Appendix 1 - Barnet Health and Well-Being Strategy – Second Annual Performance Report

This report for the Health and Well-Being Board documents the progress that has been made by local partners to improve the Health and Well-Being of Barnet's population over the past 12 months.

Evidence of progress in the second year of the Strategy has been addressed in this report in two ways. Firstly, partners have been asked to produce in-depth progress reports to highlight the work that has been taking place to progress the Year 1 priorities. Secondly, in line with the presentation of progress in the first annual performance report, snapshots of progress across the Strategy have also been presented, in response to both the priority areas identified by residents and stakeholders in the 2012 Health and Well-Being Strategy public consultation[1], and significant achievements/ issues reported by service leads.

Appendix 3 of this report, the write up of the Partnership Boards Summit (June 2014) also includes the Health and Well-Being Board with an update of the work that the Partnership Boards have been doing to deliver the objectives of the Health and Well-Being Strategy.

Delivery of the Year 1 priorities – progress reports

The series of progress reports below highlight the work that has been taking place by partners over the past 12 months to improve health and wellbeing against each of the priority areas identified by the Health and Well-Being Board in November 2013.

Preparing for a Healthy Life

Priority area	**Review of Health Visiting and School Nursing services**
Rationale	The Council is now responsible for commissioning of School Nursing services and will assume responsibility for the commissioning of Health Visiting services from October 2015. Health visiting and school nursing services help to ensure that children receive the best possible start in life and that there is identification and early intervention of needs. The impact of services in the early years can be life-long.
Activities	Reviews of health visiting, school nursing and early years services have been conducted. The Public Health team separately commissioned Community Barnet's Children and Young People team, which has significant reach to the charity sector and residents, to undertake local consultation on this issue.
Impact	The work has led to the development of a new School Nursing service specification in line with new guidance and taking into consideration

[1] A full list of activities that partners have undertaken over the past 12 months to support the delivery of the Strategy is available from the Public Health team on request.

	results of the review. Work continues to more closely align health visiting services with proposed remodelled of early year's services in the borough more widely.
Next Steps	• To consider how other health services can be more closely aligned with early years services • To ensure procurement of School nursing services in 2015 delivers good quality service and value for money and is closely aligned with 0-5 public health services

Priority area	**Children and young people (aged 0-25) with disabilities, Special Educational Needs (SEN) and high needs, CAMHS**
Rationale	Reforms were set out in the Children and Families Act (2014) challenging professionals to change the way in which they work with each other and families, to focus relentlessly on improving outcomes for children and young adults with Special Educational Needs and Disabilities (SEND), give children and families more control and choice and, critically, to earn their trust and confidence. A fundamental change will be extending the system up to 25 years, to achieve a holistic vision of development from birth through to their transition into adulthood. These challenges come to effect at a time when local and national research shows a picture of continuously growing demand for SEND services. This growth in demand is a combination of population growth (primary/secondary school population in Barnet expected to grow by 16% and 10% respectively until at least 2024) and a rise in prevalence of disabilities.
Activities	Since September 2014, several core changes have been implemented in line with the requirements of the Children and Families Act, including the replacement of Statements of SEN with new birth-to-25 combined education, health and care plans (ECHP), a right to a personal budget for some young people whose needs cannot be met by universal or targeted services and a published local offer of services available. LBB have commissioned Family Research services through the Innovation Unit to review local and national demographic and likely future challenges for service provision to children & young people with disabilities and their families. This research project included in depth work with a group of eight families to provide insights into the service user experience and support the design of new ways of working. Building on this work, LBB have commissioned an independent consultant to provide an analysis of the current ('as-is') provision and to further develop the future model of service delivery in co-production with all partners. A strategic project board with representation from Education, Social Care (Adult's & Children's), Commissioning and Health has been setup to oversee and direct this work.
Impact	This work is still in development and has not had any impact on service users at this stage.
Next Steps	• With a number of the Children and Families Act changes now in

	place, the challenge to the Council and its partners in Barnet is to embed them in such a way that enables effective relationships of trust with families, improves the way in which agencies work together in partnership with families and helps young people to achieve more. • Work on the project is progressing at pace with the key next step the development of options for future service delivery. • The next meeting for the above mentioned 0-25 disabilities model project board is being scheduled to take place in the shape of a workshop in early November. Invites will be extended to relevant heads of service/managers with a view to using half a day to develop the options for the model of future service delivery. • With the transfer of public health responsibilities to the local authority and the developing joint commissioning relationship with the CCG there is now a strong opportunity to improve services in Barnet for children with mental health issues. This should strengthen early intervention and prevention services and ensure that children and young people who need more support can access it in a timely way in a community setting with the minimum disruption to their schooling.

Priority area	**Improving reporting of immunisations COVER data to Public Health England**
Rationale	Immunisation coverage in Barnet appeared to fall dramatically following the transition of responsibilities to NHS England in April 2013. It was recognised that practices had not stopped giving vaccinations and that that there had been a breakdown in data reporting mechanisms.
Activities	• The Health and Well-Being Board invited NHS England to discuss progress at resolving this issue at the September 2014 meeting. • NHS England has had regular meetings with CLCH to address data issues. Given that the reason for the drop in rates relates to data management, the focus has been on working to improve this situation. A 'deep dive' examination of all CLCH processes (not just immunisations) is currently taking place. • Data linkage is addressed via the Quality and Performance Improvement Board held quarterly and attended by CCG's, D's PH and other stakeholders. This meeting feeds into the London Immunisation Board. Sub groups are now also held quarterly with providers to improve performance for 0-19 and flu delivery. • A protocol has been put into place across London for earlier scrutiny of immunisation rates prior to submission to COVER by the patch and central immunisation commissioning teams in NHSE. This is helped by the new minimum child health dataset which enables monthly reports on immunisations to the NHSE immunisation teams. • Home-Start Barnet, a charity partner to Healthwatch is currently undertaking community consultation with the aim of informing and gathering feedback from 400 parents of young children about their experience and barriers to immunisation. Home-Start is due to report in March 2015 and this will be shared with Public Health and the Health and Wellbeing Board.
Impact	• All practices have now signed up to QMS which enables data to be sent electronically. • A full COVER report was produced for Q1 of 2014/15. • Issues within the CLCH team have been highlighted and are being addressed via regular meetings. • CLCH is to begin targeting individual practices that have low performance.
Next Steps	• A new specification is to be written to enable more accurate upload of data onto Child Health Information System (CHIS). • It has been highlighted that there is no established relationship between GPs and CLCH-CHIS in Barnet, and that this needs to be rectified. CLCH is being asked to develop relationships with GP practices to rectify wrong coding and missing vaccinations data.

Priority area	**Supporting residents with mental health and learning disability issues back into employment**
Rationale	Mild to moderate mental health problems are the most prevalent causes of 'health-related worklessness'. 23% of Jobseeker's Allowance claimants have a mental health problem, and more than 40% of incapacity benefits claimants have mental health problems. The probability of returning to work after being in receipt of long-term health-related benefits is just 2% annually. Most recipients who have been workless for 6 months or more have only a 1 in 5 chance of returning to work within 5 years. The Barnet Benefits Cap Task Force has identified approximately 1200 individuals in the Borough who may experience a significant drop in income as a result of the Benefits Cap. The Barnet Benefit Cap Task Force – which includes Job Centre Plus (JCP), Housing Benefit and Housing Support Officers - is working closely with those people affected by the Benefit Cap to support them into work and/or affordable accommodation. Officers identified mental health problems as the biggest barrier to employment and they are not equipped to deal with mental health issues. Some people have undiagnosed mental health problems.
Activities	<u>Public Health support for those affected by welfare reforms - *'Return to Work'*</u> Health Mentors are now co-located with the Benefits Taskforce team in JCP. This work will continue until 31st October 2014, when the project will be superseded by the Employment Support project set out below. Public Health and partners, including service users, Department of Work and Pensions, Disability Employment Advisers, the Clinical Commissioning Group, IAPT Provider, Barnet Enfield and Haringey Mental Health Trust, The Network, Mind in Barnet, Barnet Voice for Mental Health, Barnet Centre for Independent Living, People Like Us, Eclipse and many other BME and user–led organisations via Mental Health Partnership Board, have successfully procured: • Individual Placement and Support service for people with severe and enduring mental health problems whose employment /vocational requirements form part of their recovery plan. Barnet Enfield and Haringey Mental Health Trust will be hosting this service. The service will move people back into work quickly and will provide 'in-work' support. • Combination of psychological, motivational and employment support intervention with Job Centre Plus for people with common mental health problems who are claiming benefits. Following presentation by Public Health to the Mental Health Partnership Board on this work, a number of steps were taken to increase service user involvement. One of the co-chairs was invited on the group developing the tender, which resulted in a stakeholder event in June which involved a number of service users and carers. The feedback from the above event contributed to the development of the

	tender. The co-chair is now on the group looking at the development of the evaluation framework, the draft of which will be brought to the board for comment and input. Public Health has also commissioned an external not for profit organisation - the National Development Team for Inclusion (NDTi) to evaluate the success of these two interventions. NDTi is also acting as a 'critical friend' to us. We are also working with West London Alliance (WLA) in co-designing an intervention for the ESA (Employment Support Allowance) claimants with mental health issues. As part of the Growth Deal, WLA is one of four areas invited to bid for funds to develop an integrated mental health and employment pilot intended to move people back into work more quickly. WLA has been asked to submit a business case by 1 October 2014 and start the Trailblazer in April 2015. Funding £1.2m from successful TCA bid and £1.2m European Social Fund. <u>Adult Social Care - Adults and Communities</u> • Adults & Communities panels monitor and ensure that employment and training is considered for individuals. • There is evidence that Direct Payments are being used to support people to train, prepare and support employment. • The Network have a strong working relationship with the Job centre plus. • Mind and the Richmond Fellowship are working in partnership to increase opportunities for people with a mental health need • Mencap as well as having a service specifically for mental health employment they also directly provide employment for people with a learning disability • BCIL will consider employment and training opportunities as part of the support planning process. • Sitting employment officers with the mental health teams will increase awareness with staff at opportunities open to service users. • The transition team have work hard to strengthen the links with education and prospects to increase the training and employment opportunities for young people transitioning in to adulthood. There are clear outcomes attached to education placement which are made for these young people. • Commissioning and care management are strengthening the way in which employment data is collected from services who may be offering opportunities to people as part their provider services. • People are paid for their time when engaged in the partnership boards and consultation exercise which empowers people to recognise their employability skills. • The new employment service and work being done to improve employment pathways is expected to result in improved outcome in 2015/16.
Impact	A total of 45 people (a success rate of 38%) gained employment

	directly as a result of the Return to Work initiative. The local rates reported in the performance dashboard below suggests the work that has been done this year has not yet had the impact that it is expected to have. This was a pilot project hence no targets were agreed, however these figures set up the baseline for the new initiative which was procured recently.
Next Steps	• The new services will commence 4th November 2014. • The WLA trailblazer modelling will start in October 2014. • Evaluation framework will be signed-off in December 2014. • Healthwatch will liaise with BAMER representatives for feedback on the effectiveness of the engagement that's taken place.

