be developed next week. 2. BCCG held its first formal meeting with the first CHIN (5 GP practices). Input was provided by Public Health, and GPs from outside of the first CHIN were also present. **Action: An adult social care representative will be identified and invited to future meetings**. The meeting participants saw CHINs as key to developing an integrated approach and were keen to establish an approach to CHINs that was replicable as CHINs are rolled out across Barnet. It was confirmed that CHINs and QUISTs will be rolled out as two parts of a single programme. The discussion centred upon investment, return-on-investment and data requirements. A number of data sources have been identified and discussions around data are ongoing with partners such as CLCH. The analytics are being packaged together and BCCG is exploring how it can provide PMO support for business case development. Discussions about data will continue over the next 3-4 weeks with a business case complete by 24 July 2017. The CHIN business cases were discussed by the Board. It was agreed that most aspects of the business case would be the same across all CHINs, but with some aspects that were specific to each locality. Reliable data and its analysis will be key to understanding local variations. DW said that in developing the business case it was important to begin by confirming the outcomes for the CHIN to deliver followed by consideration of the best care model to deliver those outcomes. It is also important to understand how money flows through the whole system and consideration will need to be given to the best way to align financial incentives with the care model. These are the things that will show if a CHIN is successful. • AiP noted that the workforce development needs of the CHIN need to be reflected in the business case, with consideration given to the people and the skills required, and how these individuals can be jointly trained. • It was noted that the CHINs that follow on from the first CHIN may need more support to get them up to the same starting point as the first CHIN. • TH added that it was important to learn and incorporate learnings from existing examples of CHINs development, for example Manchester. • AF stated it would be helpful to see data that is Social Care focused. **Action: share 'Right First Time' data at STP level for Social Care with Board Members.**	**LG/DW** **DW**

	ITEM	ACTION
	DW said that "capitation" was essentially shorthand for the different types of partnership that could be used as vehicles for delivering integrated care, whether that was the CHINs or the Modality Partnership in the West Midlands. There are many different types of alliance that are being used to deliver integrated care models, and different ways of managing contracting and risk sharing, beyond the conventional block payments that are associated with capitated budgets. To know that Care Closer to Home was achieving what was intended in terms of financial sustainability, the group would need to understand the flow of money around the system and what incentives would drive different behaviour, as CHINs are developed.	
5.	**Chief Executive/Chair meeting on 25 May** DW introduced this item explaining that the Chief Executives had met in January (notes from this meeting were circulated to Board members) where they expressed eagerness to understand the potential for new care models to improve care and outcomes, and financial sustainability. It was agreed that the agenda for the 25 May meeting should focus upon updating the Chief Executives on progress so far, and checking that they are comfortable with the current direction and speed of travel. RA informed the group that NHS England has a new business models team that is looking at financial risk and it will be important to learn from and replicate other successful models. AF noted that it appeared that while there was agreement amongst the members of the JCE/CC2H Programme Board about the programme's direction of travel, the speed of travel had not been agreed, and it would be important to commit to a pace that did not feel uncomfortable for key stakeholders. **Action: speak to Sanjiv Ahluwalia to agree GP Federation attendance at the Chief Executive/Chair meeting.** **Action: circulate examples of primary care partnership models to the Board.**	**AuP** **CD**
3.	**Care Closer to Home: Workshop discussion – what is our vision for CC2H?** The meeting held a workshop style discussion on the vision and aspirations for Care Closer to Home, which will be written up into a report and considered at a future meeting, prior to presentation at the HWB, CCG governing body, and other relevant meetings. **Action: produce report pulling together workshop outputs into a vision document for CC2H.** **Action: circulate a link to the Barnet Community Directory.** **Action: establish whether the CC2H engagement event scheduled by BCCG for 22 June could be used as an early engagement opportunity.**	**JH** **CD** **LG**
6.	**Work programme of JCE / CC2H** This item was not covered at this meeting.	

	ITEM	ACTION
7.	**Health and Wellbeing HWBB work programme** This item was not covered at this meeting.	
8.	**AOB** NH enquired about the timescales for delivering CHINs in Barnet. LG noted that we are not fixed on a specific number of CHINs, we will need to establish the most appropriate population coverage for Barnet. DW stated that the CHINs business case will help this group to work together on resourcing to ensure the timescales are met.	
9.	**Next meeting:** • 15 June, 9.00 – 10.30 (G2, NLBP) Future meeting dates: • 2 – 4: 20 July • 2 – 4: 17 August • 2 – 4: 21 September • 2 – 4: 19 October • 2 – 4: 16 November • 2 – 4: 14 December	

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AGENDA ITEM 14

	Health and Wellbeing Board **20th July 2017**
Title	**Forward Work Programme 2017-18**
Report of	Strategic Director Adults, Communities 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	Emma Coles Business Manager Emma.coles@barnet.gov.uk

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 January 2018.

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 Care Closer to Home, 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 2016 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

September 2017 – January 2018

Contact: Salar Rida (Governance) salar.rida@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
14 September 2017				
DISCUSSION				
Children and Young People's Emotional Wellbeing and Mental Health	**The Board is asked to comment on the progress to develop a joint Children and Young People's Emotional Wellbeing and Mental Health in Barnet.**	Interim Director of Commissioning Commissioning Director Children and Young People	**Head of Children's Joint Commissioning CAMHS Joint Commissioning Manager**	No
Consultation on the draft Pharmaceutical Needs Assessment	**The Board is asked to review and comment on the Pharmaceutical Needs Assessment**	Director of Public Health	**Consultant in Public Health**	Yes
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
CAHMS Contract	**The Board is asked to endorse the contract to the successful bidder**	Interim Director of Commissioning Commissioning Director Children and Young People	**Head of Children's Joint Commissioning CAMHS Transformation Lead**	Yes
Public Health Nursing	**The Board is asked to endorse the future model for Public Health Nursing**	Commissioning Director Children and Young People	**Head of Children's Joint Commissioning Commissioning Manager for PHN**	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*
Volunteering in public services: managing demand and promoting health and wellbeing	**The Board is asked to consider and shape the volunteering element of the next phase of the Council's Community Participation Strategy.**	Strategic Lead, Community Safety	**Strategy Officer, Community Participation**	No
NOTE				
Public Health and Wellbeing Performance Report - reflecting on Commissioning Plan 2016/17	**The Board is asked to note the performance of the 2016/17 Public Health and Wellbeing Commissioning Plan.**	Director of Public Health	**Consultant in Public Health**	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
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
9 November 2017				
DISCUSSION				
Joint Health and Wellbeing Strategy Implementation plan – annual 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 Director of Public Health	**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*
		CCG Accountable Officer		
Annual Director of Public Health Report	**The Board is asked to note the report.**	Director of Public Health	**Consultant in Public Health**	No
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
NOTE				
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
25 January 2017				
DISCUSSION				
NOTE				
Section 75 agreements: annual report	**The Board is asked to review the status, activity and finances associated with all Section 75 agreements.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People CCG Accountable Officer	**Strategic Lead Adults Health**	No
Minutes of the Health and Wellbeing Board Working	**The Board is asked to approve the minutes of the Joint**	Commissioning Director – Adults and Health	**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*
Groups (where available): • Joint Commissioning Executive Group	**Commissioning Executive Group and Health and Social Care Integration Programme Board**	CCG Accountable Officer		
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**	Commissioning Director – Adults and Health CCG Accountable Officer	**TBC**	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*
	developments across North Central London (NCL).			

***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.*