Priority area	**Poor Health due to Excessively Cold Housing**
Rationale	There are 149 excess winter deaths (EWD's) per year in Barnet alone (*PHO* 2014). EWD's are where there is a marked difference between the number of deaths during the winter months (Dec-Mar), the following autumn (Aug-Nov) and the preceding summer, with the winter deaths being the highest, as described by the Office for National Statistics. Not only is there a surge in deaths during the winter months, there is also a surge in cold related illnesses.
Activities	<u>Winter Well Grants</u> In the winter year 2013/2014, £10,000 of the Budget was allocated to Winter Well Grants. This avenue of the project proved successful and therefore may be reflectively increased this year. In the year 2013/2014 £9814.12 of the budget was spent on a total of 16 clients. It is estimated that this grant spend will generate a saving of £121,451.84. Due to the nature of the grant system for the Winter Well Scheme (available to privately rented and owner occupied housing) not all people who require energy efficiency measures will qualify. However, these are often referred to the Decent Homes grant scheme which has a larger budget and can assist with a wide range of interventions, including energy efficiency measures. **Other Works Completed by Energise Barnet and CAB in the Winter of 2013/14**

	Work Completed by Energise Barnet	
	297	Calls were received/made relating to Winter Well
	68	GP Practices were visited and provided with training, these were th contacted for a reminder of the scheme.
	86	Pharmacists were visited, leaflets delivered
	17	District nurse teams were contacted
	11	Visits for training were arranged with district nurses
	722	Communication organisations emailed/phoned
	20000	Pieces of campaign materials were distributed.
	27	Awareness sessions were held
	10	Events were held of which 557 people attended gaining 249 referra
	Work Completed by CAB	
	356	The number of attendees at an energy Advice Event
	389	Fuel debt enquiries *Sept 2012-Mar 2014*
	303	Fuel issue enquiries *Sept 2012-Mar 2014*
	The Council has taken many steps to re-design and target and make our promotional material accessible to elderly vulnerable residents. The Winter Well Scheme has many avenues available to Elderly residents to assist with excessively cold homes, one of which is Winter Well rants which can be given for home improves to increase the thermal efficiency of their homes, of which the, improvement materials and labour are organised by the Winter Well Grant Officer.	
Impact	Unfortunately due to the short time that Barnet's Winter Well scheme been running, with one year happening to be a relatively warm winter, it is quite speculative and projective to evaluate Barnet's Winter Well's effectiveness. Nonetheless the effectiveness was estimated using educated predictions, benchmarking and observations of the outputs. **Feedback from Service Users** Grants: The people who were provided with grants were contacted for a structured interview to be asked. Due to their age (mostly elderly) some had sadly passed away while others were not able to talk. However, of the clients who were contactable, they were very positive about the service. Materials: Focus groups were arranged with a target group of the scheme (elderly residents) to gain some feedback on the promotional materials used. A number of issues with them were highlighted during this exercise. These issues were taken on board for the re-design of the materials. From Professionals: A consensus was that the availability, processes and criteria for assistance were not made clear by the Winter Well Scheme. Professionals also highlighted different aspects of the promotional materials to the focus group such as the non-inclusion of the NHS logo causing issues with healthcare centres refusing to promote the scheme.	

Next Steps	**Materials:** Using the feedback obtained on the previous year's Winter Well promotional materials a new Communications brief has been generated. The borough wide promotion of the scheme this year incorporates thermometer cards, leaflets, and professional business cards. **Communication Networks:** A communication network of all the interlinking and relevant contacts for each main section within the assistance programmes relating to the Winter Well Scheme is going to be created and made available to all the partners within an electronic information pack on the Winter Well. **Documentation of Assistance:** We aim to improve upon our documentation of the inputs and outputs of the Winter Well Scheme this year. Energise Barnet, being an external company refused to share information due to data protection act. This year a list of standard questions have been established which can be asked to people who enquire about the scheme to be combined with the outcomes of their enquiry for future analysis.

Priority area	**Mental health**
Rationale	Barnet's thematic JSNA refresh on Mental Health (2014) highlighted that the prevalence of mental illness in Barnet is higher than the England average and has slightly increased over the past 5 years at a similar rate to that of England. A recent mental health needs assessment undertaken by Public Health for Barnet CCG highlighted: • The proportion of adults estimated to have dementia diagnosed in primary care in Barnet is 5th highest in London. Estimated number with common mental disorder in Barnet is 39762 (National Psychiatric Morbidity Survey, NPMS, 2000) • In 2012/13 within Barnet, number of patients registered with GP practices with depression age 18+ was 24,754. • Levels of antidepressant prescribing in Barnet and London boroughs were lower than the rest of the country (HSCIC 2013). • Proportion of those referred to IAPT in 2012/13 who received treatment was relatively high in Barnet (69.4%) compared with London (60.7%) and England (59.7%) • Number of adults on primary care Severe Mental Illness (SMI) register in 2012/13 was 3,685 (HSCIC 2013). Proportion of adult population on the SMI register in Barnet (1.0%) was mid-range for London (HSCIC 2013). The range for London is between 0.6% - 1.4%. • Proportion of population on the primary care SMI register who were treated by Crisis Resolution/ Home Treatment teams in 2012/13 in Barnet (16.2%) was lower compared to many London boroughs • Rate of hospital episodes for schizophrenia in Barnet is much higher

	than expected for the population, (154.6 per 100,000). This is more than double the national rates. Rates of emergency admission for schizophrenia (per 100,000) lower for Barnet (20.0) than London (24.9) but higher than England (19.2). Rates are moderately correlated with deprivation with close to expected rates for levels of deprivation. • Barnet has an admission rate of 167.6 per 100,000 for mental disorder for under 18 years, the 2nd highest in London, (London and England averages are 87.1 per 100,000 and 87.6 per 100,000 respectively. Mental health issues can result in social isolation, loneliness or disrupted relationships, or can be the catalyst for these problems. People with mental health problems also experience significant physical health risks including obesity, diabetes, heart and respiratory diseases and have lower life expectancy. Mental health provision is a significant local priority.
Activities	In May 2014, the CCG Board decided to review mental health services in Barnet with a view to determining whether re-commissioning mental health services might be beneficial. A health economic impact assessment, benchmarking on finances, a population needs assessment and a review of good practice models, have been completed. The conclusion is that such an extensive re-commissioning would de-stabilise the local health economy, and alternative approaches to improving services locally are being explored. Performance concerns relating to BEHMHT have been considered by the Health and Wellbeing Board in depth and have resulted in a multi-agency approach to supporting improvements in performance at the Trust. BEHMHT is currently working with the Trust Development Agency to assess the longer term viability of the Trust. **Talking therapies** The 'Improving Access to Psychological Therapies'(IAPT) service has been re-commissioned to ensure wider reach and increased recovery rates. The new provider, Surrey & Borders NHS Foundation Trust, commenced in October, with a new service model that is intended to improve access – to 12.5% by the end of the 2014/15 financial year, with a view to increasing to the national target rate of 15% in 2015/16. The service has specific targets for harder to reach groups, and there will be a wider range of venues in which to access treatment. **Primary care pilot** The South Barnet Locality Network is currently piloting an 'Integrated Primary Care Mental Health' model, which they have commissioned through Camden & Islington NHS Foundation Trust to run until July 2015. The pilot is funded through a non-recurrent primary care grant. The pilot aims to increase the capacity and capability of primary care to

	manage mental health care and treatment, provide high quality care closer to home and improve the experience and outcomes of patients who will otherwise fall between the gaps and who hitherto may have been difficult to manage in primary care because of the complexity of their mental health conditions. The pilot is expected to reduce the referrals of non-urgent/crisis patients to secondary care and enable better step down or discharges from secondary mental health back to primary care. There will be a robust evaluation of the project carried out which will help inform next steps. **Collaborative working** Collaborative working has been a feature of the work undertaken this year. For example, engagement events have taken place that are being used to inform the future of mental health services in Barnet. • A Mental Health Partnership Board (MHPB) workshop took place on July 2014 to look at the relationship between physical and mental health. The MHPB met in October, to discuss a range of issues, including a presentation. • A user engagement event associated with the development of employment support services took place in June 2014. • In August 2014, Healthwatch, who are members of the MHPB Board, were commissioned by Barnet CCG to gauge service users views on what 'good' would look like in relation to various strands of care provided by mental health services (both statutory and voluntary). Working with Barnet Voice for Mental Health, who ran the focus groups, they produced a report which they presented to the Mental Health sub group of the CCG. As a member of Barnet Voice, the Co-Chair of the MHPB also attended and contributed **Children's mental health** In terms of mental health support services for children: the CAMHS review is on-going. Public health's investments in emotional wellbeing in schools, as well as programmes to discourage substance misuse, are reported elsewhere. A programme to address self harm is also under way. **Delayed Transfers of Care** Tri-borough mental health commissioners have been working with BEHMHT to reduce the number of patients with delayed discharge. This is defined as a patient who is well enough to leave hospital but who is unable to leave due to factors not related to their mental health. Identifying the 'blocks' to discharge, including mapping the patient pathway in Barnet, has led to better bed management, earlier identification of and action on patients' housing needs, and good collaboration between the Trust, mental health commissioners and Barnet Housing. As a result, the average number of Barnet patients

	delayed in hospital has reduced from c.16 weekly in June to 1-2 weekly, and no out of area placements. **World Mental Health Day** Over 20 organisations in Barnet from across the statutory, voluntary and community sectors delivered a series of events leading up to World Mental Health Day on 10 October. Events were held across the borough to raise awareness of mental health, helping to tackle stigma and provide information about available support and services. **Eclipse** Eclipse is a universal mental health and wellbeing service funded by the Council and CCG. The service is into its second year and is delivered across the borough of Barnet by Richmond Fellowship in Barnet (RF) working in partnership with Mind in Barnet (MiB), the Barnet Centre for Independent Living (BCIL) and people who have or had mental health problems. The service delivers mental health and wellbeing promotions and activities, including Mindfulness and Mental Health First Aid Training, Peer Support and Recovery and Inclusion Planning. **Floating support** Barnet's floating support service has been recommissioned and now includes a specialist mental health component for people within in-patient mental health settings and hospitals and patients in recovery centres. The aim is to ensure that any housing related problems are dealt with as early as possible, minimising re-admission into hospitals, residential care and other intuitional settings and helping individuals to settle into the community and reduce social isolation. The aim is to help clients with mental health needs to: • maintain their tenancies • move on to more appropriate accommodation and services • prevent individuals' situations from reaching a crisis point and helping stabilise crisis situations. **Independent assessment and advocacy** Barnet Council, working with Enfield and Haringey, commissioned a tri-borough Independent Mental Capacity Advocacy (IMCA) and Independent Mental Health Advocacy (IMHA) service. IMCA is a type of advocacy introduced by the Mental Capacity Act 2005 ("the Act"). The Act gives some people who lack capacity a right to receive support from an independent mental capacity advocate in relation to important decisions about their care. Independent Mental Health Advocacy is a statutory form of advocacy

	which was introduced in 2009 as part of amendments to the Mental Health Act. Anyone who is detained in a secure mental health setting under the Act, is entitled to access support from an Independent Mental Health Advocate. The service is delivered by Voiceability, which also delivers the NHS Complaints Advocacy Service. **Employment and mental health:** **Individual Placement & Support (IPS)** Twining Enterprise has been commissioned tp provide an IPS service. The service commenced in early November and will continue until the end of March 2016. The service, based within the Community Teams within Barnet, Enfield and Haringey MHT. Over contract period, the service will engage and assess 180 service users and, of those, 55 job outcomes are expected. A job outcome is defined as paid employment of at least 16 hours per week. **Motivational & Psychological Support (MaPS)** Future Path Solutions Ltd has been commissioned to provide motivational and psychological support to Job Centre Plus customers. This initiative (following from the successful pilot which ran from January to October 2014) started earlier in November and will continue to March 2016. Over the contract period, 337 people will be assessed and screened, 202 people will report an improved quality of life and 124 people will commence employment which is similarly defined as paid work of at least 16 hours a week.
Impact	Too early to know.
Next Steps	• The priority for the coming months is to finalise the LA/CCG's commissioning intentions and agree any joint commissioning arrangements as appropriate, including S. 75 arrangements • To complete the reviews of adult mental health provision and CAMHS • To ensure coordination across prevention, early identification and treatment pathways • Mental health is a priority area for Healthwatch Barnet in 2014/15 • Voluntary organisations within the borough who deliver mental health and wellbeing services to black, minority ethic and refugee communities are working with the Council and CCG to develop a Community and Health Access service to improve health and social care outcomes for Barnet residents who are often coming into contact with services in times of crisis. • Commissioners across the Council and CCG are working with organisations delivering talking therapies within the borough to develop a network to share best practice and ensure pathways are working for Barnet residents and referrers. • Barnet Public Health, Adults and Communities and Job Centre Plus are working with the West London Alliance to be a "trailblazer" site for an Individual Placement and Support service for people with

	common mental health problems. (see also Individual Placement & Support). This pilot service is expected to commence in April 2015. • Support to improve capacity in the mental health system which will include an enhanced primary care model that includes an Extended Primary Care Service for people with serious mental illness and depot (injections) which will be GP/Network led, and a support hub for information and support to access a broad range of options available in the community and a Primary Care Liaison Service . • Working with tri-borough commissioners, CCG and LA commissioners will develop a local action plan for crisis care, in line with the national Crisis Concordat and London-wide recommendations published in October. • Public Health is establishing a multi-agency steering group to develop a Suicide Reduction Strategy for Barnet. There is non-recurring funding available in the current year to develop a local service for children at risk of self-harming. An outline business case is currently in development.

Priority area	**Reducing social isolation**
Rationale	Social isolation and loneliness has a significant and detrimental impact on the quality of peoples' physical and mental health, e.g. it is one of the major causes of depression. It is also one of the causes of people using high levels of health and social care, e.g. a lonely older person will use visit their doctor on average 13 times a year as opposed to 5 times a year and loneliness is one of the reasons why older people go into residential care.
Activities	A social isolation toolkit has been developed by the Council's Insight team, and qualitative research has been carried out so that we have a better picture of loneliness in Barnet (see Appendix 1). The toolkit identified that older women who lived in more well off areas were at an increased risk of social isolation. The social isolation toolkit is now available on the internet. The qualitative research discovered that people did not know about many of the activities available and did not want to access them alone. The key gap that people identified was that there was a lack of evening activities. The findings were discussed at the Ageing Well Partnership Board and also the Partnership Board summit – all Partnership Boards have been asked to look at their action plans for the year and incorporate social isolation into those actions where possible. They were also asked to identify what they could do as Boards and as individuals to tackle social isolation. Each Board identified between 6 and 13 actions ranging from volunteering, promoting and expanding existing services and increased use of technology. Individual members identified helping others, getting to know their neighbours and publicising services. The Altogether Better programme has also identified one of the key

	geographical areas where social isolation was identified as the next priority. Based on an asset based approach, the programme will begin work in High Barnet once funding has been confirmed. The Older Adults Partnership Board (OAPB) plays an integral role in the Ageing well programme which has commissioned the time banking service in Barnet. There is co-membership between the two programmes and so the OAPB has had an active role in the shaping and reviewing of this service to provide greater community links. The OAPB has played an active role in collaborating with initiatives such as the dementia café and the Casserole Club by providing feedback to ensure that the services are relevant for the core groups they are aimed at. As part of the Council's service level agreement with Community Barnet a conference on social isolation was held in September 2014 – the social isolation toolkit was presented and the voluntary sector looked at how they could impact on social isolation and loneliness. The HSCI business plan also includes an ambition to develop dementia friendly communities and community navigators – both of these initiatives will further help alleviate loneliness by increasing the access to information about activities and supporting people to access those activities by building up social networks and providing practical support.
Impact	New services commissioned by the Council and provided by Barnet Age UK – the neighbourhood day activities and later life planners, have increased their reach to older people and have proved very beneficial in providing places to meet people who are interested in similar activities as well as developing social networks on an individual basis.
Next Steps	• Barnet Council has worked closely with the Campaign to End Loneliness to develop indicators which measure the effectiveness of services in alleviating loneliness and will be piloting these by building them into contract monitoring of commissioned services. • Community Barnet will be producing a write up report of the social isolation conference. • Partnership Boards will be asked to report back on the progress of the actions they have identified.

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<tr><td>Priority area</td><td>High risk drinking</td></tr>
<tr><td>Rationale</td><td>The November 2013 performance report noted that rates of increased and higher risk drinking had risen from the 2011 rate of 17.7% to 20.0%. The Barnet HWBS set an ambition to reduce the rate of increased and higher risk drinking to the level of the best performer in the country (which was 11.5% in 2011 but which had risen to 15.7%). With local performance trailing the best nationally the Health and Well-Being Board undertook to consider in-depth how it can coordinate activities across partners to tackle increasing and higher risk drinking in the Borough, considering the various local levers it has at its disposal to affect change.</td></tr>
<tr><td>Activities</td><td>The CCG and Public Health team have both been working to prevent increasing and hazardous drinking in the Borough. The CCG has been leading on a programme of brief interventions in acute and primary settings under consideration, which has the potential to assist 1 in 8 hazardous and harmful drinkers back to sensible drinking levels. The Public Health team has been scoping options to enforce trading standards and licensing conditions to make it harder for people to make unhealthy choices.

The following actions have been taken by the public health team:
Introduced an Information & Brief Advice (IBA) service in 21 pharmacies from November 2013 to identify those with increasing and higher risk drinking patterns. The most recent performance follows below.
Completed two Drug & Alcohol needs assessments (Adult and Young Persons) in 2014.
Commissioned temporary support to improve dual diagnosis care coordination
A Drugs and Alcohol strategy is currently being produced and is expected to be presented to Health and Wellbeing Board in January 2015. In addition to the medical treatment and recovery support for the patients with alcohol dependency options for the use of local by-laws, early intervention and prevention will be explored in collaboration with community safety and other related areas of council business.
The Barnet schools wellbeing programme has provided support to schools to discourage substance misuse. It is expected that there will be further work targeted at young people</td></tr>
<tr><td>Impact</td><td>ABI performance:<table><tr><th></th><th>No of scratch cards used</th><th>Brief advice given/ brief advice & referral services</th></tr><tr><td>Target 2014-15</td><td>1400</td><td>750</td></tr><tr><td>Q1/14</td><td>447</td><td>146</td></tr></table>Results indicate that 447 people have received an alcohol screen. This</td></tr>
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	equates to 31% of the annual target. Of those who were screened 146 (32%) were given brief advice. This equates to 19% of the annual target. Of those who were given brief advice eight people were referred to the drug and alcohol service. This shows that the project was successful in providing screening and over achieved the quarterly target. However, the rate of identification of high risk drinkers is lower than that previously seen elsewhere.
Next steps	• Drugs and alcohol strategy to be agreed and reviewed in January 2015 • Healthwatch Barnet will work with public health to engage with young people and different ethnic communities to further the development and delivery of key messages and services in this area.

Priority area	**Tuberculosis**
Rationale	Rates of TB in Barnet are higher compared to England. Although, they are lower than the average for London, the rates have remained constant and are not falling.
Activities	Public health commissioned a report to look at the reasons why the rates were not falling and to understand which organisations were responsible for the prevention and management of TB, which was presented to the Health and Well-being Board in June 2014.
Impact	The report that was presented to the Health and Well-being Board had the following recommendations • It was agreed PH would commission an awareness raising campaign • CCG would look into latent TB testing and ensure robust commissioning of TB services including universal BCG provision in 2015/16
Next Steps	• Plans are in place for an awareness raising campaign to commence shortly. This will include training workshops and support to the voluntary sector to raise awareness in the community and will provide training for council staff. • A communications campaign will be conducted directed at health professionals. • CCG to consider latent TB testing. • Procurement of a new Substance Misuse Treatment and recovery Service is currently underway with the new Service commencing 1st October 2015.

Care When Needed

Priority area	**Integrated care for frail elderly/ those with long term conditions**
Rationale	Barnet will experience one of the largest increases in elderly residents out of all London boroughs over the next five to ten years, and also

	substantial increases in both the number of older carers in the borough, and the number of these carers who need support to sustain their caring role. The Health and Wellbeing Strategy sets out the Borough's ambition to make Barnet 'a place in which all people can age well'. The challenge is to make this a reality in the context of rising health and social care needs among older people, and the financial pressures facing both the NHS and the Council. Despite the many positives that come from growing older, there is also a higher risk of deteriorating health, reduced wellbeing and lack of independence. More and more older people will be living with a long-term condition over the coming decade, be that dementia, diabetes, or arthritis. As the number of older people requiring health and social care support increases, it is essential they are offered services that help them to remain independent and live healthily in their own homes for as long as possible. They need access to crisis response services, and support to recover quickly from illness. The current service provision in Barnet does not always fulfil these objectives, culminating in an over-reliance on hospital services and residential care. Plus there has been an increased take-up of adult social care support to respond to changes in acuity and urgency. This all costs the system too much money to sustain, which is another driver for transforming the model of care for these population groups.
Activities	Over the past 12 months, Barnet CCG and Adults and Communities have implemented enhanced, integrated community support for frail older people in line with the Barnet Better Care Fund model, supported by an outline and a full business case for integrated health and social care. Barnet now has in place the following: • Multi-disciplinary case management of the most frail older people, with weekly case conferences attended by community health, social care, acute care, primary care and mental health. • A team of care navigators to support this group of patients/service users to get the care they need • Rapid care team to respond to crises early on, to prevent the need for hospitalisation and improve health and quality of life, operating 7 days per week • 7 day a week social care service at Barnet and Royal Free hospitals • IT- based risk stratification tool now operational in GP practices in Barnet, to identify frail older people who would benefit from multi-disciplinary case management. • Pilot integrated locality care team of community health and social work staff • Community based dementia and stroke support services. These all form part of the Barnet 5 tier integrated care model, the business case for which demonstrates how investment from Public

	Health, the CCG and Council adult social care budgets will be used to develop and deliver this new model of care. It has been developed by a wide number of local stakeholders, including commissioners across the CCG and Council, major providers of health and social care services including GPs and other primary care staff, the voluntary and community sector, and service users. The 2 Co-chairs of the Older Adults Partnership Board had full involvement in workshops which led to the development of the 5-tier model and subsequent pathway planning. In December 2013, Healthwatch helped facilitate two focus groups on integrated care/long-term conditions, with positive feedback on the quality of responses. There have also been presentations to the Partnership Boards from the CCG regarding the development of the pilot Integrated locality team, and service users and carers have shared their views about the model. The full business case sets out the detail of the projects and programmes of work that need to be delivered in order to transform the model of care offered to frail elderly/ those with long term conditions, from programmes that will give individuals the confidence to manage their own long-term conditions, to activities that focus on keeping people mobile and active in their own homes and communities, to services in place to assist people quickly outside of A&E when they experience an episode of ill health. Following the full business case being written, the OAPB hosted a bespoke workshop with members in order to capture feedback from organisations and representations from the public. The Board shared views with project leads about the work that had been developed so far, and has made a point of highlighting 'stories' and areas of practice which could benefit from a greater joint approach i.e. hospital discharge, enablement in the community. There is further development work planned to create a specific working group with interested parties from the OAPB to further scrutinise and develop the 5 tier model to enable further development by core users.
Impact	The full business case for integrated care models an indicative, estimated saving of £12.2m from implementation of the proposals (by 2019/20), resulting by 2019/20 in an annual shift in spending away from acute hospital and residential and nursing care home services of £5.7m. To this end, this business case is an important step that will help the Health and Wellbeing Board to realise its objective of shifting the balance of spend towards prevention and wellbeing. The high level outcomes the integrated model is trying to achieve are set out below:

Measure	Baseline	Planned 2015	Planned 2016 (Q1)
(Reduced) avoidable non-elective and/or emergency admissions per 100,000 population (average per month).	1,935	1,838	1,898

Measure	Baseline	Planned 2014/15	Planned 2015/16
(Reduced) permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	486.9	417.6	354.1
(Increased) proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.	71.9%	76.8	81.5
(Reduced) delayed transfers of care (delayed days) from hospital per 100,000 population (average per month).	635.3*	492.3*	379.3*
(Improved/minimum) Patient/service user experience (national metric).	0.7	0.8	0.8
(Increased) Self directed support.	1.0	1.0	1.0

* - Average Quarterly Rate

The business case has tried to explain how the system will feel different for older people, by explaining how care will be provided for the fictional Mr Colin Dale. In terms of the impact the work is aiming to have, the following description of Mr Dale's experience of care from the newly formed integrated locality teams (a key initiative in the integrated care model) has been written:

The district nurse (as part of the integrated locality team), while managing Mr Dale's leg ulcer, identifies increased ankle swelling. During her visit she records vital signs which show low oxygen levels and increased respiratory rate. As a result, and with the patient's permission she refers Mr Dale to the weekly multidisciplinary meeting where a wider range of professionals (social care, mental health, London ambulance, GPs, geriatric consultant, pharmacy and end of life) meet. They agree that Mr Dale's medication will be titrated and that an education session will be delivered in the home by the long term conditions generic nurse (within the Rapid Care Team). In 5 days Mr Dale returns to his normal baseline. At a follow up meeting including the care home staff and Mr Dale's family, agrees to commence the use of telehealth, to better assess and monitor Mr Dale's needs, and communicate changes to the locality team and the practice in order to take rapid action. ***As a result of this multi-disciplinary care team approach, Mr Dale has less need to go into hospital, whilst the district nurse and care home have developed new skill sets that help them to provide more holistic support to older people like Mr Dale.***

The 6 month evaluation of multi-disciplinary case management and care navigators indicated that positive results have been achieved for individuals supported by the new services and that health outcomes had improved. The evaluation also showed a positive impact on use of emergency care.

Next	A Steering Group has been established to oversee delivery of this

Steps	business case, and they will report progress to the health and wellbeing board as the work develops. The Group will make sure the health and social care integration board of major providers of health and social care services meets to discuss how they can support implementation of this model, and a number of self-management and wellbeing projects will be developed over the coming year in partnership with stakeholders to ensure that there is enough support for older to people to stay well, happy and independent in their own homes and communities. Healthwatch will provide further support in identifying volunteers/patient representatives, facilitating or co-ordinating groups.

Priority area	**Developing self-care initiatives that will help residents maintain their independence and supporting the Borough's many carers to maintain their own health and well-being**
Rationale	Self-management: At present there are an estimated 20,359 people aged 65 or over with a limiting long-term illness in Barnet, as well as 13,146 who are expected to have a fall. By 2020, many chronic and long term illnesses are projected to increase by more than 20%. Nationally, over 90% of people with long term conditions say they are interested in being more active self managers and over 75% would feel more confident about self-management if they had help from a healthcare professional or peer. Despite this, many people with long-term conditions have limited knowledge of, or influence over, their care. Self-management is a critical component of integrated care models for frail elderly/ those with long-term conditions. It supports a shift in the focus of health and social care delivery away from formal institutions and towards a person's own home environment, where a lot of self-management can occur. Carers: It has also been estimated that there are 6,988 over 65s providing unpaid care to family or friends within the borough. Without adequate support, these individuals experience unnecessary strain and hardship. In addition, the added stress and pressure of being a carer can cause rapid deteriorations in health. This represents another key challenge for health and social care.
Activities	Self-management: Workshops have taken place with service users, clinical professionals, the voluntary sector, and CCG and LBB staff to define the priority pieces of work to be taken forward under a self-management programme in Barnet. Following review of the results of these sessions, completion of a formal evidence review and gap analysis, a programme of work was developed, which includes structured education being offered to people with any long term condition, in accessible venues; development of health champion and long-term condition mentor roles; development of a Healthy Living Pharmacy programme that will be rolled out across 12 pharmacies in Barnet; launch of a public media campaign and innovative structured information and advice; and development of a social prescribing service. These proposals have been tested out by a self-management

	steering group comprising colleagues from public health and the CCG, through the integrated care steering group, and most recently at the Older Adults Partnership Board. A public health project manager has been appointed to take forward this programme of work in close partnership with the CCG. The Older Adults Partnership Board has also developed a response as part of the consultation on Barnet Council's Community Offer aimed at supporting people to live independently for as long as possible. <u>Carers:</u> There has been an ambitious programme of work carried out over the last 12 months to improve the support offer for Carers in Barnet. Highlights from this work include: • A review of the Council's existing preventative services for carers is reported to the Carers Partnership Board. • There is a Carers Strategy action plan for 2014-15 which is overseen by the Carers Strategy Partnership Board. The Board is now working on its priorities for 2015 onwards which will include joint working with the CCG and health partners. • Carers Offer: The Carers Support Offer provides information about what supports and services are available for carers. The Carers Support Offer continues to be reviewed and there continues to be a joint review of some commissioned carers services and projects with the CCG to ensure that we are delivering outcomes for carers. • There is a project lead responsible for delivering the changes resulting from the Care Act for Carers. One of the work streams of the Care Act Implementation Group. The carer's strategy, policy and operational guidance for practitioners are being updated for April 2015 which will clearly reflect the changes of the Act. A programme of training for staff will communicate how carers assessments, support plans and emergency plans will be undertaken. An outcomes framework is also being developed to track carers activity, monitor and report outcomes and check for quality. There is also a strong focus on ensuring that the Carers Support Offer is more widely promoted to practitioners and the public so that the support available to carers is more readily accessible and that they are better informed about how to access support. There will be an improved information and advice offer detailing for carers what is available for them; this includes work with the Lead Provider. • Carers Centre coordinated and promoted a wide range of training programmes for carers such as mindfulness, first aid etc. • The Carer's Partnership Board is also contributing to the development of BEH MHT 'Mental Health Carers Experience strategy'
Impact	There is real momentum in the system now to develop an ambitious programme of self-management, in absence of there having been one in place before. Economic modelling estimates that the structured

	education programme will have significant impacts on the amount of primary care use individuals need, and will also result in cost savings in secondary care too. An evaluation framework is being commissioned to ensure that the impact of each of these initiatives can be fully understood and evaluated, and best practice shared with other local areas.
Next Steps	<u>Self-management</u> • There will be pilots of the structured education programmes delivered in each of the 3 GP localities before April 2015, at which point the programme will be rolled out more widely. • The project manager will be completing project documentation for each of the elements of the self-management programme to be taken forward, before beginning roll out of these initiatives at scale from April 2015. <u>Carers – also see above</u> • The Carers Strategy Partnership Board has an action plan for 2014-15 and are developing the next from 2015-16, which also focusses on the Care Act implementation. • Improvements to the quality of Information and Advice for carers and how this promoted and accessed is underway. • Healthwatch Barnet is currently in discussion with their charity partner Barnet Carers Centre to identify specific project to engage with and support carers in the Borough.

Snapshots of progress in Year 2 across the Health and Well-Being Strategy

Preparing for a healthy life

Healthy Child Development: The Barnet schools wellbeing programme, which supports schools to implement sustainable health and wellbeing measures including physical activity and healthy eating, has been established and expanded. The programme is supporting schools to work towards the Healthy School London awards, and is also implementing Healthy Children Centre standards and supporting early years staff to deliver healthy eating workshops and physical activity initiatives.

Healthy weight in children: To address the rates of childhood obesity, commissioning has commenced of a tier 2 weight management programme for children and families, and children's pathway group established with partners to develop a childhood obesity pathway.

Well-being in the community

Healthy regeneration: A jobs brokerage service is currently being commissioned and is anticipated to start delivery in early 2015 in the west of the borough with a particular focus on the regeneration estates. The Council has also been developing Regeneration, Estate, Employment and Training strategies for Colindale,

Stonegrove, Spur Road, Dollis Valley - the Strategy for Colindale is now under delivery with a refresh strategy produced annually. An Officer is now in place dedicated to the development of the strategies for Stonegrove Spur Road and Dollis Valley, which are due to be produced in Spring 2015.

Supporting people with learning disabilities into employment: The employment project 'Working For You' has been successfully retendered. The new contract and partnership arrangements commenced in October 2014. The new provider had developed a communication plan to further raise awareness of the service and to increase numbers of people being supported by the service.

Supporting individuals to move on into stable accommodation: The Barnet Winterbourne View Action Plan has been reviewed, and the Learning Disability Team based at the Council has updated a Section 75 agreement with the CCG to include the recommendations from the Winterbourne View plan. Joint Commissioners across the CCG and Council are working closely with Care Coordinators, the Multi-Disciplinary Team and the individuals and their families, to review individual's care and support plans and where a plan for move on is agreed, identifying individualised local move on options. We are working with CSG to move people in to the rented sector market with dedicated workers to ensure that people have person centred support to move. Residential placements are prioritised for reviews with people being supported in to more independent accommodation. The Council is also developing an extra care housing scheme which can accommodate people with a Mental Health or a Learning Disability.

Supporting young people into education, employment and training: the support team at the Council have tried to use Electoral canvassers to conduct some home visits and engage with young people, but this had many limited success as many had moved away from the premises. An online support presence has recently established and the internet page has been promoted widely to organisations and young people in Barnet. So far the main page has had 35 'likes', and has a growing following. 30 young people are receiving on line support. A new build for high level need learners opened in September 2014 providing approximately 50 additional places for local residents.

How we live

Learning Disability Health Checks: Easy read information templates are now available on the GP intranet to improve accessibility. Each Barnet GP now has a Link Nurse from the Learning Disability service to support with checking the quality of Annual Health Checks. Three bi-annual training sessions given by a lead speech and language therapist and Head of Psychology at Barnet Learning Disability Service have also taken place.

Supporting people with mental health problems: The CCG and Council are undertaking a review of mental health services to inform future commissioning options. The CCG has successfully re-commissioned the IAPT service with additional funding to achieve the access target of providing treatment to 6000 people per annum from 2015/16. Work on Delayed Transfer of Care has been progressing since April, resulting in better use of inpatient acute beds, B&B placement and

external bed use now nil. There has also been a refresh of the Child and Adolescent Mental Health Services (CAMHS) strategy, but the CAMHS needs assessment is not yet completed due to capacity issues.

Better use of green spaces and leisure facilities: A total of 7 new outdoor gyms and 9 marked and measured routes are installed. The outdoor gym activator programme aiming to provide advice on how to use the equipment and motivational support to residents has started the sessions in the parks and the feedback suggests that the equipment seems to be very busy. The public health team are currently formulating the Council's plans for any future outdoor gym locations.

As part of the Fit & Active Barnet campaign, the Council has been working closely with GLL and all our community providers to enhance sport and physical activity opportunities. Specific achievements to date are the introduction of a Barnet Leisure Pass for carers, foster carers and children in care. This is a live and available scheme to any registered individual with LB Barnet or Barnet Carers Centre (where applicable). In addition, GLL have hosted a number of engagement events for young people in March and Disability in August 2014, accumulative total in excess of 500 people. The GLL Better Inclusive disability membership has increased from 138 (August 13) to 438 memberships (August 14), there has also been an increase in the total number of disabled visitors at each centre. This is attributed to improved local partnerships and communication and supporting a number of targeted events (senior's assembly /urban gamez). GLL 55yrs+ Club Membership has also increased by 12% since August 2013, this is credited to a £25,000 investment by GLL at Barnet Copthall Leisure Centre into developing a "Club Lounge". A dedicated 55yrs+ social area, providing information and advice in relation to local opportunities. A GLL Barnet Team have also represented at the Club Games event hosted at the Olympic Park, the first time ever the Borough has been able to recruit for all teams inclusive of spectators.

There have also been significant financial investments into Barnet Copthall Leisure Centre Gym and Burnt Oak Leisure Centre to improve quality standards that will subsequently encourage residents to participate in a safe and accessible environment. The pricing membership structure has been amended at Burnt Oak Leisure Centre to £19.99 per month to ensure a response is met to local affordability rate and area competition. This additionally falls in line with engagement work that has taken place with Barnet Homes and the Love Burnt Oak Network. There are further planned health and fitness developments for Finchley Lido in late 2014 early 2015, which will result in driving more participation within the centre.

Care when needed

Improving dignity and quality of care for people in Barnet care homes: The CCG primary care development team have commissioned a service from GP practices, commencing in September 2014 and running until March 2015. A total 1,658 out of the 3,051 care home beds in the borough will be covered by the pilot during 2014/15. This commissioned service supports the Integrated Care Business Case to reduce unscheduled admissions from care homes. It is based around the concept of the GPs providing a weekly ward round for all their patients in the nursing home (including 6 monthly reviews, reviews after an admission to hospital and post-death

reviews). The expected outcomes are improvements in the quality of care received by residents in care homes, enabling people to die in the place of their choice and improve coordination of care between the care home and the GP. The CCG are also looking to finalise a business case to improve care pressure ulcers and sores.

The Council's Integrated Quality in Care Home's' team has been working closely with care homes to improve the learning and education offer for staff and maintain the quality of care provided to those living in care homes. The IQICH team focusses on positive engagement, prevention and the sharing of best practice through an integrated approach with internal and external colleagues. The team works with care homes on an individual basis to assist the staff address and resolve identified areas of concern. In addition, it offers a programme of regular events for the care home senior staff which includes quarterly practice forums, specialist workshops and training sessions.

Neighbourhood based support for older people: The Council commissioned Age UK Barnet's Later Life Planners team became fully operational on 1 May 2014. The advisers are available to give holistic advice across many areas affecting older people. These include planning for retirement, accessing health support services both for themselves and elderly parents and benefits, as well as suggesting ways of keeping physically and mentally active. The Later Life Planners (LLP) team is based at the Ann Owens Centre in East Finchley and advisers are available from 9-5pm, 5 days a week. Residents of the borough who are aged 55 and over can access the service by phone, email and also at drop-in and pre-booked surgeries. Clients can speak confidentially to staff or volunteer advisers about their personal circumstances and concerns on a one-to-one basis. Age UK Barnet is also bringing the service to other venues across the borough through their already flourishing partnerships with community, faith and cultural groups. The LLP service has helped Barnet residents apply for benefits, gaining an extra £75k for them over the past 6 months. The LLPs are helping people to develop action plans to achieve the best possible outcomes in working toward planning for a better future. The team with the help of their trained volunteers have also visited nearly 30 residents at home to help with claiming benefits.

A new approach to providing day services to older people has been hailed a success after reaching almost 1,800 more people in its first year. The new neighbourhood model was introduced in April 2013 with the aim of offering a wider choice of services, classes and activities, to as many people as possible, in more localised areas. These include exercise classes, social groups, befriending services, lunch clubs, IT skills classes, information and advice and falls prevention. All of these are delivered by the Barnet Provider Group, a group of 17 voluntary sector and community organisations from across the borough, led by Age UK Barnet. One of the aims for the first year has been to fill gaps in provision; targeting areas of high deprivation where there were little activities for older people. The provider group has teamed up with other local organisations: Barnet Homes and other housing associations with activities taking place in sheltered housing schemes; the Ageing Well Programme in Barnet; Waitrose has supported the cooking classes for men (which are extremely popular). RSVP is a great example of neighbourhood services. Volunteers from this organisation are active throughout the borough and have

expanded their reach, using art and craft groups, dominoes, indoor bowls, quizzes, book clubs and knitting groups; this has made a positive impact on the lives of many. Working together the Provider Group will continue to improve the lives of Barnet's older people and reduce social isolation by increasing social opportunities and opportunities to learn.

Falls Prevention: the Council and CCG have been developing a unified and comprehensive falls service for Barnet. This work has included re-modelling the existing Falls Clinic at Finchley Memorial Hospital; the new Service Model will be finalised by December 2014. The proposal is to have a unified model with AGE UK, which would help create an integrated approach and working practices between providers which is integral to improving services for users and supports local and national strategy. The last Falls Awareness Day was held on 16th June 2014, and a further awareness event will be scheduled. The Fracture Liaison Service established in 2013 for fracture patients at Barnet Hospital is providing a system for early identification of patients susceptible to falls and management of falls and osteoporosis.

Dementia: is one of the key challenges facing the UK, and Barnet, with its large population of older people, has a particular challenge as the numbers of older people grow in the Borough. Barnet has been preparing for this and along with existing services for people with dementia; has commissioned the following new services:

- The council has commissioned the Alzheimer's Society (Barnet branch) to run regular Barnet Dementia Cafés across the borough. Cafés have opened in New Barnet, Mill Hill and Finchley Memorial Hospital. They are safe, relaxed places in the community where people with dementia, their family members and carers can meet up for a coffee, get information about services and enjoy some activities. As research shows that taking part in creative activities can be of real benefit to people with dementia, the cafés offer activities such as pottery, dance, photography, film making and music. Carers can also take part in workshops to help them understand dementia and build coping skills. The cafés are an important part of Barnet's 'dementia care pathway', linking residents and carers to specialist and advice and treatment so that people with dementia are supported to live longer and better lives, with earlier diagnosis, treatment and support.
- A Dementia Advisor service has been commissioned from the local Alzheimer's Society (Barnet branch). This is a key service to support individuals and their carers following diagnosis, and assists them to live well in the community. The service provides people with dementia a named individual to support then through their journey; and can signpost to suitable local care or support services and help them to make informed decisions, to assist self management and planning ahead. The Dementia Advisor works closely with the new Memory Assessment Service, provided by the Barnet Enfield and Haringey Mental Health Trust, re-commissioned by Barnet CCG. Together the 2 services will promote early diagnosis, intervention and support, which is so crucial in enabling people with dementia to sustain independence and improve quality of life.

Community Stroke Reviews: The National Stroke Standards has indicated that establishing a formal stroke review process can result in better outcomes for patients and a reduction in entry to long term care/residential care. Successful implementation of a co-ordinated review service will help to reduce secondary strokes and better deal with unmet needs of stroke patients, preventing other conditions. People discharged from acute hospitals may find that they lose functions that do not get picked up without a review**.** Approximately 400 people have a stroke each year in Barnet. After considering the number of people who die following a stroke it was agreed all people in Barnet who have a stroke should be offered a 6 month review, and that the reviews are shared between the Stroke Association, commissioned by LBB, and the Early Stroke Discharge Team which is provided by Central London Health Care (CLCH) and commissioned by Barnet Clinical Commissioning Group. A 6 month review service has commenced with the 2 organisations working closely together to identify patients and conduct the reviews.

Impact: the Health and Well-Being Strategy Performance Dashboard

This annual report on performance is the second opportunity the Health and Well-Being Board has to look how local services are being developed to improve the health and well-being of Barnet's residents, and also to understand how the health profile of Barnet's people is changing. The performance indicators agreed in the Health and Well-Being Strategy give an indication of how well Barnet's services are responding to local population need. Positive and negative changes in performance will be influenced by more than just the local service provision in place, but it is important that the Health and Well-Being Board is aware of the health and well-being trends of Barnet's population so it can plan for and develop services strategically and in good time.

For each chapter of the Strategy, it is possible to identify areas where performance is good, areas where improvement is needed, and areas where immediate attention is required to fast-track improvements in performance. The majority of the improvements needed have been identified due to the performance data provided for the report, though a few notable exceptions have been highlighted due to significant data issues that prevent performance from being reported at this time. The headlines are summarised in the performance dashboard below:

PREPARING FOR A HEALTHY LIFE

OBJECTIVE	INDICATORS	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
Enable all women, and particularly those with complex needs such as mental ill health, to plan their pregnancies and to **prepare for pregnancy** in a way that maximises the health outcomes both for the child and mother	Increase access to NICE compliant maternity care	No data to report	79.5% (Q1 2014/15 average)	Whilst there is no baseline to compare this recent figure to, the CCG is hopefully this recent data shows an upwards trend, as the figure reported for July 2014 is 85%. The Royal Free currently reports pretty close to 90% compliance.
	Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5%	5.2% (down from last outturn of 10%)	4.1% Q1 April 2014 – June 2014 11.5% - England	Performance has improved and the public health team is now working to maintain the smoking in pregnancy rate at or below 5%.
Increase the take up of **immunisations**, particularly the MMR pre-school booster	Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet.	72.9% Barnet Q4 2013-14	79% Barnet Q1 2014-15	Reported immunisation rates for the Routine Childhood Immunisation Programme have dropped in Barnet since April 2013. In Barnet's case, the decline has been due to data linkage problems – i.e. transfer of information from GP systems to update the information on the Child Health Information System (CHIS), which since April 2013, has been the responsibility of CLCH. If there had been a similar reduction in children being vaccinated we would see a much greater increase in reported cases of disease. It has taken a great deal of time and resources to achieve a COVER report from the new system. All Barnet practices are now signed up to QMS, enabling immunisation data to be electronically uploaded to a central server. From here CLCH are required to extract this data and make it fit for RIO. CLCH have recently experienced challenges converting data received from practices into a format that can be produced for COVER.
Support families who are experiencing **significant challenges**	Include an additional 705 families with complex needs in the community budget programme	649/705	837/705 (March 2014 data)	Exceeded annual target in 2013/14 by 18%. According to data published in July 2014, Barnet is 6th out of all London Boroughs and 31st nationally against the target of "turned around families". The service also exceeded its targets for Q1 2014/15, supporting 390 families into the programme against target of 383 for the quarter

Reduce obesity in children and young people	Reduce the rate of obesity in children, specifically: reducing the proportion of children aged 4 to 5 classified as overweight or obese to 21.5% (remaining below the London average)	4-5 year olds (obesity): Local value 9.4% / England average 9.5% 4-5 year olds Overweight (including obese): Local value 21% England value 22.6%	Sept 12 – Aug 13 4 to 5 y/o Obesity: Local 10.2% England:9.3% Overweight (including obese): 23.2% England value: 22.3%	Performance against the target has deteriorated. A recovery plan has been developed by the public health team, although it is important to recognise that the indicator is influenced by far wider social trends than the public health programmes. The indicator is only reported annually and one year retrospectively. Because of this, the public health team have developed a range of process targets which include schools engagement with the healthy eating and physical activity components of the Barnet Healthy Schools Programme, engagement in an early years programme that delivers breast feeding initiatives, nutrition workshops and parent and child physical activity. The team has also developed an obesity strategy and is developing a pathway for childhood obesity which will include a tier 2 weight management programme.
	Reduce the proportion of children aged 10 to 11 classified as overweight or obese to 33 % (London average)	10-11 year olds (obesity): Local value 18.7% England: 19.2% Overweight (including obese):: Local value 34% England: 33.9%	Sept 12 – Aug 13 10 to 11 year olds Local 19.1% England: 18.9% Overweight (including obese): Local 33.7% England: 33.3%	There has been a slight improvement for in percentage of children who were overweight (including obese) who were aged10 to 11 years. However, the numbers of 10-11 year olds who are classified as obese (rather than overweight) has increased slightly.
Reduce **risk taking behaviour** in children including Sexual Health and substance misuse	Reduce the number of young people admitted to hospital with alcohol specific conditions to below the most recent London average crude rate of 35.72 per 100,000.	2009/10 -2011/12 data: 30.27 per 100,000 (equates to 74 admissions) London average: 33.0	2010-11/2012-13 Local value 26.8 per 100,000 (67 admissions) London average: 29.76	The data from last year has been updated following revisions from Public Health England to the methodology used to calculate this data set. The comparable data presented here shows that performance is improving, in line with declining number of admissions seen across London.
	Reduce the teenage pregnancy rate: rate of conceptions per 1000 females aged 15-17yrs	2010 data Local: 21.8 /1000 London:37.1/1000 Eng:34.2/1000	2012 data Local:14.7/1000 London: 25.9 /1000 England:27.7/1000	The breast screening data presented last year (19.1) was a 3 year rolling average but annual data is now available so has been presented for last year and this year to give a more accurate picture of performance. The annual figures fluctuate more than the 3 year averages but they still show an improvement.
Effectively plan for **transition** from children's services to adult services.	Increase the number of young people who have a transition plan when they are 18 to 70% in the first year, and achieve 90% by 2013/14 and 100% by 2014/15.	Reported 100% last November	No comparable data. 2014/15 shows 37 clients who are 16 and 38 clients who are 17 years. This is in addition to people	Positive progress has been made to ensure the transition process is more streamlined, for example the joint approval of long term educational plans. The team has increased their engagement with the special schools by holding transitional surgeries. The team have been engaging in the work relating to the Special Educational Needs Reforms and the planning of the 0 to 25 service and development of the 'Staying put Policy' which enables

			who have already turned 18 years. There are 31 who will be 18 in this financial year The number of Direct Payments (DP) and supported living placements among transition users has increased; DP service users 2013-14 = 22, DP service users 2014-15 year to date = 36. Supported living 2013-14 = 4 Supported living 2014-15 year to date = 8.	young people to remain after their 18 birthday with their foster families in the chosen areas. National figures indicate that the number of young people with complex needs will continue to grow, we have seen an increase in numbers for this year and based on information from children services we predict that over the next 2 years there will be an additional 77 young people requiring support from adult social care. This is an exciting time for transition services with the introduction of 'Health Education and Social Care Plans' and the team have been actively engaged in developing these for Barnet. Joint work is progressing on the work to support young carers in Barnet.

WELLBEING IN THE COMMUNITY

OBJECTIVE	INDICATOR	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
Maximise **training and employment opportunities**, through the Regeneration Strategy for those furthest from the labour market to access new job opportunities.	Increase by 9% the number of people with long term mental health problems and people with a learning disability in regular paid employment for 2012/13, increasing to 10% for 2013/14 and 11% by 2014/15.	**10%** (Learning Disabilities) **7.5%** (Mental Health) 2012/13 ASCOF data	Data from ASCOF only: Adults with a learning disability in paid employment, 2013-14: **9.4%** Adults in contact with secondary mental health services in paid employment, 2013-14: **5.7%**	Social care panels monitor and ensure that employment and training is considered for individuals. There is evidence that DPs are being used to support people to train, prepare and support employment opportunities The Network service have a strong working relationship with the Job centre plus. Mind and the Richmond fellowship are working in partnership to increase opportunities for people with a Mental Health (MH) diagnosis Mencap as well as having a service specifically for employment they directly provide employment for people with a Learning Disability (LD). Barnet Centre for Independent Living centre will consider employment and training opportunities as part of the support planning process. Siting employment officers with the MH teams will increase awareness with staff at opportunities open to service users.

OBJECTIVE	INDICATOR	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
				The transition team have work hard to strengthen the links with education and Prospects to increase the training and employment opportunities for young people transitioning in to adulthood. There are clear outcomes attached to education placement which are made for these young people. Commissioning and care management are strengthening the way in which employment data is collected from services who may be offering opportunities to people as part their provider services. People are paid for their time when engaged in the partnership boards and consultation exercise which empowers people to recognise their employability skills. The new employment service and work being done to improve employment pathways is expected to result in improved outcome in 2015/16. The Individual Placement Support (IPS) scheme has helped a total of 45 people with mental health issues (a success rate of 38%) gain employment directly as a result of this initiative. This is significant and in line with the national benchmarking.
Stable accommodation	Reducing the average length of time spent by households in short-term nightly purchased accommodation to 26 weeks	638 (Q2 13/14) against an annual target of 500	2013/14= 43.8 against target of 26	The data presented last year and this year is not comparable. However, the most recent data shows that performance is not on track to meet the target. The increase to 43.8 weeks was anticipated as a result of the work to reduce numbers of households in Emergency Temporary Accommodation (ETA). This has meant concentrating on those more recently placed in ETA as this represents the most expensive accommodation for the Council, reflecting the recent increased prices in the London housing market. It should be noted that in Barnet, no one is placed in Bed and Breakfast accommodation or accommodation with shared facilities. All ETA is currently self-contained accommodation. The average length of time in ETA is expected to continue to rise in the medium term. NB the target is not measured any more by the Council, and has been replaced by "**increase the number of private sector lettings achieved to 315**". Early indicators of performance: Apr to June 2014 = 106 against target of 79.

OBJECTIVE	INDICATOR	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
	25 vulnerable people moving to more independent living by 2012/13, 20 people by 2013/14 and a further 25 people by 2014/15.	27 (cumulative)	40 (cumulative) Move on Project. The people identified as living in NHS funded hospital placements are being supported to move on to more community based accommodation (15 people). As part other activities we have identified 22 other people who will be supported to move in to more independent accommodation.	The figure provided by the LD Move on project relates to only those LD service users who have moved from Residential Care back into community based accommodation. We are also working to move people in to the private rented sector with dedicated workers to ensure that people have person centred support plans to move successfully. Residential placements are prioritised for reviews, with people being supported to move into more independent accommodation. We are developing an extra care housing scheme which can accommodate people with MH or LD and 25 wheelchair accessible flats, with Barnet Homes.
Ensure a range of training and education opportunities and **flexible working opportunities** are available that will support people into work with a particular focus on **young people who are not in education, employment or training and disabled adults.**	Maintain the percentage of 16 to 18 year olds who are not in education, employment or training at below 4.1%	3.2% (June 2013)	2.6% against target of 4.1% (As at 30 April 2014)	There has been a reduction in the percentage NEET from 3.2% to 2.6%.

OBJECTIVE	INDICATOR	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
Work with local community leaders, community groups and service providers to develop **mutual support between citizens** using people's strengths and experiences to increase inclusion into local communities, overcome language barriers and develop stronger inter-generational support.	Achieve a 5% increase in the number of residents who identify that they have a greater sense of belonging to, and contributing to, the community in which they live to foster greater trust and mutual support, to meet the national average of 79% of residents	75% (Autumn 2012)	74% (reported in March 2014)	No data was reported last year but the last 2 comparable figures are presented in this report, and show a very slightly worsening trend against the 79% national average baseline, and the current 77% national average. However, the Spring 2014 Residents Perception Survey still showed that three quarters of residents (74 per cent) strongly feel they belong to their local area, which is positive. New data will be available after completion of the next Resident's Perception Survey in December 2014.

HOW WE LIVE

OBJECTIVES	INDICATORS	LAST FIGURE HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
Encourage and enable smokers to quit	Reduce prevalence by 20% from the 2010/11 baseline of 18.7% start over 5 years to get to 15% by 2015/16	17.5%	13.9% (Apr 11 – Mar 12) England- 28.5% London- 27.5%	Prevalence has reduced from 17.5% to 13.9%, however smoking remains the biggest cause of avoidable deaths in Barnet – causing around 330 deaths and over 2,000 hospital admissions each year.
Increase both the offer and take-up of health and lifestyle checks in primary care to all people aged between 40 and 74 years to help reduce risk factors associated with long term conditions	Year on year increase of people aged between 40 and 74 who have received an NHS Health Check to 12.7% by 2013/14 and 25.7% by 2014/15. In five years our coverage should be 60%.	5.46% - Q 1 2013/14 (NB this was the only data the public health team had validated at that time)	Q1 2014/15 No. offered check: Target – (% of eligible) 1,861 (2.0%) Actual 5,018 (5.3%) No. received check: Target - (% of eligible) 1150 (1.2%) Actual 2633 (2.8%)	Performance concerns relating to the health checks target became apparent during 2013. Recovery options were assessed and shared with performance and delivery board but it was apparent that the existing HWBS targets are unachievable within existing financial resources. In April 2014 a target was set in light of these challenges aiming to offer 15% of the eligible population a Health Check and for 10% of the eligible population to receive a Health Check. A cumulative 16% of the eligible population will have been offered a health check by year end (2013/14 and 2013/2014/15 combined). In five years, with adequate resourcing, the agreed forecast is now to achieve 46% coverage of the total eligible population. The target was changed to reflect the local circumstances, including the late start of the programme in Barnet, and the fact that a number of GP practices have not signed up to health checks and have indicated that they do

				not intend to do so. A new outreach programme offers patients an opportunity to receive a health check even if their GP doesn't offer them. The Public Health team are cautiously optimistic about the future performance of the Barnet programme. Q1 of 2014/15 shows an improvement in performance in both 'offered' and received' Health Checks as compared to the rest of London. Barnet now ranks position 16th out of 34 programmes in London for 'offered' Health Checks (during 2013/14 Barnet ranked 27th out of 34 programmes). Barnet now ranks position 10th in London for 'received' Health Checks (during 2013/14 Barnet ranked 30th out of 34 programmes). **See also Appendix 2 for more information.**
	Year on year increase of people with a learning disability who have received an annual health check.	460 annual health checks (Amber rating on 2012/13 Barnet LD Joint Health & Social Care Self Assessment Framework data)	168 annual health checks (first three quarters of LD DES data 2013/14).	We held an Annual healthy fun day for people with a LD which was attended by over 80 people this year LD partnership board has an 'active health for all' sub group which offers awareness training to professionals and service users. A dedicated senior LD nurse was seconded to primary care services. The annual health LD self-assessment framework has been completed in partnership with our customers this is in conjunction with the annual engagement event call 'How we doing day', has been held.
Make better use of the range of green spaces and leisure facilities in the Borough to **increase levels of physical activity**.	3% increase in the number of adults participating in regular physical activity by 2015.	56% (2012 - from PHOF data) London 57.2% England: 56%	53.9% (2013 – from PHOF data) London 55.5% England 55.6%	Rates have decreased locally, across London and across England. The Barnet rate is not statistically significantly different to the England rate.
Mental health – access to services	Increase in the number of people who have depression and/or anxiety disorders who are offered psychological therapies	No data reported	IAPT Treatment 2013/14: 3129 (target- 3578) 2014/15 Q1: 756 (target 736)	There is uncertainty about this year's performance as there was no baseline data provided however there is reason to be positive due to changes in the local provision. • Performance has lagged targets in the first half of the year. • Confident that access is increasing due to new commissioned services. The new provider is implementing a new model which is expected to result in approximately 2500 people entering treatment between October 2014 and March 2015, a run rate of 12.5% of Barnet's need population (national target is 15%) • The Trust has been asked to provide activity data for the previous three years and an update on how the planned changes may impact on this.

<table>
<tr>
<td>Continue Trading Standards under-age alcohol sales test purchasing programme together with enforcement of Licensed premises licence conditions in relation to sales of alcohol to people who are already drunk.</td>
<td>Rates of increasing and higher risk drinking are reduced from 17.7% of the population aged 16+ towards the best performance in England of 11.5%</td>
<td>20%</td>
<td>No comparable figure- see performance commentary</td>
<td>It is no longer possible to measure progress against the original target as the synthetic estimates of abstainers; low, increasing and high risk drinking levels has not been updated since they were published in 2011. It is possible however to compare the standardised rate of hospital admissions (Persons) for alcohol-related conditions is measured on a quarterly basis:

<table>
<tr><th>Baseline data 2011-12</th><th>2013-14</th></tr>
<tr><td>Barnet: 1910.45 per 100,000</td><td>Barnet: 1809.93 per 100,000</td></tr>
<tr><td>London: 2110.34 per 100,000</td><td>London 2081.97 per 100,000</td></tr>
<tr><td>England: 2032.02 per 100,000</td><td>England 2086.24 per 100,000</td></tr>
</table>

The rate of alcohol related admissions in Barnet is lower than the London and national rates and is decreasing whereas the national rate has increases in the past 2 years.

Licensing is only one aspect of reducing both the personal and societal impact of alcohol. Public health has introduced an alcohol awareness project in pharmacies whereby people are invited to complete an assessment scratch card and discuss the results with the pharmacist, who will refer into services if necessary.</td>
</tr>
<tr>
<td>Breast screening</td>
<td>Increase breast screening uptake and improve coverage to exceed the target of 70% by 2015</td>
<td>At March 2012
Local Value 69.4%
London Value 69.6%
England Value 77%</td>
<td>The National Standard for coverage is 70%:

Annual data for March 2013
Barnet: 69.4%
London 68.9%
England Value 76.2%</td>
<td>Performance has remained the same but is not moving towards the target of 70%.

Issues: The impact of the recent Serious Incident – Pertaining to list maintenance and FP69 issues in the call and recall of Breast Screening invitees has impacted on capacity of all screening services in London. Issues earlier in the year pertaining to Property Co charges and impacts on Screening services within year have been addressed in budgets going forward.

An uptake CQUIN has been agreed in the contract for 2014/15; this aims to achieve a 3% increase in uptake by year end through the implementation of evidence based initiatives; plans for the CQUIN will be monitored through the performance board on a quarterly basis. Coverage data can take up to 6 months to stabilise. Barnet and Chase Farm Trusts have been acquired by Royal Free Hospital Trust but no negative impact on the breast screening programme is expected.

Technical Recall rates as a whole for NLBSS increased in May 2014</td>
</tr>
</table>

				to 2.4%, radiography department are conducting an audit and will be considering purchasing equipment to reduce the 'blur' and improve on TR rates. Despite this NLBSS has performed well.
Bowel screening	Increase uptake of bowel cancer screening to meet national indicator of 60% by 2015	Not reported. However, local uptake was 47% in March 2012	Uptake in March 2013 in Barnet was 42.3%	As with the rest of the London Bowel Cancer Screening programme does not hit the 60% national indicator standard. However, bowel screening uptake among 60-69 years in Barnet increased from 42.3% to 55.3% from March 2013 to Feb 2014, an increase of 13.0%. This was the highest increase in uptake within the NECL patch.

CARE WHEN NEEDED

OBJECTIVE	INDICATORS	LAST FIGURE (HWB Nov 2013)	NEW FIGURE (HWB Nov 2014)	COMMENTARY ON PERFORMANCE
Early identification and actions to **reduce the impact of disease and disability** Develop and implement a **comprehensive frail elderly pathway** that spans Health and Social Care, moving from prevention through multiple episodes of illness to end of life care	The balance of spend on older people in both the NHS and Social Care has been realigned to provide a greater focus on prevention.	No data reported	No data to report	The development of the integrated care business case for frail elderly and those with long term conditions has demonstrated the potential to make over £12 million savings from the current health and social care system, by 2019/20. How this money will be re-profiled into preventive activities is still to be determined, but the progress made to date will support this target being achieved. . The Better Care Fund model has been designed to increase prevention and early intervention in order to increase independence and reduce reliance on acute and residential care. Delivering the model will ensure a realignment of spend towards prevention.
	The number of emergency admissions related to hip fracture in people aged 65 and over is reduced by 10% from the 2009/10 baseline of 457.3 by 2015.	404 (2011/12 data)	538 (2012/13 data)	Its early days to evaluate impact of commissioned services for falls. The proposed services commissioned to specifically impact on hip fracture emergency admissions (10% reduction) have been redesigned this year, and are currently being mobilised. The proposed start date is December 14, and performance reporting will start next quarter, March 15.
	The percentage of frail elderly people who are admitted to hospital three or more times in a 12 month period is reduced from 2009/10 baseline.	No data reported	No data to report at this stage	The CCG does not have immediate access to this data and has made a request to the CSU to provide data for this target.

	Increase the percentage of people aged 65+ who are still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services to 87% in 2013 with a stretch target to reach 90% by 2015.	83.1% (2012/13 outturn)	82.6% (June- Aug 2013) against target of 88.5% Barnet comparator group average for 12/13 = 83.1%	The Council has reported our full data from June-Sept 2013 as we are awaiting similar 3 month data from Oct-Dec 2013 from our health colleagues. This is due to reported in LBB's statutory DoH return in May 2014. LBB is reviewing with health colleagues the existing pathways of information sharing and reporting. This Indicator is also required for the Better Care Fund returns to ascertain reporting improvements. This indicator reflects the work of the CLCH NHS Trust Intermediate Care Team, along with enablement and data is collected by CLCH. Monitoring of discharges is undertaken by a NHS Intermediate Care Team.
Implement **integrated personalised support arrangements for people with social care and health needs** through the provision of personal budgets covering both health and social care.	That all people who have continuing healthcare needs have access to a personal health budget by 1st April 2014	No data reported	No data to report	For Personalisation and Personal Health Budgets (PHB) the legislation requires that patients had the right to ask for a PHB from 1 April 2014 and a right to receive one from 1 October 2014. BCCG is required to make a decision how to implement the programme of work over the next 5 months leading to operational delivery from 1 April 2015. Over the next 2/3 months the CCG expect that they will start to see a small number of individual cases where a PHB is agreed but this is as much around choice and control as a direct PHB.
Continue the **implementation of the existing multi-agency Barnet Carers Strategy** with a specific focus on increasing the number of carers with an agreed Carers contingency plan and the provision of carers' breaks.	An increase of 20% by 2015 in the number of carers who self-report that they are supported to sustain their caring role from the 2011/12 baseline (NB the baseline reported in February 2011 covered 2010/11 period)	44.1%	38.2%	• The latest data submission relates to the financial year 2012/13, and the next Carers Survey is due to be conducted in 2014/15. The baseline data is the 10/11 survey data. The response rate has dropped from the 2010/11 survey to the 2012/13 survey, so the statistical validity must be treated with caution. • The Barnet Carers Centre reported that from November 2013-September 2014 then 114 Emergency plans were completed and that 140 short breaks and health breaks were administered. • The number of carers you receive support including information and advice has risen to 33.9% between April 2014 and September 2014.
Ensure that local residents are able to **plan for their final days and to die at home** if they would prefer.	Increase in the number of people who are receiving end of life care that are supported to die outside of hospital	Percentage of deaths in hospital Barnet- 59.3% Eng.- 54.5% Percentage of deaths in own home Barnet- 16.4% Eng.- 20.3%	Percentage of deaths in hospital Barnet- 54.4% Eng.- 50.7% Percentage of deaths in own home Barnet- 18.4% Eng.- 21.5%	There is still room for improvement on the number of deaths in the place of choice i.e persons home. Further work is necessary to understand or assess effectiveness of current service provision for EOL, and identify gaps. A commissioning strategy for End of Life care is being developed as follow up to the 'mapping exercises carried out this year, which should improve Barnet's position further.

		Percentage of deaths in hospice Barnet- 6.7% Eng.- 5.2% Percentage of deaths in care home Barnet- 16.2% Eng.- 17.8%	Percentage of deaths in hospice Barnet- 6.9% Eng.- 5.6% Percentage of deaths in care home Barnet- 18.3% Eng.- 19.5%	

Horizon Scanning: The Changing Health Context in Barnet

The Health and Well-Being Strategy is based on data from the Joint Strategic Needs Assessment. The Barnet Joint Strategic Needs Assessment (JSNA) which was carried out in 2011 looked at the health needs of the population of Barnet and showed that there were significant differences in health and wellbeing across the Borough. Some areas of the Borough seemed to experience poorer health, as did some particular groups of the population. The Health and Well-Being Strategy was developed in such a way as to reduce these health differences by focusing on how people can 'Keep Well' and 'Keep Independent'.

The Strategy was never designed to measure every Health and Well-Being outcome, however, there are some trends in health and wellbeing in the Borough that are not explicitly measured in the Health and Well-Being Strategy, that are becoming increasing concerns. This information provides the HWBB with a wider set of data from which to draw conclusions about priorities for action and focus moving forward/

The data has been provided by the annual Health Profiles produced by the Public Health Observatories (produced since 2006) and the Public Health Outcomes Framework (published since 2013). The areas of concern are summarised below, categorised by the four existing chapters of the Health and Well-Being Strategy.

Preparing for a healthy life

The rate of **infant deaths** (3.0 per 1000 live births) in Barnet has dropped since last year, and is now further below the national average (4.1 per 1000 live births) this year.

The level of **child poverty** in Barnet (19.9) has continued to drop and now below the national average (20.6%)[2].

Well-Being in the Community

The proportion of households in **fuel poverty** in Barnet has improved from 12.65 in 2011 to 9.75 in 2012. (based on the Low Income High Costs indicator)

Whilst **long-term unemployment**[3] in Barnet (6.8 per 1000 population) has reduced since last year, whilst the national average has very slightly increased (9.9 per 1000 population)

Social isolation is worse than the national average, with a lower percentage of adult social care users and adult carers saying they have as much social contact as they would like. (Users 38.4% compared to 43.2%nationally and carers 35.8% compared to 41.3% nationally)[4]

[2] % children (under 16) in families receiving means-tested benefits & low income, 2011 data
[3] Crude rate per 1,000 population aged16-64, 2013
[4] PHOF 1.18i and 1.18ii data for 2012-13

How we live

The number of new cases of **tuberculosis** diagnosed in Barnet (30.0 per 100,000 population[5]) has declined by a crude rate of 0.6 per 100,000 population, whilst the national average has declined by a crude rate of 0.3 per 100,000 to 15.1. Local rates remain double the national rate but are lower than the London average.

The proportion of people diagnosed with **diabetes** is the same as last year (now 5.9%[6] people on GP registers with a recorded diagnosis of diabetes up from the 3.8% reported in the 2008 profile), and is very slightly lower than the national average of 6.0%.

Rates of **malignant melanoma** have slightly increased again (now 10.9 per 100,000 population aged under 75[7]), despite remaining below the national average (now 14.8 per 100,000 population aged under-75). **Under 75 mortality rate from cancer** have also risen slightly (now 125 per 100,000 population aged under-75[8]); but remains below the current national average (146 per 100,000 population). Deaths from cancer, heart disease, lung disease and over all life expectancy are worse in the more deprived parts of the borough.

The rate for hospital stays for **self-harm** has not risen for the first year since 2011 (now 111.1 per 100,000 population[9]). The data on hospital stays for **alcohol related harm** has changed since the last profile (and is now 507 per 100,000 population[10] against a national average of 637 per 100,000 population).

Care when needed

The ratio of **Excess winter deaths** in the over 65s (three year) remains higher (at 20.2[11]) than the national average for the third year in a row (whilst the national trend has declined, and is now 16.5).

Moving forward: priorities for year 3 of the Health and Well-Being Strategy (2015/16)

In order to focus the Health and Well-Being Board's approach to future performance management, a series of recommendations have been developed in light of the information provided for this report, and the additional data analysed during the horizon scanning process. The areas focused on below were selected for one or more of the following reasons:

[5] Crude rate per 100,000 population, 2010-2012
[6] % people on GP registers with a recorded diagnosis of diabetes 2012/13
[7] Directly age standardised rate per 100,000 population, aged under 75, 2009-2011
[8] Directly age standardised rate per 100,000 population aged under 75, 2010-12
[9] 2012/13 data
[10] The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13
[11] Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12

- That performance is off-track
- That performance cannot be currently be judged and significant effort is required to resolve this
- That the policy context has changed and a co-ordinated local response is required
- That they are a new or growing health and well-being challenge, as identified by the Barnet Health Profile.

The Health and Well-Being Board is asked to consider focusing time on the following 10 priority areas over the coming year, to have a significant impact on health and well-being in the Borough.

Preparing for a healthy life

1. **That the Health and Well-Being Board continues to work with NHS England to address the pre-school immunisations data issues they have identified so that the local area can be assured that immunisation rates are being increased (as the Strategy requires them to be and in line with the referral made to the Health Overview and Scrutiny Committee)**

2. **That the Health and Well-Being Board provides on-going strategic multi-agency leadership and ensures robust safeguarding arrangements to the two forthcoming transformation programmes in response to legislative changes that affect children and young people- namely the development of a new model for health visiting and school nursing services for 2015-16; and the development of a single, simpler 0-25 assessment process and Education, Health and Care Plans for children with special educational needs and disabilities from 2014.**

Well-Being in the community

3. **That the Health and Well-Being Board partners work collectively to promote early intervention and prevention of mental health problems for children, working aged adults and older people and ensure robust local service provision.**

4. **That the Health and Well-Being Board continues to consider what partners collectively should be doing to promote models that limit social isolation, in partnership with Older Adult's Partnership Board and Barnet Older Adults Assembly.**

5. **That the Health and Well-Being Board gives specific focus to the solutions that will most effectively reduce level of excess cold hazards in elderly people's homes.**

How we live

6. **That the Health and Well-Being Board considers an everyday prevention approach to be essential in all services, making use of Making Every Contact Count. This is an approach that considers lifestyles and wider determinants of health e.g. education, housing, the environment. All partner organisations should ensure that their contracts require providers to use every opportunity to deliver brief advice to improve health and wellbeing whether in health, social care or wider services. Priorities for brief advice are smoking, alcohol, diet and physical activity although advice should be tailored to the needs of the individual.**

7. **That the Health and Well-Being Board considers in-depth how it can coordinate activities across partners to tackle increasing and higher risk drinking in the Borough, considering the various local levers it has at its disposal to affect change.**

8. **That the Health and Well-Being Board continues to work with NHS England to address screening uptake in the Borough, to ensure that national targets are not only met (as the Strategy requires them to be and in line with the referral made to Health Overview and Scrutiny Committee).**

Care when needed

9. **That the Health and Well-Being Board oversees the implementation of the integrated care proposals, that will support Barnet's frail elderly residents and those with long-term conditions to maintain independence in their own homes for as long as possible.**

10. **That the Health and Well-Being Board provides on-going oversight and endorsement of the work taking place locally to develop self-care initiatives that will help residents maintain their independence (including telecare) and to support the Borough's many carers to maintain their own health and well-being as well as that of the people they care for.**